**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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This report is the result of complaint investigation #WI00031795 conducted on 2/15/2018 through 2/19/2018 at UnityPoint Health Meriter Hospital using Medicare Conditions of Participation 42 CFR 482 for Hospitals.

42 CFR 482.13 Condition of Participation: Patient Rights is NOT MET.

An Immediate Jeopardy (IJ) was determined on 2/19/18 at 10:35 AM regarding the facility's failure to develop and implement an effective policy to prevent suspected abuse related to injuries of unknown origin for patients in the Newborn Intensive Care Unit. The IJ began on 4/12/17 when the facility failed to protect and thoroughly investigate the first report of an injury of unknown origin for Patient #4, placing all patients in the Newborn Intensive Care Unit at risk for serious harm or injury. The facility's Chief Nursing Officer C and Director of Performance Improvement B were notified of the IJ on 2/19/18 at 2:44 PM. The IJ was not removed at the time of exit.

| A 115 | PATIENT RIGHTS | A 115 |
| CFR(s): 482.13 | |

A hospital must protect and promote each patient's rights.

This CONDITION is not met as evidenced by:
Based on record review and interview the facility failed to develop and implement an effective policy to prevent, screen, identify, train, protect, thoroughly investigate, report, and respond to any allegations of suspected abuse related to injuries of unknown origin.
Findings include:

The facility failed to thoroughly investigate and protect 5 of 6 patients (#1, #2, #3 #4 and #6) in the Newborn Intensive Care Unit when the first case was reported for Patient #4 on 4/12/17. See Tag A 0145

The cumulative effects of these deficiencies resulted in an Immediate Jeopardy potentially affecting all patients in the Newborn Intensive Care Unit during this survey (patient census 2/15/18 was 16, 2/16/18 was 17 and 2/19/18 was 18).

A 145 PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT
CFR(s): 482.13(c)(3)

The patient has the right to be free from all forms of abuse or harassment.

This STANDARD is not met as evidenced by:

Based on record review and interview the facility failed to to develop and implement an effective policy to prevent, screen, identify, train, protect, thoroughly investigate, report, and respond to any allegations of suspected abuse related to injuries of unknown origin and failed to thoroughly investigate injuries of unknown origin and protect 5 of 6 patients (#1, #2, #3 #4 and #6) in the Newborn Intensive Care Unit identified with injuries of unknown origins when the first case was reported for Patient #4 on 4/12/17.

Findings include:

Review of Bylaws and rules and Regulation of the Medical Staff dated January 2017, approved by
Continued From page 2

the Medical Executive Committee on November 15, 2016, approved by the Medical Staff at the annual meeting on January 17, 2017 and approved by the UnityPoint Health-Meriter Health Services Board on and effective January 25, 2017 under Membership and Privileges Section 1 Qualifications C. revealed "Members of the Medical Staff shall ...comply with the safety policies and guidelines put in place by the hospital and/or Medical Staff".

Review of policy titled "Child at Risk Abuse and Neglect" dated March 2001 revised 8/2016 under II. C. Statutory requirements for reporting child abuse under Wisconsin Statute 48.981 3. revealed "Each person who has a concern about suspected child abuse or neglect is responsible for either making a report directly or for verifying that the report was actually made to County Human Services or law enforcement". Under D. Investigation and documentation 1. revealed "when a concern about abuse or neglect is identified by a person required to report...that person immediately consults with, by telephone or personally... determined by the primary clinical area the child is receiving care through."

Interviews were conducted with Medical Director of the Newborn Intensive Care Unit (NICU) K on 2/16/18 at 11:05 AM, Advanced Practice Nurse Prescriber (APNP) R on 2/16/18 at 1:40 PM, Registered Nurse (RN) P on 2/16/18 at 1:26 PM and Nurse Manager NICU D on 2/16/2018  at 4:25 PM, review of hospitals timeline of abuse cases in Patients #1, #2, #3 and #4, documented incident reports Patients #1, #2 and #4 and medical records for Patients #1, #2, #3, #4 and #6 revealed the following timeline:
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<td>A 145</td>
<td>Continued From page 3</td>
<td>A 145</td>
<td>*Friday - 2/02/18 AM APNP R identified bruising on arm of Patient #1, notified Physician K 2/02/18, and notified Physician O during rounds on 2/02/18. Physician K documented in medical record 2/02/18 that injuries may have been from patient clutching wires or peripheral intravenous device arm board used for stabilization. Incident report titled &quot;Current Summary&quot; for Patient #1s injury on unknown origin that was identified on 2/2/2018 was entered &quot;2/08/18&quot; by RN CC (6 days after the event). Saturday - 2/03/18 at 8:47 AM RN P identified unexplained bruising on right forearm and left wrist of Patient #2. During first assessment in AM, APNP R was notified of findings during bedside exam at 8 AM. APNP R commented to RN P that Patient #2 had unexplained bruising similar to Patient #1. Attending Physician O was notified on 2/03/18 between 9:30 AM and 11 AM and determined the injuries were related to blanket wrapping. On the evening of 2/03/18 RN P sent an E-mail to Nurse Manager D and Assistant Nurse Manager T regarding his/her concerns of unusual markings, bruising on Patient #1 and Patient #2. On 2/16/18 at 1:29 PM during an interview, RN P stated s/he thought it would be addressed Monday 2/05/18. Incident report titled &quot;Current Summary&quot; for Patient #2s injury on unknown origin that was identified on 2/3/2018 was entered &quot;2/09/18&quot; by RN P (6 days after the event). Sunday - 2/04/18 - Medical record revealed RN U noted Patient #2 had additional injuries documented as bruising on face, periorbital edema. No incident report was completed for this</td>
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Monday - 2/05/18 Assistant Manager T called Nurse Manager D questioning what to do and was told by Nurse Manager D to ask staff.

