

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150044	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/07/2012
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NAME OF PROVIDER OR SUPPLIER  FLOYD MEMORIAL HOSPITAL AND HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 STATE ST NEW ALBANY, IN 47150
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S0000	<p>This visit was for the investigation of one (1) State hospital complaint.</p> <p>Complaint number: IN00101057 Substantiated: Deficiencies related to allegations cited.</p> <p>Date of survey: 3-7-12</p> <p>Facility number: 005040</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 05/15/12</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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S0406	<p>410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(a)(1)</p> <p>(a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on staff interview and document review, the quality department failed to effectively investigate complaints and report accurate information to the board for 1 of 5 patients (patient #1).</p> <p>Findings include:</p> <p>1. Staff member #1 indicated the following in interview beginning at 3:00 p.m. on 3/7/12: (A) Complaints are forwarded to the quality department. He/she will make the department manger of the unit aware of the complaint and the quality department may rely on management staff from the department to review/investigate the complaint and report findings to the quality department. (B) He/she logs the complaint and the</p>	S0406	<p>RESPONSIBLE PERSONS:Carol Mullen: Chief Quality and Patient Safety OfficerAngela Mead: Accreditation Manager PLAN OF CORRECTION: 3-7-12 to 4-7-12 It was deemed that the phrase "all standards of care were met" would not be used on a follow up letter to a patient unless evidence was presented through accurate documentation that in fact "all standards of care were met". 4-8-12 to 5-9-12 Patient Grievance Response Check list was developed to be used by the Accreditation Manager to ensure that all aspects of the complaint are understood and communicated to all affected department managers. Answers will be reported to the Chief Quality and Patient Safety Officer to record on the Patient Grievance Log to ensure accuracy when reporting to the</p>	06/10/2012	

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	<p>findings.</p> <p>(C) The complaint and findings are reported from the log to the hospital board.</p> <p>2. The facility received a call on 11/21/11 from the mother of patient #1 concerning a pressure area on the patients back. No problems were identified with the care and a letter was sent to the patient stating "I am pleased to report that after careful review of your stay, we find that all standards of care were met."</p> <p>3. Review of the medical record for patient #1 on 3/7/12 indicated the following:</p> <p>(A) The patient was admitted to the facility on 9/27/11 and discharged on 11/19/11.</p> <p>(B) Per history and physical dictated on 9/28/11, the patient had diagnoses including, but not limited to, a decubitus ulcer present on admission. Under plan, the document states "wound care nurse to see for the wound on her back."</p> <p>(C) An order was written on 9/28/11 for the wound care nurse to see the patient. The wound care nurse evaluated the patient on 9/29/11 and an order was written on same date for treatment to the back ulcer to cleanse with normal saline, apply Aquacell AG and Mepilex. Change dressing every 3 days. An order was also</p>		<p>board. (Please see exhibit A and B) 5-10-12 to 6-10-12 The Accreditation Manager and Chief Quality and Patient Safety officer will review the Patient Grievance Log on a monthly basis to ensure all communication was reportedly accurately. This is to take place prior to quarterly reporting to the board meeting.</p>		

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	<p>written to apply Mepilex to left side and change it every 3 days.</p> <p>(D) Per document review, the orders were not followed for the dressing changes to the back/side area. The documentation indicated the dressings were changed on 10/11, 10/15, 10/21, and 11/2. Per order, the dressings should have been changed at least 16 times. Additionally, the areas were not measured or assessed per policy. The wounds were measured initially on 9/29/11 and again on 10/12/11 only, therefore it is impossible to determine the stage or condition of the wound upon discharge on 11/19/11.</p> <p>(E) The patient was discharged to home on 11/19/11. The discharge instruction sheet did not include information about the wounds on the back or what treatment that was ordered for them. The dressing listed on the instruction sheet was for a surgical site.</p> <p>(F) The record lacked documentation that dressing changes to the wounds to the patient's back were done per order, that the wounds had been measured for 5+ weeks prior to discharge, when policy mandated weekly measurement, and that the wounds were addressed on the discharge instruction sheet for the mother to know how to care for them.</p> <p>4. The information on the quality log that</p>			

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	<p>is presented to the hospital board was not accurate concerning patient #1. The log indicated the mother had a concern with a surgical wound and staff worked together to arrange home care. The information failed to indicate the actual complaint (the area of concern was not a surgical wound) as well as the fact that the follow-up care to the wound was not addressed at the time of discharge and arrangements for care of the wound were made after discharge and after the complaint.</p> <p>5. Staff member #1 indicated at 3:00 p.m. that the information from the log is shared with the board.</p> <p>6. Staff member #5 verified the medical record information beginning at 2:00 p.m. on 3/7/12.</p>			

