| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 150176 | A. BUILDING 00<br>B. WING | 07/19/2016 |

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| KENTUCKIANA MEDICAL CENTER LLC | 4601 MEDICAL PLAZA WAY<br>CLARKSVILLE, IN 47129 |

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| S 0000<br><br>Bldg. 00 | This visit was for the investigation of a State complaint.<br><br>Complaint #IN00184621<br>Substantiated: State deficiencies related to the allegations are cited.<br><br>Survey date: 7/19/16<br><br>Facility # 0011788<br><br>QA: 09/26/16 JL | S 0000 | | |
| S 0102<br><br>Bldg. 00 | 410 IAC 15-1.2-1<br>COMPLIANCE WITH RULES<br>410 IAC 15-1.2-1 (a)<br><br>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules.<br>Based on document review and interview, the hospital failed to implement policies/procedures, follow medical staff rules and regulations and comply with Federal regulation(s) 42 CFR 482.13(a)(2) through 42 CFR 482.13(a)(2)(iii) for written complaint/grievances of a released/discharged patient (P1). | S 0102 | Plan of Action:<br>(1, 3, 4, 6) Verbal or written patient complaints received by hospital employees, contract employees, or physicians must be communicated to the CNO, COO, or CFO on the same day it is received. The complaint will be written on a Patient Complaint form and placed in the Patient Complaint Log located in the CNO's office. The complainant | 11/03/2016 |

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

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| | Findings:<br><br>1. Review of the policy titled Patient Grievances indicated the following:<br>a. A "patient grievance" is a written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) a patient, or the patient's representative regarding the patient's care, abuse or neglect, or concerns regarding premature discharge.<br>b. If a patient, family, or visitor voices a concern, complaint or grievance, the Privacy Contact Person will initiate a Patient Complaint Form and then forward the form immediately to the Chief Operating Officer. Whenever possible, the complainant will be included in all processes surrounding the complaint issue, from the investigation to its resolution.<br>c. The Center will make every attempt to complete or resolve a grievance within 7 days. If the Center is unable to complete or resolve the grievance within 7 days, the Center will inform the patient and/or their representative or visitor in writing that the hospital is still attempting to resolve the grievance and they will receive written notice of resolution within 30 days.<br>d. Review and follow-up will be | | will receive an initial response by the CNO, COO, or CFO immediately and will be presented with a resolution within 7 days. Patient Right Policy 1.09 states that if unable to resolve within 7 days, the hospital will inform the patient/complainant in writing that the hospital is attempting to resolve the complaint/grievance and will receive written notice within 30 days.<br>(2, 7, 8, 9, 10) Physicians with privileges at Kentuckiana Medical Center will follow Medical Staff Rules and Regulations. Physician peer reviews will occur in accordance with the Medical Staff Rules and Regulations Peer Review Process, Part XVIII, pages 21-23. Minutes from the peer review sessions will be kept by the Medical Staff Coordinator. Performance Improvement Policy 1.05, Medical Staff Peer Review, has been revised to reflect indications for a peer review session in coordination with the Medical Staff Rules and Regulations. The Policy will be presented to each member of the Board of Directors electronically for review, recommendations, and approval by November 3, 2016. The Policy will also be presented during the Board of Directors 4th quarter meeting. See attached pages of Medical Staff Rules and Regulations. See attached pages 21-23 of the Medical Staff Rules and Regulations and Performance | |

