

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150002	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/14/2014
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NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402
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S000000	<p>This visit was for investigation of one State hospital complaint.</p> <p>Complaint Number: IN00152447</p> <p>Unsubstantiated as an Immediate Jeopardy: Standard level deficiency cited.</p> <p>Date: 7/14/14</p> <p>Facility Number: 005002</p> <p>Surveyor: Jacqueline Brown, R.N. Public Health Nurse Surveyor</p> <p>QA: clauglin 07/17/14</p>	S000000		
S001118	<p>410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (b)(2)</p> <p>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p>			

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>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on policy and procedure review, medical record review, document review, and personnel interview, the facility failed to provide care in a safe setting for 1 of 5 (N1) closed patient medical records reviewed.</p> <p>Findings:</p> <p>1. Review of the following policies & procedures on 7/14/14 at approximately 1114, 1116, and 1625 hours indicated the following:</p> <p>A. Patient Rights, Policy No.: CORP_02, revised/reapproved 12/2/13 indicated on pg. 1 under Policy section, bulleted points, "Patients (or patient's representative as allowed under State law) have the right to...Receive care in a safe setting."</p> <p>B. Locking/Unlocking Doors, Policy No.: SECUR_06, revised/reapproved 3/2014 indicated on pg. 1 under Action section, points 2, 3, 5, and 6, "Security will lock and secure all entrance and exit doors at the end of normal operating hours. All other exterior doors not specified here should remain locked at all times...Note and identify on the Daily</p>	S001118	<p>410 IAC 15-1.5-8</p> <p>ACTION ITEM #1:</p> <p>The electronic system used to document the Daily Activity Report (DAR) was updated. The system now initiates a hard stop when a Security Guard enters any activity related to unlocked doors. The system will not allow the Security Guard to complete the entry until the location, time and employee name (if unlocked by request) is entered. This improvement ensures that all required documentation is included in the Daily Activity Report related to unlocked doors.</p> <p>All security staff have been educated on the updated process.</p> <p>Responsible Person: Director, Security</p> <p>Completion Date: 7/25/14</p> <p>Status: Complete</p>	08/18/2014			

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	<p>Activity Report (DAR) doors found unlocked. Record in the DAR the room number, time and the name of the employee(s) for whom the door was unlocked."</p> <p>C. Post Position - Southlake Campus, Policy No.: SECUR_02, revised/reapproved 3/2014 indicated on pg:</p> <p>a. 1, under PP#1 (CCTV [Closed Circuit Television] Room) Security Officer/Security Guard (Responsible Person), points 2, 3, and 5, "Monitors all entrances into the hospital, protects persons and property...monitors all CCTV...Records all calls for assistance, incidents, accidents, thefts, and all other activity on the Daily Activity Log.</p> <p>b. 2, under PP#2 (Outside Patrol) Security Officer/Security Guard (Responsible Person), point 7, "Locks and unlocks daily specified doors and entrances."</p> <p>c. 3, under PP#4 Supervisor (Responsible Person), points 2 and 4, "Insures all positions are staffed and job duties of each position are being performed...Insures all reports are completed accurately at end of shift."</p> <p>D. Security Department Scope of Service, revised/reapproved 2012, indicated on pg:</p>		<p><u>ACTION ITEM #2:</u></p> <p>After 8:00 p.m., Security checks all doors to verify they are properly secure. The evening shift Security Guard checks all doors once after they're locked at 8:00 p.m. The midnight Security Guard checks all doors twice during the midnight shift.</p> <p>On July 14th, security began documenting the date and time of all door checks on a paper log located at each door. Beginning August 11th, door checks will be documented using a new electronic program. The Director of Security reviews the documentation to confirm compliance.</p> <p>All security staff will be educated on the new electronic documentation system before implementation on 8/11/14.</p> <p><u>Responsible Person:</u> Director, Security</p> <p><u>Completion Date:</u> 8/11/14</p>				

