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BRINGING TRANSPARENCY TO FEDERAL INSPECTIONS

Home -> Search

162 reports found in Texas

Texas

Search

Date	Hospital	City	\$ State	Number of violations
Nov. 27, 2012 (read report)	KINGWOOD MEDICAL CENTER	KINGWOOD	TX	2
Nov. 15, 2012 (read report)	GUADALUPE REGIONAL MEDICAL CENTER	SEGUIN	TX	2
Nov. 9, 2012 (read report)	RIVERSIDE GENERAL HOSPITAL	HOUSTON	TX	1
Nov. 6, 2012 (read report)	METHODIST DALLAS MEDICAL CENTER	DALLAS	TX	1
Oct. 31, 2012 (read report)	WESTBURY COMMUNITY HOSPITAL, LLC	HOUSTON	TX	2
Oct. 30, 2012 (read report)	SIERRA MEDICAL CENTER	EL PASO	TX	2
Oct. 29, 2012 (read report)	PROVIDENCE MEMORIAL HOSPITAL	EL PASO	TX	2
Oct. 25, 2012 (read report)	BAPTIST MEDICAL CENTER	SAN ANTONIO	TX	1
Oct. 23, 2012 (read report)	MEDICAL CENTER OF PLANO	PLANO	TX	1
Oct. 22, 2012 (read report)	BAYLOR MEDICAL CENTER AT GARLAND	GARLAND	TX	2
Oct. 10, 2012 (read report)	SCOTT & WHITE MEMORIAL HOSPITAL	TEMPLE	TX	1
Oct. 2, 2012 (read report)	BAYLOR MEDICAL CENTER AT GARLAND	GARLAND	TX	1
Sept. 25, 2012 (read report)	BAPTIST MEDICAL CENTER	SAN ANTONIO	TX	2
Sept. 19,	SCOTT & WHITE MEMORIAL HOSPITAL	TEMPLE	TX	1

2012 (read report)				
Sept. 5, 2012 (read report)	EAST TEXAS MEDICAL CENTER	TYLER	TX	5
Aug. 30, 2012	TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON	DENTON	TX	1
(read report) Aug. 6, 2012 (read report)	RIVERSIDE GENERAL HOSPITAL	HOUSTON	TX	4
Aug. 6, 2012 (read report)	TEXAS HEALTH HARRIS METHODIST HURST- EULESS-BEDFORD	BEDFORD	TX	1
July 27, 2012	TEXOMA MEDICAL CENTER	DENISON	TX	7
(read report) July 24, 2012	DOCTORS HOSPITAL	DALLAS	TX	2
(read report) July 23, 2012	HENDRICK MEDICAL CENTER	ABILENE	TX	5
(read report) July 20, 2012	METHODIST STONE OAK HOSPITAL	SAN ANTONIO	TX	1
(read report)				
July 20, 2012 (read report)	WESTBURY COMMUNITY HOSPITAL, LLC	HOUSTON	TX	2
July 17, 2012	ST DAVID'S SOUTH AUSTIN MEDICAL CENTER	AUSTIN	TX	1
(read report) July 9, 2012	SOUTH HAMPTON COMMUNITY HOSPITAL	DALLAS	TX	3
(read report) July 5, 2012	NORTHWEST TEXAS HOSPITAL	AMARILLO	TX	1
(read report) July 2, 2012	DENTON REGIONAL MEDICAL CENTER	DENTON	TX	2
(read report) June 20,	JPS HEALTH NETWORK	FORT WORTH	TX	2
2012 (read report)				
June 15, 2012 (read report)	PARKLAND HEALTH AND HOSPITAL SYSTEM	DALLAS	TX	2
June 12, 2012 (read report)	TRUSTPOINT HOSPITAL	LUBBOCK	TX	3
June 5, 2012	MOTHER FRANCES HOSPITAL	TYLER	TX	3
(read report) June 5, 2012	TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS	DALLAS	TX	1
(read report) June 5, 2012	FOREST PARK MEDICAL CENTER	UNKNOWN	TX	3
(read report) May 30, 2012	SOUTHWEST SURGICAL HOSPITAL	HURST	TX	2
(read report) May 24, 2012	BAPTIST MEDICAL CENTER	SAN ANTONIO	TX	2
(read report)	NORTH ALISTIN MEDICAL CENTER	AUSTIN	TX	2
May 24, 2012 (read report)	NORTH AUSTIN MEDICAL CENTER	AUSTIN	1 ^	2
May 18, 2012 (read report)	SHELBY REGIONAL MEDICAL CENTER	CENTER	TX	12
May 17, 2012	PARKLAND HEALTH AND HOSPITAL SYSTEM	DALLAS	TX	1

