

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152020	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2016
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NAME OF PROVIDER OR SUPPLIER ST VINCENT SETON SPECIALTY HOSPITAL, INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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S 0000 Bldg. 00	The visit was for investigation of a State complaint. Complaint Number: IN00178600 Substantiated: Deficiencies related to the allegations are cited. Date: 4-20/21-16 Facility Number: 003350 QA: 7/20/16 jlh	S 0000		
S 0946 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-7 (c)(4) (c) Drugs and biologicals shall be prepared for administration and administered as follows: (4) In accordance with the signed written orders of the practitioner or practitioners responsible for the patient's care. When verbal or telephone orders are used they shall be accepted only by personnel that are authorized to do so by the medical staff rules. Based upon document review and interview, the facility failed to ensure medications were prepared and administered in accordance with the written orders of the responsible practitioner for two ordered medications in 1 of 5 medical records (MR) reviewed	S 0946	The Director of Patient Care Services, Manager of Pharmacy, and Manager of Case Management met with Fresenius Dialysis to improve process for dialysis schedule to include AM and PM runs Pharmacy will review the original medication order and clarify order with	09/02/2016

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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	<p>(patient #1).</p> <p>Findings include:</p> <p>1. Review of the policy/procedure Medication Administration (approved 2-15) indicated the following: "The Medication Administration Record (MAR) is to be reviewed at the beginning of each shift by reading the full medication entry for appropriateness as to order. Any medication order that is not clear in its intent and application will be clarified with the prescriber... The nurse will initial the appropriate area of the MAR, attesting to successful administration of a medication dose. The initials will match the entry on the top of the first page of the MAR, where the nurse will enter initials and full name... Laboratory Values and Medication: Prior to administering any medication whose use may be dictated by the results of laboratory testing, the nurse will review the most recent laboratory value."</p> <p>2. Review of MR#1 indicated on 6-8-15 the following admission orders: " Midodrine 5 milligrams (mg) by feeding tube every Monday, Wednesday, and Friday. " The admission orders indicated they were verified by a registered nurse, staff N15, a licensed practical nurse, staff N25, and a registered pharmacist, staff</p>		<p>dialysis schedule If no time indicated on the order, pharmacy will indicate early AM time Nursing will then verify time on MAR with the dialysis schedule each day and adjust MAR according. Nursing will communicate any changes to Pharmacy. Pharmacy and Nursing staff education on this process on September 2, 2016. Cindy Overton, Pharmacy Manager, is the responsible party for pharmacy staff. Penny Harper, Director of Patient Care Services, is the responsible party for nursing staff.</p> <p>Nursing reminded of the importance of protocols and to review the patient labs. If abnormal lab values nursing to check for an ordered protocol(s) and treat according to protocol or notify medical provider for treatment orders Reminder to nursing staff on September 2, 2016 Penny Harper, Director of Patient Care Services is the responsible party</p> <p>Quality audit established to monitor medication administration in conjunction with the scheduled dialysis. Results will be shared with nursing, pharmacy, and dialysis.</p> <p>Quality audit in place to monitor critical labs and treatments.</p>		

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	<p>A11.</p> <p>3. Review of the 6-8-15 MAR for patient #1 indicated the following: " MIDOdrine 5 MG (per) F/Tube (feeding tube) ...(and) ... 5 MG / 1 TAB PER FT Every Mon, Wed, Fri PRIOR TO DIALYSIS ... " and indicated " NO DOSES DUE " with an administration time of 1700 hours. The MAR entry indicated it was verified by the registered nurse, staff N15, and the licensed practical nurse, staff N25. It could not be determined why the administration time of 1700 hours was entered for the medication if it was to be administered before a hemodialysis (HD) treatment as indicated by the special instructions for administration.</p> <p>4. Review of MR#1 indicated on 6-10-15 (Wednesday) that a HD treatment was begun at 0821 hours and the MAR indicated the dose of Midodrine was not administered until 1700 hours by the staff nurse N25.</p> <p>5. Review of MR#1 indicated on 6-12-15 (Friday) that a HD treatment was begun at 0954 hours and the MAR indicated the dose of Midodrine was not administered (held) at 1700 hours by the staff nurse N25.</p>				

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	<p>6. Review of MR#1 indicated on 6-15-15 (Monday) that the nephrologist, MD13 rescheduled the patient ' s weekly HD treatment days from Monday, Wednesday and Friday to Tuesday, Thursday and Saturday.</p> <p>7. Review of the 6-15-15 MAR for patient #1 indicated the ordered dose of Midodrine was held at 1700 hours by the staff nurse, N25 and indicated a hand-written change for administering the Midodrine medication on Tuesday-Thursday-Saturday (the new HD treatment days).</p> <p>8. Review of the 6-16-15 MAR for patient #1 failed to indicate the corrected day (Tuesday) for administering the Midodrine or indicate the medication was administered by the staff nurse N25 prior to the start of the HD treatment at 0923 hours.</p> <p>9. Review of the 6-17-15 MAR for patient #1 indicated the 1700 hour dose of Midodrine was administered by staff nurse N15 after no HD treatment was provided.</p> <p>10. Review of the 6-18-15 MAR for patient #1 indicated a hand-written entry by staff nurse N25 for the correct HD treatment days and indicated the</p>			

