

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2022
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL AND HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 800 W 9TH ST JASPER, IN 47546		
(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
S 0000 Bldg. 00	<p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00372126</p> <p>Substantiated: Deficiency related to the allegation is cited.</p> <p>Survey Date: 6/8/22</p> <p>Facility Number: 005102</p> <p>QA: 6/28/2022</p>	S 0000		
S 1704 Bldg. 00	<p>410 IAC 15-1.6-4 OUT-PATIENT CARE SERVICES 410 IAC 15-1.6-4(a)</p> <p>(a) If the hospital provides outpatient care services, the service shall meet the needs of the patients, within the scope of the service offered, in accordance with acceptable standards of practice. The service shall be under the direction of a qualified person or persons.</p> <p>Based on document review and interview, the hospital failed to ensure that outpatient care services met the needs of the patient in accordance with acceptable standards of practice for 1 of 1 post-abdominal surgery patients (P2).</p> <p>Findings include:</p> <p>1. a. Review of the Medical Staff Rules & Regulations, approved November 1, 2018,</p>	S 1704	<p>1a. A history and physical will be completed and documented at Memorial Wound Care on every patient at initial intake. On every subsequent patient visit, a progress note will be completed that will include: final diagnosis(es), physical findings, details of treatment and disposition. Provider education</p>	07/28/2022

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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>indicated the following:</p> <p>Article IV: Surgical Care - Outpatient charts must document the discharge physical status of the patient.</p> <p>Article XII:</p> <p>Medical Records - A medical record is not considered complete until it includes an admitting diagnosis(es); final diagnosis(es); complications.</p> <p>History and Physical - The medical history and physical examination shall include all pertinent history and findings resulting from an assessment of all the systems of the body.</p> <p>If a complete history and physical examination has been performed and made a part of the medical record up to 30 days prior to the patient's admission or registration to the hospital, a reasonably durable, legible copy of this record may be used in the patient's hospital medical record in lieu of a newly recorded admission history and physician examination, provided this report was recorded by a member of the Medical Staff. In such instances, an addendum to the history and physical must be completed within 24 hours of admission or registration. The update note must document an examination for any changes in the patient's condition since the time that the history and physical was performed.</p> <p>Miscellaneous Documentation - The medical record for an outpatient service should include an authenticated Outpatient Record which includes final diagnosis(es), physical findings, details of treatment and disposition. When appropriate, other data attached to the Outpatient Records includes history and physical examination.</p> <p>b. Review of the policy titled Pain Assessment/Management of the Responsive and Non-responsive Patient, Origination</p>			<p>was completed on July 27, 2022. Five charts per month will be reviewed by the clinic manager for appropriate progress note or initial history and physical documentation.</p> <p>1b. All documentation (including pain documentation) is now on an electronic medical record. The provider sees this documentation at each visit. The clinic staff was re-educated on the Pain Assessment/Management of the Responsive and Non-responsive Patient policy and the need to notify the provider when the patient has inadequate pain relief on July 28, 2022. Five charts per month will be reviewed by the clinic manager for appropriate pain documentation.</p> <p>2a. Electronic Medical Record documentation is now available in the clinics. (This was not available at all clinics prior to July 1, 2021 and some were utilizing paper documentation). Providers are now documenting a progress note that includes: final diagnosis(es), physical findings, details of treatment and disposition at every visit. A physical exam related to the patient problem is conducted at each visit and the physical findings will be documented at each visit. Provider education was completed on July 27, 2022. Five charts will be reviewed monthly for progress note completion by the clinic manager.</p>