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(read report) May 16, 2012	MEMORIAL HERMANN HOSPITAL SYSTEM	HOUSTON	TX	1
(read report) May 15, 2012	BAYLOR MEDICAL CENTER AT WAXAHACHIE	WAXAHACHIE	TX	1
(read report) May 15, 2012 (read report)	MEDICAL CENTER OF PLANO	PLANO	TX	14
May 10, 2012 (read report)	UNITED REGIONAL HEALTH CARE SYSTEM	WICHITA FALLS	TX	8
May 7, 2012 (read report)	TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON	DENTON	TX	1
April 30, 2012 (read report)	EMERUS HOSPITAL	UNKNOWN	TX	1
April 27, 2012 (read report)	EMERUS HOSPITAL	SUGAR LAND	TX	5
April 5, 2012 (read report)	CHRISTUS SPOHN HOSPITAL CORPUS CHRISTI	CORPUS CHRISTI	TX	3
April 3, 2012 (read report)	BAYLOR REGIONAL MEDICAL CENTER AT PLANO	PLANO	TX	1
April 2, 2012 (read report)	ST DAVID'S SOUTH AUSTIN MEDICAL CENTER	AUSTIN	TX	1
March 23, 2012 (read report)	RIVERSIDE GENERAL HOSPITAL	HOUSTON	TX	2
March 23, 2012 (read report)	WEST HOUSTON MEDICAL CENTER	HOUSTON	TX	1
March 21, 2012 (read report)	TEXAS HEALTH HARRIS METHODIST HURST- EULESS-BEDFORD	BEDFORD	TX	4
March 21, 2012 (read report)	RANKIN HOSPITAL MEDICAL CLINIC	UNKNOWN	TX	1
March 21, 2012 (read report)	NORTH CYPRESS MEDICAL CENTER	CYPRESS	TX	2
March 13, 2012 (read report)	MEDICAL CENTER OF ARLINGTON	ARLINGTON	TX	3
March 13, 2012 (read report)	DALLAS REGIONAL MEDICAL CENTER	MESQUITE	TX	1
March 12, 2012 (read report)	SHELBY REGIONAL MEDICAL CENTER	CENTER	TX	2
March 6, 2012	MEDICAL CENTER OF PLANO	PLANO	TX	1
(read report) March 5, 2012	ST JOSEPH REGIONAL HEALTH CENTER	BRYAN	TX	1
(read report) March 1, 2012	GULF COAST MEDICAL CENTER	WHARTON	TX	4
(read report) Feb. 28, 2012	BROWNWOOD REGIONAL MEDICAL CENTER	BROWNWOOD	TX	1
(read report) Feb. 28, 2012	DOCTORS HOSPITAL AT RENAISSANCE	EDINBURG	TX	2
(read report) Feb. 28, 2012	TEXAS HEALTH HEART & VASCULAR HOSPITAL ARLINGTON	ARLINGTON	TX	1

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(read report) Feb. 27, 2012	MEDICAL CENTER OF PLANO	PLANO	TX	3
(read report) Feb. 27, 2012 (read report)	EMERUS HOSPITAL	SUGAR LAND	TX	1
Feb. 22, 2012 (read report)	MEMORIAL HERMANN HOSPITAL SYSTEM	HOUSTON	TX	1
Feb. 21, 2012 (read report)	EAST TEXAS MEDICAL CENTER	TYLER	TX	1
Feb. 21, 2012 (read report)	HILLCREST BAPTIST MEDICAL CENTER	WACO	TX	1
Feb. 21, 2012 (read report)	ST MARKS MEDICAL CENTER	LA GRANGE	TX	1
Feb. 8, 2012 (read report)	BAPTIST MEDICAL CENTER	SAN ANTONIO	TX	1
Feb. 7, 2012 (read report)	METHODIST DALLAS MEDICAL CENTER	DALLAS	TX	2
Feb. 1, 2012 (read report)	STEPHENS MEMORIAL HOSPITAL	BRECKENRIDGE	TX	1
Jan. 24, 2012 (read report)	PARKLAND HEALTH AND HOSPITAL SYSTEM	DALLAS	TX	2
Jan. 24, 2012 (read report)	VHS BROWNSVILLE HOSPITAL COMPANY, LLC	BROWNSVILLE	TX	1
Jan. 17, 2012 (read report)	WADLEY REGIONAL MEDICAL CENTER	TEXARKANA	TX	1
Jan. 16, 2012 (read report)	ODESSA REGIONAL HOSPITAL	ODESSA	TX	1
Jan. 10, 2012 <u>(read report)</u>	NIX HEALTH CARE SYSTEM	SAN ANTONIO	TX	1
Dec. 29, 2011 (read report)	ALLEGIANCE SPECIALTY HOSPITAL OF KILGORE	KILGORE	TX	2
Dec. 22, 2011 (read report)	ALLEGIANCE HOSPITAL OF MIDLAND-PERMIAN BASIN	MIDLAND	TX	1
Dec. 20, 2011 (read report)	HILLCREST BAPTIST MEDICAL CENTER	WACO	TX	1
Dec. 6, 2011 (read report)	VHS BROWNSVILLE HOSPITAL COMPANY, LLC	BROWNSVILLE	TX	3
Dec. 1, 2011 (read report)	ATLANTA MEMORIAL HOSPITAL	ATLANTA	TX	5
Dec. 1, 2011 (read report)	DOCTORS HOSPITAL	DALLAS	TX	1
Dec. 1, 2011 (read report)	WESTBURY COMMUNITY HOSPITAL, LLC	HOUSTON	TX	3
Nov. 30, 2011 (read report)	LUBBOCK HEART HOSPITAL LP	LUBBOCK	TX	1
Nov. 22, 2011 (read report)	CARE REGIONAL MEDICAL CENTER	ARANSAS PASS	TX	2
Nov. 17, 2011 (read report)	ALLEGIANCE HOSPITAL OF MIDLAND-PERMIAN BASIN	MIDLAND	TX	3
Nov. 16, 2011	VHS HARLINGEN HOSPITAL COMPANY LLC	HARLINGEN	TX	3