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	<p>a. 1, under Scope of Patient Needs section, "Security is provided to maintain a safe and secure environment for all our guests and hospital property."</p> <p>b. 2, under Services Provided section, point 16, "Secures all entrances to the hospital and lock and unlock areas within the hospital as needed."</p> <p>E. Security Management Plan, revised/reapproved 6/2/13, indicated on pg:</p> <p>a. 2, under Objectives section, point J, "Security department activity including investigations, routine patrol activities, special and routine requests for assistance, and other activities are appropriately documented."</p> <p>b. 4, under Processes of the Security Management Plan, I.D. Program, "Access to the hospital is controlled by the hospital's Security Department during the nightly hours, whereby visitors are screened."</p> <p>F. Patient Visitation, Policy No.: CORP_07, revised/reapproved 12/2/13 indicated on pg:</p> <p>a. 1, under Policy section, "Patient welfare is our most important responsibility."</p> <p>b. 2, under Procedure section, "Between the hours of 8:00 p.m. and 8:00 a.m. visitors are asked to acquire a</p>		<p>Status: In progress</p> <p>ACTION ITEM #3:</p> <p>A Security Supervisor position has been added to the midnight shift. This ensures the Supervisor responsibilities outlined in SECUR_02 are completed on the third shift.</p> <p>Responsible Person: Director, Security</p> <p>Completion Date: 7/27/14</p> <p>Status: Complete</p> <p>-</p> <p>ACTION ITEM #4:</p> <p>The Hospital's Closed Circuit TV's (CCTV) are monitored by Security. Every effort is made to keep one Security Guard in the CCTV room at all times. On rare occasions, the Security Guard may be required to leave the station to respond to an emergency situation in the hospital.</p>				

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	<p>visitor's pass at the Security desk near the entrance of the Emergency Department. Security will collaborate with nursing in accommodating visitors."</p> <p>2. Review of closed patient medical records on 7/14/14 at approximately 1350 hours indicated:</p> <p>A. patient N1 was an 80-year-old who presented to the Emergency Department (ED) on 7/4/14 for not being his/her usual self and was admitted to the facility for further medical management. On 7/8/11, was referred to the Rehabilitation Unit for inpatient Acute Rehabilitation Program.</p> <p>a. Review of Nurse Notes dated 7/11/14 at 0028 hours indicated, "In another patient's room when I [P1, Staff Nurse] heard screaming. Ran to patient's room. Saw a man run out. Went in room. Patient was covered in blood. Code blue was called. Saw stab wound to the left chest and abdomen. Patient was alert. CPR (cardiopulmonary resuscitation) was started. Patient transferred to ICU (Intensive Care Unit). [Physicians] made aware."</p> <p>b. Review of Code Documentation by Physician dated 7/11/14 at 0049 hours indicated the following: "Called for 'code blue'. Respond immediately. On arrival,</p>		<p>On July 31st, the hospital's security system was updated. The CCTV's will now temporarily be transferred to the opposite campus to assure 24 hour monitoring in the event of an emergency that requires the Security Guard to leave the CCTV station.</p> <p>Policy SECUR_02 was updated to reflect the change (Attachment A). All Security staff will be educated on the new process by 8/15/14.</p> <p>-</p> <p>Responsible Person: Director, Security</p> <p>Completion Date: 8/15/14</p> <p>Status: Policy update complete; Education in progress</p> <p>ACTION ITEM #5:</p> <p>House-wide education on the visiting policy was initiated, specifically related to after-hour visitors. Staff was reminded to stay alert of their surroundings and question situations that are out of</p>	

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	<p>patient is not following commands but respond to pain stimulation, spontaneous breathing, BP (blood pressure) 96/58, HR (heart rate) 96, oxygen saturation unknown...Continue resuscitation by primary team."</p> <p>c. Review of Orders on 07/11/14 at 0448 hours indicated the following: "Provider Automatic Discharge (Patient Discharged/Expired)."</p> <p>3. Review of Incident Reports for 7/1/14 through 7/14/14 on 7/14/14 at 1146 hours indicated one related to complaint.</p> <p>A. An incident report was filed 7/11/14 at 0836 hours by P1 related to the fatal stabbing of patient N1 by C1, family, on 7/11/14 at approximately 0020 hours.</p> <p>B. A code blue was called as well as security, physician notified, no family notified, patient lived with C1.</p> <p>C. Patient was transferred to ICU (Intensive Care Unit) where they died due to their injuries.</p> <p>D. A suggestion was "more safety measures need to be in place, no visitors should be allowed on the unit after visiting hours."</p> <p>E. A facility investigation and root cause analysis are currently in process, as well as a police investigation.</p> <p>4. Video Surveillance was reviewed,</p>		<p>the ordinary. All visitors require a badge. If a person does not have a badge, they are to be sent down to the Front Desk (during regular visiting hours) or Security (during off hours) to check-in.</p> <p>Responsible Person: Director, Guest Services</p> <p>Estimated Completion Date: Education to begin 8/18/14 with mandatory completion by 9/18/14</p> <p>Status: In progress</p> <p>Prevent Recurrence: Methodist Hospitals takes the security of our patients, visitors and staff very seriously. In response to this event, we have thoroughly reviewed our security processes to ensure we continue to provide care in a safe setting. Staff education continues to be provided on an ongoing basis to reinforce the importance of safety and security in the hospital. Understanding this was an isolated occurrence of domestic violence committed by a person with malicious intent, it is difficult to state these actions would unconditionally prevent a</p>				

