

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/13/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219
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S0000	<p>This visit was for the investigation of a State hospital complaint.</p> <p>Complaint #: IN00112325 Substantiated; related deficiencies cited.</p> <p>Survey Date: 12-13-2012</p> <p>Facility Number: 005068</p> <p>Surveyor: Deborah Franco, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 01/14/13</p>	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0930	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on document review and interview, the registered nurse failed to perform a post-pain medication administration assessment within one hour of administration of medication and a full nursing shift assessment as required by facility policy for 1 of 5 (N1) medical records reviewed.</p> <p>Findings:</p> <p>1. Facility policy " Pain and Symptom Management " , last reviewed/ revised 5-9-12, provided that the symptom management tool was to be used to "document pre and post interventions for all symptoms reported by the patient", ... "documentation within 60 minutes of post assessment following each pharmacologic intervention", ... and required the following be documented in the EMR: "date and time symptoms pre-intervention rating of complaint pre-intervention rating of sedation level</p>	S0930	<p>1. Remediation for the individual nurse who was out of compliance with post pain assessment frequency and required shift assessment frequency was completed and documented per the Neurology Medical Surgical Nursing Manager who is responsible for this staff nurse.2. The current "Policy for Pain and Symptom Management Policy" will be reviewed again at the mandatory February 20, 21, and 22, 2013 staff meetings with all RN's present. Close attention will be placed around post pain assessment and shift assessment frequency. The Neurology Medical Surgical Nursing Manager is responsible for completion of this reeducation which will be completed at 7pm on February 22, 2013. Every surgical patient will be audited for the next 30 days to ensure 100% compliance with this policy and immediate follow up with remediation for anyone who does not meet the current policy and expectation of care. In order to verify continued compliance is hardwired, 10 random surgical</p>	02/22/2013	

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	<p>non-pharmacologic interventions and post-intervention ratings for symptom and sedation".</p> <p>2. Facility policy "Patient Care Guidelines CHE Medical Surgical Units", last reviewed/revised 3-3-12, provided on page 1 "Complete "head to toe" physical assessment ..will be done by an RN on admission/transfer, upon return from surgery, and at the beginning of each shift for all levels of care and completely documented".</p> <p>3. Review of medical record for N1 indicated the following:</p> <p>a. On 5-8-12, N1 had a hemi-laminectomy of lumbar 4 and lumbar 5.</p> <p>b. On 5-10-12 at approximately 3:00 AM, N1 was found by the RN to be unresponsive to verbal/physical stimulation, except to deep sternal pain, with an oxygen saturation of 79 percent; respirations were 14 with stable blood pressure; the Rapid Response Team was notified; orders were obtained to reverse narcotic medication with 0.4 mg of Narcan; oxygen mask was applied, and N1 was transferred from a medical/surgical unit (5 Tower) to the PCU where N1 stayed for approximately 1 1/2 days.</p> <p>c. 8mg of Morphine IV Push was</p>		<p>charts per month for 6 months will be audited with immediate remediation for anyone who does not meet the current policy and expectation of care. 3. The "Patient Care Guidelines CHE Medical Surgical Units" will be reviewed again at the February 20, 21, 22, 2013 staff meetings with all RN's regarding full head to toe nursing assessments each shift with documentation in the electronic medical record. The Neurology Medical Surgical Nursing Manager is responsible for completion of this reeducation which will be completed at 7pm on February 22, 2013. Every surgical patient will be audited for 30 days to ensure 100% compliance with this policy and immediate follow up with remediation for anyone who does not meet the current policy and expectation of care. In order to verify continued compliance is hardwired, 10 random surgical charts per month for 6 months will be audited with immediate remediation for anyone who does not meet the current policy and expectation of care. 4. "Reporting of Suspected Adverse Drug Reactions Policy" will be reviewed again with all RN's at the February 20, 21, 22, 2013 staff meetings including documentation responsibilities in the electronic medical record. The Neurology Medical Surgical Nursing Manager is responsible for completion of this</p>		