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S0930	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on document review and staff interview, the registered nurse failed to assure wound care orders were followed for 2 of 5 patients (patients #1 and #3) and failed to provide discharge instructions related to wounds for 1 of 5 patients (patient #1).</p> <p>Findings include:</p> <p>1. Review of patient #1 medical record on 3/7/12 indicated the following: (A) The patient was admitted to the facility on 9/27/11 and discharged on 11/19/11. (B) Per history and physical dictated on 9/28/11, the patient had diagnoses including, but not limited to, a decubitus ulcer present on admission. Under plan, the document states "wound care nurse to see for the wound on her back." (C) An order was written on 9/28/11 for the wound care nurse to see the patient. The wound care nurse evaluated the patient on 9/29/11 and an order was written on same date for treatment to the</p>	S0930	<p>RESPONSIBLE PERSONS: Karen Yeager, Director of Critical Care &amp; Cardiac Intermediate ServicesMargaret Krawczyk, Director of Patient ServicesLea Ann Stirn, Director of Medical Inpatient ServicesKathy Brown, Nurse Manager Cardiac Intermediate Services PLAN OF CORRECTION: 3-19-12 to 4-7-12Survey Wound Questionnaire was circulated via the intranet. Nursing personnel took the survey in order to gage the level of re-education needed. (Please see exhibit A) 4-8-12 to 5-7-12 Discussions were held with ITS and work order was placed (3-13-12) to change the Braden scale to 18 in HED (nursing clinical documentation module). In addition, pressure ulcers will be a separate class. It will no longer be with the incision/wound screens, making it easier for staff to locate the appropriate documentation screen. A reminder will be added to document by photo on admission, transfer and discharge. (Project to be completed 8-1-2012) 5-8-12 to</p>	06/15/2012	

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	<p>back ulcer to cleanse with normal saline, apply Aquacell AG and Mepilex. Change dressing every 3 days. An order was also written to apply Mepilex to left side and change it every 3 days.</p> <p>(D) Per document review, the orders were not followed for the dressing changes to the back/side area. The documentation indicated the dressings were changed on 10/11, 10/15, 10/21, and 11/2. Per order, the dressings should have been changed at least 16 times. Additionally, the areas were not measured or assessed per policy. The wounds were measured initially on 9/29/11 and again on 10/12/11 only, therefore it is impossible to determine the stage or condition of the wound upon discharge on 11/19/11.</p> <p>(E) The patient was discharged to home on 11/19/11. The discharge instruction sheet did not include information about the wounds on the back or what treatment that was ordered for them. The dressing listed on the instruction sheet was for a surgical site.</p> <p>2. Review of patient #3 medical record indicated the following: (A) He/she was admitted 9/27/11 and discharged on 10/10/11. (B) An order was written on 9/29/11 for dressing changes to a sacral ulcer and L foot that was to be changed every 3 days.</p>		<p>6-1-12 New education was developed re-educating staff on skin assessment policy, skin risk protocol and skin audits. A new re-education course on Health Stream was built. ( Please see exhibit B) 6-1-12 to 7-1-12 Beginning June 1, 2012 each nursing unit Director or designee will communicate at staff meetings or some type of documented training the current expectations, the policy for wound documentation and the changes made in the charting with regards to pressure ulcers/wounds. Send documentation of minutes to Margaret Krawczyk for files. All training is to be completed by July 1, 2012. Monthly audits will be done and sent to the Interdisciplinary Committee through 2013. (Please see exhibit C) Also, beginning June 2012 each unit Director or designee will re-emphasize at staff meetings or some type of documented training the procedure and expectations for teaching patients at discharge with regards to wounds and dressing changes and the documentation required that this was completed. Monthly audits will include this data that will be reported to Interdisciplinary Committee through 2013. (Please see exhibit C) 6-8-12 Additional notification went out to nursing staff addressing the upcoming changes in charting, Branden</p>				

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	<p>The medical record lacked documentation that the dressing was changed on 10/5/11 per order.</p> <p>3. Facility policy titled "Wound Assessment and Documentation" last reviewed/revised 4/09 states under policy on page 1: "All wounds will be assessed and documented in the patient's permanent record. This will be done upon initial identification of the wound, hen (known error) with each dressing change. Wound measurements are to be taken initially then weekly."</p> <p>4. Facility policy titled "Discharge Instructions" last reviewed/revised 12/2/10 states under procedure on page 1: "2. Nurse to document....., incision and/or dressing care, supplies and equipment and document any special instructions."</p> <p>5. Staff member #5 verified the lack of documentation for treatments per order for patients #1 and 3 and lack of wound care instructions on the discharge instruction sheet for patient #1 as indicated above. Interview/verification began at 2:00 p.m. on 3/7/12.</p>		<p>Scale, Skin Protocols and Skin Audit Changes. (Please see exhibit D) 7-1-12 to 8-1-12 Audits to continue at 30 charts per month. ITS project to be completed by 8-1-12. Skin audits will be conducted based off of the Braden Scale report of 18 or less that will be generated and sent to managers or their designees. The documentation will be reviewed with nurses caring for the patients. Any missing documentation will be followed up on with the individual at that time. Documentation of these audits will be sent to Director of Patient Services.</p>	

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