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| | reported to the Performance Improvement Committee, Medical Executive Committee and Board of Managers as indicated by the nature of the complaint.<br>e. Date Last Updated: 3/31/2015<br><br>2. Review of Medical Staff (MS) Rules and Regulations indicated the following:<br>a. Reports generated from any source (letters, complaints, memos, risk management or incident report/unusual occurrence report, referrals from medical directors, etc.) will be forwarded to the appropriate Department Committee...The following process will be used:<br>i. A physician within the same Department will perform initial peer review...standards or care classifications will be assigned.<br>ii. Quality assessment staff will be in attendance at peer review sessions to offer supplemental information about the case or the peer review process.<br>iii. The Medical Staff Coordinator will record and maintain minutes determination from peer review sessions.<br>iv. Updated, Reviewed and Adopted by the Medical Staff June 25, 2015. Approved by Board of Directors June 25, 2015.<br><br>3. Review of Federal regulations indicated the following: | | Improvement Policy 1.05.<br><br>(3, 5) The Board of Directors will be responsible for the review and resolution of the grievance process until their next board meeting in the 4th quarter 2016, at which time the Board of Directors will vote "for" or "against" delegation of review and responsibility to a Grievance Committee.<br>Communication with the patient/complainant will occur during the investigation process to provide updates and a timely resolution within the time frame designated in Patient Rights Policy 1.09. Once the complaint has been resolved, the complainant will receive a letter with notice of its decision, the name of the hospital contact person, steps taken on behalf of the patient to investigate the grievance, results of the grievance process, and date of completion. Complaints reviewed and resolved will be presented at the Quality Assurance Performance Improvement Committee Meetings monthly along with any follow-up from previous month's complaint/grievance investigations. See attached Patient Rights Policy 1.09.<br>Responsible: The Chief Nursing Officer is responsible for compliance of all sections of this standard, except 3 and 5, for which the Board of Directors will | |

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| | a. 42 CFR 482.13(a)(2) indicated the hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. Interpretive Guideline indicated: A "patient grievance" is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient's representative, regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present). 42 CFR 482.13(a)(2) also indicated the hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. Interpretive Guidelines indicated: The hospital's governing body is responsible for the effective operation of the grievance process. This includes the hospital's compliance with all of the CMS grievance process requirements...A committee is more than one person.<br>b. 42 CFR 482.13(a)(2)(ii) indicated, At a minimum: The grievance process must specify time frames for review of the grievance and the provision of a response. Interpretive Guidelines indicated: The hospital must review, investigate, and resolve each patient's grievance within a reasonable time | | be responsible for compliance. | |

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| | frame...However, regardless of the nature of the grievance, the hospital should make sure that it is responding to the substance of each grievance while identifying, investigating, and resolving any deeper, systemic problems indicated by the grievance...On average, a time frame of 7 days for the provision of the response would be considered appropriate.<br>c. 42 CFR 482.13(a)(2)(iii) indicated, At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. Interpretive Guideline indicated: The hospital must maintain evidence of its compliance with these requirements<br><br>3. Review of hospital complaint/grievance documentation indicated that on on 1/21/15 a Patient Events report was created regarding patient P1, attending physician MD2 and surgeon MD3 and filed in with complaint/grievances. The documents lacked evidence of a Patient Complaint Form initiated and lacked evidence of any resolution follow-up with the patient, patient representative or family. | | | |

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| | 4. Review of State documentation dated October 13, 2015 indicated a complaint/grievance was voiced to the hospital in reference to P1 by C1 and that C1 had conversation with A4, chief nursing officer, in which A4 was to return a call to C1 to set up a meeting with the "appropriate staff", but as of that time had failed to do so.<br><br>5. Review of Quality Assurance/Performance Improvement (QAPI) meeting minutes indicated the following:<br>a. Minutes dated 2/26/15 indicated the following: FINDINGS/ANALYSIS: Patient Relations: Patient Complaints/Grievances; RECOMMENDATION/ACTION: See attached patient chart for review... Cases will be discussed at next Board meeting for review and recommendations, if necessary. Documentation lacked evidence of a Patient Complaint Form, resolution of the issue reported to the patient/family, an anticipated timeframe for resolution or planned follow-up with the patient/family.<br>b. Review of meeting minutes for the remainder of the year 2015 lacked documentation of follow-up with the patient/family regarding resolution of the incident/complaint/grievance of P1. | | | |

