

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151307	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2013
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NAME OF PROVIDER OR SUPPLIER ST VINCENT WILLIAMSPORT HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 412 N MONROE ST WILLIAMSPORT, IN 47993
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S000000	<p>This visit was for the investigation of a State complaint.</p> <p>Complaint Number: IN00123068 Substantiated: State deficiencies related to the allegations are cited.</p> <p>Facility Number: 005092</p> <p>Date of Survey: 04/11/2013</p> <p>Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: clauglin 05/23/13</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.

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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 chief executive officer failed to provide procedures for staff to follow to thoroughly investigate complaints/grievances.</p> <p>Findings included:</p> <p>1. The facility policy "Patient/Customer Complaints", last approved 04/2012, indicated, "When the provision of care or the perception of the care provided by St. Vincent Williamsport Hospital does not meet expectations, there is a process in place to recognize and address these issues. ...1. Complaint Management: Expressions of concerns characterized by dissatisfaction and/or complaints received should be addressed whenever possible at the department levels. The caregiver and/or the appropriate supervisory person</p>	S000322	<p>Effective May 21, 2013 the current patient/customer complaint policy has been revised by the CNO and has been electronically submitted through Policy STAT (online policy program) administrative flow process, which includes administration, quality and clinical service lines. The updated policy includes complaint management with specific procedures for documentation, investigation and/or follow-up to ensure that the following is addressed:</p> <ul style="list-style-type: none"> •Address patient and family concerns at the appropriate level; •Assure prompt and courteous attention to concerns and expedite the investigation through resolution; •Provide consistency in complaint management and service recovery; •Utilize the electronic data base for trending complaints; 	05/21/2013

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	<p>according to the established departmental procedures of the area should address the situation."</p> <p>The policy continued, "4. Documentation of Correction Action: 1. All actions taken concerning the resolution of concerns/complaints expressed by patients will be appropriately documented in accordance with existing procedures relating to the specific area and/or type of concern." The policy lacked any further directions or specific procedures for documentation, investigation, or follow-up.</p> <p>2. At 4:00 PM on 04/11/13, staff member #N1 indicated there were no departmental procedures or any other policies/procedures specific to complaints or grievances. He/she indicated he/she was also in charge of risk management and did follow-up with letters to complainants, but could not provide any documentation of step by step procedures to follow.</p>		<p>•Respect the need for patient, associate, and physician privacy and for confidentiality of issues. This deficiency has been corrected by Chief Nursing Officer. Updating the Patient/Visitor policy with specific directions and a time line for follow-up will prevent this from occurring in the future. See attached policy # 453350 with attachments.</p>		

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S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on medical record review, policy and procedure review, administrative document review, and interview, the nurse executive failed to ensure the facility's pain assessment policy and standing orders were followed for 1 of 2 patients receiving IV (intravenous) medication (#P1) and</p>	S000912	Effective, May 31, 2013, The Nursing Guidelines for the Assessment and Management of Pain has been revised and has been electronically submitted through Policy STAT clinical	05/31/2013

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	<p>failed to ensure a thorough investigation of a complaint was conducted for 1 of 1 patients who complained about care received while hospitalized (#P1).</p> <p>Findings included:</p> <p>1. The medical record for patient #P1, who was admitted by MD1 at 1500 on 01/11/13 for uncontrolled right shoulder pain after a rotator cuff repair on 01/09/13, indicated the following:</p> <p>A. Vital signs taken only at 1800 and 2200 on 01/11/13 and at 0200 on 01/12/13.</p> <p>B. A pain rating of 10 at 1500 on 01/11/13 with check marks in the spaces each hour after that and no further numeric ratings on the flow sheet or in the nursing notes.</p> <p>C. Documentation of medication given of Dilaudid 0.2 mg. (milligrams) IV at 1645 on 01/11/13, Dilaudid 0.2 mg. IV at 1815 on 01/11/13, Morphine 2 mg. IV loading dose at 1905 on 01/11/13 and a Morphine PCA (patient controlled analgesia) started per standard protocol, Morphine 2 mg. IV for breakthrough pain at 2135 on 01/11/13, and Dilaudid 1 mg. IV at 0150 on 01/12/13.</p> <p>D. Physician's standing orders "Adult PCA Orders", received per telephone at 1850 on 01/11/13, which indicated, "Monitor patient's vital signs, respirations, ability to deep breathe, cough, sedation and pain scale rating every 1 hour for 4 hours and until patient's response is stabilized, then every 4 hours thereafter until PCA is discontinued. ...Impairment of patient's vital signs, respirations and/or pain scale rating of greater then or equal to 3, on a scale of 0 to 10, and/or constant pain at any level must be reported to the physician and pharmacist."</p> <p>E. Nursing documentation by staff member #N6 at 2300 on 01/11/13, "Told patient [he/she] has enough pain med on board to put an animal</p>		<p>service flow process, which includes pharmacy, medical staff, quality, pharmacy and clinical service lines. Furthermore, patient controlled analgesia form has been modified for use in conjunction with the updated pain management policy, see attached PCA order form. Pain management was an item of discussion on 5/2/2013 at the Med/Surg staff meeting and 5/16/2013 at the Emergency staff meeting.</p> <p>This deficiency has been corrected by Chief Nursing Officer.</p>	