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	<p>accompanied by P15 (Security Manager), on 7/14/14 at approximately 1815 to 1835 hours for 7/11/14 and indicated the following:</p> <p>A. At 0010 hours, a motorcycle rider arrives and parks between two trucks then walks up to dock doors.</p> <p>B. At 0012 hours, disappears from view.</p> <p>C. At 0033-0034 hours, arrives at motorcycle and gets on, turns on lights, sat for about a minute, backs out, and turns.</p> <p>D. At 0036 hours, driver out of frame.</p> <p>5. Daily Activity Report dated 7/10/14 and 7/11/14 was reviewed on 7/15/14 at approximately 1410 hours and confirmed:</p> <p>A. This is the security log for these dates.</p> <p>B. The Daily Activity Report lacked documentation on 7/10/14 at 2003 hours and 2318 hours and 7/11/14 at 0655, 2046, and 2338 hours of what doors were unlocked and whether or not they were relocked.</p> <p>6. Personnel P15 (Security Manager) was interviewed on 7/14/14 at approximately 1517 and 1759 hours and confirmed:</p> <p>A. Got a phone call approximately 12:45 AM from [P19], Police Officer and</p>		recurrence of this type of event in the future.	

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	asked if I was aware of what was going on. I responded no and he/she stated there was a stabbing on the 3rd floor and I told him/her I was on my way in. On my way in I called [P20], Security Director, and informed him/her of what I knew at that point about a report of a stabbing. I told him/her I would update him/her as I had more information. I arrived at the hospital at approximately 1:10 AM and immediately checked in with my dispatch officer and then I went up to the unit 3W1. At that time I met up with [P18], Security Officer/Police Officer] and he/she explained more of what had transpired. I met with [P21], House Manager that night, the purpose was to see what steps he/she had taken and if he/she had contacted the Administrator on Call; he/she had not yet. I then contacted [P9, Vice President of Operations] who was the Administrator on Call. Informed him/her of the situation and told him/her I would update him on the situation. At that time, I returned back to the scene with the Police Officers to see if they knew if the suspect was still in the facility or had left. They said they had a K-9 unit on the outside who had picked up a track, but were not certain that was a positive track. So at that time we had multiple police officers doing a sweep of the perimeter and the grounds of the facility. I went back downstairs to the			

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	<p>dispatch office with [P22, Detective and [P18] to review video to see if we could identify the suspect's egress. During the cursory review, I called [P23], Emergency Preparedness Coordinator, so that he/she could initiate the incident command center. I also made a call to Environmental Services [EVS] to use their manpower to keep an eye on areas that we had already cleared, as well as secondary entrances. I determined it was going to take too long to review the footage and we should start a search and clearance of the inside of the hospital. I had 3 teams of 3, 2 teams of 3 police officers, and another team that consisted of myself and 2 police officers. I reiterated to my staff that there are to be zero visitors entering and if we came across any visitors they would be asked to leave. I assigned areas to the teams and they started in the basement with instructions to meet at an agreed upon point with myself coordinating the areas they were to search. There was a Police Officer on each team that does work at the hospital so they would be familiar with the facility to direct the search. We searched and cleared every room in the hospital from the boiler room, IT rooms, patient rooms, up to the roof, every room. This process took approximately 2.5 hours, maybe more. Upon completion, the Police Officers were finishing up</p>				

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	<p>their crime scene investigation. The majority of police officers cleared the scene and left the building. I went to the established incident command center and [P23] was there and I informed him/her the facility had been cleared and the suspect had not been found. This includes pavilion A & B. We began moving into discussions on continuing the operation of the hospital. Updated [P20] and [P9] via phone. Hospital was on lockdown from 1 AM to about 5 AM.</p> <p>B. Once the lockdown was lifted, we had been informed the suspect was apprehended. We had the midnight shift stay over, so we had double security staff (approximately 5 security personnel) and I brought the Security Supervisor from F2 for additional manpower. Also during my conversation with [P20] I suggested he/she call AB1, a security personnel company, to initiate our standing contract we have for situations such as this if we need additional personnel. We requested 2 additional security guards from that company.</p> <p>C. Suspect gained entry through alternate means, he/she entered through double doors in the dock area. It is unclear whether they were propped open or closed. Those doors are meant to be locked. There is a procedure titled, "Post Position-Southlake Campus", SECUR_02 related to this that specifies</p>			