(read report) Nov. 10, 2011	BAPTIST MEDICAL CENTER	SAN ANTONIO	TX	8
(read report) Nov. 9, 2011 (read report)	TRUSTPOINT HOSPITAL	LUBBOCK	TX	1
Nov. 7, 2011 (read report)	NORTHWEST HILLS SURGICAL HOSPITAL	AUSTIN	TX	1
Nov. 4, 2011 (read report)	PARKLAND HEALTH AND HOSPITAL SYSTEM	DALLAS	TX	1
Nov. 2, 2011 (read report)	LAKE GRANBURY MEDICAL CENTER	GRANBURY	TX	2
Oct. 28, 2011 (read report)	MEMORIAL HERMANN BAPTIST BEAUMONT HOSPITAL	BEAUMONT	TX	2
Oct. 27, 2011 (read report)	DENTON REGIONAL MEDICAL CENTER	DENTON	TX	2
Oct. 27, 2011 (read report)	ST LUKE'S PATIENTS MEDICAL CENTER	PASADENA	TX	2
Oct. 13, 2011 (read report)	BAYLOR MEDICAL CENTER AT WAXAHACHIE	WAXAHACHIE	TX	3
Oct. 3, 2011 (read report)	ST LUKE'S THE WOODLANDS HOSPITAL	THE WOODLANDS	TX	1
Sept. 22, 2011 (read report)	SCOTT & WHITE MEMORIAL HOSPITAL	TEMPLE	TX	1
Sept. 21, 2011 (read report)	VHS HARLINGEN HOSPITAL COMPANY LLC	HARLINGEN	TX	1
Sept. 7, 2011 (read report)	CARE REGIONAL MEDICAL CENTER	ARANSAS PASS	TX	1
Sept. 6, 2011 (read report)	NIX HEALTH CARE SYSTEM	SAN ANTONIO	TX	2
Sept. 6, 2011 (read report)	HOPKINS COUNTY MEMORIAL HOSPITAL	SULPHUR SPRINGS	TX	1
Sept. 6, 2011 (read report)	ODESSA REGIONAL HOSPITAL	ODESSA	TX	1
Aug. 24, 2011 (read report)	PALESTINE REGIONAL MEDICAL CENTER	PALESTINE	TX	1
Aug. 12, 2011 (read report)	SURGERY SPECIALTY HOSPITALS OF AMERICA SE HOUSTON	PASADENA	TX	2
Aug. 4, 2011 (read report)	METHODIST DALLAS MEDICAL CENTER	DALLAS	TX	21
Aug. 3, 2011 (read report)	TEXAS HEALTH HARRIS METHODIST HURST- EULESS-BEDFORD	BEDFORD	TX	1
July 22, 2011	PROVIDENCE MEMORIAL HOSPITAL	EL PASO	TX	2
(read report) July 22, 2011	HUMBLE SURGICAL HOSPITAL, LLC	UNKNOWN	TX	8
(read report) July 5, 2011 (read report)	METROPLEX HOSPITAL	KILLEEN	TX	4
July 1, 2011 (read report)	PARKLAND HEALTH AND HOSPITAL SYSTEM	DALLAS	TX	2
July 1, 2011 (read report)	PLAZA MEDICAL CENTER OF FORT WORTH	FORT WORTH	TX	3
June 29,	DALLAS REGIONAL MEDICAL CENTER	MESQUITE	TX	2

