

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

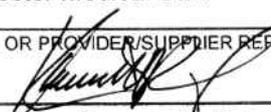
PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2011
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NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562
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A 000	<p>INITIAL COMMENTS</p> <p>The following reflects the findings of the California Department of Public Health during a Full Validation Survey.</p> <p>Representing the California Department of Public Health:</p> <p>25338, HFEN 18930, HFEN 22384, HFEN 21898, HFEN 22465, HFEN 25628, HFEN 28294, HFEN 26881, Medical Consultant 25281, Pharmacy Consultant 28135, Dietary Consultant</p> <p>Facility Census Average: Rancho Springs Medical Center - 81 Inland Valley Medical Center - 91 Sample Census: 73</p> <p>Abbreviations used in this document:</p> <p>cm - centimeter CEO- Chief Executive Officer CMO- Chief Medical Officer CNO- Chief Nursing Officer COO - Chief Operating Officer CSLS - Clinical Supervisor Lab Services D/C - Discontinue DCCS - Director Critical Care Services DHIM - Director Health Information Management DHR - Director Human Resources DIS - Director of Imaging Services DMS - Director Medical Staff</p>	A 000	<p>Southwest Healthcare System submits the following as its credible allegation of compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO / Managing Director	(X6) DATE 9.20.11
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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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A 000	Continued From page 1 DRM- Director of Risk Management ED - Emergency Department EMTALA - Emergency Treatment and Labor Act F/C - Foley catheter HIMC - Health Information Management Coordinator hp - history & physical HR/hr - Hour HRG - Human Resources Generalist ICU - Intensive Care Unit IVMC - Inland Valley Medical Center lab - Laboratory LC - Laboratory Courier MAR - Medication Administration Record MD - Physician mg - milligrams MS - Medical Staff MSE - Medical Screening Exam M/S/T - Medical/Surgical/Telemetry NM - Nurse Manager NMT - Nuclear Medicine Technologist NST - Nonstress Test OB - Obstetrics OBTVUE - Obstetrical electronic monitoring and documentation system OR - Operating Room PA - Physician Assistant PCU - Progressive Care Unit PO - By mouth PRN - As needed QA - Quality Assurance QRC - Quality Review Committee RD - Registered Dietician RN - Registered Nurse SCLS - Supervisor Clinical Laboratory Services UR - Unable to recall > - greater than	A 000		
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF	A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF GRIEVANCES	

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A 119	<p>Continued From page 2 GRIEVANCES</p> <p>[The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to follow its grievance policy when it failed to investigate all grievance allegations, and failed to completely investigate the allegations, for two of five grievances reviewed, (grievances of Complainant 2 and Patient 1).</p> <p>Findings:</p> <p>1. During a review on July 26, 2011, of the investigation of a health plan complaint submitted to the facility regarding facility treatment of Complainant 2, the complainant felt that the patient received inadequate treatment from a Physician Assistant (PA 3) in the Emergency Department (ED). No evidence was seen that PA 3 was interviewed as part of the complaint investigation.</p> <p>An interview was conducted with the Patient Advocate on July 26, 2011, at 3:45 p.m. The Patient Advocate reviewed the complaint and stated the chart was reviewed in response to the complaint, but there was no evidence that PA 3 had been interviewed. She stated that PA 3 should have been interviewed as part of the</p>	A 119	<p>Continued From page 2</p> <p>Findings 1 and 2: Action Taken: 1. The Director of Risk Management (DRM) reviewed the Grievance: Customer Complaint Policy, which details the process for receiving, reviewing and resolving all patient grievances. The DRM incorporated reliability tools into the process as follows: a. The "Grievance Investigation Checklist" for the Patient Advocate to utilize as a trigger and standardized reporting mechanism to assure consistency and reliability for addressing all grievances; b. The DRM or qualified designee reviews all Grievance Investigation Checklists and letters drafted to patients/representatives prior to being sent out and initiates further investigation if necessary; c. A trigger has been added to the electronic tracking system to ensure all referred peer review cases have been completed; and d. The case summary with all relevant data is reviewed monthly by the Grievance Committee prior to reporting to the Board of Governors.</p>	<p>8/30/11</p> <p>09/06/11</p> <p>09/06/11</p> <p>09/06/11</p> <p>09/06/11</p>

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A 119	<p>Continued From page 3</p> <p>complaint investigation. A response letter to the health plan was sent on June 8, 2011.</p> <p>2. The grievance regarding the care of Patient 1, sent from the health plan to the facility on April 12, 2011, was reviewed. Patient 1's allegations were related to an inpatient stay [REDACTED] 2011, to [REDACTED] 2011, and subsequent emergency room visits. The allegation related to his inpatient stay was that he found a urinary catheter (a tube extending from the bladder to the outside of the body) uncomfortable, and physicians were "not handling the issue."</p> <p>The facility's April 12, 2011, written response to the health plan regarding the inpatient stay allegation included excerpts from Patient 1's inpatient medical record indicating the patient complained of discomfort and the physician's statement that he would come to see the patient. In the response to the health plan, the excerpts from the inpatient chart were followed by the sentence, "Case referred to Medical Staff Office for peer review, tracking and trending. Medical record to be provided by the Health Information Department."</p> <p>The medical record of Patient 1 during his inpatient stay from [REDACTED] 2011, until [REDACTED] 2011, was reviewed. The nursing documentation indicated on [REDACTED] 2011, Patient 1 complained of discomfort related to the urinary catheter, and that the physician had been contacted and stated he (the physician) would come to see the patient. However, there was no documentation that the physician came to see the patient. Patient 1 complained of pain 10/10 (on a scale of one to ten, with ten the highest level of</p>	A 119	<p>Continued From page 3</p> <p>The elements of the Grievance Investigation Checklist include: a) identification and notification of the appropriate Department Manager to investigate the grievance; b) evidence of a timely report from the Department Manager to the Patient Advocate of the investigation results; c) review of the investigation to ensure all applicable individuals are interviewed; d) evidence that investigation and summary is documented; and e) applicable cases are referred to the Peer Review Coordinator and if necessary, the Quality Review Committee for peer review. The Grievance Committee is responsible for oversight of the grievance process, including ensuring that grievances are managed timely, investigations are as complete as possible and that appropriate actions and resolutions are taken. The Grievance Committee approved the Checklist.</p> <p>2. The DRM in-serviced the Grievance Committee, the Chief Medical Officer (CMO), the Patient Advocates, the Director of Quality, and the Director of Performance Improvement on the Grievance Policy, procedures and Checklist.</p> <p>3. The DRM spoke with the Patient Advocate regarding the investigation of Complainant 2's grievance, with special emphasis on conducting comprehensive reviews (e.g., interviewing all applicable individuals). Failure to comply will result in disciplinary action. The DRM reviewed the investigation and referred it to the CMO for review and further investigation, including interviewing the PA. The Peer Review Coordinator also reviewed the case in accordance with the peer review process. The Patient Advocate sent a revised letter to the patient regarding conclusion of the investigation.</p> <p>4. The CMO reviewed the case regarding Patient 1 and spoke with the Peer Review Coordinator and Director of Quality regarding</p>	09/06/11 09/06/11 09/06/11
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A 119	Continued From page 4 pain) during the night, and was discharged the next day, [REDACTED] 2011, with the catheter still in place. Patient 1's grievance was reviewed with the Chief Medical Officer, (CMO) on July 28, 2011, at 9 a.m., and he concurred that the physician who stated he would come to see Patient 1, should have gone to assess the patient in response to Patient 1's complaint about discomfort. During an interview with the Director of Risk Management, (DRM) on July 28, 2011, at 10:30 a.m., she stated the physician who stated he was coming to see the patient in response to his (Patient 1) complaint of discomfort should have gone to assess the patient. The DRM stated the physician who was the object of the inpatient allegation had not been subjected to peer review. She concurred the grievance process had not addressed the inpatient allegation in the complaint. The facility policy, "Grievance: Customer Complaint" (revised May, 2011), was reviewed on July 29, 2011, and read in part, "A concern is considered resolved when the patient is satisfied with the actions taken on their behalf, or the investigation has been completed, actions taken and the patient has been notified in writing of the grievance investigation and the Committee's conclusions," and "Grievance Committee is responsible for ensuring grievances are managed timely, that investigations are as complete as possible, and that actions and resolutions are appropriate."	A 119	Continued From page 4 the issues, emphasizing the importance of referring appropriate cases to peer review for evaluation in accordance with the peer review process. Failure to comply with hospital policy will result in disciplinary action. The Surgery Quality Review Committee reviewed Patient 1's grievance and investigated the issue on 7/27/11 in accordance with the peer review process. 5. The Hospital assigned a Patient Advocate to each hospital to facilitate a complete investigation into patient grievances. 6. Review of patient grievances is a standing agenda item at the monthly Patient Safety Council meetings and performance improvement initiatives are addressed. Compliance and Monitoring: The DRM or qualified designee (e.g., Director of Quality) reviews all grievance investigations with the goal of achieving 100% compliance with appropriately investigating, taking action and resolving patient grievances. Corrective action is taken as necessary. The review will occur for three months and then be re-evaluated. The DRM will report on compliance to the CMO and the Grievance Committee on a monthly basis. The Grievance Committee reports on compliance through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis. Person Responsible: Director of Risk Management	09/06/11 09/06/11
A 132	482.13(b)(3) PATIENT RIGHTS: ADVANCED DIRECTIVES	A 132	482.13(b)(3) PATIENT RIGHTS: ADVANCED DIRECTIVES Action Taken:	

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A 132	Continued From page 5 The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104 of this part (Effective dates). This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that patient advance directives (desires for medical care in the event that they could not speak for themselves) were requested and documented for one of 73 sampled patients (Patient 7). This failed practice had the potential to create the risk that healthcare decisions could be made contrary to the patients' wishes. Findings: The medical record of Patient 7 was reviewed on July 25, 2011. The record contained a Patient Self Determination Record which requested information about whether the patient had an advanced directive and other questions related to self-determination, but the form was not completed. During an interview with NM 2 on July 25, 2011, at 9:45 a.m., she reviewed Patient 7's incomplete "Patient Self Determination Record", and stated that it was to be filled out by the admitting department.	A 132	Continued From page 5a at the PI Committee and performance improvement initiatives are addressed. Compliance and Monitoring: The PI Director or qualified designees perform a concurrent record review of a minimum of 70 records monthly with the goal of achieving 100% compliance with obtaining and documenting necessary information concerning advanced directives. Corrective action is taken as necessary. This review will occur for three months and then be re-evaluated. The PI Director will report on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis. Person Responsible: Director of Performance Improvement	09/06/11 Ongoing	
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy.	A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY Actions Taken: 1. The Women's Services Director reviewed	7/25/11	

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A 143	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the personal privacy for one of 73 sampled patients (Patient 58) when the patient was interviewed by an RN in the waiting area off of the elevator on the second floor Women's Center. This failed practice provided the opportunity for other visitors in the waiting area to hear Patient 58's personal medical information. Findings: On July 25, 2011, at 2:35 p.m., Patient 58 was observed in the waiting area off of the elevator on the second floor Women's Center being interviewed by RN 5. RN 5 was asking Patient 58 questions to complete the "Women's Services - OB Intake" to include Patient 58's name, the number of pregnancies, number of live children, the date the infant was due, the reason for Patient 58's visit, any current medical problems, and previous cesarean sections (delivery of the infant through the abdomen). There were three other individuals in the waiting area to include another pregnant patient and two visitors. The interview conducted by RN 5 was overheard by individuals waiting in this area and individuals passing through this area. On July 26, 2011, at 8:20 a.m., an interview was conducted with RN 6. She stated obstetrical patients were "verbally assessed in the waiting area if the patient care rooms were completely full or labor nurses were not available." On July 26, 2011, at 1:50 p.m., an interview was	A 143	Continued From page 6 the "Patient Rights and Responsibility" policy, which includes the patient's right to personal and informational privacy. Nurses shall not conduct patient interviews in waiting areas or any other areas when other visitors can hear personal medical information. In the Women's Center, nurses will conduct patient intake interviews in private rooms/area. Any issues with availability of rooms will be addressed by the Women's Services Director or designee. Women's Center Labor and Delivery nursing staff were in-serviced on the Patients Rights and Responsibility policy, with special emphasis on conducting patient interviews in a private room/area and not in public areas. The nurses completed a "read and sign" affidavit acknowledging understanding of the policy. Failure to comply will result in disciplinary action. Education on Patients Rights and Responsibility is part of annual education and upon hire. 2. The Women's Service's Director spoke with the applicable nurse regarding the finding, emphasizing that patient interviews are not to be conducted in public areas. Compliance and Monitoring: The Women's Services Manager or qualified designee performs weekly direct observations of the Women's Center for three months (and then re-evaluate) to achieve a goal of 100% compliance with maintaining a patient's personal privacy. Corrective action is taken immediately for noncompliance. The Women's Service Manager reports on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis. Person Responsible: Women's Service Director	8/20/11 9/6/11 Ongoing
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A 143	Continued From page 7 conducted with RN 7. She stated she would not interview obstetrical patients in the waiting area because it could be a privacy issue. In addition, RN 7 stated she would take the obstetrical patient to a room and interview the patient in private.	A 143		
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The facility policy and procedure titled "Patient's Rights and Responsibilities" reviewed December 2010, indicated "... The patient has the right within the law to personal and informational privacy. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. ..." The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to implement a process for identifying and analyzing adverse events such as the death of one of 73 sampled patients (Patient 3). This failed practice had the potential to create the risk of substandard healthcare for all patients receiving care at the facility. Findings: The medical record of Patient 3 was reviewed on July 26, 2011, through August 2, 2011. Patient 3 came to the ED on [REDACTED] 2011, at 9:42 p.m., via ambulance with complaints of weakness and leg pain. The medical record showed that lab samples were obtained, and a critical	A 267	482.21(a)(2) QAPI QUALITY INDICATORS Actions Taken: 1. The Director of Quality and the CMO reviewed the 2011 Quality and Safety Plans, which delineates the process for identifying, analyzing, and tracking quality indicators, including adverse events/occurrences. The Chief of Staff also reviewed and revised (and the MEC and Board of Governors approved) the Medical Staff Peer Review Policy to address the process for ensuring operational issues identified during the peer review process are reported to the QI Committee for analysis and action planning. The QI Committee may refer an issue to an appropriate committee (e.g., the Patient Flow Steering Committee, or Patient Safety Council) for further review and corrective action, if necessary. Any hospital employee who discusses or responds to an occurrence (as defined in the Occurrence Notification Process Policy) completes or directs completion of a risk event report (known as a "HPRR" - Healthcare Peer Review Report). Risk Management and the applicable Department Manager (in charge of where the event occurred) are subsequently notified through the electronic reporting system. Based on the Department Manager and Risk Management's initial review and issues identified, the matter is	9/1/11

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A 267	<p>Continued From page 8</p> <p>potassium level of 8.8 mmol/L (normal 3.6-5.1 mmol/L, elevated potassium can cause fatal heart rhythms) was reported on [REDACTED] 2011, at 12:50 a.m. MS 2 provided treatment orders between 1:18 a.m., and 1:20 a.m. However, the medical record showed that the medications were not administered until hours later, from 3 a.m. to 4:30 a.m. Other medication orders were not carried out prior to the patient expiring at 6:20 a.m.</p> <p>The medical record of Patient 3 also showed that nursing assessments were not documented as frequently as the patient's condition warranted. There was a delay in obtaining a bed for the patient, and nurse communication with the admitting physician was not carried out and documented per physician orders (see A1112).</p> <p>In an interview with NM 7 on July 26, 2011, at 9:30 a.m., she stated she could not explain the delay in administration of medications to Patient 3. She stated there was no documentation in the progress notes of any delay in the ED receiving the medications, and that the time frame of administering the medications was not acceptable. NM 7 stated the vital signs of Patient 3 at 12:50 a.m. were very concerning, and that waiting until 2:30 a.m. to recheck them was too long. She stated for patients with critical conditions, the vital signs should be checked as often as every 15 minutes.</p> <p>According to the medical record the ED physician, MS 2, was walking by the bed of Patient 3 in the ED and noted that she had agonal (dying) respirations. Patient 3 was the subject of a code blue (emergency response) at 5:50 a.m.,</p>	A 267	<p>Continued From page 8</p> <p>referred to the appropriate committee (e.g., physician peer review or a hospital-based operational team) for further investigation. This process includes a thorough analysis, identification and implementation of necessary corrective action, and follow up to ensure completion.</p> <p>2. The CMO held a meeting with Quality Department staff, and made presentation to the Medical Staff Committee members, the MEC, the hospital leadership and the Board of Governors regarding the Quality and Safety Plans and the revised Peer Review Policy, with special emphasis on identification of quality indicators, performing a comprehensive investigation, taking appropriate corrective action, and performing adequate follow up of the issue. Nursing staff received occurrence event reporting education February - May 2011 through a learning education module. Occurrence event reporting education is provided annually, upon hire and as needed for all applicable staff.</p> <p>3. The Director of Quality and CMO defined the process for mortality review, which identifies exceptions to reviewing mortality cases and the revised criteria used to review mortality cases. The MEC and Board of Governors approved the process, the revised criteria and applicable staff were educated. Except for DNR or comfort care admissions, all mortality cases are reviewed by the appropriate committee utilizing the approved mortality review criteria. The revised mortality review criteria includes, among other things, the following: a) was death expected or anticipated on admission?; b) was death explained by the condition and/or diagnosis?; c) did the progress notes document a poor prognosis?; d) did death occur within 24 hours of admission?; e) did death occur within 48</p>	<p>9/6/11</p> <p>9/6/11</p>

