

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150088	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/19/2012
NAME OF PROVIDER OR SUPPLIER SAINT JOHN'S HEALTH SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 2015 JACKSON ST ANDERSON, IN 46016		
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S0000	<p>The visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN 00104124 Substantiated: no deficiencies related to the allegations are cited; deficiencies unrelated to the allegations are cited</p> <p>Dates: 3-15-2012 and 3-19-2012</p> <p>Facility Number: 005078</p> <p>Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor</p> <p>QA: cloughlin 05/18/12</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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S0322	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility failed to ensure that its policies/procedures were updated and/or reviewed at least triennially.</p> <p>Findings: 1. The policy/procedure Documentation Requirements (approved 9-08) failed to indicate that an update and/or review had occurred in the past three years. 2. On 3-19-12 at 0835 hours, staff A4 confirmed that the policy/procedure lacked a triennial review.</p>	S0322	<p>The ADMIN policy/procedure Documentation Requirements was reviewed and approved by the Executive Leadership Team 5/22/12. All other ADMIN policies that are due for triennial review are in process for review and approval. (Director; Quality, Risk Management, and Regulatory Compliance is responsible for this review and approval process.) Completion Date: 6/20/12.</p>	06/20/2012			

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S0732	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4)</p> <p>(d) The medical record shall contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results.</p> <p>Based upon document review and interview, the facility failed to follow its policy/procedure and ensure that the medical record (MR) contained sufficient information to accurately document the course of treatment and results for 1 of 6 MR reviewed (P12).</p> <p>Findings:</p> <p>1. The policy/procedure Documentation Requirements (approved 9-08) indicated the following: " All medical records ...must contain sufficient information to ...document the course and results of care, treatment, or service ... "</p> <p>2. A radiology report dated 10-14-09 and signed at 1411 hours indicated that the naso-gastric (NG) tube was coiled in patient P12 ' s neck following a nursing entry at 1350 hours of NG insertion by staff N24. The MR lacked a nursing entry indicating that the NG tube was removed following receipt of the radiology report.</p>	S0732	<p>Findings 1, 2, and 3 - The ADMIN policy/procedure Documentation Requirements was reviewed and approved 5/22/12. The documentation of care, in accordance with this policy, that was provided to the patient between 1350 and 1613 10/14/09 was reviewed and while the specific note that the NG tube was removed had not been documented it could be inferred by the chronological chain of events documenting the coiled tube and the subsequent attempt to reinsert another one. Patient location in the Radiology Department is documented and the fact that the patient was transported could also be inferred from the documentation . The importance of thorough documentation and the ADMIN Documentation Requirements policy/procedure will be reviewed with Nursing Leadership at Nursing Operations Council 6/20/12. They will then be advised to review this policy with all nursing staff at their</p>	06/20/2012			

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	<p>3. A radiology report dated 10-14-09 and signed at 1613 hours indicated that a radiologist made multiple attempts using fluoroscopy to replace the NG tube in the radiology department without success. The MR lacked a nursing entry indicating that patient P12 was transported to the radiology department for the procedure.</p> <p>4. On 3-19-12 at 0830 hours, staff A4 was requested to provide documentation of progress notes for patient P12 made by MD1 on 10-14-09, 10-15-09, and 10-16-09 which corresponded to electronic MR entries by MD1 that indicated the following: " Please see pt chart for hard copy of note " and none was provided prior to exit from the facility.</p> <p>5. During an interview on 3-19-12 at 0905 hours, staff A2 and staff A4 confirmed that the requested documentation was not found in the MR for patient P12 following an exhaustive review conducted on 3-17-12 and confirmed that the facility failed to follow its policy/procedure.</p>		<p>next department meeting. (Director; Quality, Risk Management, and Regulatory Compliance is responsible for reviewing this policy at Nursing Operations Council.) Findings 4 and 5 - Physician MD1 is no longer privileged at this facility. The electronic medical record entries were documented under the progress notes portion of the medical record and contained pertinent information in accordance with the Documentation Requirements policy. The statement at the end of the note "Please see pt chart for hard copy of note." is unexplainable without MD1's presence to explain. Hard copy notes were not an acceptable documentation practice in addition to electronic medical record entries in 2009. Ongoing medical record audits and billing compliance audits have not identified a trend in missing Physician Progress Notes. These audits will continue to be conducted by the Clinical Documentation Improvement Nurses and Quality Nurses and compliance reported quarterly to the Performance Improvement Committee. (Quality Nurse).</p>		

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S0744	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete;</p> <p>Based upon document review and interview, the facility failed to follow its policy/procedure ensuring that medical record (MR) documentation will be completed for 1 of 6 MR reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Patient Death (approved 8-11) indicated the following: " Proper documentation on the Death Dismissal Record ...will be completed before releasing the body to the mortuary. The Death Dismissal Record for patient P12 lacked an entry indicating: <ol style="list-style-type: none"> what staff pronounced the patient dead what time the body was released what nursing staff completed the Death Dismissal Record On 3-19-12 at 0830 hours, staff A4 confirmed that the Death Dismissal Record was not completed and that the facility failed to follow its policy/procedure. 	S0744	<p>The Death Dismissal Record policy/procedure will be reviewed with Nursing Leadership at Nursing Operations Council 6/20/12. They will then be advised to review this policy with all nursing staff at their next department meeting. (Director; Quality, Risk Management, and Regulatory Compliance is responsible for reviewing this policy at Nursing Operations Council.) Ongoing medical record audits have not identified a trend in incomplete Death Dismissal Records. These audits will continue to be conducted by the Quality Nurses and compliance reported quarterly to the Performance Improvement Committee. (Quality Nurse).</p>	06/20/2012	