STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150169	A. BUILDING 00 B. WING	05/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL NORTH	7150 CLEARVISTA DR INDIANAPOLIS, IN 46256

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S0000	This was a State hospital complaint investigation. Complaint: #IN00103812 Substantiated: State deficiencies related to the allegations are cited. Facility Number: 011437 Survey Dates: 05/30/2012 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor QA: claughlin 07/12/12	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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S0732	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4) (d) The medical record shall contain sufficient information to: (1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results. Based on medical record review and interview, the facility failed to accurately document and justify the treatment for 1 of 5 behavioral health patients reviewed (#P1). Findings included: 1. The Emergency Room Report by MD5 from 01/25/12 for patient #P1 indicated, "...Lithium level is 1.63 [therapeutic normal range 0.6- 1.2], ...we feel he/she needs to be admitted to watch his/her lithium level and further observation, ...Diagnosis: lithium toxicity, suicidal ideation, acute psychoses". 2. Physician's orders indicated the following: A. Those addressing Lithium: 1. On 01/26/12 at 1500 by MD1, "Hold Lithium".	S0732	Deficiency: S 732 By 7-29-12 This issue was not known to us until the report was received which was later than 30 days after the exit. Thus our answers are 30 days from the date at the right for this standard. 2. A. and B. On 7-24-12 the ISDH deficiencies and medical record were reviewed by the BHS Medical Director, Nursing Director, Quality/Risk Site Leader and Risk Management Coordinator and a plan of correction was developed. By 8-28-12 We did not feel this citation was based on complete information. During an in depth review of the chart after the exit, the following clarifications are being made. We found that the documentation and rationale for the changes in Ativan and Valium were not located in the same part of the medical record consistently. Thus they were missed	05/30/2012

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	2. On 01/27/12 at 0245 by MD1, "Discontinue Lithium". 3. On 01/27/12 at 9:00 PM by MD1, "Lithium 300 mg. (milligrams) iii orally every HS (hour of sleep)". 4. On 02/03/12, (unable to determine physician's name), "Serum lithium level in AM". 5. On 02/04/12 at 0735 by MD4, "Hold lithium" and "Repeat lithium level 02/05/12". 6. On 02/06/12 at 12:45 PM by MD4, "Discontinue lithium- guardian withdrawing consent". 7. On 02/06/12, (unable to determine physician's name), "Serum lithium in AM". B. Those addressing other sedating medications (Ativan, Valium): 1. On 01/28/12 at 1530 by MD4, "Behavioral Care Services Symptom Triggered Detoxification Protocol", which was a printed order sheet for various doses of Ativan based on a scoring system. 2. On 01/28/12 at 1540 by MD3, "Discontinue Ativan triggered detox protocol" and Valium was ordered instead. 3. On 01/28/12 at 1830 by MD1, "Discontinue all Valium orders" and "Symptom trigger detox" with Ativan was again reordered.		on the day of the survey. We feel we are in compliance with the standard. 3. Clarification: the lab report of Lithium level of 1.8 on 2-4-12 was "Critical". The report of the critical lab was done @ 7:24 on 2-4-12 to the nursing unit. At 7:35 the same day, the MD ordered a "hold" on Lithium and a repeat of Lithium level on 2-5-12. This communication time line meets with the policy for reporting critical labs. 4. Clarification: the rationale for use of medication and detox was found on review of the medical record. Details are noted below: On 1-28-12 @ 5:50 a.m. Ativan 2 mg PO now was ordered. Valium 5mg PO now and Valium 5 mg PO not was ordered @ 9:20. The MD note on that date stated patient was hyperactive, had slept little, and had labile mood/affect and paranoid delusions. At 15:05 on 1-28-12 Valium 5mg PO/IM now was ordered for agitation and DTs. At 15:30 the MD ordered an Ativan symptom triggered detox protocol. The patient had a history of drug/alcohol abuse noted in her initial evaluation. There was also a consult ordered for evaluation of the patient by the addictions specialist. The addictions specialist, after doing the consult, discontinued the Ativan detox protocol @ 1540 and ordered Valium 15 mg PO/IM now and repeat again at 1930. He also	

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	4. On 01/30/12 at 0736, (surveyor and staff unable to determine physician's name), "Hold Ativan (decreased blood pressure and sedation)". 5. On 02/02/12 at 10:30 AM by MD4, "Discontinue Ativan". 3. Lab reports of lithium levels of 1.6 on 01/25/12, 1.0 on 01/26/12, 1.8 on 02/04/12, 1.2 on 02/05/12, and 0.3 on 02/07/12. The therapeutic range was 0.6 to 1.2. The results of 1.6 and 1.8 were designated as critical results that were called to the nursing unit and read back and verified. 4. A "Behavioral Care Services Subsequent Visit Inpatient Psychiatry Note" by MD1 from 02/07/12 discussed the lithium levels on 01/04/12, 01/05/12, and 01/06/12, but the labs were actually from 02/04/12, 02/05/12, and 02/07/12. The record lacked documentation to explain why the Lithium was placed on hold, stopped, then reordered, but the level was not checked for 9 days, from 01/26/12 to 02/04/12, when the patient was originally diagnosed as lithium toxicity. Other medications (Ativan, Valium) were stopped and started by different physicians with no documentation of the rationale. 5. At 4:10 PM on 05/30/12, both staff		ordered Valium 10 mg. PO/IM q.i.d. At 18:30 the MD ordered Ativan 2 mg. PO t.i.d. and discontinued the Valium orders. The MD note on 1-29-12 stated the patient was sedated. The MD note on 2-2-12 gives rationale for holding the Ativan. By 9-27-12 4. Physician management of the patient was referred to the Psychiatry QA committee by the Medical Director. The QA Committee action was done in an imminent review of patient care by the Medical Director and the Chair of the Psychiatry QA Committee on 7-13-12. A letter was sent to the two treating physicians to notify them that the care for this patient did not meet standards. Also, the Medical Director recommended to the Psychiatry Department Chair that guidelines be developed for the use of Lithium for all inpatients in order to prevent future deviations from the standard of care. The BHS pharmacist worked with the Medical Director and Department Chair in developing the Lithium Guidelines on 8-15-12. To assure these changes in practice are implemented and maintained, an audit of all patient records where Lithium is used in treatment is done by the Clinical Nurse Managers to assess application and compliance with the Guidelines. Any deviation from the Guidelines will be	

