STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150017	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/28/2011
NAME OF PROVIDER OR SUPPLIER LUTHERAN HOSPITAL OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 7950 W JEFFERSON BLVD FORT WAYNE, IN46804	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	This visit was for the investigation of two State hospital complaints. Complaints: #IN00086910 Substantiated: No deficiencies related to the allegations are cited. #IN00093592 Unsubstantiated: Lack of sufficient evidence. Unrelated deficiency is cited. Facility Number: 005016 Survey Date(s): 09/27/11 through 09/28/11 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Quality Review: claughlin 10/17/11	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(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 provide accurate documentation to justify the treatment provided to 1 of 5 patients (#N1) whose records were reviewed. Findings included: 1. The medical record for patient #N1 indicated the following: A. The patient was admitted through the ED on 07/04/11 with the complaint of chest pain. Past history included chronic renal failure syndrome, completed stroke, diabetes mellitus, and previous myocardial infarction. The patient was alert and oriented. B. The physician ordered Percocet 10/325 orally 3 to 5 times a day as needed for pain which was a medication the patient had been on at home. The patient received this medication at 1840 on 07/04/11, at 0332, 1108, and 2029 on 07/05/11, and at 0012, 0442, and 1059 on 07/06/11.	S0732	Review of the medical record was completed by the Administrative Director of Nursing Service and the RN involved the care of the patient. Results of the review indicated that no reason was given as to why Narcan was ordered. The RN was counseled as to the need for documentation that supports the treatment provided to the patient. As the finding involved only one medical record, follow-up will involve reviewing a sample of medical record documentation by this RN. The Manager of the nursing unit will conduct the medical record review.Results of the chart review will be shared with the RN by the unit manager and corrective action will be taken as necessary.	11/11/2011

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	C. The patient was going to be discharged on the second day, but began complaining of knee pain. D. All of the neurological checks were documented as alert and oriented x3 including documentation at 1600 on 07/06/11. E. Other documentation on the patient at 1600 on 07/06/11 included a pain rating of 9 out of 10 with the pain location as everywhere, alert and oriented x3, restlessness, crying out, fidgeting, impulsive, moaning, panicky, poor eye contact, and skin pale, warm, diaphoretic. F. Nurses' notes from 1600 on 07/06/11, "Pt. confused, MD said to hold pain meds for the time being. Called MD about pt.'s status, asked for Narcan to see if that would help the patient, orders received." G. A telephone physician order from 1556 on 07/06/11, "Narcan IV 0.4 mg. now." H. Nurses' notes from 1622 on 07/06/11, "Pt. very restless, up and down, hyperventilating, called MD about pt.'s status, orders received." I. A telephone physician order from 1618 on 07/06/11, "1/2 mg. IV Haldol now. Head CT." J. Telephone physician order from 1641 on 07/06/11, "Change Percocet to every 6 hours as needed for pain." K. The physician's progress notes lacked documentation regarding the patient's			

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	status and orders given the evening of 07/06/11. 2. At 2:00 PM on 09/28/11, staff member A2 confirmed the documentation regarding the 1600 charting on 07/06/11 for patient #N1 was contradictory. He/she indicated since the patient required dialysis, he/she might not have been able to handle the doses of Percocet that he/she received which could have been the reason for the Narcan. He/she confirmed the charting did not present a clear picture and confirmed the lack of any physician documentation regarding the issue. 3. The medical record lacked sufficient documentation to indicate the reason for the administration of Narcan.			