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A 267	<p>Continued From page 9 and was pronounced dead at 6:20 a.m.</p> <p>During an interview with the Chief Nursing Officer, (CNO) on July 27, 2011, at 3:20 p.m., she stated Patient 3's care was sent to the ED for review by that department's nursing leadership. The CNO stated she thought RN 17 had not been documenting the patient's condition because he had difficulty using the new computer system. When asked if RN 17 was provided with additional education regarding use of the computer system, she stated that the nurses had already been educated on the use of the computer system at that time.</p> <p>Documentation of the interview, dated February 9, 2011, with RN 17 regarding Patient 's care was reviewed on July 27, 2011. RN 17 explained the delays in care given to Patient 3 by saying he was unfamiliar with the new (in place for 10 days) computer system, and that he was very busy the night he cared for Patient 3. He stated he notified the charge (supervising) nurse that he needed assistance, but did not receive adequate assistance.</p> <p>During an interview with NM 7 on July 26, 2011, at 9:30 a.m., she stated RN 17 was an experienced, detailed and thorough nurse.</p> <p>A written interview of the charge nurse by NM 7 on February 10, 2011, was reviewed on July 27, 2011. In the interview, the charge nurse on the night of Patient 3's ED stay recalled RN 17 had asked for help several times due to his "heavy assignment."</p> <p>NM 7, in an interview on July 26, 2011, at 9:30</p>	A 267	<p>Continued From Page 9 hours of surgery or a procedure?; f) were appropriate care measures provided (diagnostic, therapeutic or supportive)?; g) did a complication related to treatment or care contribute to death?; h) did the complication relate to an omission of care?; i) was there a medication error or adverse drug event?; j) was there communication failure related to the death?; and k) was there a system failure contributing to the death?</p> <p>4. The CMO, Director of Quality and multiple members of applicable departments re-reviewed Patient 3's care and identified issues related to complying with physician orders, timely medication administration, handling of critical lab results, patient assessments, nursing documentation, addressing and reporting of changes in patient's condition, addressing staffing issues when there is a change in patient's condition, utilization and understanding of new computer system, and utilizing appropriate chain of command measures to effectuate the safe delivery of patient care. Action Plans were developed and implemented. This included educating nurses on handling abnormal lab values, timely implementing physician orders, performing and documenting nursing assessments based on the patient's condition, and chain of command procedures for requesting assistance and reporting issues. In addition, applicable leadership staff were inserviced on applicable policies and procedures for addressing increases in staff to meet current patient care needs. Meetings were held with applicable nurses regarding Patient 3's care. In addition, Hospital and Physician Leadership, Quality Department staff and the Board of Governors were inserviced on the process for completing thorough investigations of adverse events/occurrences.</p>	9/6/11	

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A 267	<p>Continued From page 10</p> <p>a.m., was asked regarding processes for nursing oversight in the ED. She stated that the charge nurse provided oversight by making rounds every 4 hours. She stated the charge nurse provided assistance or obtained assistance to meet patient care needs. She was not able to explain why Patient 3's care had not received oversight by the charge nurse.</p> <p>The facility process for coping with increases in patient care needs in the ED was reviewed with NM 7 on July 26, 2011, at 9:30 a.m. She stated the charge nurse should respond to the need for the patient to be changed to critical status, and for the need for additional nurse time for the patient. NM 7 stated when the charge nurse was unable to provide the required assistance, nursing staff was to go up the chain of command to obtain needed assistance.</p> <p>In an interview with the CNO, on July 26, 2011, at 10 a.m., she stated that the ED staffing during patient care increases was a process that had been informally in place for a year.</p> <p>During an interview with the ED Director on July 29, 2011, at 8:45 a.m., she stated that the chain of command had not been activated while Patient 3 was in the ED. She was not able to explain why RN 17 did not activate the chain of command to obtain assistance. She stated that the nurse staffing during Patient 3's stay on January 14, to January 15, 2011, in the ED had not been subject to analysis.</p> <p>During a review of the facility policy, Patient Flow and Capacity Management: Hospital Wide (revised December, 2010, reviewed March, 2011)</p>	A 267	<p>Continued From page 10</p> <p>5. Review of adverse events/occurrences is a standing agenda item at the Patient Safety Council and performance improvement measures are addressed.</p> <p>Compliance and Monitoring:</p> <p>The CNO or qualified designee and CMO collaboratively review all adverse events/occurrences at least bimonthly for three months (and then re-evaluate) to achieve the goal of 100% compliance with effective identification of issues, appropriate committee referral, effective analyzing of the issues, development of corrective action measures and sufficient follow up. This includes following up with Nursing Supervisors regarding adverse events/occurrences and checking to make sure that an HPRR was entered into the electronic system. Corrective action is taken as necessary. The CMO and CNO report on compliance monthly to the hospital PI Council, who will report on compliance through the hospital Quality Oversight Structure to the Board of Governors monthly.</p> <p>Persons Responsible:</p> <p>CNO and CMO</p>	9/6/11	

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A 267	<p>Continued From page 11</p> <p>on July 29, 2011, conditions that signified a "yellow" status included, "Patients are holding in the ED or Post Anesthesia Care Unit...ED wait time to bed > (greater than) 2 hours." The actions to be taken during a "yellow" status read in part, "Call Emergency bed Huddle after paging Joint Leadership...Charge nurse to take patients...Per Diem (paid by the day) and regular staff to be called in."</p> <p>During an interview with the CNO on July 29, 2011, at 8:45 a.m., she reviewed hospital records from the night of [REDACTED] 2011, and the morning of [REDACTED] 2011, when Patient 3 was in the ED, and stated that no emergency bed huddle had been held.</p> <p>The ED quality review committee, (QRC) was given Patient 3's case on February 8, 2011, and asked the single question, "Were orders appropriate and timely?" The QRC decided that orders were appropriate and timely. However, the ED QRC noted a delay in the nurse carrying out the orders. The case was forwarded to the nursing department for review of that issue. The ED quality review committee did not identify the failure to perform and document timely assessments, the failure to obtain a bed within facility time goals, or the failure of the nurse to notify the admitting physician promptly of the patient's worsening respiratory distress.</p> <p>The May 10, 2011, ED QRC minutes indicated that in response to the delay in medication administration, "the Nurse Manager of ED has educated nursing staff," and the matter was labeled "closed." The content of the education was not described, and there was no monitoring</p>	A 267		
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A 267	<p>Continued From page 12 or any other follow-up activity mentioned.</p> <p>During an interview with the Director Of Regulatory Compliance (DRC) on August 2, 2011, at 11:45 a.m., she stated the facility had two systems for reviewing incidents-the department quality assurance and the risk management/quality management system. She stated that all deaths were reviewed by a quality assurance department nurse, using criteria, to determine if there were quality of care issues, and if triggered by the criteria, the case was reviewed by quality assurance or risk management departments. She stated that all incidents that were the subject of an occurrence notification were reviewed by the risk department.</p> <p>On July 29, 2011, a review of the facility policy, Occurrence Notification Process, (review date December, 2010), read in part, "An occurrence is any event, which is not consistent with the routine operation of the hospital or the routine care of a particular patient. The results of this event require or could have required (near miss) unexpected medical intervention, unexpected intensity of care, or causes or had the potential to cause an unexpected physical or mental impairment."</p> <p>The DRC stated on August 2, 2011, at 11:45 a.m., that she hoped an incident that involved delays in assessment and treatment for a patient who subsequently died would be the subject of an occurrence notification.</p> <p>During an interview with the Director Of Risk Management, (DRM) on August 2, 2011, at 12:30 p.m., she stated no occurrence notification had</p>	A 267		
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A 267	<p>Continued From page 13 been filed regarding Patient 3.</p> <p>During an interview with the Chief Medical Officer, (CMO) and the Medical Director of the ED, they stated that the death of Patient 3 had been reviewed, using criteria, by a QA nurse. The nurse reviewed the care as appropriate, so it was not subject to further review by the quality department, but, as with all deaths in the ED, the case was sent to the ED for quality review by the ED QRC.</p> <p>On July 27, 2011, the DRC supplied the criteria used by the QA department nurse in the review of patient deaths to determine if quality of care issues occurred. The criteria were listed on a piece of paper, but there was no associated policy, and no evidence of approval by the facility, and no date on the criteria when they were approved or implemented.</p> <p>The mortality review criteria included: "surgery/invasive procedure within 24 hr of death, death related to healthcare associated infection, hp (history and physical exam) on chart within 24 hrs, If in ICU, was the required consultations obtained?, were consultations done timely?, death report completed by nursing, OPO (organ procurement organization) called within 1 hr of death, coroner's office called, death summary/DC summary by MD within 14 days, pain management addressed appropriately, patient support measures provided, family support measures provided." The mortality review criteria did not have the capability of identifying quality of care problems such as the timeliness or adequacy of nursing assessments, nor the timeliness or correctness of treatments</p>	A 267		
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A 267	Continued From page 14 administered, nor nursing failure to notify physician of a change in the patient's condition, nor whether necessary consultations had been obtained in areas other than the ICU, nor for delays in bed availability. During an interview with the CNO on July 27, 2011, at 12 p.m., she stated there had been no quality assurance follow-up to determine if the QA mortality review criteria were being accurately assessed.	A 267			
A 311	482.21(e)(1) EXECUTIVE RESPONSIBILITIES [That an ongoing program for...] patient safety, including the reduction of medical errors, [is defined, implemented, and maintained.] This STANDARD is not met as evidenced by: Based on interview and record review, the Governing Body failed to ensure that the process for mortality review was defined and implemented as part of a quality assurance process to reduce medical errors. This failed practice could potentially result in the risk of an ineffective mortality review process and substandard healthcare for all patients using the facility. Findings: During an interview with the Management Consultant on July 26, 2011, at 11:20 a.m., she stated the quality review committee was reviewing all deaths related to the ED since January 5, 2011. The medical record of Patient 3 was reviewed on July 26, 2011, through August 2, 2011. Patient 3 came to the ED on [REDACTED] 2011, at 9:42	A 311	482.21(e)(1) EXECUTIVE RESPONSIBILITIES Actions Taken: 1. The CMO addressed the Board of Governors concerning the importance of having a defined mortality review process with comprehensive criteria to assess and address issues and to reduce medical errors. The CMO defined the process for mortality review, which identifies exceptions to reviewing mortality cases and the revised criteria used to review mortality cases. The MEC and Board of Governors approved the process, criteria and applicable staff were inserviced. Except for DNR or comfort care admissions, all mortality cases are reviewed by the appropriate committee utilizing the approved mortality review criteria. The revised mortality review criteria includes, among other things, the following: a) was death expected or anticipated on admission?; b) was death explained by the condition and/or diagnosis?; c) did the progress notes document a poor prognosis?; d) did death occur within 24 hours of admission?; e) did death occur within 48 hours of surgery or a procedure?; f) were appropriate care measures provided (diagnostic, therapeutic or supportive)?; g) did a complication related to treatment or care	9/6/11	

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A 311	<p>Continued From page 15</p> <p>p.m., via ambulance with complaints of weakness and leg pain. The medical record of Patient 3 showed there were delays in providing treatment to Patient 3, nursing assessments were not documented as frequently as the patient's condition warranted, there was a delay in obtaining a bed for the patient, and nurse communication with the admitting physician was not carried out and documented per physician orders. Patient 3 expired at 6:20 a.m. in the ED (see A1112).</p> <p>During an interview with the Chief Medical Officer (CMO), and the ED Medical Director, they stated the death of Patient 3 had been reviewed, using criteria, by a QA nurse. The nurse reviewed the care as appropriate, so it was not subject to further review by the quality department, but, as with all deaths, the case was sent to the ED for quality review. The ED Quality Review Committee (QRC) was presented with the case and the single question for evaluation, "Were orders appropriate and timely?" The ED QRC was not asked to evaluate other aspects of Patient 3's care such as the failure to perform and document timely assessments, the failure to obtain a bed within facility time goals, or the failure of the nurse to notify the admitting physician promptly of the patient's worsening respiratory distress.</p> <p>On July 27, 2011, the Director Of Regulatory Compliance (DRC), supplied the criteria used by the QA department nurse in the review of patient deaths to determine if quality of care issues occurred. The criteria were listed on a piece of paper, but there was no associated policy, and no evidence of approval by the facility, and no date</p>	A 311	<p>Continued From page 15</p> <p>contribute to death?; h) did the complication relate to an omission of care?; i) was there a medication error or adverse drug event?; j) was there communication failure related to the death?; or k) was there a system failure contributing to the death?</p> <p>2. The CMO, Director of Quality and multiple members of applicable departments re-reviewed Patient 3's care and identified issues related to complying with physician orders, timely medication administration, handling of critical lab results, patient assessments, nursing documentation, addressing and reporting of changes in patient's condition, addressing staffing issues when there is a change in patient's condition, utilization and understanding of new computer system, and utilizing appropriate chain of command measures to effectuate the safe delivery of patient care. Action Plans were developed and implemented. This included educating nurses on handling abnormal lab values, timely implementing physician orders, performing and documenting nursing assessments based on the patient's condition, and chain of command procedures for requesting assistance and reporting issues. In addition, applicable leadership staff were inserviced on applicable policies and procedures for addressing increases in staff to meet current patient care needs. Meetings were held with applicable nurses regarding Patient 3's care. In addition, Hospital and Physician Leadership, Quality Department staff and the Board of Governors were inserviced on the process for completing thorough investigations of adverse events/occurrences. Compliance review and performance improvement measures for this</p>	9/6/11

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A 311	<p>Continued From page 16 on the criteria when they were approved or implemented.</p> <p>The mortality review criteria included: surgery/invasive procedure within 24 hr of death, death related to healthcare associated infection, hp (history and physical exam) on chart within 24 hrs, If in ICU, was the required consultations obtained?, were consultations done timely?, death report completed by nursing, Organ Procurement Organization (OPO) called within 1 hr of death, coroner's office called, death summary/DC summary by MD within 14 days, pain management addressed appropriately, patient support measures provided, family support measures provided.</p> <p>The mortality review criteria did not have the capability of identifying quality of care problems such as the timeliness or adequacy of nursing assessments, nor the timeliness or correctness of treatments administered, nor nursing failure to notify physician of a change in the patient's condition, nor whether necessary consultations had been obtained in areas other than the ICU, nor for delays in bed availability.</p> <p>In an interview with the Director Of Risk Management (DRM), on August 2, 2011, at 10:55 a.m., she stated that she did not know where the mortality review criteria came from.</p> <p>In an interview with the DRC on August 2, 2011, at 11:00 a.m., she stated she was not sure of the origins of the mortality review criteria. She stated that the goal of the mortality review criteria was to identify quality of care issues. She concurred that quality of care issues such as treatment errors, or</p>	A 311	<p>Continued From page 16 case were reported through the hospital Quality Committee and the Quality Oversight Structure to the Board of Governors. The Board of Governors assessed the hospital's review and ongoing program for monitoring patient safety and determined that the case was sufficiently reviewed and effective measures implemented.</p> <p>3. Review of adverse events/occurrences is a standing agenda item at the Patient Safety Council and performance improvement measures are addressed and reported through the Quality Committee and the hospital Quality Oversight Structure to the Board of Governors on a monthly basis for their evaluation and comments.</p> <p>Compliance and Monitoring:</p> <p>The Director of Quality and the CMO or qualified designee review all mortality cases to achieve the goal of 100% compliance with the Mortality Review Process and mortality review criteria, and with ensuring communication of the issues to the Board of Governors for review and evaluation. Corrective action is taken as necessary. The CMO and Director of Quality report on compliance monthly to MEC for medical staff concerns/issues and to the Quality Committee for operational concerns/issues, who will report on compliance through the hospital Quality Oversight Structure to the Board of Governors monthly. This review will occur for 3 months and then be re-evaluated.</p> <p>Persons Responsible:</p> <p>CMO and Director of Quality</p>	<p>9/6/11</p> <p>9/6/11 and ongoing</p>

