

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150012	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
S000000	<p>The visit was for investigation of 2 State hospital complaints.</p> <p>Complaint Number: IN 00109742 Substantiated: deficiencies cited related to the allegations.</p> <p>Complaint Number: IN 00120542 Unsubstantiated: lack of sufficient evidence.</p> <p>Date: 2-12 and 2-13-13</p> <p>Facility Number: 005012</p> <p>Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor</p> <p>QA: cloughlin 05/06/13</p>	S000000			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150012		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2013	
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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			
S000322	<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:</p> <p>(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 all policy/procedures in use were updated as needed and reviewed and approved for use by an authorized representative of the facility for 1 of 10 policy/procedures reviewed.</p> <p>Findings:</p> <p>1. The Trinity Health system policy/procedure Health Record Form and Content Standards lacked a date of facility review/approval with the name of a responsible person at the facility:</p> <p>2. During an interview on 2-13-13 at 1045 hours, the medical records director A11 confirmed that the policy/procedure lacked documentation of hospital review and approval with the name of a</p>	S000322	The Health Record Form and Consent Policy has been reviewed. After the review the new policy is now titled, Health Record and Use of Electronic Signature. which is in the SJRMC format. The policy will be approved by the HIM Committee on June 5, 2013. Leadership is aware that all Trinity policies sent to SJRMC will be reviewed and approved by the respective PI team and placed into the SJRMS policy system with approval date. Person responsible - HIM Director	06/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150012	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	responsible person.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150012	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
S000732	<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/procedures and ensure that the medical record (MR) contained sufficient information to support the diagnosis and accurately document the course of treatment and results for 1 (patient 27) of 5 MR reviewed.</p> <p>Findings:</p> <p>1. The Trinity Health system policy/procedure Health Record Form and Content Standards (no facility approval date) indicated the following: "The content of documentation in the health record is the basis for the Ministry Organization to defend itself in a legal proceeding and provide evidence of medical treatment delivered....Health entries shall be documented at the time the treatment is rendered and shall be legible, complete, and permanent."</p>	S000732	<p>1.Rhythm strips with the interpretation will be attached to the paper form, which is later scanned into the electronic medical record (EMR). Education regarding this component of patient care was conducted on May 23, 2013 during a staff meeting. A note in nurses notes stating the fact that patient was placed on a monitor will be included. Monthly chart audits are being performed to monitor compliance and the compliance will be reported to the ED staff and the Provision of Care Committee monthly Compliance - 90% .</p> <p>2.In the event that a patient is moved from one treatment room to another, a note will be entered in EMR with an explanation for the purpose and reason of the change. It is not a frequent occurrence that patients are moved from room to room in the ED. Staff education regarding this note was conducted on May 23, 2013 during the ED staff meeting. Monthly chart audits are being</p>	05/23/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150012	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>2. Patient 27's MR indicated Chest Pain protocol ordered by physician at 2128 on 6-1-12. MR lacked documentation to indicate the following in response to Chest Pain protocol orders:</p> <p>A. cardiac monitor or defibrillator rhythm strip to validate initial cardiac monitoring</p> <p>B. non-monitored ED room (6) transfer to ED room (2-M) with a cardiac monitor</p> <p>C. oxygen provided to patient and oximetry level</p> <p>D. periodic chest pain level reassessment</p> <p>3. During an interview on 2-13-13 at 0930 hours, staff A10 confirmed that the MR lacked documentation to indicate cardiac monitoring was performed, oxygen was provided or chest pain reassessed in response to the chest pain protocol orders for patient 27 while in ED.</p>		<p>performed to monitor compliance and the compliance will be reported to the ED staff and the Provision of Care Committee monthly. Compliance 90%</p> <p>3.**IDR for the oxygen therapy portion only** - The oxygen therapy in the chest pain protocol was ordered "as needed," and the patient did not require oxygen therapy. The nursing documentation indicates that based on the assessment and patient needs, the patient was on room air on 6-1-12 at 2016 and on 6-2-12 at 0048, 0152, 0200, 0800, 1200, and 1500. The documentation indicates that pulse oximetry was performed on the patient on 6-1-12 at 2016 and on 6-2-12 at 0048, 0200, 0500, 0800, 1200, and 1500. Based on the patient's pulse oximetry results the patient did not require O2 to be applied. This was reflected in the patient's EMR.</p> <p>4. The pain level was assessed on 6-1-12 at 2016 and reassessed on 6-2-12 at 0200, 0308, 0323, and 0500. It is recognized that the pain assessments were insufficient. The pain assessment and reassessment procedures were discussed at the ED staff meeting on May 23, 2013. All RN staff members are to review SJRMC and unit specific pain management policies Monthly chart audits are being performed to monitor compliance and the compliance will be reported to the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150012	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