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| | 6. On 7/19/16 at 4:25pm, A4 indicated the Event Report of P1 was filed as both an incident/event and a complaint due to C1 voiced a concern/complaint related to the event/incident. A4 indicated that he/she spoke with the patient on the day of the complaint and did not feel more follow up was needed, and therefore, did not send written notice of resolution to the patient or family. A4 also indicated that copies of medical record (MR) reports and an email attached to the Event form indicated the investigation and follow-up conclusion of the event.<br><br>7. On 7/19/16 at 10:15am, A1, Medical Director indicated the hospital reviewed a case in which a patient x-ray read that something was "there", but when the surgeon went to perform the surgery for removal of a gallbladder, a gallbladder could not be located (there was no gallbladder). A1 indicated the case was reviewed with the MS and the outcome was determined to be an unfortunate incident without error. A1 indicated uncertainty if the discussions and reviews were documented in any meeting minutes.<br><br>8. Review of MS credential files for MD2 and MD3 lacked documentation of Peer Review of the | | | |

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| | incident/complaint/grievance for P1.<br><br>9. On 7/19/16 at 1:15pm, A6, Director of Credentialing, indicated there was no documentation of Peer Reviews initiated by any reports, reprimands or write-ups for physicians MD2 or MD3 between 1/1/15 and present.<br><br>10. On 7/19/16 at 2:00pm, A2, Chief Operating Officer, indicated the hospital did not have documentation/evidence of MS/Peer Review meeting(s) pertaining to the Incident Report of P1 on 1/21/15. | | | |
| S 0422<br><br>Bldg. 00 | 410 IAC 15-1.4-2.2<br>QUALITY ASSESSMENT AND IMPROVEMENT<br>410 IAC 15-1.4-2.2(a)(2)<br><br>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's quality assessment and improvement program to have occurred within the hospital.<br>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner.<br>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:<br>(1) The report shall: | | | |

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| | (A) be made to the department;<br>(B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program;<br>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and<br>(D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any:<br>(i) patient;<br>(ii) individual licensed under IC 25; or<br>(iii) hospital employee involved;<br>or any other information.<br>(2) A potential reportable event may be identified by a hospital that:<br>(A) receives a patient as a transfer; or<br>(B) admits a patient subsequent to discharge;<br>from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.<br>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.<br>(4) A quality assessment and improvement program may refrain from making a | | | |

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| | determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.<br>(d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually.<br>(e) Any reportable event listed in subsection (a)(1) that:<br>(1) is determined to have occurred within the hospital between:<br>(A) January 1, 2009; and<br>(B) the effective date of this rule; and<br>(2) has not been previously reported;<br>must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2)<br><br>Based on document review and interview, the hospital failed to report a wrong surgical procedure performed on a patient as an adverse reportable event for 1 of 5 patients (P1).<br><br>Findings:<br><br>1. Review patient medical records (MR) indicated the following for patient P1: The patient was admitted 1/18/15 through the ED (emergency department) with RUQ (right upper quadrant) pain and discharged on 1/20/15. MR documentation titled Consent to Surgical | S 0422 | Plan of Action: (1, 2, 3, 4, 5, 6)<br>Reportable events will be submitted to ISDH not later than 15 working days after the reportable event is determined to have occurred by the hospital's Quality Improvement Committee and not later than 4 months after the potential reportable event was brought to the Committee's attention.<br>Leadership Policy 1.16, titled Incident Reports and Reportable Events, has been revised to include the definition of a Reportable Event and the process for identifying reportable events according to the Indiana State Department of Health. Leadership Policy 1.16 will be | 11/03/2016 |

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| | Operation or Procedure and Administration of Anesthesia indicated that on 1/19/15 at 1600 hrs, P1 signed consent for a Laparoscopic Cholecystectomy to be performed. Surgical Documentation, service date 1/20/15 indicated the patient had a diagnostic laparoscopy with lapararoscopic lysis of adhesion procedure on that date.<br><br>2. Review of hospital complaint/grievance documentation indicated that on on 1/21/15 a Patient Events report regarding patient P1 was included in with complaint/grievances. The Event documentation indicated P1 was taken to surgery related to a "gallbladder full of stones" and during surgery it was revealed that the patient did not have a gallbladder. Attached event documentation indicated the following: Discussion: MD (doctor) notified of CT (computed tomography) results, but did not feel patient s/s's (signs and symptoms) were attributed to gallbladder. Date of Initial Investigation 1/21/15. Date completed 1/21/15. Standard of Care Met. The document was signed by A4, Chief Nursing Officer<br><br>3. Review of Quality Assurance/Performance Improvement (QAPI) meeting minutes indicated | | presented to each member of the Board of Directors electronically for review, recommendations, and approval by November 3, 2016. The Policy will also be presented during the Board of Directors 4th quarter meeting. See attached Leadership Policy 1.16.<br>Responsible: The Chief Operating Officer will be responsible for compliance of this standard. | |