2011 (read report)				
June 24, 2011 (read report)	MEMORIAL HERMANN HOSPITAL SYSTEM	HOUSTON	TX	2
June 23, 2011	WADLEY REGIONAL MEDICAL CENTER	TEXARKANA	TX	2
(read report) June 23, 2011	WESTBURY COMMUNITY HOSPITAL, LLC	HOUSTON	TX	2
(read report) June 22,	EAST TEXAS MEDICAL CENTER	TYLER	TX	6
2011 (read report)	CUDICTUS ST MICHAEL HEALTH SVOTEM	TEVADIZANIA	TV	4
June 22, 2011 (read report)	CHRISTUS ST MICHAEL HEALTH SYSTEM	TEXARKANA	TX	1
June 9, 2011 (read report)	JPS HEALTH NETWORK	FORT WORTH	TX	3
June 9, 2011	TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO	PLANO	TX	1
(read report) May 24, 2011 (read report)	MEMORIAL HERMANN BAPTIST BEAUMONT HOSPITAL	BEAUMONT	TX	5
May 23, 2011	ST DAVID'S SOUTH AUSTIN MEDICAL CENTER	AUSTIN	TX	1
(read report) May 19, 2011 (read report)	TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON	DENTON	TX	3
May 18, 2011 (read report)	METHODIST CHARLTON MEDICAL CENTER	DALLAS	TX	11
May 17, 2011 (read report)	PALESTINE REGIONAL MEDICAL CENTER	PALESTINE	TX	5
May 12, 2011 (read report)	PARKLAND HEALTH AND HOSPITAL SYSTEM	DALLAS	TX	4
May 4, 2011 (read report)	LONGVIEW REGIONAL MEDICAL CENTER	LONGVIEW	TX	2
April 28, 2011 (read report)	MEDICAL CENTER OF PLANO	PLANO	TX	1
April 28, 2011 (read report)	MAYHILL HOSPITAL	DENTON	TX	1
April 22, 2011 (read report)	NACOGDOCHES MEDICAL CENTER	NACOGDOCHES	TX	2
April 19, 2011	WADLEY REGIONAL MEDICAL CENTER	TEXARKANA	TX	2
(read report) April 12, 2011	NORTH CYPRESS MEDICAL CENTER	CYPRESS	TX	2
(read report) April 7, 2011	MEMORIAL MEDICAL CENTER LIVINGSTON	LIVINGSTON	TX	1
(read report) April 6, 2011 (read report)	NIX HEALTH CARE SYSTEM	SAN ANTONIO	TX	1
March 31, 2011	SHELBY REGIONAL MEDICAL CENTER	CENTER	TX	4
(read report) March 29, 2011 (read report)	HENDRICK MEDICAL CENTER	ABILENE	TX	1
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2011	h 28, I <u>report)</u>	TEXAS SPECIALTY HOSPITAL AT LUBBOCK	UNKNOWN	TX	6
Marc 2011	h 24,	BAYLOR MEDICAL CENTER AT IRVING	IRVING	TX	1
Marc 2011	h 17,	COZBY-GERMANY HOSPITAL	GRAND SALINE	TX	2
Marc 2011	h 17,	WESTBURY COMMUNITY HOSPITAL, LLC	HOUSTON	TX	7
Marc 2011		FIRST STREET HOSPITAL LP	BELLAIRE	TX	5
Marc 2011	h 14,	EAST TEXAS MEDICAL CENTER	TYLER	TX	3
Marc 2011	h 7,	COZBY-GERMANY HOSPITAL	GRAND SALINE	TX	13
Marc 2011	h 7,	METHODIST CHARLTON MEDICAL CENTER	DALLAS	TX	2
Marc 2011	h 3,	MEMORIAL HERMANN KATY HOSPITAL	KATY	TX	1
Marc 2011	h 3,	NORTH CENTRAL SURGICAL CENTER LLP	DALLAS	TX	1
Feb. 2011	28,	UNIVERSITY MEDICAL CENTER	LUBBOCK	TX	1
Feb. 2011	25,	PARKVIEW REGIONAL HOSPITAL	MEXIA	TX	1
Feb. 2011	18,	RED RIVER REGIONAL HOSPITAL	BONHAM	TX	3
Feb. 2011	16,	TEXAS INSTITUTE FOR SURGERY AT PRESBYTERIAN HOSPIT	DALLAS	TX	2
Feb. 2011	11,	TEXAS HEALTH HARRIS METHODIST HURST- EULESS-BEDFORD	BEDFORD	TX	2
Feb. 2011	11,	WESTBURY COMMUNITY HOSPITAL, LLC	HOUSTON	TX	2
Feb.	9, 2011 I report)	TRUSTPOINT HOSPITAL	LUBBOCK	TX	1
Feb.	8, 2011 I report)	LIMESTONE MEDICAL CENTER	GROESBECK	TX	4
Feb.	2, 2011 I report)	UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE	AUSTIN	TX	3
Feb.	1, 2011 I report)	UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE	AUSTIN	TX	4
Feb.	1, 2011 I report)	ETMC HENDERSON	HENDERSON	TX	2
Jan. : 2011	21,	PARKLAND HEALTH AND HOSPITAL SYSTEM	DALLAS	TX	3
Jan. 1 2011	21,	HARRIS HEALTH SYSTEM	HOUSTON	TX	1
Jan. 2011	13,	COVENANT MEDICAL CENTER	LUBBOCK	TX	4
Jan.		WISE REGIONAL HEALTH SYSTEM	DECATUR	TX	2