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	members #N3 and N7 confirmed the medical record findings and indicated there was confusion regarding why the Lithium was put on hold, stopped, then reordered and the level was not monitored when there were numerous references to lithium toxicity.		discussed immediately with the attending psychiatrist for a corrective action. The people responsible are: Medical Director, Nursing Director, Clinical Nurse Managers, and attending Psychiatrists.	

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S0930	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on medical record review, policy and procedure review, and interview, the registered nurse failed to ensure assistance with ADLs (activities of daily living) was provided, failed to document meals consumed, and failed to notify family related to restraint application according to policy for 1 of 5 patients (#P1) in the Psychiatric Intensive Care Unit (PICU). Findings included: 1. The medical record for patient #P1, admitted through the Emergency Department on 01/25/12 with diagnoses of lithium toxicity, suicidal ideation, and acute psychoses indicated the following: A. "Behavioral Care Services Inpatient Nursing Flow Sheets", which were the nursing assessments for each shift, lacked documentation of any assistance with ADLs (activities of daily living) for 01/27/12, 01/28/12, and 01/29/12 although the patient's appearance was marked as "Disheveled" and "Poor Hygiene". The first documentation of a shower was on 01/30/12 with the assistance of a family member. The areas on the forms for documentation of meals consumed was blank for those days. B. A Release of Information form, signed by the patient on 01/26/12, giving permission for	S0930	Deficiency S 930: By 6-29-12 1. A. The Clinical Nurse Manager communicated with PICU RN and MHC staff to coach them regarding the adequate documentation of nursing care (assistance with ADLs, monitoring of fool and fluid intake) on 6-19-12. To prevent recurrence, a monitor for this documentation was included in the daily chart audit done by the night nurses, with communication to individual staff where there was a need to correction. Results of chart audits will be shared with the staff and staff will be held accountable for accurate and complete documentation. Person responsible: BHS Nursing Director. By 7-29-12 B. The Nursing Director required that all RNs, LPNs and MHCs review the restraint policy on 7-27-12. Further, the Director directed that supervisors (who review the face-to-face evaluations of restrained patients) also review the medical record to assure that the family is notified of the restraint	05/30/2012

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	information to be released to 3 specific people. C. A "Behavioral Care Adult Services Restriction of Movement:Patient" form explaining the possibility of restricting the patient in some manner, signed by the patient on 01/26/12. A similar form explaining this process to the family indicated, "...Loss of control can be very scary and frustrating. If you wish, we will be in contact with you if this type of emergency occurs." A box was checked on the form, "I would like to be notified immediately if an emergency such as this occurs" followed by the phone number and name of the patient's family member. D. A telephone order from 1305 on 01/28/12 for restraints due to "falling, nondirectable, combative,threatening" and a renewal of the order at 1704 on 01/28/12. E. "Behavioral Care Services Restraint/Seclusion Check Sheet" indicating the patient was restrained from 1245 until 1815 on 01/28/12 with 15 minute checks documented. The column marked "Fluids & Toileting", which was part of the assessment specified in the policy, was marked 14 out of 23 times, but there was no documentation of a meal provided. The record also lacked documentation of a family member being notified as requested when the restraints were initiated or of a debriefing session afterwards. 2. The facility policy "Restraint for Emergent Destructive and/or Assaultive Behavior", effective 06/25/10, indicated, under Procedure, "...8. Patient and/or Family Information/Education: a. At the beginning of hospitalization, as appropriate, the RN will share with the patient/family the patient's rights and hospital philosophy about restraint, and will inform family (with consent of adult patients) that they can request to be notified		when requested on 7-26-12. The Nursing Director also directed the RNs to write notes regarding information about incidents of toileting, intake of fluids/foods every two hours during restraint (7-27-12). To prevent recurrence, a monitor for this documentation was included in the daily chart audit done by the night nurses, with communication to individual staff where there was a need to correction. Results of chart audits will be shared with the staff and staff will be held accountable for accurate and complete documentation. Person responsible: BHS Nursing Director	

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	of restraint. ...9. Patient Observation and Care: ...c. The RN will assess the patient every 15 minutes, or more frequently, if indicated. This assessment includes: equipment security, signs of injury associated with the application of restraint, vital signs, symptoms of respiratory distress, adequate circulation, redness, irritation, edema, physical and psychological status, safety, comfort, privacy, level of self control, nutrition, hydration, and elimination needs, and readiness for release." The policy also indicated, "...11. Debriefing: staff and patient (family when appropriate) participate, within 24 hours, in a debriefing about the restraint episode." The policy continued, "...Documentation in the medical record will demonstrate that use of restraint is consistent with policy and includes the content listed below. ...12. Notification of the patient's family when appropriate." 3. At 4:10 PM on 05/30/12, both staff members #N3 and N7 confirmed the medical record findings and indicated there were issues with the ADLs and meals not being marked on the appropriate sheets and no other documentation about them. They indicated there was no specific policy regarding this, but the expectation was for the form to be completed. The staff members confirmed the lack of documentation of family notification when the patient was transferred to the PICU and when restraints were applied.			