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| | minutes dated 2/26/15 included review of Patient Complaint/Grievances that included the following: One patient admitted from ER (emergency room) with a complaint of RUQ pain...MD and surgeon suggested clinical signs of gallbladder disease...Surgeon proceeded with laparoscopic surgery for gallbladder removal.<br><br>4. Review of hospital documentation lacked evidence of the wrong surgery event of P1 on 1/20/15 having ever been reported to the State.<br><br>5. On 7/19/16 at 5:00pm A5, Informatics Manager, indicated P1 did provide consent for laparoscopic cholecystectomy and had a diagnostic laparoscopy with lapararoscopic lysis of adhesion on 1/20/15.<br><br>6. On 7/19/16 at 4:25pm, A4 indicated the Event of P1 on 1/20/15 was filed as both a complaint and an incident. A4 indicated investigation of the event was concluded on 1/21/15 and the event was not reported to the State as a Reportable event. | | | |
| S 0868<br><br>Bldg. 00 | 410 IAC 15-1.5-5<br>MEDICAL STAFF<br>410 IAC 15-1.5-5(b)(3)(M)(i)(ii)(iii) | | | |

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| | (b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:<br>(3) include, but not be limited to, the following:<br><br>(M) A requirement that a complete physical examination and medical history be performed:<br>(i) on each patient admitted by a practitioner who has been granted such privileges by the medical staff;<br>(ii) within seven (7) days prior to date of admissions and documented in the record with a durable, legible copy of the report and changes noted in the record on admission; or<br>(iii) within forty-eight (48) hours after an admission.<br>Based on document review and interview, medical staff (MS) failed to document history and physical examinations (H&P) in accordance with MS Rules and Regulations within 24 hours after an admission and prior to surgery with required medical and physical information for 5 of 5 medical records (MR) (P1, P2, P3, P4 and P5).<br><br>Findings:<br><br>1. Review of MS Rules and Regulations indicated the following:<br>a. The admitting Practitioner shall assume responsibility for the overall aspects of the patient's care throughout | S 0868 | Plan of Action: (1, 2, 3, 4) The Medical Staff Rules and Regulations will be followed by Medical Staff and enforced through actions of the Board of Directors. Delinquency reports for H&Ps will be generated bi-weekly by the HIM department. Letters will be auto-faxed to physician office for delinquencies. Physicians with delinquencies will be addressed in accordance with Medical Staff Rules and Regulations, p11-14. See attached pages of the Medical Staff Rules and Regulations. Nursing staff will review patient medical record prior to procedure or surgery to ensure presence of H&P. A history and physical examination must be recorded | 10/10/2016 |

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| | the Hospital stay, including the medical history and physical examination.<br>b. A complete H&P shall in all cases, be performed and a report thereof dictated or written within 24 hours after admission of the patient and prior to surgery.<br>c. The medical information should include the following:<br>i. Chief complaint<br>ii. Details of the present illness including, where appropriate, assessment of the patient's emotional, behavioral and social status.<br>iii. Relevant past, social and family history<br>iv. An inventory of body systems<br>v. Information source and reliability<br>vi. Other conditions<br>vii. Medications<br>viii. Allergies<br>d. The physical information should included the following if pertinent (not all inclusive): Mental status<br>e. A H&P examination must be recorded and operative consent forms completed before any surgical information is undertaken, unless the physician certified, in writing, that any delay incurred for this purpose would constitute a hazard (loss of life or limb) to the patient.<br>f. H&Ps must be complete within 24 | | before any surgical procedure is to be undertaken, unless the physician certifies, in writing, that any delay incurred for this purpose would constitute a hazard (loss of life or limb) to the patient- in accordance with Medical Staff Rules and Regulations, p 12. See attached page of the Medical Staff Rules and Regulations.<br>Responsible: The HIM department and Medical Staff President will be responsible for compliance of delinquent reports. Nursing staff will be responsible for ensuring H&Ps are on the patient chart prior to procedures or surgeries. | |