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A 311	Continued From page 17 delay or omission of assessment and treatment, or failure to notify the physician of a change in the patient's condition, or failure to obtain a necessary consult outside of the ICU, were not included in the mortality review criteria, and hence might not be sent for the quality department to review. She concurred that Patient 3's care was not identified by the criteria for quality assurance review. During an interview with representatives of the Governing Board on August 2, 2011, at 12:40 p.m., the Board members were asked if they were aware of the criteria for mortality review in the facility, and if they were aware that there was no facility policy regarding mortality review. The CMO stated that he believed the criteria had been in place for many years. Board Member 1 stated the subject of morbidity and mortality had come up for discussion a year and a half prior, but more pressing concerns had supervened. He stated that since then, there had been only informal discussion regarding morbidity and mortality.	A 311			
A 340	482.22(a)(1) MEDICAL STAFF PERIODIC APPRAISALS The medical staff must periodically conduct appraisals of its members. This STANDARD is not met as evidenced by: Based on interview and record review, for one of nine members of the Medical Staff reviewed, Physician Assistant (PA) 1, there was no documented evidence of ongoing professional practice evaluations being completed. This failed practice had the potential for the risk of substandard healthcare for patients receiving services from PA 1.	A 340	482.22(a)(1) MEDICAL STAFF PERIODIC APPRAISALS Actions Taken: 1. The Chief of Staff reviewed the Medical Staff Bylaws, which requires that the medical staff periodically performs appraisals of its members, including Allied Health Professionals (e.g., PAs). The CMO reviewed the Professional Practice Evaluation Policy, which defines ongoing professional practice evaluations (OPPE) and its use in determining whether to continue, limit or revoke existing privileges and reappointment, and the criteria used for assessing OPPE. The CMO also reviewed the OPPE form used with PAs and	8/3/11	

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A 340	Continued From page 19 months, and that the system had been in place for two years. She stated that the data from PA 1 would need to be collected manually, and this had not been done yet.	A 340	Continued From page 19 compliance to the MEC and the Board of Governors each review period.	
A 353	482.22(c) MEDICAL STAFF BYLAWS The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must: This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility's medical staff failed to adopt and enforce bylaws by failing to: 1. Ensure the basic responsibilities of the medical staff were implemented for one of 73 sampled patients (Patient 22). This failed practice resulted in the lack of follow up with an order for a urinalysis (a urine test), potentially contributing to the patient's readmission three days later with a diagnosis of urinary sepsis and bacteremia (severe infection manifested by the presence of bacteria in the blood). 2. Ensure the outpatient medical screening exam (MSE) or the nonstress test (NST), performed by the perinatal nurse, were authenticated by the physician to determine if patients' exams was appropriate and patients were appropriately discharged for 23 of 24 outpatient perinatal visits. This failed practice had the potential for a pregnant patient to have been seen at the facility and not to have been appropriately discharged from care. 3. Ensure the physician assessed the patient when the patient reported discomfort and concerns about a Foley catheter (tube draining	A 353	482.22(c) MEDICAL STAFF BYLAWS	

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A 353	<p>Continued From page 20</p> <p>urine from the bladder) for one of 73 sampled patients (Patient 1). This failed practice had the potential of creating the risk of unnecessary patient discomfort and a poor health outcome for Patient 1.</p> <p>4. Ensure the physician documented the continued need for a Foley catheter for one of 73 sampled patients (Patient 1). This failed practice had the potential of creating the risk of unnecessary catheter use and the attendant risks of pain and infection.</p> <p>5. Ensure the physician submitted a pathology specimen to the laboratory for one of 73 sampled patients (Patient 9). This failed practice had the potential of creating the risk of an undiscovered health condition due to tissue not being inspected.</p> <p>Findings:</p> <p>1. On [REDACTED] 2011, at 9:20 a.m. Patient 22 was observed lying in bed in the ED. The patient was moaning aloud, stating, "my sides hurt." Patient 22 was subsequently diagnosed with urinary sepsis and bacteremia, with gram negative rods, (a bacteria which is highly resistant to antibiotics).</p> <p>A family member seated next to the patient stated Patient 22 was at the facility [REDACTED] 2011, and will now be readmitted.</p> <p>A review of Patient 22's [REDACTED] 2011, admission was conducted. Patient 22 presented to the ED on [REDACTED] 2011, at 1:43 p.m., with a chief complaint of syncope (fainting). A urinalysis (a urine test) was ordered by the ED physician on</p>	A 353	<p>Continued From page 20</p> <p>Finding 1:</p> <p>Actions Taken:</p> <p>1. The CMO reviewed the Medical Staff Bylaws regarding physician responsibilities. 9/1/11</p> <p>2. The CMO reviewed Patient 22's case and met with the Emergency Department Chair to discuss the physicians responsibility for reviewing all ordered test results and any other necessary data prior to determining the course of treatment for the patient (e.g., admitting to the hospital or discharging the patient home) to ensure the safe and effective delivery of quality patient care. 9/1/11</p> <p>3. This case was referred to Surgery Quality Review on July 27, 2011. 7/27/11</p> <p>4. The CMO discussed the issue with the Chief 9/1/11</p>	

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A 353	<p>Continued From page 21 July 21, 2011, at 2:06 p.m.</p> <p>A review of the July 21, 2011, ED note indicated, "Nursing Procedure:Urine Collection...Indication for catheter: (tube which empties urine from the bladder) unable to void. Procedure performed at 3 p.m. Straight cath (catheter) performed using 8 fr (french-catheter size) kit in 1 attempt. Amount 15, ml (milliliters). Specimen labeled and sent to lab (laboratory)."</p> <p>Further record review of Patient 22's [REDACTED] 2011, admission failed to show a lab result for the urine specimen obtained on [REDACTED] 2011.</p> <p>An interview was conducted with the Laboratory Assistant on July 26, 2011, at 1:55 p.m., who stated when the ED physician enters an order into the system for a urinalysis, the label prints automatically and sometimes the lab receives urine specimens without orders, and sometimes the lab receives orders with no urine specimen.</p> <p>An interview was conducted with RN 12 on July 27, 2011, at 12:30 p.m., who stated, "If a urinalysis is ordered and completed it is the nurse's as well as the physician's responsibility to follow up with the result."</p> <p>An interview was conducted with the Supervisor of Clinical Lab Services (SCLS) on July 27, 2011, at 4 p.m., who stated after reviewing the laboratory specimen log and speaking with the lab courier, the urinalysis was ordered for Patient 22 on July 21, at 2 p.m., but the urine specimen never reached the lab and the order was cancelled July 23, 2011, at 12 p.m., after the patient was discharged.</p>	A 353	<p>Continued From page 21</p> <p>of Staff and drafted a letter to medical staff members concerning their responsibility for following up on ordered laboratory testing.</p> <p>Compliance and Monitoring:</p> <p>The CMO or a qualified designee will randomly review a minimum of 10 inpatient records monthly to monitor physician compliance with assuring orders are carried out (e.g., laboratory tests) and take corrective action as necessary in accordance with the hospital's peer review process. The CMO will report on compliance monthly to the MEC and Board of Governors. This review will occur for 3 months and then be re-evaluated.</p> <p>Person Responsible:</p> <p>CMO</p>	9/6/11	

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A 353	<p>Continued From page 22</p> <p>An interview was conducted with the SCLS on August 2, 2011, at 8:30 a.m., who stated, if the lab receives an order for a urinalysis and no urine specimen arrives the lab assistant would call to the floor and follow up with the order, however this process is not tracked or documented.</p> <p>An interview was conducted with MD 1 on July 28, 2011, at 10:30 a.m. MD 1 stated when one of his patients is transferred from the ED to the hospital as an inpatient, he would call the physician who is admitting the patient and communicate with him regarding the status of all outstanding orders. The situation with Patient 22 was a flaw in the process.</p> <p>A review of the facility's 2011 "Medical Staff Bylaws," indicate the basic responsibilities of medical staff membership include, "providing patients with the quality of care meeting the professional standards of the Medical Staff of this Hospital."</p> <p>Patient 22 was re-admitted to the facility three days later, on [REDACTED] 2011, complaining of side and back pain. The patient was subsequently diagnosed with urinary sepsis and bacteremia (critical urine infection that spread into the bloodstream).</p> <p>2a. On July 28, 2011, the record for Patient 51 was reviewed. Patient 51 was seen at IVMC Women's Center on:</p> <p>i. [REDACTED] 2011, at 4:35 p.m., with a chief complaint of no fetal movement for 24 hours. The</p>	A 353	<p>Continued From page 22</p> <p>Finding 2a - d:</p> <p>Actions Taken:</p> <p>1. The CMO reviewed the Medical Staff Bylaws regarding the basic responsibilities of medical staff membership, which includes their</p>	9/6/11

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A 353	Continued From page 23 "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 51 was evaluated by the RN and discharged home at 5:20 p.m. There was no indication the physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record." ii. [REDACTED] 2011, at 11:14 p.m., with a chief complaint of pain in lower back and vagina to butt, and 6 uterine contractions in an hour. The records dated [REDACTED] 2011, indicated Patient 51 was evaluated by the RN and discharged home at 1:06 a.m. There was no indication the physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record." iii. [REDACTED] 2011, at 6:30 p.m., with a chief complaint of green yellow vaginal discharge and cramps. The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 51 was evaluated by the RN and discharged home at 9 p.m. There was no indication the physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record." iv. [REDACTED] 2011 at 4:35 p.m., with a chief complaint of pain to right lower back and cramping. The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 51 was evaluated by the RN and discharged home [REDACTED] 2011, at 1:10 a.m. There was no indication the physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record." v. [REDACTED] 2011 at 7:15 p.m., with a chief complaint of back pain and vaginal pressure. The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 51 was evaluated by the RN and	A 353	Continued From page 23 responsibility in complying with approved Hospital policies and procedures. The CMO reviewed the findings identified during the survey regarding physician compliance with reviewing and initialing non-stress tests, and evaluating and signing the OB Outpatient Record regarding fetal monitoring strips in accordance with the applicable hospital policies. The CMO discussed the findings with the Chief of Staff and applicable Department Chairs and emphasized the importance of physician compliance with the hospital's policies and procedures. The CMO spoke with the applicable physicians regarding the hospital's policies for initialing non-stress tests and OB Outpatient Records regarding fetal monitoring strips. Failure to timely comply with the policies will lead to suspension of medical staff privileges for incomplete medical records per the Medical Staff Bylaws. 2. The CMO worked with the Directors of Health Information Management (HIM) and Women's Services to assist the physicians with ensuring that they sign all applicable records. HIM initiated a process to create a PDF file of Fetal Heart Tracing (FHT) and the MSE record that are uploaded into the "Document Imaging" system, providing the physician with remote access to review the documents, enter comments if necessary, and provide an electronic signature on the FHT and MSE. Applicable physicians were in serviced on this process. HIM also created a process to flag the charts for physician to review and sign applicable documents. Failure to comply will result in the entry of an HPRR (Healthcare Peer Review Report) and an investigation will be performed by the Peer Review Coordinator and lead to suspension of medical staff privileges for incomplete medical records per the Medical Staff Bylaws.	9/6/11

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A 353	<p>Continued From page 24</p> <p>discharged home at 11 p.m. There was no indication the physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>vi. [REDACTED] 2011 at 11:10 p.m., with a chief complaint of low back pain and occasional cramps. The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 51 was evaluated by the RN and discharged home at 1:40 a.m. The physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record," but not until [REDACTED] 2011, 17 days after the visit.</p> <p>vii. [REDACTED] 2011 at 11:30 p.m., with a chief complaint of worsening pain. The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 51 was evaluated by the RN and discharged home at 12:55 a.m. There was no indication the physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>viii. [REDACTED] 2011 at 8:51 p.m., with a chief complaint of uterine cramping and not feeling good. The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 51 was evaluated by the RN and discharged home at 11:30 p.m. There was no indication the physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>ix. [REDACTED] 2011 at 7:57 p.m., with a chief complaint of uterine contractions and no fetal movement all day. The records dated [REDACTED] 2011, indicated Patient 51 was evaluated by the RN and discharged home at 9:35 p.m. There was</p>	A 353	<p>Continued From page 24</p> <p>3. The Director of Medical Staff drafted a letter to all OB/GYN medical staff regarding the expectation of compliance with the FHT and MSE policy requirements for reviewing and signing records. The OB/GYN Medical Staff Department Chair reviewed and approved the letter prior to being sent to all OB/GYN medical staff members.</p> <p>Compliance and Monitoring:</p> <p>The HIM Director coordinates a concurrent record review of a minimum of 50 OB/GYN records with the goal of achieving 100% compliance with physician reviewing and signing non-stress tests and signing OB Outpatient Records regarding fetal monitoring strips. Bimonthly, the aggregate data is provided to the OB/GYN Department for analysis and action planning, who forwards the reports, analysis, conclusions and recommendations to the MEC and Board of Governors. The frequency of the concurrent record review will be re-evaluated in three months.</p> <p>Persons Responsible:</p> <p>HIM Director CMO</p>	9/6/11 9/6/11 and ongoing

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A 353	<p>Continued From page 25</p> <p>no indication the physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>2b. On July 28, 2011, the record for Patient 52 was reviewed. Patient 52 was seen at IVMC Women's Center on:</p> <p>i. [REDACTED] 2011 at 4:47 p.m., with a chief complaint of uterine contractions. The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 52 was evaluated by the RN and discharged home at 10:15 p.m. There was no indication the physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>ii. [REDACTED] 2011 at 4:35 p.m., with a chief complaint of uterine contractions every 30 min, cramping, dizziness, nausea and vomiting. The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 52 was evaluated by the RN and discharged home at 2:45 a.m. There was no indication the physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>iii. [REDACTED] 2011 at 5:35 p.m., with a chief complaint of contractions in the lower back. The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 52 was evaluated by the RN and discharged home at 9 p.m. There was no indication the physician evaluated the outpatient record and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>2c. On [REDACTED] 2011, the records for patient 56 were reviewed. Patient 56 was seen as an outpatient in the labor and delivery department</p>	A 353		

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A 353	<p>Continued From page 26 on:</p> <p>i. [REDACTED] 2011, at 5:53 p.m., with a diagnosis of "vaginal bleeding." The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 56 was evaluated by the nurse and discharged home on [REDACTED] 2011, at 9:55 p.m. There was no indication the physician had evaluated the written outpatient record and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>ii. [REDACTED] 2011, at 4:18 p.m., with a diagnosis of "preterm labor (contractions prior to the 37th week of pregnancy)." The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 56 was evaluated by the nurse and discharged home on [REDACTED] 2011, at 5:20 p.m. There was no indication the physician had evaluated the written outpatient record and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>2d. On [REDACTED] 2011, the records for patient 57 were reviewed. Patient 57 was seen as an outpatient in the labor and delivery department on:</p> <p>i. [REDACTED] 2011, at 9:30 a.m., with diagnosis of premature contractions. The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 57 was evaluated by the nurse and discharged home on [REDACTED] 2011, at 4:45 p.m. There was no indication the physician had evaluated the written outpatient record and fetal monitor strips by signing the "OB Outpatient Record."</p> <p>ii. [REDACTED] 2011, at 11:50 a.m., with a diagnoses of mild contractions, nonstress testing (monitoring to aid in the determination of fetal well-being) and</p>	A 353		