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	<p>down."</p> <p>F. Documentation of unsuccessful attempts to contact MD1 (who was on call) regarding patient's desire to be transferred at 2320 and 2335 on 01/11/13 and 0010 and 0040 on 01/12/13.</p> <p>2. The medical record for patient #P2 lacked documentation of reassessment of pain levels, vital signs, and gastrointestinal status as per policy and physician's orders.</p> <p>3. The facility policy "Pain Management", last approved 04/2013, indicated, "A. 1. The pain assessment tool to be utilized is a verbal or visual analogue scale available in English and Spanish. This tool may be used by showing a diagram to the patient and asking the patient to indicate his/her pain on a scale from 1-10 with 0 being no pain, and 10 being the worst pain imaginable. ...A. 1. After each pain management intervention, once a sufficient time period has elapsed for treatment to reach peak effect, re-assessment should minimally be documented within 1-2 hours after administration of oral pain medication and 15-30 minutes for IM or IV administration." The policy continued regarding pain assessment and control via programmable PCA system/continuous infusion analgesic, "A. 1. The 0-10 pain assessment tool will be utilized. ...2. All patients placed on a PCA pump or continuous infusion of analgesic medication will be assessed at baseline and every hour for the first 4 hours with the initiation of analgesia and each dosing change based on pain assessment. ...5. Assess the patient's respiratory rate and ability to cough and breathe deeply. 6. Assess gastrointestinal status (nausea, vomiting, constipation, bowel sounds)."</p> <p>4. The facility administrative documentation regarding the complaint by patient #P1 indicated the following:</p>			

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	<p>A. Phone call received by staff member #N4 at 5:19 PM on 01/18/13 from patient #P1 complaining of treatment by staff member #N6, inability to reach MD on call, and inability to manage his/her pain.</p> <p>B. Documentation of phone call to patient by staff member #N1 at 3:46 PM on 01/22/13.</p> <p>C. Notation of an apology letter being sent to the patient on 01/26/13, but no copy of the letter.</p> <p>D. Notation of staff members #N1 and N2 talking with staff member #N6 on 01/30/13. The documentation lacked any indication that the patient's medical record had been reviewed, that the patient's evening shift nurse, staff member #N5, had been interviewed, or that the physician, MD1, had been interviewed regarding the problem of notification.</p> <p>5. At 2:20 PM on 04/11/13, staff member #N5, was interviewed. He/she indicated he/she was bad about documenting pain scores because he/she felt any patient complaints of pain were indicators of some sort of intervention. He/she indicated he/she was unsure of the exact policy to follow when a physician was not responding, but indicated he/she would call the Emergency Department physician in a true emergency. He/she confirmed staff member #N6 made the statement, "Patient has received enough medication to kill a horse."</p> <p>6. At 4:00 PM on 04/11/13, staff member #N1 indicated there were no other policies specific to complaints or grievances other than "Patient/Customer Complaints" which did not specify steps to be taken in an investigation. He/she indicated he/she was also in charge of risk management and did follow-up with letters to complainants, but could not provide any documentation of step by step procedures to follow. He/she indicated he/she did follow-up with MD1,</p>			

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	<p>but confirmed there was no documentation of this. He/she also confirmed there was no documentation of the actual investigation of this complaint, other than the discussion with staff member #N6, but felt appropriate treatment and actions were taken. At this time, both staff members #N1 and N2 confirmed they were unaware of the statement charted by staff member #N6.</p>			