2011 (read report) Jan. 5, 2011 (read report)

EAST TEXAS MEDICAL CENTER

TYLER

TX

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BRINGING TRANSPARENCY TO FEDERAL INSPECTIONS

Search hospital inspections

Welcome to hospitalinspections.org, a website run by the Association of Health Care Journalists (AHCJ) that aims to make federal hospital inspection reports easier to access, search and analyze. This site includes details about deficiencies cited during complaint inspections at acute-care and critical access hospitals throughout the United States since Jan. 1, 2011. It does not include results of routine inspections or those of psychiatric hospitals or long-term care hospitals. It also does not include hospital responses to deficiencies cited during inspections. Those can be obtained by filing a request with a hospital or the U.S. Centers for Medicare and Medicaid Services (CMS).

This effort follows years of advocacy by AHCJ to encourage federal officials to publish this information electronically. Until now, this information has only been available through Freedom of Information Act requests - and only in paper form. Funding for this project was provided by the Ethics & Excellence in Journalism Foundation.

Because CMS has just begun gathering this data and releasing it in electronic format, it remains incomplete. Some reports are missing narrative details, and those are noted on each hospital's page. Beyond that, CMS acknowledges that other reports that should appear may not. CMS has pledged to work with AHCJ to make future iterations of this data more complete. At this time, this data should not be used to rank hospitals within a state or between states. It can be used to review issues identified at hospitals during recent inspections.

Clicking on a state on the map will retrieve a list of all hospitals with their violations grouped together; choosing a state from the drop down menu will list all inspection reports separately, so a hospital may appear more than once.

Last updated: March 2013



Search your state

For all visitors

- A Q&A with CMS: Getting up to speed on inspection reports
- How to read inspection reports
- Sample inspection report
 Points to keep in mind about this data
- States that put hospital inspection reports online

For AHCJ members

- How to use 2567 forms in your reporting
- Having discussions with hospitals
- Beyond the 2567: Rounding out your story

Reporter resources on covering hospital quality

Resources page

Download entire dataset

All states Search Examples: abuse; "medication error";

Washington D.C.



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BRINGING TRANSPARENCY TO FEDERAL INSPECTIONS

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KINGWOOD MEDICAL CENTER ->

Report No. 1570

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

KINGWOOD MEDICAL CENTER

22999 US HWY 59 KINGWOOD, TX 77325

Nov. 27, 2012

Tag No: A0123

Tag No: A0395

VIOLATION: PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION

Based on interview and record review the Hospital failed to send a complainant a letter acknowledging their grievance per the Hospital's policy. (Patient ID# 1)

Findings include:

Interview 11/27/12 at 8:30 a.m. with the Chief Nursing Officer (CNO) revealed she was aware of a complaint regarding patient ID# 1. The CNO stated that patient ID# 1's daughter made a complaint 10/31/12 about her Father 's heels being " soft and mushy " once he arrived on the Rehabilitation Unit from the Intermediate Medical Intensive Care Unit (IMU). The patient had a history of diabetes, poor circulation and loss of one toe.

Record review of a policy titled "Patient / Family Complaint "dated 10/2010 stated "A patient grievance is a written or verbal complaint by a patient, or the patient 's representative, regarding the patient 's care, abuse or neglect, issues related to the hospital 's compliance with the CMS Hospital Conditions of Participation. Procedure: Patient Advocate is responsible for: Initial response will include an acknowledgement of the complaint and will indicate that review has been initiated. Initial response letter will be mailed within seven working days of the alleged incident by the Quality Management Office."