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	<p>administered to N1 on 5-9-12 at 20:09 as a prn medication for reported 10 of 10 pain; a post intervention assessment was documented at 22:00 "resting quietly with eyes closed" (1 hour and 41 minutes after the intervention).</p> <p>d. there was no full nursing assessment at midnight on 5-10-12.</p> <p>4. During interview with S4 on 12-13-12 at 4:45 PM, S4 indicated:</p> <p>a. N1's medical record lacked a full nursing assessment at the beginning of the night shift (MN) 5-10-12 as required by facility policy.</p> <p>b. N1's medical record contained a post-intervention pain assessment on 5-9-12 at 22:00 which was 41 minutes later than as required per policy.</p> <p>c. based on N1's reported pain and muscle spasms and the medication administered to treat the reported symptoms (Morphine, Valium, Zanaflex, Oxydocone, and Acetaminophen) ; post-intervention assessments and full nursing assessments were important nursing tools to monitor for relief of symptoms as well as N1's response to the above medications including narcotics and muscle relaxers.</p>		<p>reeducation which will be completed at 7pm on February 22, 2013. Every surgical patient will be audited for 30 days to ensure 100% compliance with this policy and immediate follow up with remediation for anyone who does not meet the current policy and expectation of care. In order to verify continued compliance is hardwired, 10 random surgical charts per month for 6 months will be audited with immediate remediation for anyone who does not meet the current policy and expectation of care.</p>		

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S1038	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7 (d)(3)(4)(5)(6)</p> <p>(d) Written policies and procedures shall be developed and implemented that include the following:</p> <p>(3) Review the use of medications with the standards developed by the medical staff, which include stop orders for scheduled drugs and biologicals not specifically prescribed as to time or number of doses.</p> <p>(4) Allow for adequate drug therapy monitoring procedures to exist.</p> <p>(5) Minimize medication errors and document, monitor, evaluate, and report adverse drug reactions and medication errors.</p> <p>(6) Provide for the maintenance of drug and poison information materials.</p> <p>Based on document review and interview, the facility failed to implement its policy for the reporting of suspected adverse drug reactions in 1 of 5 (N1) medical records reviewed.</p> <p>Findings:</p> <p>1. Facility policy "Reporting of Suspected Adverse Drug Reactions ", last reviewed/revised 8-18-10, stated purpose was to "define the process of reporting suspected adverse drug reactions to the Medical Staff, the Pharmacy Department,</p>	S1038	<p><u>Plan of Correction</u> <u>Action Date Completed</u> <u>Completed By:</u> Submitted ADR report regarding this incident 2/1/13 CHE Director of Pharmacy ADR report submitted to P&T Committee for review. ADRs are reported to the committee on a quarterly basis as a standing agenda item titled "ADR Quarterly Report" Quarterly report will be reviewed during P&T Committee scheduled on 5/14/2013 Network Medication Safety Officer and Drug Information Pharmacist Submitted Medwatch form to FDA</p>	02/01/2013

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	<p>the Quality Resource Department and the FDA". It provided under Policy Statements that "an adverse drug reaction (ADR) " is one that is noxious and unintended and occurs at doses routinely used in humans. It can include, but is not limited to, one that is toxic to the patient, one that requires treatment with another drug...results in temporary or permanent disability, one that increases length of stay or one that results in death"... "Reactions need only be suspected; definitive proof of the cause is not required". Under Procedure for Reporting a Suspected Adverse Drug Reaction" it provided that "any member of the health team may report a suspected ADR..."</p> <p>2. Review of N1's medical record on 12-13-12 with S4 indicated the following:</p> <p>a. N1 was an in-patient from 5-8-12 and was discharged to home on 5-12-12.</p> <p>b. On 5-8-12, N1 had a hemi-laminectomy of lumbar 4 and lumbar 5.</p> <p>c. Nursing notes indicated on 5-10-12 N1 at approximately 3:00 AM, N1 was found by the RN to be unresponsive to verbal/physical stimulation, except to deep sternal pain, with an oxygen saturation of 79 percent; respirations were 14 with stable blood pressure, the Rapid Response Team was notified; orders were obtained to reverse narcotic medication</p>		<p>2/1/13 CHE Director of Pharmacy Updated presentation given to all new Community Health Network nurses during their RN orientation program to emphasize the importance of submitting ADRs as well as how to submit one</p> <p>1/27/13 CHE Director of Pharmacy Medication Safety Officer has started forwarding the ISMP Nursing Newsletter to RN managers. The newsletter will provide them with current medication safety issues they can focus on with their nursing staff.</p> <p>1/27/13 Network Medication Safety Officer Response to S1038 - Pharmaceutical Services 1. (d) (3) NPP D-017A policy addresses stop times of medications 2. (d) (4) Numerous examples of med monitoring polices approved by the Medical Staff via the P&T Committee a. Pain Consult Guide (not a P&T Approved protocol but does provide assistance with monitoring pain) b. Acetaminophen IV conversion to PO c. Metformin monitoring d. Anticoagulation Monitoring e. Automatic Renal Dosing Protocol 3. (d)(5) Minimize med errors and report ADRs a. Currently ADRs are communicated to the network Medical Staff via P&T committee on a quarterly basis b. Currently ADRs are reported to Network board via the Quality Care Committee on a quarterly basis c. The network employs a</p>				