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A 353	Continued From page 27 administration of betamethasone (a medication used to mature fetal lungs). The "OB Outpatient Record" dated [REDACTED] 2011, indicated Patient 57 was evaluated by the nurse and discharged home on [REDACTED] 2011, at 2:45 p.m. There was no indication the physician had evaluated the written outpatient record by signing the "OB Outpatient Record." iii. [REDACTED] 2011, at 2:25 p.m., with diagnosis of "fetal monitoring." The "Nursing Flowsheets" dated [REDACTED] 2011, indicated Patient 57 was evaluated by the nurse and discharged home on [REDACTED] 2011, at 3:30 p.m. There was no indication the physician had reviewed and initialed the fetal monitor strips. iv. [REDACTED] 2011, at 9:10 a.m., with diagnosis of nonstress testing (NST) for preterm labor. The "Nursing Flowsheets" dated [REDACTED] 2011, indicated Patient 57 was evaluated by the nurse and discharged home on [REDACTED] 2011, at 9:45 a.m. There was no indication the physician had reviewed and initialed the fetal monitor strips. v. [REDACTED] 2011, at 9:05 a.m., with diagnosis of nonstress testing for preterm labor. The "Nursing Flowsheets" dated [REDACTED] 2011, indicated Patient 57 was evaluated by the nurse and discharged home on [REDACTED] 2011, at 9:45 a.m. There was no indication the physician had reviewed and initialed the fetal monitor strips. vi. [REDACTED] 2011, at 9:25 a.m., with diagnosis of nonstress testing for preterm labor. The "Nursing Flowsheets" dated [REDACTED] 2011, indicated Patient 57 was evaluated by the nurse and discharged home on [REDACTED] 2011, at 10:05 a.m.	A 353		

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A 353	<p>Continued From page 28</p> <p>There was no indication the physician had reviewed and initialed the fetal monitor strips.</p> <p>vii. [REDACTED] 2011, at 10:12 a.m., with diagnosis of nonstress testing for preterm labor. The "Nursing Flowsheets" dated [REDACTED] 2011, indicated Patient 57 was evaluated by the nurse and discharged home on [REDACTED] 2011, at 11:30 a.m. There was no indication the physician had reviewed and initialed the fetal monitor strips.</p> <p>viii. [REDACTED] 2011, at 4:03 p.m., with diagnosis of nonstress testing for preterm labor. The "Nursing Flowsheets" dated [REDACTED] 2011, indicated Patient 57 was evaluated by the nurse and discharged home on [REDACTED] 2011, at 4:50 p.m. There was no indication the physician had reviewed and initialed the fetal monitor strips.</p> <p>ix. [REDACTED] 2011, at 3:55 p.m., with diagnosis of nonstress testing for preterm labor. The "Nursing Flowsheets" dated [REDACTED] 2011, indicated Patient 57 was evaluated by the nurse and discharged home on [REDACTED] 2011, at 5:40 p.m. There was no indication the physician had reviewed and initialed the fetal monitor strips.</p> <p>On July 27, 2011, at 2:15 p.m., an interview was conducted with the Director of Health Information Management (DHIM), Nurse Manager (NM) 2, and Educator 1. They stated the physician was supposed to sign the outpatient record. In addition, they stated the physician should sign an NST within 24 hours of the test occurring and authenticate a medical screening exam performed by the perinatal nurse within 48 hours of the examination occurring.</p>	A 353			

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A 353	<p>Continued From page 29</p> <p>During an interview with Educator 1, on July 27, 2011, at 4:30 p.m., she reviewed the clinical records for Patients 56 and 57, and was not able to find documentation that the physicians had reviewed and initialed the fetal monitor strips for nonstress testing outpatient visits or had evaluated the written outpatient record and fetal monitor strips by signing the "OB Outpatient Record" for MSE visits.</p> <p>The facility "Medical Staff Bylaws 2011" dated June 23, 2011, indicated "Basic Responsibilities of Medical Staff Membership ... (b) abiding by the Medical Staff bylaws, Medical Staff rules and regulations, and policies and Medical-Staff approved Hospital policies and procedures, ... (d) preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the Hospital ..."</p> <p>The facility policy and procedure titled "Standardized Procedure: EMTALA-2-Perinatal Medical Screening Exam" reviewed July 2011, indicated "... The primary physician shall evaluate the written outpatient record and any fetal monitor strips obtained during the observation period. The physician will countersign his telephone orders and sign the outpatient record. ..."</p> <p>The facility policy and procedure titled "Nonstress Test" dated November 2010, indicated "... The physician must review and initial the NST within twenty-four (24) hours of completion of the test. This may be done remotely via the electronic documentation system (OBTVUE). ..."</p> <p>3. Patient 1 submitted a grievance regarding care</p>	A 353	Continued From page 25		
			Finding 3:		

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A 353	<p>Continued From page 30</p> <p>received at the facility to the health plan, which sent it to the facility. Patient 1's allegations related to an inpatient stay [REDACTED] to [REDACTED] 2011, and subsequent emergency room visits. The allegation related to his inpatient stay was that he found a urinary catheter (a tube extending from the bladder to the outside of the body) uncomfortable, and physicians were not handling the issue.</p> <p>The medical record for Patient 1 during his inpatient stay from [REDACTED] 2011, was reviewed. The nursing documentation showed that Patient 1 complained on [REDACTED] 2011, of discomfort he related to the urinary catheter, and the physician had been contacted and stated he would come to see the patient. However, there was no documentation that the physician came to see the patient. Patient 1 complained of pain 10/10, (on a scale of one to ten, with ten being the highest level of pain) during the night, and was discharged the next day, [REDACTED] 2011, with the catheter still in place.</p> <p>Portions of the medical record for Patient 1 were reviewed with the Chief Medical Officer (CMO) on July 28, 2011, at 9 a.m. The CMO concurred that the physician, who stated he would come to see Patient 1 in response to Patient 1's concern about the catheter and discomfort, should have gone to see Patient 1.</p> <p>During an interview with the Director Risk Management (DRM) on July 28, 2011, at 10:30 a.m., she stated the physician who stated he was coming to see the patient in response to his complaint of discomfort should have gone to</p>	A 353	<p>Continued From page 30</p> <p>Actions Taken:</p> <ol style="list-style-type: none"> 1. The CMO reviewed the findings identified during the survey, Patient 1's grievance and the medical record. The CMO met with the applicable physician to discuss the issues and his responsibility for providing patient care that meets the professional responsibilities of the Hospital's Medical Staff, including timely assessing patients' status and developing a treatment plan. 2. The Surgery Peer Review Committee reviewed Patient 1's grievance and investigated the issue in accordance with the peer review process. 3. The CMO developed an education program for the next medical staff meeting to discuss the physicians responsibilities for providing patient care that meets the professional responsibilities of the hospital's Medical Staff in accordance with the Medical Staff Bylaws, which includes, at a minimum, timely assessing patients' status and developing a treatment plan. Physicians who are unable to attend will be mailed a copy of the educational program. <p>Compliance and Monitoring:</p> <p>The CMO or qualified designee will randomly review a minimum of 10 inpatient records monthly to monitor physician compliance with assessing a patient's status and developing a treatment plan and take corrective action as necessary in accordance with the hospital's peer review process. The CMO will report on compliance to the MEC and Board of Governors. This review will occur for 3 months and then be re-evaluated.</p> <p>Person Responsible: CMO</p>	9/1/11 7/27/11 9/6/11 9/6/11 and ongoing	

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A 353	<p>Continued From page 31 assess the patient.</p> <p>The Medical Staff Bylaws (dated June 23, 2011), reviewed on July 28, 2011, read in part, "Except for the honorary and retired staff the ongoing responsibilities of each member of the Medical /Staff include: providing patients with the quality of care meeting the professional standards of the Medical /Staff of this Hospital. ..."</p> <p>4. Review of the medical record of Patient 1 on July 26, 2011, showed that Patient 1 had a Foley catheter (a tube extending from the bladder to outside the body to drain urine) placed prior to surgery on [REDACTED] 2011. The medical record contained three stickers placed in the "Physician's Orders" section of the chart, for documentation of the medical necessity of central lines (tubes extending from a major blood vessel to outside the body) and Foley catheters. The pre-printed stickers contained check-boxes on which the existence of central lines or a Foley catheter were to be documented, and boxes to indicate the reason for the lines or catheter.</p> <p>The first such sticker in Patient 1's medical record was inserted on February 9, 2011, and had no boxes checked, was unsigned, and the pre-printed sticker was left blank. The second sticker was placed on February 10, 2011, had the box "medical condition prohibits use of bedpan or bedside commode" checked, and the physician's signature, but no date or time signed. Review of the Patient Progress Notes on February 10, 2011, showed Patient 1 ambulated in the hallway on that date. There was no documentation provided in the medical record that Patient 1 was unable to use a bedpan or commode. A third sticker</p>	A 353	<p>Continued From page 31</p> <p>Finding 4:</p> <p>Actions Taken:</p> <ol style="list-style-type: none"> 1. The CMO reviewed the findings identified during the survey and Patient 1's medical record. The CMO met with the applicable physician to discuss the issues and his responsibility for providing patient care that meets the professional responsibilities of the hospital's Medical Staff and complies with hospital policy regarding assessing and documenting the ongoing medical necessity for Foley catheters on the pre-printed sticker placed in the physician orders section of the medical record. 2. The Surgery Peer Review Committee reviewed Patient's 1 medical record and investigated the issues in accordance with the peer review process. 3. The Chief of Staff discussed at the September general medical staff meeting the physicians responsibilities for providing patient care that meets the professional responsibilities of the hospital's Medical Staff in accordance with the Medical Staff Bylaws, which includes, at a minimum, following hospital policy regarding documentation of a daily assessment supporting medical necessity for 	<p>7/30/11</p> <p>7/27/11</p> <p>9/2/11</p>

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A 353	Continued From page 33 During an interview with Nurse Manager (NM) 5 on July 28, 2011, at 11:15 a.m., she concurred that there was no description of the skin lesion removed, and no documentation of a specimen sent to pathology. During a review on July 27, 2011, of the facility policy, "Specimen Collection: Pathology," the policy read in part, "In compliance with regulatory guidelines, all anatomical parts, tissue and foreign objects removed by an operation/procedure will be delivered to the pathology department for examination with the exception of the -do not submit list (see Examination section below)." The examination list was reviewed, and the list did not include a "skin lesion" or "skin mass" in the list of specimens that did not need to be sent to pathology. Below the exemption list, the policy reiterated in all capital letters: "ALL OTHER SPECIMENS MUST BE SENT TO PATHOLOGY FOR EXAMINATION." The Medical Staff Bylaws (dated June 23, 2011), reviewed on July 28, 2011, read in part, "Except for the honorary and retired staff, the ongoing responsibilities of each member of the Medical Staff include: (b) abiding by the Medical Staff bylaws, Medical Staff rules and regulations, and policies and Medical-Staff approved Hospital policies and procedures, including those related to the security of electronic health records ..."	A 353	Continued From page 33 tissue and foreign objects removed during surgery/procedure are sent to pathology for exam unless the specimen is listed on the "Do Not Submit" list approved by the Board of Governors. In addition, documentation is required in the medical record describing the particular specimen. Ongoing failure to comply will result in a referral to the Peer Review Committee for investigation and corrective action. 2. On 9/1/11, The Department of Surgery reviewed the "Do Not Submit" exemption list to include two additional specimens pending approval from the MEC and Board of Governors at the September meetings. 3. At the September Surgery Committee meeting, the CMO discussed the Specimen Collection: Pathology policy and the "Do Not Submit" list of exempted pathology specimens. The CMO also emphasized the importance of describing the specimen in the medical record. In addition, all physicians were mailed a letter regarding their responsibility for complying with Medical Staff approved policies and procedures, including the policy for pathology specimens. A copy of the policy and the "Do Not Submit" list was included in the above correspondence. 4. The CMO and Director of Surgical Services met to discuss nursing support in ensuring that specimens obtained during surgery/procedure are sent to pathology unless exempted on the "Do Not Submit" list by the Board of Governors. The Director of Surgical Services re-inserviced applicable clinical staff regarding the policy and to initiate the Chain of Command per policy with any instances of attempted noncompliance for immediate corrective action with the surgeon.	9/1/11 9/6/11 9/1/11
A 358	482.22(c)(5) MEDICAL STAFF RESPONSIBILITIES [The bylaws must:] Include a requirement that--	A 358		

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A 353	Continued From page 33 During an interview with Nurse Manager (NM) 5 on July 28, 2011, at 11:15 a.m., she concurred that there was no description of the skin lesion removed, and no documentation of a specimen sent to pathology. During a review on July 27, 2011, of the facility policy, "Specimen Collection: Pathology," the policy read in part, "In compliance with regulatory guidelines, all anatomical parts, tissue and foreign objects removed by an operation/procedure will be delivered to the pathology department for examination with the exception of the -do not submit list (see Examination section below)." The examination list was reviewed, and the list did not include a "skin lesion" or "skin mass" in the list of specimens that did not need to be sent to pathology. Below the exemption list, the policy reiterated in all capital letters: "ALL OTHER SPECIMENS MUST BE SENT TO PATHOLOGY FOR EXAMINATION." The Medical Staff Bylaws (dated June 23, 2011), reviewed on July 28, 2011, read in part, "Except for the honorary and retired staff, the ongoing responsibilities of each member of the Medical Staff include: (b) abiding by the Medical Staff bylaws, Medical Staff rules and regulations, and policies and Medical-Staff approved Hospital policies and procedures, including those related to the security of electronic health records ..."	A 353	Continued From page 34 Compliance and Monitoring: The CMO or qualified designee will randomly review a minimum of 10 surgical/procedure records monthly to monitor physician compliance with sending specimens to pathology for review in accordance with the Hospital's policy and "Do Not Submit" list. Corrective action will be taken as necessary in accordance with the hospital's peer review process. The CMO will report on compliance monthly to the MEC and Board of Governors. This review will occur for 3 months and then be re-evaluated. Person Responsible: CMO	9/6/11 and ongoing
A 358	482.22(c)(5) MEDICAL STAFF RESPONSIBILITIES [The bylaws must:] Include a requirement that--	A 358	482.22(c)(5) MEDICAL STAFF RESPONSIBILTIES Actions Taken: 1. The CMO reviewed the Medical Staff Bylaws, Rules and Regulations and history and physical requirements. Compliance with the Medical Staff Rules and Regulations	8/30/11

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A 358	<p>Continued From page 34</p> <p>(i) A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified individual in accordance with State law and hospital policy.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, for one of 73 sampled patients (Patient 9), the facility failed to ensure a complete and accurate pre-operative history and physical examination was completed by the surgeon. This failed practice potentially could create the risk of a poor health outcome for Patient 9 due to failure to review the patient's medical needs.</p> <p>Findings:</p> <p>During a review of medical record of Patient 9 on July 26, 2011, discrepancies were noted when comparing the patient's history and physical documentation by the pre-admitting nurse, the surgeon and the anesthesiologist. On the pre-admitting nursing assessment dated July 21, 2011, Patient 9 was described as having a 12 year history of limb girdle muscular dystrophy (a disorder affecting muscle strength), a 10 year history of sleep apnea (pauses in breathing during sleep, a condition that can give rise to significant health problems, including heart damage) morbid obesity, and a surgical history</p>	A 358	<p>Continued From page 34a</p> <p>concerning complete and accurate history and physical exams is a standing agenda item in performance review, and trending of noncompliance, incomplete or inaccurate history and physicals results in the physician being referred for peer review in accordance with the peer review process.</p> <p>2. The CMO reviewed the survey findings and medical record for Patient 9. The CMO spoke with the surgeon regarding the findings and emphasized the physician's responsibility to ensure a complete and accurate pre-operative history and physical exam is in the medical record. The history and physical exam shall include the chief complaint and admitting diagnosis, details of present illness, past history, review of body systems, relevant past/social/family/psychosocial history and a relevant physical exam. Any inconsistencies between patient assessments/history shall be addressed by the physician.</p> <p>3. The CMO discussed the issue with the Chief of Staff and Department Chair for Surgery. The CMO issued a written communication to surgeons on the medical staff regarding their responsibility for obtaining a complete and accurate preoperative history and physical examination. This issue was also discussed at the 09/01/11 Department of Surgery Committee meeting. In addition, the CMO sent a written communication to Medical Staff members reinforcing the Hospital's expectation that history and physicals are to be performed timely and complete and accurate. Any discrepancies between disciplines assessments will be addressed and</p>	9/6/11 9/6/11	