The Quality Assurance Director (ID# 2) acknowledged 11/27/12 at 2:50 p.m. that the complainant should have been sent a letter from the hospital within 7 days acknowledging her complaint. The hospital inadvertently failed to send the 7 day letter.

VIOLATION: RN SUPERVISION OF NURSING CARE

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the nursing staff failed to supervise patient care in 3 of 3 patient records reviewed on the Intensive Medical Care Unit (IMU). Records reviewed failed to:

- 1) Document measurements of pressure ulcers per facility policy,
- 2) Obtain physician orders for pressure ulcer treatments,
- 3) Accurately perform Braden skin risk assessment

(Patient ID#'s 1, 2, 3)

Findings include:

Record review of a policy titled "Skin Care Assessment dated 6/13/11 stated: Purpose: to describe the process and documentation format for wound and skin assessment. Procedure: The Risk Assessment is completed based on criteria including sensory, perception, moisture, activity, mobility, nutrition, and friction and sheering. (If the score is 16 or less, the patient may be at risk for impaired skin integrity) Document wound measurements one time per week ... "

PATIENT ID# 1

Record review of the medical record for patient ID# 1 revealed he was admitted to the hospital 10/10/12 and discharged on [DATE].

A History and Physical dated 10/10/12 stated "A [AGE]-year-old male presented with severe shortness of breath, and orthopnea..He was found to have decompensated systolic congestive heart failure as well as evidence of acute MI. Past Medical History: Hypertension, COPD, [DIAGNOSES REDACTED], Diabetes, Poor compliance, Peripheral neuropathy, Peripheral arterial disease, bilateral pneumonia ...Past Surgical History: Left fifth toe amputation. Plan of Treatment: The patient is being admitted to the hospital for cardiovascular surgeon evaluation. "

Record review of a Cardiovascular Surgeon evaluation dated 10/11/12 stated "Extremities: I am unable to palpate pulses in either foot " Preparation for open heart surgery

The nursing staff used a Braden Risk Assessment for patient ID# 1 on 10/11/12 to evaluate the risk of developing pressure ulcers and the patient was scored at " 20 " or no risk of developing pressure ulcers. (According to the Hospital 's Skin Care Assessment policy only a score of 16 or less is at risk).

The patient had open heart surgery and was transferred to the Intensive Medical Care Unit (IMU). The patient had no skin problems upon admission 10/10/12 according to the nursing shift assessments.

Nursing shift assessments noted [DIAGNOŠES REDACTED] (redness) to buttocks bilaterally beginning 10/15/12 while on the IMU unit. The Nursing assessments failed to document any problems with the patient's heels while in IMU. No measurements were taken of the redness to the buttocks bilaterally. No heel protectors nor a pressure relieving mattress was ordered by the physician.

Patient ID# 1 was transferred 10/25/12 from the IMU unit to the Rehabilitation Unit on the first floor.

The nursing admission assessment on the Rehabilitation Unit noted "[DIAGNOSES REDACTED] (Redness) to buttocks bilaterally, Left lower extremity monitoring due to bruise and Left foot heels [DIAGNOSES REDACTED]." No measurements were taken of the redness to the buttocks or the patients heels.

On 10/29/12 the nursing assessment noted "closed blister bilateral feet." Preventative boots were provided to the patient. No measurements were documented of the patient's heels.

On 10/30/12 the nursing assessment noted " Scabs bilateral heels, Bruise and closed blister on right foot and Left foot closed blister. No measurements were documented of the patient's heels.

On 10/31/12 the nursing assessment noted " Closed blister bilateral heels and [DIAGNOSES REDACTED] to bilateral buttocks. " No measurements were documented.

On 11/4/12 the nursing assessment noted "Skin tear right buttock and [DIAGNOSES REDACTED] bilateral buttocks, Bilateral heels blister open. "No measurements were documented.

On 11/6/12 the nursing assessment noted " Left heel open blister and 4x4 and ace bandage. No measurements were documented and no physician order was obtained for the 4x4 and ace bandage. The Right heel open blister was not noted. No measurements were documented.

On 11/7/12 the nursing assessment noted "Left heel open blister and 4x4 and ace bandage." The Right heel open blister was not noted. No measurements were documented of the patient's blisters. The patient was discharged [DATE] to a Rehabilitation Hospital.

The Quality Assurance Director acknowledged 11/27/12 at 2:50 p.m. that no measurements were documented of patient ID# 1's pressure ulcers. The Director further stated that nursing staff should have measured the patient's pressure ulcers according to hospital policy.

PATIENT ID# 2

Record review of the History and Physical revealed this 71- year- old patient was admitted to the hospital 11/22/12 with increased confusion and could not move his right side. The patient had a history of coronary artery disease, hypertension, [DIAGNOSES REDACTED] and diabetes.