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	<p>with 0.4 mg of Narcan; oxygen mask was applied, and N1 was transferred from a medical/surgical unit (5 Tower) to the PCU where N1 stayed for approximately 1 1/2 days.</p> <p>d. Nursing notes on 5-9-12 indicated N1 had reported muscle spasms with pain of 10 out of 10 in N1's neck and as documented on the medication administration record dated 5-9-12 had received the following medications to treat pain and muscle spasms:</p> <ul style="list-style-type: none"> i. Zanaflex 4 mg p.o. at 15:47 (an every 8 hour order) and Zanaflex 4mg p.o. at 19:10 (one time order). ii. Oxycodone 40 mg p.o. at 19:33 (an every 12 hour order) iii. Nucynta 100 mg at 19:10 (an every 4 hours order) iv. Valium 10 mg IV Push at 14:07 (one time order) and Valium 10 mg p.o. at 18:23 (a prn every 8 hours order) v. Morphine 10 mg IV push at 14:07 (one time order) and Morphine 8 mg IV Push at 17:10 and 20:09 (a prn every 3 hours order). vi. 1000 mg Acetaminophen IV at 15:11, and on 5-10-12 at 00:22, 1000 mg Acetaminophen (an every 8 hour order). <p>e. While in PCU, N1 was seen by a hospitalist (M2) for respiratory depression and over-sedation; medications were adjusted and closely monitored for effective treatment of pain and muscle</p>		<p>full time Medication Safety Officer who focuses on preventing medication errors and learning from those that do occur. d. Quarterly ISMP action agenda is reviewed proactively by pharmacy leadership who perform a GAP analysis. Any possible action steps that would improve patient safety are acted upon e. Policies that address medication errors and ADRs</p> <ul style="list-style-type: none"> i. High Alert Medications (CLN 3080) ii. Reporting of Suspected Adverse Drug Reactions (CLN 2050) <p>4. (d)(6) a. The Network maintains a Drug Information center per PPP Clin006 policy b. Poison and Drug information can be found in the following locations</p> <ul style="list-style-type: none"> i. Micromedex – available via intranet ii. Lexi-Comp – available via Pyxis machines iii. Krames – available via link on the Epic MAR c. MSDS information can be found on INCOMM >> Safety and Security >> MSDS Online 		

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	<p>spasms while controlling respiratory depression and over-sedation.</p> <p>f. N1's discharge diagnoses included poisoning by sedative/hypnotic and accidental poisoning by sedative/hypnotic.</p> <p>3. During interview with S5 on 12-13-12 at approximately 3:30 P.M., and after reviewing the medication administration record for N1, S5 indicated:</p> <p>a. S5 holds a doctorate in pharmacology and is a pharmacist.</p> <p>b. had not received an Adverse Drug Reaction Variance report regarding N1's in-patient hospitalization in May 2012.</p> <p>c. The medications listed above for N1 were in amounts routinely ordered and given to humans.</p> <p>4. During interview with S2 on 12-13-12 at 4:45 PM, S2 indicated that no Variance report had been generated regarding the unanticipated change in N1's condition on 5-10-12 at 3:00 AM following the administration of the above-medications.</p> <p>5. During interview with S4 on 12-13-12 at 4:30 P.M., S4 indicated:</p> <p>a. confirmed the findings in N1's medical record.</p> <p>b. nursing staff should have submitted an Adverse Drug Reaction</p>			

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	Variance report within one day of N1's 5-10-12 change in condition per facility policy for suspected/actual adverse drug reaction for N1 which was unintended and occurred at doses routinely used in humans.			