STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	150034	A. BUILDING 00 B. WING	07/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST MARY MEDICAL CENTER INC	1500 S LAKE PARK AVE HOBART, IN 46342

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S 0000 Bldg. 00	This visit was for the investigation of a state licensure hospital complaint. Complaint Number: IN00245622 Substantiated: deficiency related to the allegation is cited. Unrelated deficiency is cited. Survey Date: 07/26/2021 Facility Number: 005786 QA: 7/29/21	S 0000	See attached	
S 0418 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2(b)(1)(2) (b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows: (1) The action shall be documented. (2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care. Based on document review and interview, the facility failed to ensure a complaint/grievance, which had occurred in the Emergency Department (ED), was investigated/resolved, a certified letter mailed within seven (7) days and a written response within 45 days in one (1) instance	S 0418	Action Items Plan Target Dates Responsible Designee Complete Date S418	08/23/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	(Patient # 1). Findings include: 1. Review of the hospital policy titled, "Patient Complaints/Grievances", policy/procedure number 20.00, indicated complaints/grievances are reviewed by those directly involved in the situation. The complaints/grievances are forwarded to the Patient Relation Department for investigation and/or tracking. A written response, sent by certified mail, regarding the patient grievance/complaint "is provided within seven (7) days" (See Attachment A). If the grievance will not be resolved or if the investigation will not be completed within seven (7) days, the Patient Relations Department will inform the patient that the hospital "is still working to resolve" the grievance and that the hospital would follow up with a written response which would be sent within forty-five (45) days. This policy was last revised in 01/2017. 2. Review of the Midas Care Management electronic report documentation, indicated the patient felt the staff showed a lack of compassion, treated him/her disrespectful and failed to address his/her symptoms. The report continued by assuring the patient his/her concerns would be forwarded to the Medical Director and Director of Emergency. The report lacked documentation the complaint/grievance had been investigated/resolved and if a seven (7) day or forty-five (45) day letter had been sent to the patient. 3. Review of the Complaint/Grievance Log dated 09/01/2017 through 12/30/2017, indicated the complaint/grievance for patient # 1 was open and lacked documentation any letter had been sent to		410 IAC 15-1,4-2 (b)(1)(2) The hospital shall take appropriate action to address opportunities for improvement found through the QA and improvement program. Identified complaint/grievance did not have appropriate follow-up per policy- Emergency Department complaints/grievances · All management re-educated on Complaint Grievance policy at Management Meeting. Focus on timely investigation response. · Complaints Grievances added to daily safety leadership huddle to create a shared awareness and communicate needed follow-up. · Report for Complaints/Grievances updated and will be ran weekly. Patient Advocate to discuss open issues weekly with Director Quality and Risk to resolve any barriers to required investigation from managers and physician medical directors. · Meeting with Emergency Department (ED) Medical Staff Chair and Vice Chair, Patient Advocate and Director Critical Care Services regarding timely investigation on ED physician	

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	the patient as of 07/26/2021. 4. Review of the letter, provided by A # 2 (Patient Advocate) that was sent to patient # 1 on 10/26/2017, indicated "the concerns you expressed regarding the physician and staff have been forwarded to the Medical Director of the Emergency Department for review". Please understand that we are not allowed to share the outcome of that review because it "is peer protected", but be assured each complaint "is followed through and will be addressed appropriately". 5. Review of Attachment A, (Review of Sample 7 Day Letter), indicated we appreciate you bringing your concerns to our attention and allowing us the opportunity to "review" our (practice, policy, actions) and "respond". Please be assured that the issues you have raised will be "investigated" and the responsible administrative and supervisory staff will take "appropriate follow-up action". You will "receive a written response within 45 days". 6. Review of the "Sample 45 Day Letter", indicated "the following steps have been taken to investigate your concern" and because of the concerns that you have voiced, we have taken the following steps to improve customer service. 7. In interview on 07/26/2021 at approximately 12:30 pm with administrative staff member A # 4 (Director of Quality & Risk), confirmed "we don't send certified letters" so the letter was not sent by certified mail. We don't include the results of the investigation in the letter sent to the patient. 8. In interview on 07/26/2021 at approximately 2:15 pm with administrative staff member A # 2 (Patient		complaints. Process and new form developed. 08/23/2021 8/9/21 8/6/21 8/5/21 Director Quality and Risk Management Patient Advocate Patient Advocate	

