

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150011		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/18/2013	
NAME OF PROVIDER OR SUPPLIER MARION GENERAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 441 N WABASH AVE MARION, IN 46952			
(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 a State hospital complaint.</p> <p>Complaint IN00122010 Unsubstantiated: lack of sufficient evidence; deficiency cited unrelated to the allegations.</p> <p>Date: 3-18-13</p> <p>Facility Number: 005011</p> <p>Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor</p> <p>QA: claughlin 04/03/13</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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S000784	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(5)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(5)Description of treatment given or prescribed, clinical observations, including the results of treatment, and the reports of procedures and test results, if applicable.</p> <p>Based upon document review and interview, the facility failed to ensure that Emergency Department (ED) documentation included the results of pain medication administration for 5 of 7 medical records (MR) reviewed (patients 21, 22, 23, 25 and 27)</p> <p>Findings:</p> <p>1. The policy/procedure Pain Standards-Standards of Practice for Pain Management (revised 4-12) indicated the following: " Pain intensity will be assessed using a 0-10 numerical scale if the patient has cognitive and language ability to do so ...Interventions will occur if pain is at an unacceptable level of pain for the patient and/or rated by patient at greater than 3 ...after an intervention, pain will be reassessed within 1 hour. "</p> <p>2. The MR for patients 21, 22, 23, 25 and</p>	S000784	<p>1. Emergency Department Nursing staff meeting held on 4/10/13. Reviewed Pain Standards policy and expectations set.2. ED Unit Shift Managers will audit 5% of charts randomly to include all RN's and address deficiencies with responsible nurse. This will be 5% of the 45,000 visits per year.3. Unit Shift Managers – Cindy Canida Woodward RN, Michelle Hart RN, Interim Unit Shift Leader – Brenda Wanderlich RN & Administrative Director – Tammy Cornelious RN</p>	04/10/2013			

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	<p>27 lacked documentation of pain reassessment following the administration of pain medication in the ED.</p> <p>3. During an interview on 3-18-13 at 1630 hours, staff A4 confirmed that the patient records failed to indicate the results of pain medication administration in accordance with facility policy.</p>			