

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/14/2011
NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN46206		
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S0000	<p>This visit was for the investigation of two State complaints.</p> <p>Complaint Number: #IN00090106- Substantiated: No State deficiencies related to the allegations are cited. #IN00088632- Substantiated: State deficiencies related to the allegations are cited.</p> <p>Facility Number: 005051</p> <p>Date of Survey: 10/13/11 through 10/14/11</p> <p>Surveyor: Sandra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 11/04/11</p>	S0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0912	<p>410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on medical record review, facility document review, and interview, the nurse executive failed to ensure 1 of 5 patients hospitalized for over 3 weeks (#N2) received the required care to prevent skin breakdown.</p>	S0912	Preparation and execution of this response and plan of correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the	11/14/2011	

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	<p>Findings included:</p> <p>1. The medical record for patient #N2, indicated the following:</p> <p>A. The patient was admitted through the emergency department on 05/19/09 with the complaints of drowsiness and sleepiness.</p> <p>B. The physician history and physical from 05/19/09 indicated the patient had a history of hypertension and morbid obesity. It was noted that the left foot was erythematous, but there was no skin breakdown.</p> <p>C. Upon admission to the unit, the initial skin assessment was done at 1630 on 05/19/09 and indicated redness of both feet, but no skin breakdown. The height was 5 ft. 5 in., the weight was 300.27 pounds, and the Braden score was 15.</p> <p>D. A physician order from 2355 on 05/19/09 was to initiate skin and wound care protocol as appropriate.</p> <p>E. The patient experienced increased respiratory problems and was intubated and transferred to ICU on 05/20/11.</p> <p>F. A nursing notation from 05/24/09 indicated a healing skin tear on the left buttock. No previous documentation of a skin tear was found.</p> <p>G. A nursing notation from 05/25/09 indicated peeling, rash, and redness on the left buttock.</p>		<p>statement of deficiencies.</p> <p>This plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law.</p> <p><u>Credible Allegation of Correction and Compliance:</u></p> <p>For the purpose of any allegation that IU Health, Inc. is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health's credible allegation of correction and compliance.</p> <p>S 912 410 IAC 15-1.5-6 Nursing Service Corrective Action(s):</p> <p>The Methodist Hospital Director of Nursing Practice and Quality, Clinical Nurse Managers, and Clinical Nurse Specialists reviewed organization policy NADM 1.30AP <i>Documentation Standards: Inpatient</i> as well as the Skin and Wound Care Protocol Order Set to ensure both documents met the required standards of practice. A plan was implemented to provide re-education/ and re-emphasis on policy and protocol</p>		

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	<p>H. A nursing notation from 05/28/09 indicated red blisters and fluid filled sacs on the sacrum.</p> <p>I. A physician order from 1755 on 05/29/09 was for a wound consult for pressure ulcer stage 1 or 2, on the buttocks, sacrum, large area of deep tissue with open stage II, blisters, oozes.</p> <p>J. A Braden score was documented every day except 05/30/09 and the scores ranged from 13- 17, indicating the patient was at risk for skin breakdown.</p> <p>K. An initial wound team consult from 1115 on 06/01/09 indicated the following: "...Presents with multiple pressure ulcers on and around sacral area. Largest 7 x 6 centimeters (cm.), right of sacrum, unstageable. ...Margins of wound 11, 1, 2, and 4 o'clock are purple, possible orig. as DTI (deep tissue injury). ...Multiple partial thickness wounds around main wound. Likely shear and friction are adding to this wound."</p> <p>L. Nursing documentation for every 2 hour position change indicated the following times were missed: 0400 and 2200 on 05/23/09, 0600, 1200, 1600, and 2200 on 05/24/09, all night on 05/25/09 until 0800, 2200 on 05/26/09 and 0600 and 0800 were both listed as right side, 1800 on 05/27/09 and both 0600 and 0800 were listed as right side, 1800 and 2000 on 05/28/09 were listed as left side, 2200 on 05/29/09, 1800 on 05/30/09 and 1600</p>		<p>expectations to nursing. The objective of the plan was to assure order-set components were implemented, including repositioning requirements and follow-up to assure consultations are performed on a timely basis. The plan included re-education on skin assessment and the importance of documenting nursing interventions as well as review of the above-referenced policy.</p> <p>By November 14, 2011, weekly interdisciplinary rounds were being conducted with each registered nurse on the units in question to provide real-time education on Braden scores, the appropriate interventions required based on the score obtained, and the expectation of immediate implementation of interventions, including bed surface, turning every two hours, moisture management, nutrition consultation, and the process for obtaining wound consultation.</p> <p>New nurses attend Central Nursing orientation which includes pressure ulcer prevention and the process for obtaining wound consultation.</p>		