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	Advocate), confirmed he/she had forwarded the information to A # 3 (Director of Emergency Department & Critical Care) and had sent a letter (not certified) to the patient on 10/26/2017 (9 business days). He/she further indicated that no 45-day letter was sent. 9. In interview on 07/26/2017 at approximately 2:30 pm with administrative staff member A # 3, confirmed the complaint/grievance lacked documentation it had been investigated. The ED Manager "should have investigated it".		Emergency Department (ED) Medical Staff Chair and Vice Chair 8/23/21 8/9/21 8/6/21 8/5/21 Action Items Plan Target Dates Responsible Designee Complete Date S930 410 IAC 15-1.5-6 Nursing Services. Nursing staff will ensure assessment and documentation of pain assessment and re-assessment of pain after medication administration per policy.- Emergency department	

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			· Meeting with Director Critical Care Services, ED Nurse manager, Quality Care Program Coordinator to discuss action plan for ED. · Policy ADPC 16.1 Pain Assessment and Management discussed in the ED staff meeting. · An EPIC report specific to the ED for Pain assessment and Reassessment which include initial pain level, Pasero scale, pain medication given, date and time medication given, re-assessment within 1 hour, RN who administered pain medication, respiratory rates before and after will be pulled weekly for ED management to follow-up with staff directly on Non-compliance. Antidotal to be issued for education in employee files. · ED Operational Assistant Trained to pull report to provide to ED Manager and ED Clinical Nurse Leader. · Education assigned to ED nursing staff on pain assessment and reassessment in the electronic education system. · EPIC I.T request for ED narrator to provide alerts to nursing staff on overdue pain reassessments and vitals.PASERO added to ED	

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			narrator for ease of documentation. 8/9/21 8/9/21 8/18/21 9/3/21 8/18/21 ED Manager and ED Clinical Nurse Leader ED Manager and ED Clinical Nurse Leader	

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			ED Manager and ED Clinical Nurse Leader ED Manager and ED Clinical Nurse Leader Director Clinical Informatics, Epic 8/17/21 8/17/21 8/18/21 9/3/21	

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			8/18/21	
S 0930 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview, the registered nurse failed to follow the facility policy and procedure related to evaluating the effectiveness within sixty (60) minutes of administering a pain medication for one (1) of the five (5) patient medical records (MR's) reviewed (Patient # 1). Findings include: 1. Review of the hospital policy titled, "Pain Assessment and Management", policy/procedure number ADPC 16.1, indicated the patient's pain should be reassessed within sixty (60) minutes of administering a medication for pain and/or reassess pain level prior to discharge in outpatient areas. This policy was last revised in 12/2014. 2. Review of the hospital policy titled, "Documentation, General Guidelines", policy/procedure number PCS-D, indicated documentation should be accurate and complete. This policy was last revised in 07/2017. 3. Review of the closed MR's indicated patient #1	S 0930		09/03/2021

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	was admitted to H # 2's (Acute Care Hospital) Emergency Department (ED). The MR indicated the following: A. The patient was admitted on 10/15/2017. The patient indicated his/her pain was a six (6) out of ten (10) at 3:00 pm. At that time the patient was given Toradol (NSAID-Non-Steroidal Anti-Inflammatory Drug) 60 mg (milligram) injection. In addition the patient was given Norflex (Skeletal Muscle Relaxant) 60 mg injection at 3:01 pm. The patient was given Valium (Benzodiazepine) 5 mg injection at 4:03 pm. The MR lacked documentation the patient had been reassessed sixty (60) minutes after receiving the medications for pain. 4. In interview on 07/26/2021 at approximately 12:00 pm with administrative staff member A # 1 (Nursing Quality), confirmed nursing should have reassessed one (1) hour after administering the medication for pain and documented the findings in the patient's MR.			