Initial nursing assessments on 11/22/12 revealed no skin problems. Nursing assessments on 11/27/12 documented Stage II pressure sore on the high back, Stage II on the left thigh, and Stage I on the coccyx. The nurse applied Dueoderm to the coccyx with no physician order and no measurements were documented of the pressure ulcers.

PATIENT ID# 3

Record review of the History and Physical revealed this [AGE]-year-old patient was admitted on [DATE] for elective redo of a total hip replacement. The patient had a tracheotomy that resulted from previous history of head and neck cancer.

Initial nursing assessments on 11/13/12 revealed no skin problems Nursing assessments on 11/18/12 revealed a Stage I pressure sore on the buttocks. No measurements were documented.



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Home -> Texas -> KINGWOOD MEDICAL CENTER KINGWOOD MEDICAL CENTER

22999 US HWY 59 KINGWOOD, TX 77325 | Proprietary

View hospital's federal Hospital Compare record

Report date Number of violations

Nov. 27, 20122 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. Incomplete reports

No incomplete reports available.



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Tag No: A0283

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GUADALUPE REGIONAL MEDICAL CENTER ->

Report No. 1492

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

GUADALUPE REGIONAL MEDICAL CENTER 1215 E COURT ST SEGUIN, TX 78155 Nov. 15, 2012

VIOLATION: PROGRAM DATA, PROGRAM ACTIVITIES

Based on record review and staff interview, the facility failed to develop a performance improvement plan based on the failure of a process that would ensure documentation of patient allergies in different departments of the hospital would be captured through their electronic documentation system. At exit, the facility did not have a process in place to measure, analyze, and trend data to ensure the process changes in the electronic record system was effective in capturing the documentation of allergies in patient 's medical record entered from any department in the hospital. There was no current audit of patient medical records to ensure patients did not receive medications that caused an allergic reaction.

Findings included:

This resulted in patient #1 having an allergic reaction to a medication that should have been electronically documented as an allergy. Record review of Patient #1's History and Physical, completed on 08/04/12 and again on 08/06/12 by Physician #1 (Hospitalist), revealed Patient #1 was allergic to Penicillin, Tetanus Toxoid, Pneumococcal Vaccine, Cipro, and Levaquin.

Record review of Patient #1's History and Physical, completed on 08/05/12 by Physician #2 (Surgeon), revealed Patient #1 was allergic to

the previously listed medications.

Record review of Patient #1's handwritten Anesthetic Record, dated 08/06/12 at 1132 AM, revealed she was allergic to Penicillin, Tetanus Toxoid, Cipro, and Levaquin.

Record review of Patient #1's Operative Report, dated 08/06/12 revealed she had a laparoscopic appendectomy and tru-cut liver biopsy on this date.

Record review of an electronic operating room (OR) assessment note, dated 08/06/12 at 1240, revealed Patient #1 was allergic to Cipro, Levaquin, Penicillian, and Tetanus Toxoid.

Record review of a pharmacy order, ordered 08/06/12 at 1249 and discontinued on 08/08/12 at 0827 by Physician #2, revealed he had ordered Levaquin 500 MG Bag/Dextrose 5% in water at a rate of 100 MLS/HR by IV Piggyback for one hour for Patient #1, to be given after her surgical procedure.

Record review of electronic documentation of medications given revealed Patient #1 had received the Levaquin on 08/06/12 at 1504 and again on 08/07/12 at 1039. Patient #1 was in ICU at the time she received the Levaquin. She was transferred to the surgical floor on

Record review of an electronic nursing note, occurring on 08/08/12 at 0930 and documented at 08/08/12 at 1042, revealed that Patient #1 complained of itching, was medicated per as needed (PRN) orders for the itching, patient reports allergy to Levaquin, allergies updated in computer, Physician #1 was notified and telephone order to discontinue Levaquin was obtained.

Record review of electronic nursing notes, dated from 08/07/12 at 1415 through 08/08/12 at 0750 revealed seven documentations that

Patient #1 complained of generalized itching, especially to her face and received PRN medication for the itching. Her face was described as "red and swollen and she had informed nursing staff that was not her norm".

Record review on drugs.com (http://www.drugs.com/sfx/levaquin-side-effects.html) revealed side effects of Levaquin included but was not limited to severe skin reaction -- fever, sore throat, swelling in your face or tongue, burning in your eyes, skin pain, followed by a red or

purple skin rash that spreads (especially in the face or upper body) and causes blistering and peeling.

Record review of a facility policy originating in nursing and titled "Patient Allergy Management through Electronic Documentation", dated 04/2011, revealed the following statement, "Develop a process for obtaining and electronically documenting a complete list of the patient's current allergies upon admission to or before any outpatient service in this organization. Include in this process a method for electronically updating the patient's allergy list with current information at each subsequent visit."