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| | hours of admission or on the chart prior to surgery (whichever comes first). Patients scheduled for operative/invasive procedures will not be allowed to transfer to the operating room until the H&P is completed an on the chart.<br>g.The author must authenticate entries of H&Ps, operative reports, consultations and discharge summaries.<br>h. A MR is considered complete when the required contents, including any required clinical resume or final progress note, are assembled and authenticated...<br>i. MS members shall be given 30 days to complete MRs of discharged patients, from date of discharge.<br>j. All documentation will be in compliance with CMS regulations.<br>k. The Rules and Regulations were revised 6/25/2015.<br><br>2. Review of the policy titled History and Physical indicated the following:<br>a. The H&P exam shall be completed prior to the patient having any procedure or surgery.<br>b. A patient being admitted to the center must have a H&P completed within 24 hours after the admission describing the patient's current condition.<br>c. The policy was last updated: 9/30/15.<br><br>3. Review of MRs indicated the | | | |

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| | following:<br>a. P1 was admitted 1/18/15 and discharged on 1/20/15. A H&P was documented as performed on 1/21/15, signed on 2/24/15 and verified on 2/24/15. Surgical Documentation, service date 1/20/15 indicated the patient had a diagnostic laparoscopy with lapararoscopic lysis of adhesion procedure on that date. The H&P lacked documentation of the patient's mental status.<br>b. P2 was admitted 12/7/14 and discharged on 12/8/14. A H&P was indicated as performed on 12/9/14 and signed on 2/24/15. Operative Report, Date of Procedure 12/8/14, indicated the patient had a diagnostic laparoscopy with laparoscopic cholecystectomy on that date. The H&P lacked documentation of the patient's mental status.<br>c. P3 was admitted 12/31/14 and discharged on 1/29/15. A H&P was indicated as performed on 2/16/15 and verified 3/6/15. Operative Report, Date of Procedure 1/19/15, indicated the patient had an endotracheal tube exchanged on that date. The H&P lacked documentation of the patient's mental status.<br>d. P4 was admitted 1/16/15 and discharged 1/17/15. The MR lacked documentation of a dictated or written H&P. The MR indicated the patient had | | | |

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| | a right hernia repair on 1/16/15.<br>e. P5 was admitted 12/10/14 and discharged 12/15/14. A H&P was indicated performed on 12/11/14, signed and verified on 2/24/15. The H&P lacked documentation of the patient's emotional behavioral status or mental status. Operative Report, Date of Procedure 12/10/14, indicated the patient had an EGD (esophagogastroduodenoscopy) procedure on that date.<br><br>4. On 7/19/16 at 5:00pm, A5, Informatics Manager, indicated the H&Ps for patient MRs P1, P2 and P3 were not completed in time accordance with the MS Rules and Regulations, that the MR of P4 lacked documetation of a H&P and that MRs P1, P2, P3 and P5 lacked documentation of emotional behavioral status or mental status. A5 also indicated the H&Ps for P1-P5 were not verified in a timely manner (within 30 days). | | | |
| S 0872<br><br>Bldg. 00 | 410 IAC 15-1.5-5<br>MEDICAL STAFF<br>410 IAC 15-1.5-5(b)(3)(P)<br><br>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall:<br>(3) include, but not be limited to, | | | |