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A 358	<p>Continued From page 35 that included three surgeries under general anesthesia,</p> <p>The surgeon's History and Physical Examination, dated July 26, 2011, was reviewed on July 26, 2011. The medical history included degenerative joint disease, gastroesophageal reflux disease and morbid obesity, but "otherwise negative for cardiac, pulmonary, GI, or neuroskeletal disease." Also the surgeon documented on the line for past surgical history, "none."</p> <p>The anesthesiologist's "Preoperative Anesthesia Evaluation" for the July 26, 2011, surgery indicated that Patient 9 had limb girdle muscular dystrophy, gastroesophageal reflux, sleep apnea for which he used CPAP (a machine to help with breathing).</p> <p>None of the assessments provided a description of a right leg mass or lesions, although one was removed during surgery, and not sent to the laboratory.</p> <p>During an interview with the Director Of Risk Management (DRM) on July 28, 2011, at 10:30 a.m., she concurred that there were discrepancies between Patient 9's preoperative history and physical exam and the pre-admitting history and the anesthesiologist's history information.</p> <p>During an interview with NM 5 on July 28, 2011, at 11:15 a.m., she agreed that there were multiple discrepancies between the nurse, anesthesiologists, and the surgeon's history and physical examination. She concurred that the failure to describe the skin lesion that was</p>	A 358	<p>Continued from page 35</p> <p>documented in the medical record. The CMO placed this issue as an agenda item on the next Medical Staff Committee meeting agenda. Issues with physician noncompliance with history and physical requirements are addressed through the peer review process.</p> <p>4. The CMO met with the Director of Surgical Services regarding the revised Admission Perioperative Services policy for nursing services, which requires a nursing review of the pre-operative history and physical exams to identify any discrepancies and immediate steps to be taken prior to the surgery/ procedure. The involved physicians (e.g., surgeon and anesthesiologist) shall be notified of a discrepancy in the history and physicals and nursing assessments and a repeat discussion will be performed with the patient to ensure that complete history and physical is obtained and placed in the medical record. If the nurse brings the discrepancy to the physician's attention and it is not addressed, the nurse shall initiate the Chain of Command for immediate action and if necessary, enter an HPRR into the system for peer review. The Director of Surgical Services shall ensure that all such cases are discussed with the CMO and that the peer review referral is initiated when necessary. The Board of Governors approved the revised Admission Perioperative Services policy. The Director of Surgical Services inserviced the perioperative and preadmission surgery nurses on the policy.</p>	9/6/11

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A 358	Continued From page 36 removed, especially in light of the fact that it was not sent to pathology, presented a risk to the patient. The Medical Staff Rules and Regulations (June, 2011) read in part, "The patient's attending physician and each practitioner involved in the care of the patient shall be responsible for preparing a complete and legible medical record for each patient. Admitting physician, or his designee, is responsible for the completion of the patient's H & P and discharge /transfer summary," and "A history and physical examination shall be dictated/legible written and include chief complainant and admitting diagnosis, details of present illness, past history (including allergies, current medications, and conditions), inventory of body systems, relevant past/social/family history and psychosocial history, relevant physical exam ..."	A 358	Continued From page 36 Compliance and Monitoring: The CMO or qualified designee reviews a minimum of 10 medical records monthly (both medical and surgical cases) to achieve a goal of 100% compliance with accurate and complete history and physicals and take corrective action as necessary. The CMO performs random "real time" preoperative reviews of a minimum of 5 surgical cases to monitor compliance with the preoperative history and physicals prior to the surgery/ procedure and takes immediate corrective action if necessary. This shall occur for 3 months and then be re-evaluated. The CMO reports on compliance monthly to the MEC and Board of Governors. Person Responsible: CMO	9/6/11 and ongoing	
A 363	482.22(c)(6) CRITERIA FOR MEDICAL STAFF PRIVILEGING [The bylaws must:] Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. This STANDARD is not met as evidenced by: Based on interview and record review, for 1 of 9 credential files reviewed (PA 2), the facility failed to identify specific privileges that the PA was granted. This failed practice potentially created the risk of PA 2 attempting to perform services for which he was not deemed competent, and hence the risk of substandard services for patients	A 363	482.22(c)(6) CRITERIA FOR MEDICAL STAFF PRIVILEGING Actions Taken: 1. The CMO reviewed the Medical Staff Bylaws, specifically the criteria for determining privileges granted to individual practitioners (including AHPs) and the process for applying the criteria. The CMO reviewed the survey findings and the credential file for PA 2. The CMO spoke with the applicable Medical Staff Department Chair concerning the PA's specific privileges and the importance of reviewing and documenting the privileges granted to each medical staff physician and AHP member. The Department Chair re-reviewed the PA's credential file and completed the necessary documentation for practice privileges. The Chair of Surgery revised the privilege forms for granting privileges and the revised forms were	8/30/11	

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A 363	Continued From page 37 cared for by PA 2. Findings: During a review of the credential file of PA 2, who worked in the ED, on July 26, 2011, at 2:30 p.m., with the Director of the Medical Staff (DMS), no documentation was found to show that specific privileges were requested or granted for PA 2. During a concurrent interview with the DMS, she stated that PAs had been given general privileges in accordance with their license and supervisory agreement. She stated that new privilege sheets had been implemented in the facility in early 2011, but they had not yet been put into place for PA 2. During a review of the Medical Staff Bylaws (multiple approval dates January through June, 2011), the bylaws read in part, "Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant."	A 363	Continued From page 37 approved by MEC and the Board of Governors. PA's are not allowed to perform privileges that have not been reviewed and approved in accordance with the Medical Staff appointment and reappointment process. 2. The CMO spoke with the Medical Staff Director regarding responsibility for maintaining complete medical record credential files. The Medical Staff Director reviewed all PA credential files to ensure 100% compliance with identification of specific practice privileges. The Director of Medical Staff is responsible for ensuring that all credential files for all practitioners identifies approved privileges. Compliance and Monitoring: The CMO or qualified designee performs a 100% review of the initial and re-appointment profiles for PA's prior to submission to credentials committee to ensure specific practice privileges are contained in the file. The credentials committee makes recommendations for appointment/ re-appointment to MEC who report the recommendations to the Board of Governors.	8/30/11	
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide nursing service to meet the needs of all patients by: 1. Failing to ensure all licensed nurses administered medications in accordance with the facility's policy and procedure consistent with	A 385	Person Responsible: CMO 482.23 NURSING SERVICES Southwest assures that it has an organized nursing service that is furnished or supervised by registered nurses (RN). Hospital Nursing Leadership discussed the immediate jeopardy and other nursing findings identified during the survey and reviewed all applicable policies and procedures (e.g., medication administration and medication error reporting policy) to ensure adequacy for promoting and maintaining compliance with applicable nursing services. Hospital Nursing Leadership met with the CMO and Director of Pharmacy to discuss medication related issues, including "pop up" alerts in Pyxis and notices on the	9/6/11 and ongoing 8/12/11	

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A 385	<p>Continued From page 38</p> <p>accepted standards of practice. RN 1 administered an excessive dose of an injectable medication (desmopressin- a medication to decrease urination. It is used to treat diabetes insipidus, which is a condition in which the kidneys are unable to conserve water.) and did not use a filtered needle while withdrawing the medication out of a glass ampul. RN 1 also administered an injectable medication (Protonix-medication used to reduce stomach acid production to prevent heartburn and gastrointestinal ulcers) at a rate faster than manufacturer's recommendations.</p> <p>This resulted in medication errors which potentially placed the patient (Patient 11) at risk for serious harm by not following manufacturer's recommendations and the facility's policy and procedure for preparing intravenous injectable medications, the effect of which would not be easily reversible. In addition, the facility failed to respond timely to address the serious medication errors and immediately implement preventive actions to minimize the impact to patients.</p> <p>Due to the facility's failure to administer injectable medications in ICU (Intensive Care Unit) and failure to take steps to prevent further medication errors, the survey team called an immediate jeopardy on July 26, 2011, at 6:55 p.m., in the presence of the CEO, CNO, CMO, and DRM.</p> <p>The survey team accepted the facility's plan of action to resolve the immediate jeopardy situation on July 27, 2011, at 1:50 p.m. Refer to A0404.</p> <p>2. Failing to ensure a registered nurse supervised and evaluated the nursing care for 8</p>	A 385	<p>Continued From page 39</p> <p>until a supervised management re-remediation plan was completed with daily monitoring. Nursing staff receives medication administration competencies upon hire, annually and as necessary for identified issues.</p> <p>Nursing Leadership also reviewed the findings related to RN assessments, following of physician orders, and identifying and following through on the need for nutritional consults. Nursing received education on these issues, with special emphasis on a) the nurse's ultimate responsibility for performing comprehensive assessments to address patient care issues (e.g., Foley issues, skin care/turning and nutritional assessments); and b) ensuring that all physician orders on their patients are carried out, documented in the medical record and appropriate communication occurs with physicians and other applicable disciplines. Failure to comply will result in disciplinary action, including termination if necessary.</p> <p>Compliance and Monitoring:</p> <p>The QAPI Committee tracks, trends, analyzes, and implements corrective action and follow up for the nursing service issues identified during the survey. Compliance is reported through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis.</p> <p>Person Responsible:</p> <p>CNO</p>	9/6/11 9/6/11 and ongoing

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A 385	Continued From page 39 of 73 sampled patients (Patient 8, 9, 18, 21, 22, 23, 31, and 39) by failing to ensure physician's orders were carried out, patients were fully assessed, and/or nutritional consultations were obtained. Refer to A0395 and A0404. The cumulative effect of these systemic problems resulted in the failure of the facility to provide adequate nursing care and services, which had the potential to result in serious harm, injury, and/or death.	A 385		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a registered nurse supervised and evaluated the nursing care for 7 of 73 sampled patients (Patient 8, 9, 18, 21, 22, 31, and 39) by: 1. Failing to ensure physician's orders for a urinalysis (urine test to check for infection) were implemented as ordered for Patient 22. This failure potentially contributed to Patient 22's readmission to the facility three days later with a diagnosis of urinary sepsis (severe urinary infection which causes an infection in the blood). 2. Failing to ensure the RN assessed an indwelling urinary catheter (a tube placed into the bladder to drain urine.) for Patient 31. This had the potential to result in Patient 31 acquiring an infection.	A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE	

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A 395	<p>Continued From page 43</p> <p>On July 26, 2011, Patient 31's record was reviewed. The patient was admitted through the ED on [REDACTED] 2011, with chief complaint of drug overdose.</p> <p>The "Emergency Record" timed at 1 a.m. ([REDACTED] 2011), indicated Patient 31 was unable to urinate and that was the purpose for the indwelling urinary catheter.</p> <p>The "Admitting/Intra-Facility Transfer Orders" dated July 24, 2011, at 7:22 a.m., indicated a transfer to the ICU (Intensive Care Unit). The record had a section indicating if Patient 31 needed a indwelling urinary catheter. The section was blank.</p> <p>During the review of the ICU Flow Sheet and records, there was no documented evidence of an assessment of Patient 31's indwelling urinary catheter.</p> <p>The "Admitting/Intra-Facility Transfer Orders" dated July 24, 2011, at 5:50 p.m., indicated a transfer from the ICU to the PCU. The record had a section indicating if Patient 31 needed a indwelling urinary catheter. The section was also blank.</p> <p>During the review of the PCU Flow Sheet and records, there was no documented evidence of an assessment Patient 31's indwelling urinary catheter.</p> <p>A review of the "Physician's Order Sheet" dated July 25, 2011, at 5:30 p.m., indicated, "...D/C (Discontinue) F/C (indwelling urinary catheter)."</p>	A 395	<p>Continued From page 43</p> <p>2. Nurses were inserviced on the policy, (e.g., including applicable nurse) with special emphasis on a) the need for a comprehensive patient assessment upon admission and/or upon transfer from another hospital unit; and b) the importance of documenting the patient assessment and reassessment on the applicable forms to promote the safe and effective care of the patient throughout the hospital stay. Patient assessment and reassessments, and any other nursing charting in the medical record, shall be thorough and complete. Nurses were also inserviced on completion of applicable forms (e.g., completing assessment of patient's indwelling urinary catheter). Failure to comply shall result in progressive corrective action.</p> <p>3. Education on patient assessments/ reassessments is provided annually and upon hire, and as needed.</p> <p>Compliance and Monitoring:</p> <p>The Director PI or qualified designees perform a concurrent record review of a minimum of 50 records monthly with the goal of achieving 100% to compliance with implementing physician orders and following through on execution of orders. Corrective action is taken as necessary. This review will occur for three months and then be re-evaluated. The PI Director will report on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis.</p> <p>Person Responsible:</p> <p>CNO</p>	9/6/11 9/6/11 9/6/11 and ongoing	

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A 395	<p>Continued From page 44</p> <p>On July 26, 2011, at 10:10 a.m., Patient 31's record was reviewed with RN 14. She stated, while the patient was in the PCU, Patient 31 had a F/C. The F/C was discontinued when the physician ordered it, prior to the transfer to the M/S/T west unit. The RN was unable to find any documented evidence that an assessment was conducted of the F/C in the PCU records.</p> <p>On July 26, 2011, at 10:20 a.m., Patient 31's record was reviewed with RN 1. She stated Patient 31 was admitted to the ICU, from the ED, and was transferred to the PCU with a F/C. RN 1 was unable to find documented evidence that an assessment was conducted of the F/C in the ICU.</p> <p>On July 26, 2011, at 10:30 a.m., the CNO stated there should have been documentation of an assessment of the F/C in the ICU and PCU.</p> <p>The facility policy titled, "Urinary Catheters," issued December 2010, was reviewed and indicated, "Purpose: To provide criteria to reduce the incidence of hospital acquired, catheter associated urinary tract infections..."</p> <p>The policy titled, "Assessment/Reassessment of Patient," reviewed October 2010, was reviewed and indicated, "Assessment of Patient...An initial assessment of each patient's physical...functional status...is completed by a Registered Nurse at time of admission..."</p> <p>The policy further indicated, "...The initial assessment is used to determine...The need for care or treatment..."</p>	A 395		
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A 395	<p>Continued From page 45</p> <p>3. During a review of the record for Patient 9 on July 26, 2011, discrepancies were noted in the patient's history and physical documentation by the pre-admitting nurse, the surgeon and the anesthesiologist.</p> <p>The following was noted on the pre-admitting nursing assessment dated July 21, 2011, Patient 9 was described as having a 12 year history of limb girdle muscular dystrophy (a disorder affecting muscle strength), a 10 year history of sleep apnea (pauses in breathing during sleep, a condition that can give rise to significant health problems, including heart damage) morbid obesity, and a surgical history that included three surgeries under general anesthesia.</p> <p>The surgeon's "History and Physical Examination", dated July 26, 2011, indicated the medical history included degenerative joint disease, gastroesophageal reflux disease, and morbid obesity, but no muscular dystrophy, sleep apnea or the history of previous surgeries was listed.</p> <p>The anesthesiologist's "Preoperative Anesthesia Evaluation" for the July 26, 2011 surgery, indicated that Patient 9 had limb girdle muscular dystrophy, gastroesophageal reflux, sleep apnea for which he used a CPAP (a machine to help with breathing).</p> <p>During an interview with the NM 5 on July 28, 2011, at 11:15 a.m., she confirmed there were multiple discrepancies between the nurse, the surgeon and the anesthesiologist's history and physical examinations. She stated that it was the pre-operative and operative nurses' responsibility</p>	A 395	<p>Continued From page 44</p> <p>Finding 3:</p> <p>Actions Taken:</p> <ol style="list-style-type: none"> Nursing Leadership reviewed the "Admission, Perioperative Services" policy, which describes the nursing process for preoperative services. The OR circulating nurse is responsible for assessing the patient record to make sure it is in order and contains all pertinent information for the clinical team to review prior to performance of the procedure/ surgery. Incomplete records and/or any discrepancies (e.g., inconsistent patient assessments or history and physicals) are addressed with the physician (and anesthesiologist if applicable) prior to the surgery/procedure so that safe and effective care is provided to the patient. The OR Nurses were inserviced on the policy, emphasizing that the patient's record will be reviewed for completeness and accuracy prior to any surgery/ procedure. Any incomplete or inconsistent documentation will be discussed with the physician (and anesthesiologist if applicable) and the surgery/ procedure will not be performed until the issues are resolved and documented in the medical record. Any problems shall be immediately referred to the Director of Surgical Services or designee for immediate action. Failure to comply shall result in disciplinary action. <p>Compliance and Monitoring:</p> <p>The Director of PI or qualified designees perform a concurrent record review of a minimum of 50 records monthly with the goal of achieving 100% compliance with determining the preoperative record is in order prior to the surgery/procedure.</p>	<p>9/1/11</p> <p>9/6/11</p> <p>9/6/11 and ongoing</p>

