

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 08/11/2016
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
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S 0000 Bldg. 00	<p>This visit was for the investigation of a State hospital complaint.</p> <p>Complaint Number: IN00204940</p> <p>Substantiated: Deficiencies related to the allegations are cited</p> <p>Date of survey: 8/10/16-8/11/16</p> <p>Facility number: 005051</p> <p>QA: JL 08/16/16</p>	S 0000		
S 0912 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE 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>			

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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	<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 document review, interview and observation, the nurse executive failed establish the standards of care related to evidence that meals were provided and meal consumption documented per policy for 11 of 12 patients (patients #1-10 and #12), failed to ensure supplements were provided and consumption documented for 2 of 12 patients (#1 and 6), failed to accurately document patients weights for 1 of 12 patients (patient #1), and failed to ensure orders were received for restraints for 2 of 12 patients (patients #1 and #11).</p>	S 0912	<p>S912 15-1.5-6 Nursing Service The nurse executive failed to establish the standards of nursing care related to evidence that meals were provided and meal consumption documented per policy, failed to ensure supplements were provided and consumption documented, failed to accurately document patient weights, and failed to ensure orders were received for restraints. Corrective Action(s): The Clinical Managers of IUH Methodist Hospital B8, A4S, and NCC or their designee will complete education of nursing and support staff by September</p>	09/30/2016

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	<p>Findings include;</p> <p>1. Facility policy titled "DOCUMENTATION STANDARDS: INPATIENT" effective date of 3/31/16 states on attachment titled "Daily Assessments and Care Standards" under Nutrition/All Intake and Output....."Document Percentage of meal or snack eaten....."</p> <p>2. Review of patient #1 medical record for visit #1 indicated the following: (A) He/she had an order written on 5/19/16 at 0957 hours for Ensure to be given with lunch and dinner. The medical record lacked documentation that the Ensure was given at lunch and dinner on 5/19/16, lunch on 5/20/16, lunch or dinner on 5/21/16 and 5/22/16, and lunch on 5/23/16. (B) The medical record lacked documentation of meal consumption for breakfast, lunch, and dinner on 5/20/16, lunch on 5/21/16, lunch on 5/22/16, and dinner on 5/23/16, (C) The patients admission weight was documented as 70.0 kg on admission date of 5/15/16. His/her weight was documented as 67.3 kg on discharge date of 5/24/16.</p> <p>3. Review of patient #1 medical record for visit #2 indicated the following:</p>		<p>30, 2016 on the following:</p> <p>1.Documentation of meal and supplement consumption in CERNER</p> <p>2.Accuracy of weights</p> <p>3.Requirements for restraint orders, including roll belts utilized as restraints</p> <p>The education will be conducted via unit huddles, staff meetings, unit professional practice council, unit newsletter, and email blasts. Any staff required to complete the outlined education that is presently on an approved leave will be required to complete this task on an individual basis upon returning to work. Additionally, education will be provided to all inpatient nursing and support staff at IUH Methodist and University Hospitals. The policies, Documentation Standards: Inpatient and Use of Restraints and Seclusion, will be sent to all Methodist and University nursing staff with emphasis to review documentation requirements related to meals or snacks eaten and requirements for restraint orders. All education will be completed by October 31, 2016. Any staff required to complete the outlined education that is presently on an approved leave will be required to complete this task on an individual basis upon returning to work. Monitoring: To ensure compliance, beginning October 1, 2016, the Clinical Managers on IUH Methodist Hospital B8, A4S, and NCC will</p>		

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	<p>(A) The medical record lacked of documentation of meal consumption for dates including, but not limited to, lunch and dinner on 5/27/16, dinner on 5/28/16, breakfast, lunch, and dinner on 6/5/16, lunch on 6/9/16, breakfast, lunch and dinner on 6/10/16, breakfast, lunch and dinner on 6/14/16, lunch on 6/25/16, breakfast and lunch on 6/27/16, breakfast, lunch, and dinner on 7/2/16, breakfast, lunch and dinner on 7/4/16, breakfast, lunch, and dinner on 7/14/16, breakfast, lunch, and dinner on 7/24/16.</p> <p>(B) An order was written at 1350 hours on 7/5/16 for Ensure pudding to be given tid (three times a day) with meals. The medical record lacked documentation that the pudding was given 7/5/16 through 7/18/16 and from 7/20/16 through 7/24/16.</p> <p>(C) The patients admission weight was documented as 62.0 kg on 5/25/16, a 5.3 kg loss in 24 hours from discharge on 5/24/16. His/her weight was documented as 60.9 kg on discharge date of 7/29/16.</p> <p>4. Review of patient #2 medical record indicated the following: (A) The medical record lacked documentation of meal consumption for dinner on 5/11/16, and breakfast and lunch on 5/12/16.</p> <p>5. Review of patient #3 medical record</p>		<p>initiate a monthly audit of thirty (30) patient records in total. The audit will include monitoring of meal consumption, supplement consumption, weights, and restraint orders. Any identified gaps will immediately be discussed with the staff on an individual basis for performance improvement. This audit will be completed for three months, with expectations for 90% compliance or greater. If this threshold is achieved, then the auditing process will be transitioned to a periodic spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive three month period reflects achievement of the 90% threshold. Results of audits will be included in unit quality display boards and analyzed and trended through the unit Professional Practice Council.</p> <p>Responsible Person(s): Vice President and Chief Nursing Officer for IU Health Academic Health Center Adult Hospitals and the IU Health University Associate Chief Nursing Officer will be responsible for oversight. IU Health Methodist Clinical Directors along with the Clinical Managers of B8, A4S, and NCC will be responsible for ensuring that staff has a clear understanding of monitoring of these corrective actions to ensure the deficiency is corrected and will not recur.</p>	