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| | the following:<br><br>(P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.<br>Based on document review and interview, medical staff (MS) failed to document discharge summaries for 2 of 5 medical records (MR) (P2 and P4), failed to complete discharge summaries within 7 days of discharge for 4 of 5 MRs (P2, P3, P4 and P5) and failed to authenticate discharge summaries for 5 of 5 MRs (P1, P2, P3, P4 and P5) within 30 days of discharge.<br><br>Findings:<br><br>1. Review of MS Rules and Regulations indicated the following:<br>a. All relevant diagnoses established, as well as all operative procedures performed, are recorded on the Face Sheet or discharge summary by the attending physician at the time of discharge...<br>b. Each MR shall include at a minimum the following as pertinent (not all inclusive): Conclusions at termination of hospitalization or evaluation/treatment.<br>c. Discharge Summary (DCS) Report and Diagnosis: A DCS must be | S 0872 | Plan of Action: (1, 2, 3) The Medical Staff Rules and Regulations will be followed by the Medical Staff and enforced by the Board of Directors. Delinquency reports for discharge summaries will be generated bi-weekly by the HIM department. Letters will be auto-faxed to physician office for delinquencies. Physicians with delinquencies will be addressed in accordance with Medical Staff Rules and Regulations, p11-14. See attached pages of the Medical Staff Rules and Regulations. Responsible: The Medical Staff will be responsible for following the Medical Staff Rules and Regulations. The HIM department and Medical Staff President will be responsible for compliance of delinquency reports. The Board of Directors will be responsible for enforcing the Medical Staff Rules and Regulations. | 11/03/2016 |

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| | completed within 7 days of the discharge...<br>d. The author must authenticate entries of H&Ps, operative reports, consultations and discharge summaries.<br>e. All documentation will be in compliance with CMS regulations.<br>f. A MR is considered complete when the required contents, including any required clinical resume or final progress note, are assembled and authenticated...<br>g. MS members shall be given 30 days to complete MRs of discharged patients, from date of discharge.<br>h. The Rules and Regulations were revised 6/25/2015.<br><br>2. Review of patient MRs indicated the following:<br>a. P1 was admitted 1/18/15 and discharged on 1/20/15. Discharge Documentation indicated Perform Information 1/21/15 the DCS was signed 2/24/15 and verified that same date.<br>b. P2 was admitted 12/7/14 and discharged on 12/8/14. The MR lacked documentation of a DCS.<br>c. P3 was admitted 12/31/14 and discharged on 1/29/15. The DCS indicated Performed 2/16/15 and verified 3/6/15.<br>d. P4 was admitted 1/16/15 and discharged 1/17/15. The MR lacked documentation of a DCS. | | | |

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| | e. P5 was admitted 12/10/14 and discharged 12/15/14. The DCS indicated Performed 3/27/15 and verified 4/4/15.<br><br>3. On 7/19/16 at 5:00pm, A5, Informatics Manager, indicated the MRs for P2 and P4 lacked documentation of a DCS and that the DCSs for P1, P3 and P5 were not completed and authenticated within appropriate timeframes. | | | |
| S 0912<br><br>Bldg. 00 | 410 IAC 15-1.5-6<br>NURSING SERVICE<br>410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v)<br><br>(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:<br><br>(2) A nurse executive who is:<br>(B) responsible for the following:<br>(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.<br>(ii) Maintaining a current nursing service organization chart.<br>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.<br>(iv) Ensuring that all nursing personnel meet annual in-service | | | |

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| | requirements as established by hospital and medical staff policy and procedure, and federal and state requirements.<br>(v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.<br>Based on document review and interview, the nurse executive failed to ensure nursing personnel followed standards of care and policy and procedure (P&P) for pain management of 1 of 5 patients (P1) or History and Physical pre-operative processing for 4 of 5 patients (P1, P2, P3 and P5).<br><br>Findings:<br><br>1. Review of the policy titled Pain Management indicated the following:<br>a. Purpose: To provide standardized pain assessment throughout the hospital which will allow for standardized pain control through medications and other pain relieving techniques.<br>b. For all Inpatients and Outpatients the pain scoring system will be the American Society of Pain Management: 1-3 = Mild pain: Administer lowest dosage in the range; 4-7 = Moderate pain: Administer middle dosage in the range or the lowest dosage that has been previously effective; 8-10 = Severe pain: Administer highest dose in range | S 0912 | Plan of Action:<br>(1, 4, 5) Emergency Department Policy 4.10 and Nursing Pain Management Policy 3.21 have been revised to include notification to the physician when pain levels for acute medical condition necessitates administration of pain medication. Nursing will document a pain assessment on each patient. When pain medication is ordered by the physician, nursing personnel will administer the medication and perform a pain -reassessment post medication administration to determine effectiveness of pain medicine. Patients will also receive a final pain assessment before discharge. If the physician does not order pain medications for a patient, the physician will document supporting reasons for withholding pain medication. The nursing staff will document patient pain level through Emergency Room and/or Inpatient stay and physician response to requesting pain medication administration. See attached Emergency Department Policy 4.10 and Nursing Pain Management Policy | 11/03/2016 |