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A 395	<p>Continued From page 48</p> <p>On July 23, 2011, a physician's order for parenteral nutrition (PN, intravenous nutrition that goes directly into the vein) was noted. The "Parenteral Nutrition (PN) Order Form - Adult" dated July 23, 2011, indicated that a dietary consult was ordered as part of the automatic orders on the form.</p> <p>A review of the hospital's policy titled, "Nutrition Assessment: Standards of Care," dated March 2010, indicated to provide optimal nutritional support and recommendations...through the daily planning, implementation and evaluation of the nutrition care spectrum...Nutritional consultations ordered by the Nursing or the physician are addressed within 24 hours of receipt of the consult."</p> <p>A review of the Nutrition Progress Notes for Patient 18 showed that a Nutrition Assessment was completed by Registered Dietitian 2 (RD 2) on July 21, 2011. The assessment indicated recommendations for the nutrition care of the patient and the RD was to follow-up in 2-4 days to monitor (the patient's) renal indices (labs related to kidney function), blood glucose test results (for diabetes) and the patient's food intake and weight trends.</p> <p>Further review of the Nutrition Progress Notes showed that the next RD note was dated July 25, 2011, 2 days after the order was written for Parenteral Nutrition that included an order for a dietary consult. RD 2 indicated that the PN had been ordered and was providing 1610 kilocalories and 90 grams of protein a day. The follow-up note also indicated that the patient had eaten well for dinner the day before and breakfast that</p>	A 395	<p>Continued From page 48</p> <p>24 Hour" policy, applicable forms, and the process for identifying and communicated the need for nutritional assessments to the Registered Dietician (RD). The Associate Chief Nursing Officer (ACNO) conducted a meeting between the Charge Nurses and the Director of Nutritional Services to review the nutritional screening process, referrals to the Registered Dietician and the RD Assessment process. The ACNO reiterated the importance of the nurse a) identifying a patient's nutritional needs and completing the Admission Database (admission assessment); b) documenting and communicating issues identified by the assessment to the physician and RD on admission (and when identified on reassessment); c) implementing physician orders in a timely manner; and d) maintaining the IPOC as an interdisciplinary communication tool regarding the patient's plan of care needs. Dietary Consult requests are to be timely entered into the computer system and nurses are required to perform a 24 hour chart check review to ensure orders are appropriately transcribed and effectuated. All clinical nurses were inserviced on these issues, with special emphasis on nutritional assessments, the relationship between nutrition and wound care, importance of documentation, and timely referrals to RDs. Failure to comply shall result in progressive corrective action.</p> <p>2. Education on nursing process issues (e.g., assessments, documentation requirements, 24 hour chart checks) is provided annually, upon hire and as necessary.</p>	9/6/11	

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A 395	<p>Continued From page 49</p> <p>morning. Under the Assessment and Plan section of the follow-up note, RD 2 indicated, "Inappropriate use of PN as related to intact GI (gastrointestinal) tract as evidenced by the patient is able to take p.o. (oral) meds (medications) and consume (meal) tray. Patient is without any overt (obvious) signs and symptoms of malabsorption (problems with absorbing nutrients)." The note further recommended to discontinue the PN.</p> <p>During an interview with the Nurse Manager (NM 1) for Patient 18 on July 26, 2011 at 2:45 p.m., she stated that the dietary consult ordered on July 23, 2011 was never entered in the computer system designed to inform the RD of the consult. During a concurrent interview with RD 2 she confirmed that the order was not communicated to the dietary department. RD 2 further stated that the RD's depend on the communication of the dietary consults to know which patients have been started on PN, in order to assess the nutrition status of those patients within 24 hours of initiation.</p> <p>The hospital policy titled. "Chart Check: 24 Hour" (dated December 2010) was reviewed. The purpose of the policy was to outline a method to assure that physician orders are carried out in a timely manner. It further states that all charts will be checked a minimum of every 24 hours...the Registered Nurse (RN) will compare all orders on the physician's order sheet from the previous chart check. In the event that there is a discrepancy between the order and the transcription, the error should be corrected at this time to prevent further delay in service or continuing error. This system did not detect and correct the omission of the dietary consult</p>	A 395	<p>Continued From page 49</p> <p>Compliance and Monitoring:</p> <p>The Director of PI or qualified designees perform a concurrent record review of a minimum of 50 records monthly with the goal of achieving 100% compliance with adequately addressing the patient's nutritional needs and following through on orders/referrals for dietary consults. Corrective action is taken as necessary. This review will occur for three months and then be re-evaluated. The Director of PI will report on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis.</p> <p>Person Responsible:</p> <p>CNO</p>	9/6/11 and ongoing

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A 395	<p>Continued From page 50 communication to the RD.</p> <p>Further review of the Physician Orders for Patient 18 revealed an order to taper off and discontinue the PN on July 26, 2011, according to RD 2's recommendations. There was the potential that this could have occurred sooner if the dietary consult was communicated according to the hospital policy, to avoid overfeeding the patient.</p> <p>6. The medical record for Patient 21 was reviewed on July 28, 2011 at 9:40 a.m. The patient was admitted to the hospital on [REDACTED] 2011, with diagnoses that included [REDACTED] ocular [REDACTED]. The patient underwent an exploratory laparotomy (abdominal surgery) with a colon resection on [REDACTED] 2011.</p> <p>A review of the Emergency Record for Patient 21 revealed that the patient complained of having nausea, vomiting and abdominal pain for 4 days. It further stated that the patient reported a pain level of 10 (on a scale of 0 - 10 with 10 being high). The Emergency Report indicated that the nurse from the emergency department gave a report to the PCU (Progressive Care Unit) nurse regarding the patient's history and condition of the patient on July 23, 2011 at 3:00 a.m. The patient was admitted to the PCU on [REDACTED] 2011 at 3:45 a.m. from the Emergency Department.</p> <p>The Admission Database (nursing admission assessment) dated July 23, 2011 at 3:45 a.m. for Patient 21 was reviewed. The database showed the Nutrition Screen included a box to be checked if the patient had vomiting and/or diarrhea for 3 or</p>	A 395			

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A 395	<p>Continued From page 51</p> <p>more days. The box was not checked. The only information contained in the Nutrition Screen was the patient's appetite was listed as "Good" and his diet at home was "Regular." The instructions for the Nutrition Screen stated, "Any boxes marked require a nutritional consult." No nutritional consult was ordered for Patient 21 despite being brought to the hospital via ambulance with complaints of nausea, vomiting and abdominal pain for 4 days.</p> <p>7. On July 25, 2011, at 9:45 a.m. a review of Patient 39's record was conducted. Patient 39 was a [REDACTED] year old male admitted to the facility on [REDACTED] 2011, at 2:59 a.m., through the ED with complaints of generalized weakness. During the physician's initial assessment, the physician documented the patient had multiple large infected wounds.</p> <p>On [REDACTED] 2011, at 10:10 a.m., the RN completed the Admission Data Base, a form used to determine the need for a nutritional consult. The document indicated the patient had a poor appetite. However, the patient's large infected wounds were not listed and therefore a nutritional consult was not triggered and not completed.</p> <p>On July 25, 2011, at 10:35 a.m., an interview was conducted with RD 1. After reviewing photos of the patient's wounds, she stated, "Absolutely. I agree. I could have started some vitamins and zinc."</p> <p>In an interview with RN 2, at 10:45 a.m. that same day, she stated, "The patient should have been referred to the RD on admission."</p>	A 395		

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A 396	<p>482.23(b)(4) NURSING CARE PLAN</p> <p>The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure an individualized plan of care was implemented for one of 73 sampled patients (Patient 18). This failed practice potentially caused a delay in a dietary referral for this nutritionally compromised patient.</p> <p>Findings:</p> <p>The medical record for Patient 18 was reviewed on July 26, 2011 at 2:00 p.m. The patient was admitted to the hospital on [REDACTED] 2011, with diagnoses that included [REDACTED]</p> <p>A review of the Nutrition Progress Notes for Patient 18 showed that a Nutrition Assessment was completed by Registered Dietitian 2 (RD 2) on [REDACTED] 2011, 3 days after admission. The assessment indicated that the patient's family member reported that the patient had a poor appetite for 3 - 4 days. It further indicated that the patient's recorded meal intakes were only 10 to 40 % of her meals.</p> <p>Review of the physician's order showed an order for peripheral parenteral nutrition (PPN, intravenous nutrition that goes directly into the vein) was noted on July 23. The record indicated that the patient was on PN from [REDACTED] when it was tapered off and discontinued. The</p>	A 396	<p>482.23(b)(4) NURSING CARE PLAN</p> <p>Actions Taken:</p> <p>1. Nursing Leadership reviewed the survey findings, the "Care Planning: Patient" policy and applicable forms. Nursing Leadership revised the Admission Data Base to provide a more consistent format, including revising the nutritional screening and referral section. Nursing Leadership also reviewed the existing care planning forms and no additional revisions were necessary. The Forms Committee approved the revised Admission Data Base form.</p> <p>2. Nursing Leadership inserviced all clinical nurses on the nursing care plan policy and the revised form. Special emphasis was placed on the following: a) the Registered Nurse is responsible for initiating the nursing care plan on admission, which reflects an accurate and comprehensive assessment of the patient's care needs; b) the importance of documentation in the IPOC as a tool to effectuate communication about the patient's plan of care among all disciplines involved in the patient's care; and c) the importance of revising/updating the IPOC to reflect any changes in the patient's status based on evaluations by nursing and other members of the healthcare team. Education was also provided on the actual drafting of plans of care to ensure that nursing staff understand how to document applicable interventions to problems identified (e.g, identifying the patient is on parenteral nutrition rather than writing "special diet"). Failure to comply will result in disciplinary action.</p>	<p>7/27/11</p> <p>9/6/11</p>

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A 396	<p>Continued From page 53</p> <p>"Parenteral Nutrition (PN) Order Form - Adult" dated July 23 indicated that a dietary consult was ordered as part of the automatic orders on the form. There was no record that the dietary consult order was communicated to the RD.</p> <p>A review of the "Interdisciplinary Plan of Care: Potential/Actual Alteration in Nutrition," dated July 21 indicated that RD 2 had initiated the nutrition plan of care for the patient 3 days after the patient was admitted. At the time the plan of care was initiated, the patient had had 3 - 4 days of poor appetite and poor meal intake. The plan of care indicated that the only intervention for the patient's alteration in nutrition status was, "Special Diet." There was no indication in the interdisciplinary plan of care that the patient had been on PN for 3 days or that a dietary referral had been made.</p> <p>During an interview with the Nurse Manager (NM 1) of the Intensive Care Unit (ICU), where the patient was located on July 26, 2011, at 3:00 p.m. she stated that the nutrition plan of care should have been initiated by the nurse caring for the patient on admission. She further stated that the plan of care should also indicate that one of the nutrition interventions the patient received was PN. Also, if the interventions section of the plan of care had been completed, a dietary referral would have generated a more timely assessment of the patient when the PN was initiated.</p> <p>A review of the hospital's policy titled, "Care Planning: Patient," (dated January, 2011) indicated that the purpose of the policy was to provide the interdisciplinary healthcare team with guidelines for developing and prioritizing an</p>	A 396	<p>Continued From page 53</p> <p>3. Education on nursing care plans is provided annually, upon hire and as necessary.</p> <p>Compliance and Monitoring:</p> <p>The Director of PI or qualified designees perform a concurrent record review of a minimum of 50 records monthly with the goal of achieving 100% compliance with developing sufficient nursing care plans. Corrective action is taken as necessary. This review will occur for three months and then be re-evaluated. The Director of PI will report on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis.</p> <p>Person Responsible:</p> <p>CNO</p>	<p>9/6/11</p> <p>9/6/11 and ongoing</p>

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A 396	Continued From page 54 individualized patient plan of care. It further stated that the Registered Nurse shall be responsible for the initiation of a plan of care based on the nursing process within 24 hours of admission. It also stated that the patient's care plan shall be revised/updated to reflect changes in patient status, as evaluated and assessed by the Registered Nurse and other members of the healthcare team.	A 396			
A 397	482.23(b)(5) PATIENT CARE ASSIGNMENTS A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to complete a 90 day performance evaluation for RN 1 until the employee had been at the facility for seven months. This failed practice had the potential for the facility not to know if the employee was competent to perform her duties. Findings: On July 27, 2011, the employee record for RN 1 was reviewed. RN 1's hire date was November 16, 2010. The "90-Day Staff Performance Appraisal" was signed by RN 1 and dated June 20, 2011, and indicated the next review date was "June 2011." RN 1's annual "Formal Performance Evaluation" was reviewed with RN 1 on June 20, 2011.	A 397	482.23(b)(5) PATIENT CARE ASSIGNMENTS Actions Taken: 1. The CNO inserviced the Joint Leadership team regarding the timely completion of the 90 day nursing performance evaluations. 2. The Human Resources (HR) Generalists will generate a reminder notice to the Nursing Managers at least 60 days prior to the 90 day due date. Reminder notices will also be sent to the Director of Nursing and Senior Leadership. 3. The HR Department will notify the CNO of any failures to obtain a timely 90 day nursing performance evaluation and immediate corrective action will be taken with the Nurse Manager responsible for obtaining the evaluation. Compliance and Monitoring: The Human Resource Director or qualified designee will review 100% of required 90 day nursing performance evaluations for the next 6 months (and then re-evaluate) to achieve the goal of 100% compliance with timely 90 day performance evaluations. Corrective action will be taken immediately. Reports will be submitted monthly to the Quality Improvement Committee and to the Board of Governors. Persons Responsible: Human Resources Director CNO	9/6/11 9/6/11 9/6/11 9/6/11	

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A 397	Continued From page 55 The facility policy and procedure titled "Performance Evaluations" reviewed December 2010, indicated "... Conduct an initial written performance evaluation on or before the first 90 days of employment. ..." On July 28, 2011, at 8:50 a.m., an interview was conducted with the Director Human Resources (DHR) and the Human Resources Generalist (HRG) II. They stated the facility "Performance Evaluations" policy and procedure affects all facility employees to include per diem employees. The HRG II stated the "90-Day Staff Performance Appraisal" should be completed 90 days after the date of hire, and if an extension was given an explanation for why the extension was given should be written under "Summary." In addition, the HRG II stated RN 1 should of had either a 90 day evaluation completed in late February or early March, or an extension should have been documented with the reason for the extension. A subsequent interview was conducted with the DHR, the HRG II, and the Director Critical Care Services (DCCS), on July 28, 2011, at 3:30 p.m. They stated they were unable to find documentation of a "90-Day Staff Performance Appraisal" being given to RN 1 before June 20, 2011.	A 397		
A 404	482.23(c) ADMINISTRATION OF DRUGS Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.	A 404	482.23(c) ADMINISTRATION OF DRUGS	

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A 404	<p>Continued From page 56</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed ensure medications were administered in accordance with the facility's policy and procedure consistent with accepted standards of practice for 2 of 73 sampled patients (Patient 11 and 23).</p> <p>1. For Patient 11, RN 1 administered an excessive dose of an injectable medication (desmopressin- a medication to decrease urination. It is used to treat diabetes insipidus, which is a condition in which the kidneys are unable to conserve water) and did not use a filtered needle while withdrawing the medication out of a glass ampul. RN 1 also administered an injectable medication (Protonix-medication used to reduce stomach acid production to prevent heartburn and gastrointestinal ulcers) at a rate faster than manufacturers recommendations.</p> <p>These failed practices resulted in medication errors which potentially placed the patient at risk for serious harm by not following manufacturer's recommendations and the facility's policy and procedure for preparing intravenous injectable medications, the effect of which would not be easily reversible.</p> <p>In addition, the facility failed to respond timely to address the serious medication errors and immediately implement preventive actions to minimize the impact to patients.</p> <p>2. For Patient 23, the facility RN failed to follow a physician's order to administer a medication to lower blood pressure. Failure to administer</p>	A 404			