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	<p>and 2000 were listed as left side, on 1400, 1600, 1800, 2000, and 2200 on 05/31/09 were all listed as "chair", no every 2 hour documentation from 1600 on 06/01/09 until 0800 on 06/02/09, all of the 2 hour notations on 06/02/09 were listed as chair", and almost all of the 2 hour notations on 06/03/09 and 06/04/09 were listed as "chair".</p> <p>M. A plastic surgery note from 06/06/09 indicated the patient would need to go to surgery for wide excision of multiple decubitus ulcers and wound vac placement.</p> <p>N. The "Skin and Wound Care Protocol Order Set", which the physician ordered at 2355 on 05/19/09, stated the patient should be turned every 2 hours and a Clinical Nurse Specialist/Outcome Specialist consult should be ordered for the management of skin tears/abrasions. Documentation failed to indicate the consult was done or the every 2 hour turning was performed consistently. The medical record indicated a wound consult was ordered by the physician at 1755 on 05/29/09, but was not done until 1115 on 06/01/09. Documentation indicated the patient was up in a chair for 10-12 hours after the skin breakdown on the sacrum and buttocks had been identified.</p> <p>2. The facility policy titled "Documentation Standards: Adult", last</p>		<p>To ensure ongoing compliance, by January 1, 2012, all registered nurses will have received educational review of appropriate interventions, including bed surface, turning every 2 hours, moisture management, nutrition consults, and the process for obtaining a wound consultation.</p> <p>Monitoring: Beginning with care provided November 1, 2011, weekly retrospective audits have been conducted to determine if the Braden score was assessed correctly and if appropriate interventions were implemented. One-on-one re-education occurred with individual nurses when documentation was lacking. Data from weekly audits is assessed to determine trends in hospital-acquired pressure ulcer rates, completion of skin/wound orders, evaluation of appropriate bed surfaces, and referrals for nutritional and wound consultation.</p> <p>A minimum of 10 audits per unit per month will be conducted to ensure compliance for a period of three consecutive months. The audit process will be complete when 90% or greater compliance is achieved for three consecutive months. At that time, audits will continue on a random basis. If</p>		

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	<p>approved October 2008, stated on page 7, "H. Risk Assessment ...2. Complete the Braden Risk Assessment for Pressure Ulcers on all patients. Identify and document appropriate interventions that will be implemented to prevent pressure ulcers." ...J. Patient Activity ...6. Position in bed- document position every 2 hours only if one or more of the following conditions exists: a) patient is immobile b) patient is on bedrest." The policy continued on page 10, "R. Pressure Ulcer Prevention 1. Score all patients at the time of admission, and daily, using the Braden scale laminate in the patient's chart at the beginning of the Day Shift (or time defined by unit standards)."</p> <p>3. The Braden Scale for Predicting Pressure Sore Risk identified a score of 15-18 as an at risk patient and a score of 13-14 as a moderate risk patient. Both categories indicated the patient should be turned every 2 hours.</p> <p>4. The Skin and Wound Care Protocol Order Set, dated Jan/09/09, stated to turn every 2 hours, including head for prevention of skin breakdown for patients at risk and to obtain a nutrition consult. The order set stated that a Clinical Nurse Specialist/Outcome Specialist Consult should be obtained for the management of skin tears/ abrasions and for stage I</p>		<p>the required threshold is not met on random audits, consistent auditing will resume until such time that data for a consecutive three months reflects achievement of 90% or greater compliance. Results of the audits will be communicated to the Methodist Hospital Director of Nursing Practice and Quality. Data and will be shared with units throughout the hospital and at monthly Clinical Practice Council Meetings.</p> <p>Responsible Person(s): The Methodist Hospital Director of Nursing Practice and Quality, Clinical Nurse Managers, and Clinical Nurse Specialists</p>		

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	<p>breakdown. A Wound Team Consult was required for all stage III/IV wounds.</p> <p>5. At 1:00 PM on 10/14/11, staff member P3 presented documentation that patient #N2 was on a ventilator from 05/20/09 through 06/01/09. Staff member P3 indicated the patient was also on sedatives and would have been on bedrest and dependent on staff for repositioning.</p> <p>6. At 2:10 PM on 10/14/11, staff member P8 indicated it was routine in the intensive care unit to turn patients every 2 hours. He/she confirmed that the Braden scores indicated the patient was at risk for skin breakdown. He/she indicated the BariMax II bed would have taken the place of a waffle mattress and the Bari Sport had a low air loss surface and was usually only used for actual skin breakdown.</p> <p>7. At 3:00 PM on 10/14/11, staff member P1 confirmed the patient was not turned every 2 hours and according to documentation, was left up in a chair for long periods after the skin breakdown had been identified. Both staff members P1 and P3 questioned the accuracy of the Braden scores based on documentation of sedatives and a ventilator during that time.</p>				

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