On Monday, 2/05/18, injuries of unknown origin were discussed by RN's P & X and APNP R and reviewed with Physicians L and O by nursing staff about RN H who had cared for both Patient #1 and Patient #2 in interview with APNP R.

Tuesday - 2/06/18 Nurse Manager D and Assistant Manager T were not working in the hospital. Nurse Manager D stated, during an interview on 2/16/18 at 4:25 PM, that the Charge Nurse BB was responsible for the floor.

Wednesday - 2/07/18 Lump was discovered on side of Patient #2's head by RN, head ultrasound was ordered by Physician L which was negative.

Thursday - 2/08/18 Physician L consulted Child Abuse Expert N regarding unexplained injuries of Patient #2. N recommended additional tests including a skeletal survey and head computed tomography which revealed recent skull fractures and arm fractures.

On 2/08/18 Nurse Manager D suspended suspected Caregiver RN H, disabled RN H's badge access and access to the electronic medical record.

Friday - 2/09/18 Nurse Manager D stated in interview on 2/16/18 at 4:25 PM, the Hospital, in collaboration with Child Protective Services, commenced an internal investigation.
The course of the Hospital's investigation revealed through interview and record review:

On 2/09/18 Physician V recalled patient #3 with unexplained bruising in the past. It was verified by the hospital that RN H had been one of the primary caregivers during Patient #3's hospitalization in the NICU 9/17/17 thru 10/13/17. During this hospitalization, Patient #3 had bruising of left foot and scalp bruising. Patient #3's mother had taken pictures of the bruising at that time, which were presented to Child Abuse Specialist N on 2/09/18. On 2/09/18 N reviewed the photographs of Patient #3 from the past hospitalization and determined bruising was consistent with child abuse. N reported case to Madison Police Department on 2/09/18. RN H was primary caregiver on nights for Patient #3 September 21-22, 2017. There were no marks noted in medical record on Patient #3 prior to this shift. RN H did not note any bruising in any documentation. Physicians O and AA documented bruising in the medical record on 9/22/17 at 7:16 AM.

Patient #4 was identified on 2/09/18 through incident report review, Event #115245 which was entered by RN W on 4/12/17. Report titled "Current Summary" was dated 2/26/2018. Under File State revealed "In-Progress". Brief Factual Description revealed "2 RNs conducted scheduled assessment/hands on 0900 (9:00 AM) and observed bilateral bruising on calves, ankles and left foot. Although bruises consistent with monitor cord size, no cords were observed in this location. MD notified and x-rays ordered. Under Injury details Nature of Injury revealed "Bruise/Contusion". Specific Body Part revealed "Ankle-Both, Foot-Left, Leg-Both". Treatment
A 145 Continued From page 6

Provided revealed "x-ray ordered". Party Involved revealed Physician K. Follow-Up Actions revealed "not specified." Review of Patient #4's medical record on 2/19/18 with Patient Safety Officer revealed chest x-ray 3/19/17 "multilevel vertebral segmentation and fusion abnormalities in thoracic spine". 4/12/17 two view x-rays of the tibia, view one normal, view 2 "somewhat limited evaluation". RN H was primary caregiver on night shift. April 11-12, 2017. There were no bruises noted on Patient #4 prior to the shift including RN Hs end-of-shift note dated 4/12/17 at 6:09 AM. Bruising was documented in medical record dated 4/12/17 at 7:29 AM by Physician K.

As part of the hospital investigation, Patient #6s's parents were notified of safety plan. Patient #6 had scattered bruising on lower extremities during the hospital stay on 1/20/18 that staff believed to be related to birth. Parents of Patient #6 informed hospital staff they were uncomfortable with suspected caregiver RN H who was the primary caregiver on the night shift of January 23-24, 2018. Due to these concerns, Physician Z consulted Child Abuse Expert N on 2/12/18 who recommended skeletal survey and CT. The results revealed multiple fractures including rib and arm fractures per interview with Nurse Manager D.

Interview with Director of Performance Improvement B on 2/16/18 at 2:12 PM, B stated there was no policy or process that guided the staff or physicians how to report abuse or neglect other than what was given already.