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A 404	<p>Continued From page 57</p> <p>medication for high blood pressure could potentially lead to complications such as stroke, heart attack and/or kidney failure.</p> <p>Findings:</p> <p>1. Medication pass observation was conducted with RN 1 on July 26, 2011, starting at 9:16 a.m. RN 1 prepared and administered four medications during the time of observation for Patient 11, and the following medication errors were observed:</p> <p>a. RN 1 prepared Protonix (medication used to reduce stomach acid production to prevent heartburn and gastrointestinal ulcers) IV (intravenous) 40 mg injection vial, diluted with 10 ml (milliliters) of normal saline, but failed to administer via IV over a period of at least two minutes. Instead, RN 1 was observed to administer the 40 mg dose of Protonix IV push over 11 seconds;</p> <p>b. RN 1 prepared and administered an injectable dose from 1-ml glass ampul of Desmopressin (medication used) 4 mcg/ml (microgram per milliliter) without using a filter needle to withdraw the medication from the glass ampul after opening it by breaking the top portion of the glass ampul;</p> <p>c. RN 1 was observed to withdraw and administer 0.8 ml from the 1-ml glass ampul of Desmopressin 4 mcg/ml (total dose of 3.2 mcg Desmopressin).</p> <p>Review of Patient 11's record indicated the physician order written on July 24, 2011, was for</p>	A 404	<p>Continued From page 56</p> <p>Finding 1: Action Taken:</p> <p>1. The CEO, CMO, Nursing Leadership and the Director of Pharmacy met to discuss the immediate jeopardy findings identified during the survey process and to develop immediate measures to address the findings. 7/26/11</p> <p>2. The Nurse Manager and assigned RN notified the patient's physician concerning the administration of Protonix and Desmopressin IV and of the patient's stable clinical status after the medication administration. The physician did not provide further orders. The nursing staff continued to monitor the patient throughout the day for any change in clinical status related to the Protonix and the Desmopressin administration and none was observed. 7/26/11</p> <p>3. The Nurse Manager notified family 7/26/11. The Physician informed the patient and family of the medication errors and of the patient's condition following the issue on 7/27/11. 7/27/11</p> <p>4. The involved RN was placed on immediate administrative leave on 7/26/11 pending investigation. Based on the investigation, the RN was subsequently terminated on 7/27/11. 7/27/11</p> <p>5. The Clinical Manager was placed on immediate administrative suspension on 7/26/11 and was subsequently relieved of management duties until a supervised management remediation plan was completed with daily monitoring for 27 days by the Director of Critical Care upon return to management duties. The Critical Care Director spoke with the Clinical Manager about responsibilities for timely addressing 7/26/11</p>		

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A 404	<p>Continued From page 59</p> <p>On July 26, 2011, at 6 p.m., it was observed RN 1 was continuing to care for patients in the ICU.</p> <p>Review of the ICU shift schedule indicated RN 1 was assigned two ICU patients including Patient 11 during her shift.</p> <p>On July 26, 2011, at 6 p.m., during an interview, NM 3 stated that she had spoken to RN 1 about the medication errors made that morning but did not address the Desmopressin dosing error with RN 1.</p> <p>NM 3 stated that she thought 1 ml of Desmopressin equaled 2 mcg and failed to realize the dosing error was made until she saw the concentration of 4 mcg/ml on the glass ampul of Desmopressin, the physician order for Desmopressin IV 2 mcg, and the morning dose of Desmopressin 3.2 mcg administered to Patient 11 by RN 1. NM 3 failed to investigate and respond to the full extent the dosing error and its potential consequences.</p> <p>Record review for Patient 11 indicated he was a [redacted] year old male admitted from the Emergency Room with a chief complaint of altered mental status and generalized weakness due to severe hypernatremia (high sodium blood level) caused by his condition of diabetes insipidus (condition in which kidneys are unable to conserve water). His home medication included DDAVP (Desmopressin).</p> <p>Review of Patient 11's MAR revealed the precautionary comment for Protonix was missing from the MAR.</p>	A 404	<p>Continued From page 59 with manufacturer recommendations for preparation and administration rates. RNs were also informed of the pharmacy "pop up" alerts in Pyxis and notices on the MAR. In addition, the nurses were provided educational information reiterating the requirement to draw up and administer the prescribed dose. The MAR reflects the prescribed dose and volume of IV medication, based upon the physician's order. If the nurse administers a dose that is different than what is pre-printed on the MAR, the nurse will document the actual dose given to the patient on the MAR. Nurses were also reminded of the availability of nursing reference materials on the units and to consult the Pharmacy Department for any issues or concerns related to medications/medication administration.</p> <p>9. Upon hire and annually, the RN must satisfactorily complete medication administration competencies. Frequency of competencies may be adjusted more frequently if necessary.</p> <p>10. Medication errors is a standing agenda item for the Patient Safety Council.</p> <p>Compliance and Monitoring: 1. The Nursing Managers or qualified designees will perform direct observation of at least 30 IV medication administrations over a three month period (and then re-evaluate) to achieve a goal of 100% compliance with IV medication preparation and administration. Immediate corrective action will be taken with the nurse. The Medication Safety Officer will report on compliance to the Hospital Patient Safety Council, who will report through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis. 2. The Director of Pharmacy or qualified designee (e.g., Medication Safety Officer) will review all medication error reports monthly and</p>	7/27/11 9/1/11 9/1/11 and ongoing 9/1/11

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A 404	<p>Continued From page 60</p> <p>During an interview on July 29, 2011, at 10 a.m., the DP explained that the pharmacy order entry into the computer system for Protonix IV could be done in two ways: (1) By use of PCO, preset order form for Protonix IV or (2) Manual pick of the drug, Protonix IV from the list of drugs. The DP stated that by manually picking the drug, the pharmacist who was entering the order in the computer system would have to manually enter precautions/warnings in the comment field for it to print on the MAR. The DP further stated that she had identified two pharmacists who were manually picking the drug and not entering the precautionary comment to be printed on the MAR to alert the nurses of the administration time that was included in the PCO for Protonix IV.</p> <p>The DP acknowledged that there were inconsistencies in drug order entries and stated that 90 percent of the time the MAR would have the intended printed comments.</p> <p>The facility's document titled, "Guidelines for the Administration of Intravenous Medications, Adult" was reviewed and it stipulated in foot notes on each page of the document,</p> <p>"Use filter needle for all ampuls."</p> <p>On July 28, 2011, at 10 a.m., during an interview, NM 4 stated that the above document was available on her nursing unit as a resource.</p> <p>On August 2, 2011, at 2 p.m., during an interview, the DP stated that "Guidelines for the Administration of Intravenous Medications, Adult" was an attachment to the facility's IV guideline policy and stated that on the front page of the</p>	A 404	<p>Continued From page 60</p> <p>assess actions by the Nursing Managers in evaluating and responding to the medication error in accordance with Hospital policy. Corrective action will be taken as necessary. The CNO will report on compliance to the Patient Safety Council and Board of Governors monthly.</p> <p>Person Responsible: CNO</p>	

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A 404	<p>Continued From page 61 attachment was added, "When withdrawing medication contained in a glass ampule, a filter needle must be used."</p> <p>The facility's policy and procedure titled, "Intravenous Therapy" was reviewed and it stated,</p> <p>"B. Intravenous Medications Given by Registered Nurses 1. Registered nurses may give medications IV push or IV infusion according to the 'Guidelines for Administration of Intravenous Medications.'"</p> <p>The facility's policy and procedure titled, "Clinical Resource - Lippincott" was reviewed and it stated,</p> <p>"Purpose: To establish guidelines to outline process for approved nursing reference materials. Policy ... E. Reference: Lippincott's Nursing Procedures; Lippincott Williams & Wilkins, is available electronically through the hospital intranet navigation menu, and hard copy text on nursing units and in administration."</p> <p>The printout of the section on "Mixing drugs in a syringe using two ampules" of the electronically available reference, Lippincott's Nursing Procedures stated the following:</p> <p>"Insert a syringe (with a filter needle attached) to filter out any glass splinters" into the ampule without allowing the needle to come in contact with the rim of the ampule ..."</p>	A 404		

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A 404	<p>Continued From page 62</p> <p>American Society of Health-Systems Pharmacists (ASHP), a nationally recognized pharmacy organization, published a guideline titled, "ASHP Guidelines on Quality Assurance for Pharmacy-Prepared Sterile Products" was reviewed which stated,</p> <p>"Solutions from ampuls should be properly filtered to remove particles ..."</p> <p>The facility's failure to use best practices for safe and effective administration of injectable medications in ICU (Intensive Care Unit) and avoid medication misadventures, the survey team called an immediate jeopardy on July 26, 2011, at 6:55 p.m., in the presence of the CEO, CNO, CMO, and DRM.</p> <p>The survey team accepted the facility's plan of action to resolve the immediate jeopardy situation on July 27, 2011, at 1:50 p.m., and ongoing observations, interviews, and record reviews revealed that the facility implemented the following action plan:</p> <p>"1. The assigned nurse and nurse manager notified the patient's physician concerning the Protonix and Desmopressin medication administration, and of the patient's clinical status. 2. The physician informed the patient and family of the medication errors. 3. RN 1 and NM 3 were placed on immediate administrative leave. 4. The policies related to medication administration and intravenous therapy were reviewed to ensure they reflect medications would be administered in accordance with physician orders and manufacturer's recommendations</p>	A 404		

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A 404	<p>Continued From page 63</p> <p>including the use of filtered needles with glass ampules.</p> <p>5. All bedside Registered Nurses (RN), including registry and traveling RNs, would be re-inserviced through a read and sign on medication administration with special emphasis on administration of IV medications in accordance with manufacturer recommendations for preparation and rate of administration.</p> <p>6. The Pharmacy would add a pop up alert in Pyxis (automated drug dispensing cabinet: ADC) to administer Protonix IV over two minutes per manufacturer's recommendations.</p> <p>7. All Clinical Managers and Clinical Directors would be reinserviced on the Medication Error Reporting Policy with special emphasis on their responsibility in investigating, reporting, and instituting follow up actions to ensure patient safety."</p> <p>The immediate jeopardy situation was removed on July 28, 2011, at 2:15 p.m.</p> <p>2. On July 25, 2011, Patient 23's medical record was reviewed. A physician telephone order, on July 22, 2011, at 10:45 p.m., indicated, "Hydralazine (medication used to lower blood pressure) 5 mg every four hours intravenous as necessary for a systolic blood pressure greater than 150, diastolic over 90."</p> <p>The documentation in the "Patient Progress Note", on July 22, 2011, at 10:45 p.m., indicated the physician was informed of the patient's blood pressure, 152/72, and orders were made and carried out.</p>	A 404	<p>Continued From page 61</p> <p>11 SEP 21 AM 10:31 LICENSING & CERT. VERMILION COUNTY</p> <p>CA DEPT OF PUBLIC HEALTH</p> <p>Finding 2:</p> <p>Actions Taken:</p> <p>1. Nursing Leadership reviewed the medication administration policies and procedures, which detail the process for nurses to document medication administration. 7/26/11</p> <p>2. Nursing Leadership inserviced clinical nurses (e.g., including the applicable nurse) on medication administration, emphasizing the importance of documenting when medication is administered. Failure to comply will result in progressive corrective action. 8/5/11</p>	

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A 404	Continued From page 64 According to the "Graphic & Fluid Balance Record", Patient 23's blood pressure was over 150 systolic during the following times. 152/72 8 p.m. July 22, 2011 165/81 12 a.m. July 22, 2011 170/83 4 p.m. July 23, 2011 184/89 8 p.m. July 23, 2011 A report from Pyxis (automated drug dispensing cabinet) was reviewed between July 22, 2011, at 7:13 a.m., and July 23, 2011, at 10:36 p.m. The report indicated Hydralazine was first removed from Pyxis on July 23, 2011, at 6:51 p.m. There was no documentation in the medical record to indicate whether Patient 23 received the medication, Hydralazine 5 mg between the hours of 8 p.m. and 12 midnight, on July 22, 2011, as ordered by the physician. There was no documentation to indicate why the medication was not given. In an interview and concurrent review of the medical record on July 25, 2011, at 2:10 p.m., RN 9 agreed that there was no documentation in the medical record to indicate the medication was administered during these times. In an interview on July 25, 2011, at 3:15 p.m., RN 9 stated there was no documentation of Patient 23's vital signs other than what was documented on the vital signs record and on the Patient Progress Note. The manager stated, "there was no documentation to indicate the medication was given."	A 404	Continued From page 64 3. Education on medication administration is provided annually, upon hire and as necessary. Compliance and Monitoring: The Director of PI or qualified designee will perform 50 concurrent record reviews monthly with the goal of achieving 100% compliance with documenting medication administration. Corrective action is taken as necessary. This review will occur for three months and then be re-evaluated. The Director of PI will report on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis. Person Responsible: CNO	9/6/11 9/6/11 and ongoing	
A 438	482.24(b) FORM AND RETENTION OF RECORDS	A 438	482.24(b) FORM AND RETENTION OF RECORDS		

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A 438	<p>Continued From page 65</p> <p>The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure medical records were accurate, complete, and/or accessible for 9 of 73 sampled patients (Patients 4, 7, 32, 33, 34, 53, 54, 55, and 56), by failing to ensure:</p> <ol style="list-style-type: none"> 1. A complete medical record is provided by the medical records department to ED patients upon their request post discharge for Patients 33, and 34. 2. Their medication reconciliation policy was implemented for Patient 32. 3. The dose, as indicated by "UR," was clarified with the physician when an order was written on the "Medication Reconciliation Admission Orders, Inpatient" on July 25, 2011, at 9:40 a.m., until the next day for Patient 53. 4. The "Outpatient Home Medication List" was signed at discharge by the patient/representative for Patients 54, 55, 56, and 57. 5. The echocardiogram ordered for Patient 4, on [REDACTED] 2011, was performed or a cancellation order was obtained and recorded. 	A 438		
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A 438	<p>Continued From page 66</p> <p>6. That the "Labor and Delivery Summary" Patient 7, accurately reflected the patient's labor medications.</p> <p>These failed practices could potentially impact the provision of medical care for patients and their providers regarding medication management and their medical needs across the continuum of care.</p> <p>Findings:</p> <p>1. A review of Patient 34's record viewed through the facility's main electronic record system was conducted. Patient 34 was admitted to the facility on [REDACTED] 2011, with a diagnosis of [REDACTED]. [REDACTED] The record failed to reflect the patient's discharge instructions.</p> <p>A review of Patient 33's record viewed through the facility's main electronic record system was conducted. Patient 33 was admitted to the facility on [REDACTED], 2011, with a diagnosis of a kidney cyst (tumor) and a urinary track infection. Patient 33 was discharged the same day. The record failed to reflect the patient's discharge instructions.</p> <p>A review of the facility document, "Documentation Content: Medical Record (Reviewed: 12/2010)," indicated the purpose as, "To establish guidelines to ensure complete, timely and legible medical records for all patients admitted or accepted for treatment." The procedure indicated the ED medical record shall consist of, "Discharge instructions to provide the education to the patient/family, including discharge medications."</p>	A 438	<p>Continued From page 65</p> <p>Finding 1: Actions Taken: 1. The HIM Director revised the policy and procedure "Patient Access: Medical Records" to provide the process of obtaining copies of all individual discharge instructions from the computerized discharged instruction program if the patient/representative indicates this in their request. The P & P Committee approved the policy. The HIM Director also revised the "Authorization for Use or Disclosure of Health Information" request form to allow for the patient/representative to request their medical record with discharge instructions. In addition, the HIM Director implemented a new process for retrieving and printing all discharge instruction forms from ExitWriter and ExitCare. 2. The HIM Director instructed Health Information Management staff on the revised policy and form. If the patient checks the box on the medical records request form to include all records, the medical record will include the individual discharge instruction form in addition to the summary document that lists the individual instructions. Any issues or questions concerning producing records shall be directed to the HIM Director.</p>	8/16/11	

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A 438	<p>Continued From page 67</p> <p>A review of the facility document, "Authorization For Use Or Disclosure Of Health Information, (undated)," indicated when an individual authorizes the use and/or disclosure of health information choosing box "a" indicates a request for, "All health information pertaining to my medical history..." There was no area on the document which notifies the individual requesting their medical records that the discharge information from the ED must be requested specifically.</p> <p>An interview was conducted with the Director Of Health Information Management (DHIM) on August 2, 2011, at 9 a.m. The DHIM stated, "The discharge section of the ED record is in a separate electronic system called 'Exit Rider', which does not interface with the rest of the electronic record. If a patient wants a copy of their discharge instructions they would have to request that document specifically. The staff would then go to the ED and print it, otherwise the patient requesting their medical record would not receive it."</p> <p>2. A review of Patient 32's record was conducted on July 26, 2011, at 9:30 a.m. Patient 32 was admitted to the facility on [REDACTED] 2011, at 7:50 p.m., with a diagnosis of chronic obstructive lung disease.</p> <p>A review of Patient 32's "Medication Reconciliation Admission Orders, Inpatient," (a listing of which medications that the patient was taking prior to admission that the patient will or will not continue to take during the hospital stay), indicated the document was approved and reconciled by Patient 32's physician on July 25,</p>	A 438	<p>Continued From page 67</p> <p>Compliance and Monitoring:</p> <p>The HIM Director or qualified designee performs a random review of 70 medical record requests monthly to achieve a goal of 100% compliance with providing discharge instructions when applicable for patients/ representatives who request a complete medical record. The HIM Director reports on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors on a monthly basis. This review will occur for 3 months and then be re-evaluated.</p> <p>Person Responsible:</p> <p>HIM Director</p> <p>Finding 2:</p> <p>Actions Taken:</p> <p>1. Nursing Leadership reviewed the "Medication Reconciliation Across the Continuum of Care" policy, which indicates the process for obtaining patient medication histories and reconciling medications on admission, at each level of care, and on discharge. The completed form is faxed to the pharmacy and placed in the medical record. When the patient is transferred to another facility, the medication reconciliation form is faxed or transferred with the patient to that facility. When the patient is discharged home, a list of the medications is provided to the</p>	<p>9/1/11 and ongoing</p> <p>9/6/11</p>	