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	<p>1/2000/Reviewed 01/2022, indicated the following:</p> <p>Physician is notified of inadequate pain relief, as defined by the patient, and by failing to provide intervention(s) for severe pain.</p> <p>As approved by Pharmacy and Therapeutics Committee, pain rated 7-10 = severe pain.</p> <p>2. a. Review of the Outpatient medical record (MR) for patient P2 indicated the following: On 6/2/21, P2 presented to Outpatient Wound Care Clinic 1 (OPC 1). The Outpatient Wound Care Intake Form indicated the patient's Current Symptoms/Chief Complaint(s) included pain and weakness and an incision from surgery/ostomy take down. The Pain Profile indicated the patient reported the following responses: Do you have pain now? Yes. Pain rating from 0 to 10 (0 = no pain, 10=worst pain ever): Now = 7; Worst = 9; Best = 3. Pain was indicated to have been in the lower abdomen and described as intermittent and sharp. Nursing assessment documentation on the Wound Care Record recorded pain as 0. The MR lacked documentation of the physician having been notified of the patient's reported pain. The MR document titled Mini Nutritional Assessment indicated the following: Screening score 12-14 points: Normal nutritional status; 8-11 points: At risk of malnutrition; 0-7 points: Malnourished. The form was incomplete due to lack of documentation in areas F1 Body Mass Index (BMI) and/or F2 Calf circumference (CC). The form indicated if BMI is not available, replace question F1 with question F2. The patient's score without F1 and/or F2 was 10. The physician's Progress Note (PN), by physician MD1, for Date of Service 6/2/21 indicated the patient's suture line/site was assessed (noted to have been obscured by a Penrose drain). The PN indicated the reader should refer to the chart for a "pictorial</p>			This patient was an established patient at the outpatient wound care center. The surgeon anticipated involved wound care post operatively, so scheduled the patient's first post op visit at the wound care center and not the surgeon's office. The process of seeing all patients for their first post-operative visit at the surgeon's office, even if they are an established patient at the wound care center, was started on June 13, 2022. Five charts will be reviewed monthly by the clinic manager to monitor that all first post operative visits occur in the surgeon's office.
				3. The surgeon that performed the surgery on 5/27/21, saw the patient for his first post operative visit at the wound care center on 6/2/21. This same surgeon performed the exploratory surgery on 6/5/21. This surgeon was the appropriate provider to see this patient and had the knowledge and expertise to care for this patient.

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	<p>description". Review of a photograph in the MR dated 2021-6-2 appeared to show a rotund abdomen with an incision line partially closed by 4-5 staples with what appeared to be the Penrose drain exiting the bottom of the suture line. The PN lacked documentation of a physician examination for changes in the patient's condition including, but not limited to the patient's nutritional risk assessment and reported abdominal pain. The MR lacked documentation of a history and physical and/or an update note with documentation of an examination for any changes in the patient's condition, including but not limited to bowel function, bowel sounds, abdominal distension, and/or malnutrition.</p> <p>b. Review of hospital medical records indicated patient P2 presented to the Emergency Department (ED) on 6/5/21 with a chief complaint of abdominal pain and constipation post ileostomy reversal 5/27/21 by MD1. ED Physician Documentation indicated the patient also had nausea and pain was rated 8/10 and reported the pain had been worsening since surgery. The CT (computed tomography) of the abdomen/pelvis on 6/5/21 at 14:20 hour indicated the need for further exploration by surgery. Operative Report 6/5/21 indicated the following "Findings": Recurrent rectal cancer that was eroding into the patient's colorectal anastomosis and also into loops of small bowel creating bowel obstructions from a colon standpoint, as well as small-bowel standpoint. The report indicated there were no immediate complications of surgery. The Discharge Summary/Death Summary, dated 6/7/21, indicated the following: Patient came to the hospital for abdominal pain. He/she was found to have a large bowel obstruction and sepsis secondary to recurrent rectal cancer. MD1 performed the surgery with a creation of end</p>				

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	<p>colostomy. The patient's kidney function continued to get worse. Advance care planning discussion took place with family. They requested to withdraw care and proceed with comfort measures only. The patient was terminally weaned off the ventilator and died shortly after.</p> <p>3. On 6/8/22, beginning at approximately 5:00 PM, MD5, Ear, Nose and Throat (ENT) physician/President of the Medical Staff, indicated that if a patient presented to his/her clinic practice with a complaint unrelated to his/her area of expertise he/she would likely refer the patient to another provider for assessment of complaints and/or changes in condition.</p>			