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	<p>on page 2 under PPP#2 point 7, "Locks and unlocks daily specified doors and entrances". There is no list of daily specified doors, but it is an expectation of security staff that the dock doors are part of the specified doors. Hospital staff was not aware that the suspect was in the facility until a security officer, [P24], was notified by a nurse's aide (NA) that this suspect was acting strange. They both approached the patient's room and the NA asked the patient if everything was okay and he/she said yes (C1 is family). Immediately after that [P24] was called to the Emergency Department (ED) to lockdown the ED due to a gunshot wound victim arriving. A code blue was called overhead and it is standard procedure for security to respond to code blue. So Police Officer [P18] and Security Guard [P17] headed upstairs to respond to the code. Upon arrival they heard the commotion going on and were told that a victim had been stabbed and one of the staff on the floor told them they observed C1 getting on an elevator. They pursued in another elevator to the ground floor but lost sight of the suspect but were told by EVS that they had observed someone matching that description heading out the dock door. It was at that time that [P18] contacted his Police Department and officers started showing up.</p>			

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	<p>7. Personnel P17 (Security Guard) was interviewed via phone on 7/15/14 at approximately 1116 and 1402 hours and confirmed:</p> <p>A. Yes the dock door area cameras were monitored the night of the incident by myself (the Unit 1 dispatcher) from the CCTV camera room, but that night I received a call that a gunshot wound (GSW) victim was being brought in. I had to leave the CCTV room to assist Unit 3 [P24] (a new employee) with locking down the Emergency Room, which is protocol when a GSW comes in. No one is available to monitor these cameras if the person watching them is called out. Around the same time of the GSW victim coming in, the suspect pulled up in the dock area. I called in Unit 2 [P18] who was patrolling the outside perimeter at the time, but the cameras were not being monitored by security when the suspect arrived. A few minutes later, I got a call about the stabbing incident on 3W1 and responded.</p> <p>B. There were only 3 security guards on a shift, which was not enough for what happened that night. The dock doors have no badge swipe entrance and employees are often seen entering through these doors. During the time I have been working here, those dock doors have never been locked. I work interior patrol</p>			
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	<p>and checking those doors is not part of my responsibilities. It is the responsibility of Unit 2. All security guards switch working the 3 different Units and when I work Unit 2 I make sure they are locked, but then they sometimes get unlocked and propped open. Not sure who unlocks them, all the security guards have keys.</p> <p>C. The Unit 1 Security Guard/Security Officer is to log entries in the Daily Activity Report (DAR) when other Security Guard/Security Officer Units report the information to them. I was the Unit 1 Security Guard on the midnight shift from 11 pm on 7-10-14 to 7:30 am on 7-11-14. The DAR for this time period should have documented what door is locked or unlocked and what patient unit or room was involved for each entry.</p> <p>8. Personnel P15 (Security Manager) was interviewed via phone on 7/15/14 at approximately 1318 hours and confirmed, it is the responsibility of the Unit 1 Security Guard/Security Officer to log entries in the Daily Activity Report (DAR) when other Security Guard/Security Officer Units report the information to the Unit 1 Security Guard/Security Officer. All fields are to be complete, for example what door is locked or unlocked and what patient unit or room the activity took place in, as well</p>			

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NAME OF PROVIDER OR SUPPLIER METHODIST HOSPITALS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 600 GRANT ST GARY, IN 46402			
(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>as any other information given. The DAR for 7-10-14 and 7-11-14 is incomplete.</p> <p>9. Personnel P18 (Security Officer/Police Officer) was interviewed via phone on 7/15/14 at approximately 1321 hours and confirmed:</p> <p>A. The dock door area cameras are monitored by the Unit 1 Security Guard/Security Officer/Dispatcher from the CCTV room. They are not usually called away from their station, but may be in an emergency and then no one is there monitoring the security cameras. I was working on the midnight shift from 11 pm on 7-10-14 to 7:30 am on 7-11-14. I check the exterior perimeter of the facility 2 times during my shift usually 2 hours after my shift begins and 2 hours prior to the end of my shift. I did not get to the dock door area prior to the stabbing incident that occurred on 7-11-14, so I am unsure whether or not the dock doors were locked. The dock door is considered an exterior door. There were back to back gunshot wound (GSW) victim security calls that night and those are considered emergencies, so all security personnel were called to respond to secure the Emergency Room.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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