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	<p>indicated the following:</p> <p>(A) The medical record lacked documentation of meal consumption for breakfast, lunch, and dinner on 5/10/16, lunch and dinner on 5/11/16, breakfast, lunch, and dinner on 5/12/16, dinner on 5/13/16, breakfast, lunch, dinner on 5/14/16 through 5/16/16, and dinner on 5/17/16.</p> <p>6. Review of patient #4 medical record indicated the following:</p> <p>(A) The medical record lacked documentation of meal consumption for the hospital stay despite an order for a regular diet written at 0850 hours on 5/12/16. An order was written on 5/12/16 at 0600 hours for daily weights. The patients weight at 1521 hours on 5/11/16 was 75.5 kg. His/her weight at 0600 on 5/13/16 was 73.7 kgs. The patient was discharged on 5/14/16.</p> <p>7. Review of patient #5 medical record indicated the following:</p> <p>(A) The medical record lacked documentation of meal consumption for hospital stay after diet order was placed at 1410 hours on 5/13/16. The patient was discharged on 5/15/16.</p> <p>8. Review of patient #6 medical record indicated the following:</p> <p>(A) The medical record lacked</p>			

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	<p>documentation of meal consumption for hospital stay after diet order was placed on 5/16/16 at 0414 hours except for a 20% intake documented at 10:28 a.m. on 5/18/16. Additionally, Ensure plus with meals was ordered on 5/19/16 at 0946 hours. The medical record lacked evidence that the Ensure plus was given.</p> <p>9. Review of patient #7 medical record indicated the following: (A) The medical record lacked documentation of meal consumption for hospital stay after diet order was placed on 5/10/16 at 1946 hours. The patients weight was documented as 82.6 kg on admission date of 5/10/16 and 78.5 kg on discharge date of 5/12/16.</p> <p>10. Review of patient #8 medical record indicated the following: (A) The medical record lacked documentation of meal consumption for lunch and dinner on 8/6/16 and breakfast, lunch, and dinner on 8/7/16 through 8/10/16.</p> <p>11. Review of patient #9 medical record indicated the following: (A) The medical record lacked documentation of meal consumption including, but not limited to, breakfast, lunch, and dinner on 7/25/16-7/28/16 and breakfast, lunch, and dinner on</p>			

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	<p>8/7/16-8/9/16. The patients weight was documented as 95.9 kg on 7/24/16 and 92.6 on 8/1/16.</p> <p>12. Review of patient #10 medical record indicated the following: (A) The medical record lacked documentation of meal consumption for dinner on 8/10/16.</p> <p>13. Review of patient #12 medical record indicted the following: (A) The medical record lacked documentation of meal consumption for lunch and dinner on 8/8/16, and breakfast, lunch and dinner on 8/9/16.</p> <p>14. Facility policy titled "USE OF RESTRAINTS AND SECLUSION" with an approval date of 6/30/13 states on page 4 of 16: "H. Restraints or seclusion are only used when ordered by a practitioner."</p> <p>15. Review of Posey Self-releasing roll belt application instructions states "If the patient is not able to easily self-release, it is considered a restraint and must be prescribed by a physician."</p> <p>16. Facility document review indicated that an incident report was completed for 10:30 p.m. on 6/4/16 indicating that a staff member (staff member #8, Licensed</p>			

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	<p>Practical Nurse) took one of the wrist restraints off of patient #1's arm and put on his/her leg.</p> <p>17. Review of patient #1 medical record indicated the following: (A) The nursing flowsheets indicated the patient was in restraints at 0200 hours on 5/29/16 through 1600 hours on 5/30/16 and 1800 hours on 5/3/16 to 0038 on 6/1/16. (B) The medical record lacked an order for restraints for the above dates/times. (C) The patient had an order for wrist restraints and not ankle/leg restraints on the evening of 6/4/16 when the wrist restraint was removed and placed on leg per staff.</p> <p>18. Review of patient #11 medical record indicated the following: (A) The patient was admitted on 8/5/16 and had a roll belt utilized beginning on 8/5/16. (B) The record lacked an order for a restraint.</p> <p>19. During observation on the B8 Medical/Surgical unit at 11:45 a.m. on 8/11/16, patient #11 was observed with a Posey roll belt on while in bed. In the presence of staff member #6 (Patient Care Tech), the patient was requested to remove the belt. He/she worked with the</p>						

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	<p>belt and could not release the buckle. He/she stated "I can't."</p> <p>20. Staff member #7 (Registered Nurse [RN]) indicated in interview at 12:05 p.m. on 8/11/16 that he/she went back to the patients room (patient #11) and the patient could not release the belt because the patient had not been shown how. He/she indicated that is how the facility keeps the patient safe and keeps them from falling. He/she indicated that they explained to the patient how to release the belt and it took the patient a couple times and then they could release the buckle. He/she indicated now the patient would probably be releasing the belt. He/she voiced understanding that if the patient cannot release the device, it would be a restraint. He/she verified the medical record for patient #11 lacked an order for a restraint.</p> <p>21. Staff member #2 (Clinical Informatics Coordinator) verified medical record information beginning at 11:30 a.m. on 8/10/16.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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