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| | c. The pain scale of 0-10, where 0=no pain and 10=worse pain, will be used for patients who can understand the number scale.<br>d. The RN (registered nurse) will complete a pain assessment on each patient. This is recorded on the patient's electronic medical record.<br>e. Pain medication will be administered according to the following unless the patient refuses to be treated or states that they are "OK" and do not want to be medicated: If patient rates their pain a 5-10, they may be medicated with IM (intramuscularly) or IV (intravenous) medication as ordered; once a patient has reached a 5 or less on the pain scale, the patient may advance to the appropriate oral medication...<br>f. A final pain assessment must be completed and documented on the nurse's notes prior to patient's discharge from the facility.<br>g. The policy indicated Date Last Update: 9/30/15<br><br>2. Review of the policy titled History and Physical Information Management indicated the following:<br>a. The history and physical (H&P) exam shall be completed prior to the patient having any procedure or surgery.<br>b. A patient being admitted to the center must have a H&P completed | | 3.21.<br>The Emergency Department Policy 4.10 and Nursing Pain Management Policy 3.21 will be will be presented to each member of the Board of Directors electronically for review, recommendations, and approval by November 3, 2016. The Policy will also be presented during the Board of Directors 4th quarter meeting.<br>(2, 5) The Medical Staff Rules and Regulations will be followed by the Medical Staff and enforced through the Board of Directors. Medical records documentation delinquency reports will be generated bi-weekly by the HIM department. Letters will be auto-faxed to physician office for delinquencies. The Medical Staff Rules and Regulations will be followed in accordance with deficiency type, specifically pages 11-13 and 16-17 of the Medical Staff Rules and Regulations.<br><br>Responsible: The Chief Nursing Officer will be responsible for sections 1, 4, and 5 of this standard. The Board of Directors will be responsible for sections 2 and 5 of this standard. The Chief Nursing Officer will randomly audit pain assessment/reassessment monthly to ensure compliance with above stated actions. | |

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| | within 24 hours after the admission describing the patient's current condition.<br>c. If a H&P exam is not recorded or dictated before an operation or procedure, the procedure/surgery shall be delayed or rescheduled until after the H&P is completed or the case will be canceled.<br>d. Physical examination may be conducted by the physician or privileged allied health staff member, if reviewed and signed by the physician.<br>e. The pre-operative nurses, Operating Room nurses, and Catheterization Laboratory nurses will review the patients chart to ensure that a H&P is on the patient's chart prior to the patient being taken to the Operating Room...<br>f. Date Last Updated: 9/30/15<br><br>3. Review of patient medical records (MR) indicated the following:<br>a. P1 was admitted 1/18/15 at 12:52 hrs and discharged on 1/20/15 at 12:45 hrs. The MR Emergency Patient Assessment Form dated 1/18/15 at 12:52 hrs indicated RUQ (right upper quadrant) pain at a 10/10 on arrival. The Physician's Progress Note 1/19/15 (time not documented) indicated pain. The Anesthesia Record dated 1/20/15 from 07:15 hrs to 0810 hrs indicated Fentanyl was administered, the MR lacked documentation of any other pain | | | |