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	<p>medication was appropriately administered at 0900 hours before the HD treatment was begun.</p> <p>11. On interview on 4-20-16 at 1605 hours, the director of clinical excellence, staff A2 confirmed the MR#1 failed to indicate documentation on 6-10-15, 6-12-15, 6-16-15 and 6-17-15 that the medication Midodrine was administered appropriately.</p> <p>12. Review of MR#1 indicated on 6-15-15 a new order to use a potassium protocol to treat a potassium level of less than (<) 3.5 milli Equivalents per Liter (mEq/L)(normal reference range 3.6-5.2 mEq/L).</p> <p>13. Review of MR#1 indicated on 7-7-15 a potassium level of 3.2 mEq/L and no MR documentation indicated a potassium medication was administered by the responsible nurse as directed by the potassium protocol.</p> <p>14. On interview on 4-20-16 at 1550 hours, the director of clinical excellence, staff A2 confirmed the MR#1 failed to indicate documentation on 7-7-15 that a potassium replacement was administered as directed by the protocol.</p> <p>15. Review of MR#1 indicated on</p>			

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S 1038 Bldg. 00	<p>7-11-15 a potassium level of 2.8 mEq/L and indicated an order by the nephrologist, MD15, for a potassium replacement using Potassium Phosphate 15 millimoles by intravenous (IV) route over six hours with an order to recheck a potassium and phosphorus level on 7-12-15.</p> <p>16. Review of MR#1 failed to indicate on 7-12-15 that a potassium or phosphorous level was obtained and on 7-14-15 the MR indicated a critical potassium level of 2.3 mEq/L before treatment and a corrected level of 3.5 mEq/L after treatment.</p> <p>17. On interview on 4-20-16 at 1550 hours, the director of clinical excellence, staff A2 confirmed the MR#1 failed to indicate documentation on 7-12-15 that lab tests were performed as ordered.</p> <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</p>						

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	<p>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. Based on document review and interview, the facility failed to follow its policy/procedure and ensure all medication errors were reported and reviewed for 1 of 5 medical records (MR) reviewed (patient #1).</p> <p>Findings include:</p> <p>1. Review of the policy/procedure Medication Error (approved 1-15) indicated the following: "It is the policy of the Hospital to provide safe and effective health services to its patients. A medication occurrence report will be completed for all potential and/or actual medication errors. By reporting these events, the whole medication system and process can be evaluated for potential unsafe and ineffective medication occurrences... A medication error has occurred when any of the following occurs: omitted drug... wrong time..."</p>	S 1038	<p>Reminder sent to all staff on the importance of reporting of all medication errors. Reminder sent on September 2, 2016. Penny Harper, Director of Patient Care Services and Cindy Overton, Manager of Pharmacy are the responsible parties. Medication errors are monitored via the event reporting system and reported on the pharmacy dashboard. Pharmacy to conduct audit of orders versus administration to verify errors are captured in the event reporting system.</p>	09/02/2016

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	<p>2. Review of MR#1 on 6-8-15 indicated the following admission orders: "Midodrine 5 milligrams (mg) by feeding tube every Monday, Wednesday, and Friday." The admission orders indicated they were verified by a registered nurse, staff N15, a licensed practical nurse, staff N25, and a registered pharmacist, staff A11.</p> <p>3. Review of the MAR for patient #1 on 6-8-15 indicated the following: "MIDOdriNE 5 MG (per) F/Tube (feeding tube) ...(and)... 5 MG / 1 TAB PER FT Every Mon, Wed, Fri PRIOR TO DIALYSIS..." and indicated "NO DOSES DUE" with an administration time of 1700 hours. The MAR entry indicated it was verified by the registered nurse, staff N15, and the licensed practical nurse, staff N25. It could not be determined why the administration time of 1700 hours was entered for the medication if it was to be administered before a hemodialysis (HD) treatment as indicated by the special instructions for administration.</p> <p>4. Review of MR#1 on 6-10-15 (Wednesday) indicated that a HD treatment was begun at 0821 hours and the MAR indicated the dose of Midodrine was not administered until</p>			

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	<p>1700 hours by the staff nurse N25.</p> <p>5. Review of MR#1 on 6-12-15 (Friday) that a HD treatment was begun at 0954 hours and the MAR indicated the dose of Midodrine was not administered (held) at 1700 hours by the staff nurse N25.</p> <p>6. Review of MR#1 on 6-15-15 (Monday) indicated that the nephrologist, MD13 rescheduled the patient's weekly HD treatment days from Monday, Wednesday and Friday to Tuesday, Thursday and Saturday.</p> <p>7. Review of patient #1's MAR on 6-15-15 indicated the ordered dose of Midodrine was held at 1700 hours by the staff nurse, N25 and indicated a hand-written change for administering the Midodrine medication on Tuesday-Thursday-Saturday (the new HD treatment days).</p> <p>8. Review of patient #1's MAR on 6-16-16 failed to indicate the corrected day (Tuesday) for administering the Midodrine or indicate the medication was administered by the staff nurse N25 prior to the start of the HD treatment at 0923 hours.</p> <p>9. Review of patient #1's MAR on 6-17-15 indicated the 1700 hour dose of</p>			

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	<p>Midodrine was administered by staff nurse N15 after no HD treatment was provided.</p> <p>10. Review of patient #1's MAR on 6-18-15 indicated a hand-written entry by staff nurse N25 for the correct HD treatment days and indicated the medication was appropriately administered at 0900 hours before the HD treatment was begun.</p> <p>11. Review of facility event/occurrence reports for the period 6-1-15 to 7-31-15 failed to indicate a medication error report for Midodrine was completed.</p> <p>12. On interview on 4-20-16 at 1620 hours, the director of clinical excellence, staff A2 confirmed no event reporting or risk management documentation indicating the Midodrine medication errors between 6-8-15 and 6-17-15 were reviewed by an appropriate staff or committee was available.</p>			