			ED staff and the Provision of Care Committee monthly. Compliance - 90% 5. Responsible Person - ED Manager	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150012	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
S000930	<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 upon document review and interview, the registered nurse failed to ensure that the patient's report of pain was reassessed based on the chief complaint of pain and the 6/10 pain rating reported by the patient on arrival in the Emergency Department (ED) for 1 of 5 medical records (MR) reviewed.</p> <p>Findings:</p> <p>1. The policy/procedure Pain Management in Emergency Department: Unit Specific Guidelines (approved 8-11) indicated the following: "Patient presents with pain level of 4 or greater should be assessed and reassessed for pain..[and] ...refer to SJRMC Pain Management policy."</p> <p>2. The policy/procedure Pain Management (approved 10-11) indicated the following: "A positive finding for pain on admission will initiate further questioning, which includes ...patient's personal goal for pain relief ...[and]</p>	S000930	<p>Staff education regarding the pain assessment component of patient care was conducted on May 23, 2013 during the ED staff meeting. The Pain policy was reviewed and the focus was on the required aspects of the pain assessment, all of which are built into EMR. The pain assessment in the EMR includes, but is not limited to; the patient's pain score, numeric pain goal, pain location, pain duration, pain radiation, and pain characteristics. Monthly chart audits are being performed to monitor compliance and the compliance will be reported to the ED staff and the Provision of Care Committee monthly. Person responsible - ED Manager Compliance 90%.</p>	05/23/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150012	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/13/2013
NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
	<p>...methods of pain management (current and past regimens and effectiveness)."</p> <p>3. Patient 27's MR failed to indicate that a registered nurse re-evaluated the 6/10 pain level reported on arrival at 2016 hours until transfer to a room at 0200 hours. The MR failed to indicate that a registered nurse evaluated the patient's goal for pain control or relief and current method of pain management and failed to indicate any interventions initiated and patient response to treatment provided or physician contact for analgesic orders.</p> <p>4. During an interview on 2-13-13 at 0930 hours, staff A10 confirmed that no documentation indicated the pain level reported on arrival in ED was reassessed and/or treated and/or physician contacted prior to transfer from ED.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150012	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
S001510	<p>410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following: (A) Provision for the care of the disturbed patient. (B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care. (C) Provision for transfer of patients when care is needed which cannot be provided.</p> <p>Based on document review and interview, the facility failed to follow its policy for patient rounding in the Emergency Department (ED) for 1 of 5 (patient 27) medical records (MR) reviewed.</p> <p>Findings:</p> <p>1. The policy/procedure Assessment and Reassessment (approved 9-12) indicated the following: "The licensed staff shall document patient status observations ...[and] ...Attachment A. Emergency Department ...Document every 30 minutes Patient Rounding within ED Progress Notes."</p> <p>2. Review of patient 27's ED Progress Notes lacked any MR entry to indicate that patient rounding was performed for 5 of 10 (30 minute)</p>	S001510	The Assessment/Reassessment Policy was reviewed and updated. The issue of timely rounding was discussed in the staff meeting on May 23, 2013. The updated Assessment/Reassessment policy will go the June 5th Provision of Care meeting for final approval. Monthly chart audits are being performed to ensure compliance with the revised assessment and reassessment policy. The audit results will be reported to the ED staff and the Provision of Care Committee. Person Responsible - ED Manager. Compliance - 90%	06/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150012	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT JOSEPH REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5215 HOLY CROSS PKWY MISHAWAKA, IN 46545
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
	<p>rounding intervals (2100, 2200, 2359, 0030 and 0100 hours).</p> <p>3. During an interview on 2-13-13 at 0930 hours, staff A10 confirmed that the MR lacked documentation of patient rounding for the indicated intervals.</p>			