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| | management medication administration or patient refusal of such. The MR lacked documentation of a final pain assessment prior to discharge from the facility. A H&P was documented as performed on 1/21/15, signed on 2/24/15 and verified on 2/24/15. Surgical Documentation, service date 1/20/15 indicated the patient had a diagnostic laparoscopy with lapararoscopic lysis of adhesion procedure on that date.<br>b. P2 was admitted 12/7/14 and discharged on 12/8/14. A H&P was indicated as performed on 12/9/14 and signed on 2/24/15. Operative Report, Date of Procedure 12/8/14, indicated the patient had a diagnostic laparoscopy with laparoscopic cholecystectomy on that date.<br>c. P3 was admitted 12/31/14 and discharged on 1/29/15. A H&P was indicated as performed on 2/16/15 and verified 3/6/15. Operative Report, Date of Procedure 1/19/15, indicated the patient had an endotracheal tube exchanged on that date.<br>d. P5 was admitted 12/10/14 and discharged 12/15/14. A H&P was indicated performed on 12/11/14, signed and verified on 2/24/15. An Operative Report, Date of Procedure 12/10/14, indicated the patient had an EGD (esophagogastroduodenoscopy) procedure on that date. | | | |

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| | 4. On 7/19/16 at 2:15pm, A7, Director of Pharmacy, indicated the MR MAR (medication administration record) of P1did not indicate administration of any pain medication(s).<br><br>5. On 7/19/16 at 5:00pm, A5, Informatics Manager, indicated the MR of P1 did not indicate pain medication was administered for the documented pain rated at 10/10, a final pain assessment was not documented at time of discharge for P1 and that patient's P1, P2, P3 and P5 underwent procedures/surgery without evidence of a completed H&P in the MR prior to the procedure/surgery. | | | |
| S 2136<br><br>Bldg. 00 | 410 IAC 15-1.6-8<br>SURGICAL SERVICES<br>410 IAC 15-1.6-8 (c)(7)<br><br>(c) Surgical services shall have policies governing surgical care designed to assure the achievement and maintenance of standards of medical practice and patient care, as follows:<br><br>(7) An operative report describing techniques, findings, and tissue removed or altered shall be written or dictated immediately following surgery and authenticated by the surgeon.<br>Based on document review and | S 2136 | Plan of Action: (1, 2, 3) The Medical Staff Rules and | 11/03/2016 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 150176 | A. BUILDING 00<br>B. WING | 07/19/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KENTUCKIANA MEDICAL CENTER LLC | 4601 MEDICAL PLAZA WAY<br>CLARKSVILLE, IN 47129 |

| (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 |
|---|---|---|---|---|
| | interview, surgical services failed to ensure an operative report was authenticated within 24 hours of surgery per medical staff (MS) Rules and Regulations for 1 of 5 surgical patients (P1).<br><br>Findings:<br><br>1. Review of MS Rules and Regulations indicated the following:<br>a. Operative/procedure notes are to be dictated or written in the medical record (MR) immediately following the surgery/procedure.<br>b. The completed operative/procedure report shall be authenticated by the physician and filed in the MR within 24 hours following the surgery/procedure.<br>c. The Rules and Regulations were revised 6/25/2015.<br><br>2. Review of P1's MR indicated the following: P1 was admitted 1/18/15 and discharged on 1/20/15. Surgical documentation indicated the following: "Perform Information": a proxy for MD 3 (12/17/2015), dictated (DD) 1/20/15, signed on 1/26/15 and verified 1/26/15.<br><br>3. On 7/19/16 at 2:30pm, A5, Informatics Manager, indicated the operative note for P1 was not authenticated within 24 hours of the | | Regulations will be enforced through actions of the Board of Directors. Delinquency reports for operative/procedure notes will be generated monthly by the HIM department Delinquency reports for discharge summaries will be generated bi-weekly by the HIM department. Letters will be auto-faxed to physician office for delinquencies. Physicians with delinquencies will be addressed in accordance with Medical Staff Rules and Regulations, p11-14.<br><br>Responsible: The Medical Staff will be responsible for compliance of this standard. | |

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|---|---|---|---|---|
| | procedure/surgery. | | | |