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A 438	<p>Continued From page 68</p> <p>2011, at 3:55 p.m., four days after admission. There was no documentation to show the Medication Reconciliation document was faxed or scanned to the pharmacy.</p> <p>An interview was conducted with RN 11 on July 26, 2011, at 10:45 a.m., who stated Patient 32's Medication Reconciliation form was not completed upon admission nor was it scanned to the pharmacy.</p> <p>Patient 32 was discharged to a skilled nursing facility on [REDACTED] 2011, at 10 a.m. Further record review failed to show that the Medication Reconciliation form was completed upon discharge, or faxed to the receiving facility.</p> <p>A review of the facility document, "Medication Reconciliation Across The Continuum Of Care, (Issued 5/2011)," indicated the purpose, "To minimize the risk of medication errors by obtaining patient medication histories and reconciling medications on admission, at each level of care, and on discharge."</p> <p>The procedure indicates, " At admission to all units of (the facility), a licensed caregiver will obtain from the patient or caregiver the current medications used at home...The completed form is now a physician's admitting order and will be faxed to the pharmacy and placed in the medical record in front of the physician's orders...If the patient is being transferred to another facility, the reconciliation sheet and Discharge Form will be faxed or transferred with the patient to that facility."</p> <p>3. On July 26, 2011, the record for Patient 53 was reviewed. Patient 53 was admitted to the facility</p>	A 438	<p>Continued From page 68</p> <p>patient/representative. Each nursing unit contains a reference guide to completing the medication reconciliation process. All clinical nurses were inserviced on the medication reconciliation process, with special emphasis on the importance of completing the document, faxing it to pharmacy, placing it in the medical record, and ensuring that a medication reconciliation form is completed on discharge/transfer to another facility, placed in the medical record and provided to the patient/representative or sent to the receiving facility. Noncompliance with the process will result in disciplinary action.</p> <p>2. Patient 32's admission medication reconciliation form was faxed to the Pharmacy on 7/26/11. 7/26/11</p> <p>3. On 7/27/11, the hospital confirmed that the skilled nursing facility had Patient 32's medication information and did not need any further documents from the hospital. 7/27/11</p> <p>4. The Director of Pharmacy Identified a method to track receipt of the medication reconciliation forms faxed to the Pharmacy for admitted patients. On a daily basis, the Pharmacy will review the forms received and compare it to the admitted patient census. If a form has not been received, the Pharmacy will contact the patient's nurse so that the admission medication reconciliation process can be completed within 24 hours. 9/6/11</p> <p>Compliance and Monitoring:</p> <p>The Director of Nurses or qualified designee will conduct a concurrent medical record of at least 50 charts/month with the goal of achieving 100% compliance with medication reconciliation forms. 8/27/11 and ongoing</p>		

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A 438	<p>Continued From page 68</p> <p>2011, at 3:55 p.m., [REDACTED] There was no documentation to show the Medication Reconciliation document was faxed or scanned to the pharmacy.</p> <p>An interview was conducted with RN 11 on July 26, 2011, at 10:45 a.m., who stated Patient 32's Medication Reconciliation form was not completed upon admission nor was it scanned to the pharmacy.</p> <p>Patient 32 was discharged to a skilled nursing facility on [REDACTED] 2011, at 10 a.m. Further record review failed to show that the Medication Reconciliation form was completed upon discharge, or faxed to the receiving facility.</p> <p>A review of the facility document, "Medication Reconciliation Across The Continuum Of Care, (Issued 5/2011)," indicated the purpose, "To minimize the risk of medication errors by obtaining patient medication histories and reconciling medications on admission, at each level of care, and on discharge."</p> <p>The procedure indicates, " At admission to all units of (the facility), a licensed caregiver will obtain from the patient or caregiver the current medications used at home...The completed form is now a physician's admitting order and will be faxed to the pharmacy and placed in the medical record in front of the physician's orders...If the patient is being transferred to another facility, the reconciliation sheet and Discharge Form will be faxed or transferred with the patient to that facility."</p> <p>3. On July 26, 2011, the record for Patient 53 was reviewed. Patient 53 was admitted to the facility</p>	A 438	<p>Continued From page 69</p> <p>The CNO reports on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly. This review will occur for 3 months and then be re-evaluated.</p> <p>Person Responsible: CNO</p> <p>Finding 3:</p>		

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A 438	<p>Continued From page 69</p> <p>on [REDACTED] 2011, with diagnosis of surgical laparoscopic hysterectomy (removal of the uterus through an abdominal scope).</p> <p>The "Medication Reconciliation Admission Orders, Inpatient" indicated the home medications taken by the patient prior to admission was gathered by the nurse on June 25, 2011, at 6:30 a.m. The medications "Robitussin DM" and "Pepcid" had "UR (unable to recall)" for the "Dose." The physician signed the order on July 25, 2011, at 9:40 a.m., and indicated "Physician Medication Order - Continue Medication" and the box for "Yes" was checked for "Robitussin DM" and "Pepcid." RN 3 noted the orders on July 25, 2011, at 5 p.m.</p> <p>A second "Medication Reconciliation Admission Orders, Inpatient" indicated the home medications prior to admission information was gathered by the nurse on June 25, 2011, at 5 p.m. The medication "Robitussin DM" indicated two tablespoons for the dose and the medication "Pepcid" indicated 20 milligrams for the dose. The order was a telephone order taken by RN 3 on July 25, 2011, at 5 p.m.</p> <p>The "Medication Administration Record (MAR)" dated July 25, 2011, did not include "Robitussin DM" or "Pepcid."</p> <p>On July 26, 2011, at 1:10 p.m., an interview was conducted with RN 3. She stated she "scanned" the orders to the pharmacy on July 25, 2011, at 5 p.m., but she did not clarify the orders with the physician until July 26, 2011, sometime in the morning, even though the "revised" "Medication Reconciliation Admission Orders, Inpatient"</p>	A 438	<p>Continued From page 69a</p> <p>Actions Taken:</p> <ol style="list-style-type: none"> 1. Nursing Leadership reviewed the survey findings and Medication Reconciliation and Physician Orders policies and procedures. Nurses were inserviced (including applicable nurse) on the policies with special emphasis on: a) the expectation that a complete medication reconciliation form will be completed on admission; b) if the physician checks "yes" to continue a medication on the list that does not include all the elements for a complete order, then the nurse shall call the physician to clarify the order or take necessary steps to have the Pharmacist clarify the order; and c) an addendum to the patient's initial medication reconciliation form shall be completed when necessary. Nurses were also advised that their documentation in the medical record is to be accurately dated and timed. Failure to comply shall result in a progressive action plan. 2. Each nursing unit contains references regarding the medication reconciliation process. <p>Compliance and Monitoring:</p> <p>The CNO or qualified designee performs a concurrent review of 50 records monthly for 3 months (and then re-evaluate) to achieve a goal of 100% compliance with completing medication reconciliation forms. Corrective action is taken as necessary. The CNO reports on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly.</p> <p>Person Responsible: CMO CNO</p>	<p>9/6/11</p> <p>9/6/11</p> <p>9/6/11 and going</p>

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A 438	<p>Continued From page 70</p> <p>indicated she had taken a telephone order from the physician on July 25, 2011, at 5 p.m., clarifying the "Dose" orders for both "Robitussin DM" and "Pepcid." In addition, RN 3 stated she should have clarified the dose orders for both "Robitussin DM" and "Pepcid" with the physician on July 25, 2011, before she noted the order, and she should have dated the "revised" "Medication Reconciliation Admission Orders, Inpatient" with the date she actually wrote the order or wrote the order as a "late entry."</p> <p>The facility policy and procedure titled "Physician's Orders" reviewed December 2010, indicated "To establish guidelines for obtaining and processing physician's orders to ensure prompt quality patient care is provided. ... Physician's orders will be accurately processed and promptly followed. ... Written orders will be transcribed and implemented promptly. ... If the order is not complete, the ordering physician will be called to clarify the order. ..."</p> <p>4a. On July 26, 2011, the record for Patient 54 was reviewed. Patient 54 was seen as an outpatient in the labor and delivery department for possible leaking of vaginal fluid on July 25, 2011, at 4:50 p.m.</p> <p>The "Nursing Flowsheet" dated July 25, 2011, indicated Patient 54 received a medical screening examination by a nurse and was discharged home in stable condition with instructions on July 25, 2011, at 9:10 p.m.</p> <p>The "Outpatient Medication Reconciliation and Physician's Order" dated July 25, 2011, indicated "As a result of this visit, home medications will not</p>	A 438	<p>Continued From page 70</p> <p>Findings 4 a-d:</p> <p>Actions Taken:</p> <ol style="list-style-type: none"> 1. The CNO discussed the survey findings with the Director of Women's Services. 9/6/11 2. The labor and delivery nurses were inserviced on the medication reconciliation policy and completion of the Outpatient Medication Reconciliation and Physician's Order form, with special emphasis on educating the patient regarding their home medication instructions and having the patient sign to acknowledge their understanding. 9/6/11 3. Each nursing unit contains references regarding the medication reconciliation process. 9/6/11 		

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A 438	<p>Continued From page 71</p> <p>be changed" was marked. The "Outpatient Medication Reconciliation and Physician's Order" indicated "I have received this list of my home medications and the importance of managing my medication information has been explained to me including ... " was not signed by Patient 54 or her representative.</p> <p>b. On July 26, 2011, the record for Patient 55 was reviewed. Patient 55 was seen as an outpatient in the labor and delivery department for decreased fetal movement on July 25, 2011, at 10:05 p.m.</p> <p>The "Nursing Flowsheet" dated July 25, 2011, indicated Patient 55 received a medical screening examination by a nurse who determined there was "no emergency medical condition." Patient 54 was discharged home on July 25, 2011, at 12:44 a.m., and discharge instructions were given.</p> <p>The "Outpatient Medication Reconciliation and Physician's Order" dated July 25, 2011, indicated "As a result of this visit, home medications will not be changed" was marked. The "Outpatient Medication Reconciliation and Physician's Order" indicated "I have received this list of my home medications and the importance of managing my medication information has been explained to me including ... " was not signed by Patient 55 or her representative.</p> <p>c. On July 26, 2011, the record for Patient 56 was reviewed. Patient 56 was seen as an outpatient in the labor and delivery department for vaginal bleeding on June 7, 2011, at 5:53 p.m.</p> <p>The "Nursing Flowsheet" dated June 7, 2011,</p>	A 438	<p>Continued From page 71</p> <p>4. Education on medication reconciliation and applicable forms is performed on hire, annually and as needed.</p> <p>Compliance and Monitoring:</p> <p>The CNO or qualified designee performs a concurrent review of 50 records monthly for 3 months (and then re-evaluate) to achieve a goal of 100% compliance with having patients sign the Outpatient Medication Reconciliation and Physician's Order form. Corrective action is taken as necessary. The CNO reports on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly.</p> <p>Person Responsible:</p> <p>CNO</p>	<p>9/6/11</p> <p>9/6/11 and ongoing</p>

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

PRINTED: 08/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2011	
NAME OF PROVIDER OR SUPPLIER SOUTHWEST HEALTHCARE SYSTEM		STREET ADDRESS, CITY, STATE, ZIP CODE 25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562		
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A 438	<p>Continued From page 72</p> <p>indicated Patient 56 received a medical screening examination by a nurse and was discharged home on June 7, 2011, at 9:50 p.m., with discharge instructions.</p> <p>The "Outpatient Home Medication List" dated June 7, 2011, indicated "No change to your current home medications. If you have any questions, please contact your doctor." was marked. The area "I have reviewed this information & provided the list to the (check box) patient (check box) _____" was not marked and the "Outpatient Home Medication List" was not signed by Patient 56 or her representative.</p> <p>d. On July 26, 2011, the record for Patient 57 was reviewed. Patient 57 was seen as an outpatient in the labor and delivery department for mild contractions, nonstress testing (monitoring to aid in the determination of fetal well-being) and administration of betamethasone (a medication used to mature fetal lungs) on May 11, 2011, at 11:50 a.m.</p> <p>The "Nursing Flowsheet" dated May 11, 2011, indicated Patient 57 was "discharge to home undelivered and stable" and "written discharge instructions given" on May 11, 2011, at 2:45 p.m.</p> <p>The "Outpatient Home Medication List" dated May 11, 2011, indicated neither "No change to your current home medications. If you have any questions, please contact your doctor." nor "Change the following: ____" were marked. The area "I have reviewed this information & provided the list to the (check box) patient (check box) _____" was not marked and the "Outpatient Home Medication List" was not</p>	A 438		

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A 438	<p>Continued From page 73 signed by Patient 57 or her representative.</p> <p>On July 26, 2011, at 1:50 p.m., an interview was conducted with RN 7. She stated for outpatients, the discharge instructions and home medications lists were signed by the patient and a copy of both were given to the patient upon discharge.</p> <p>The facility policy and procedure titled "Medication Reconciliation Across the Continuum of Care" issued 2008, revised April 2011, indicated "... Upon discharge, the nurse will review the Medication Reconciliation form. ... The copy will be given to the patient and the patient will sign the form indicating that they have received the list and that the importance of medication information has been explained to them. ..."</p> <p>5. During a review of the medical record of Patient 4 on July 26, 2011, an order for an echocardiogram (ultrasound of the heart), was seen dated July 24, 2011. However, there was no notation that the test had been performed, and there was no echocardiogram found that was done in response to the July 24, 2011, order.</p> <p>In an interview with RN 11 on July 26, 2011, at approximately 1 p.m., she stated that the echocardiogram technologist had called a physician who was on-call for the patient's condition. That physician cancelled the order for the echocardiogram. RN 11 stated that the cancellation should have been recorded in an order from the physician.</p> <p>6. During a review of the medical record of Patient 7 on July 25, 2011, the record contained a</p>	A 438	<p>Continued From page 72</p> <p>Finding 5:</p> <p>Actions Taken:</p> <p>1. The Director of Cardiovascular Services (C/V Director) and CNO discussed the survey findings. The C/V Director clarified the process for documenting when a physician cancels the test, including documenting the cancellation in the physician orders, writing a progress note, if applicable, and communicating to the patient's nurse that the physician canceled the order. All technicians in the C/V department were inserviced.</p> <p>2. The C/V Director met with the involved technician to discuss the survey findings.</p>	8/12/11 9/6/11 9/6/11

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A 438	Continued From page 74 form titled, "Labor and Delivery Summary." The pre-printed form had boxes to be checked to indicate which conditions and treatments applied to Patient 7. The box for "Augmentation" (the act of accelerating the labor process) and "Pitocin" a medication that can induce or accelerate labor) were checked. A review of the medical record failed to reveal an order for Pitocin for augmentation, and there was no documentation in the medication records or the progress notes to indicate that Pitocin had been given during labor. The facility policy, "Documentation: Labor and delivery Room Procedures and Care", reviewed 12/2010, was seen on July 27, 2011, and included the directive, "Documentation of the labor patient's assessment and ongoing care shall occur in both the paper and electronic patient record." During an interview with RN 10 on July 25, 2011, at 9:45 a.m., she stated that the right column on the form was for post-partum medications, and that the terms "augmentation" and "Pitocin" appeared to have been marked in error. She stated there was no record of Pitocin being ordered prior to the delivery of the infant.	A 438	Continued From page 74 Compliance and Monitoring: The Director of PI shall coordinate a random record review of a minimum of 50 records a month for 3 months (and then re-evaluate) to achieve the goal of 100% compliance with documentation supporting cancellation of tests (or any other orders from physicians). Corrective action is taken as necessary. The PI Director reports on compliance monthly to the hospital PI Council, who will report through the hospital Quality Oversight Structure to the Board of Governors monthly. Persons Responsible: Director of Cardiovascular Services Director of Performance Improvement	9/6/11 and ongoing
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the	A 450	482.24(c)(1) MEDICAL RECORD SERVICES	