Record review of the facility's Performance Improvement Plan for 2012 revealed the following statement: The Performance Improvement

Plan is designed to achieve four goals including but not limited to (2) To pursue opportunites for improving patient safety and customer services by evaluating and analyzing processes associated with patient care. To identify and resolve problems that cause less than optimal patient care or clinical outcome. and (4) To assure appropriate communication, reporting and documentation of all performance improvement and patient safety activities to the Governing Board, hospital administration, medical staff, and appropriate hospital personnel.

Interview on 11/06/12 at 1:45 PM with the facility's Chief Nursing Officer (CNO) revealed she was aware that Patient #1 received two doses of Levaquin. She stated the facility had a "glitch" in their computer system. She stated that although the documentation of Patient #1's allergy to Levaquin was put into the electronic medical records as part of her operating room (OR) assessment, the information failed to propagate over to the other departments (ICU, Surgical Floor, and Pharmacy) who would depend on the electronic medical records to know Patient #1 was allergic to Levaquin. The CNO confirmed Patient #1's allergy to Levaquin was listed on her identification bracelet at the time Patient #1 informed nursing staff on the surgical floor that she was allergic to Levaquin. She stated that the exact date and time that Patient #1's allergy to Levoquin was added to her identification bracelet was unknown. She stated it is believed the allergy was added to her bracelet prior to her surgical procedures. She stated the facility had made some changes to their computer system in order for the allergies to propagate into all areas of electronic documentation. She stated the facility considered this issue a medication error only and did not see it as a process error.

Continued interview on 11/13/12 between 9:20 AM and 12:00 PM with the facility's CNO revealed that nursing staff have the ability to look at the physician's history and physical documentation and it would be her expectation that nursing staff look at these documents when completing a nursing plan of care. She stated the facility does not currently have a process in place for verifying allergies listed on the history and physical completed by the physician. She confirmed that nursing staff should be informing patients what medications they are receiving whether they receive those medications through an IV or orally. She further confirmed that nursing staff should be looking at a patient's identification bracelet every time they administer medications to determine if they have allergies to ordered medications. She stated nursing staff have been "talked to" about these issues but she confirmed there was no documentation of these discussions. Continued interview on 11/13/12 in the morning with the facility CNO revealed that none of the changes made in how the allergies were documented in the computer were put in writing, no data has been collected on whether these changes were adequately capturing what medications are documented as allergies, and the changes in this process were not documented and/or discussed as part of their performance improvement plan. She further stated they do not currently have any audit to measure the effectiveness of their process change in regard to documentation of patient allergies into the electronic medical record from all departments of the hospital.

VIOLATION: NURSING CARE PLAN

Based on record review and interview with facility staff, the facility failed to ensure that one of one patients (patient #1) had a documented medication allergy included in her initial nursing plan of care. This resulted in patient #1 receiving two doses of the medication and displaying an allergic reaction to the medication.

Tag No: A0396

Findings included:

Record review of Patient #1's History and Physical, completed on 08/04/12 and again on 08/06/12 by Physician #1 (Hospitality), revealed Patient #1 was allergic to Penicillin, Tetanus Toxoid, Pneumococcal Vaccine, Cipro, and Levaquin.

Record review of Patient #1's History and Physical, completed on 08/05/12 by Physician #2 (Surgeon), revealed Patient #1 was allergic to the previously listed medications.

Record review of Patient #1's handwritten Anesthetic Record, dated 08/06/12 at 1132 AM, revealed she was allergic to Penicillin, Tetanus Toxoid, Cipro, and Levaquin.

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Record review of electronic nursing notes, dated from 08/07/12 at 1415 through 08/08/12 at 0750 revealed seven documentations that Patient #1 complained of generalized itching, especially to her face and received PRN medication for the itching. Her face was described as "red and swollen and she had informed nursing staff that was not her norm".

Record review of Patient #1's complaint form revealed she was given Levaquin even though it was listed as an allergy on her hospital identification bracelet. She stated she knew she received two doses of the medication. She stated she almost immediately had a "reaction that got worse and worse." She stated she felt as if she was "being boiled in oil and her face especially around her mouth felt scalded." She stated that at one point a nurse brought her a "pill" and she asked about what antibiotic she was getting and the nurse told her Levaquin. She pointed out her allergy to the medication and the nurse told her it was not on her record but when the nurse looked at her identification bracelet, the Levaquin was listed as an allergy."

Record review on drugs.com (http://www.drugs.com/sfx/levaquin-side-effects.html) revealed side effects of Levaquin included but was not limited to severe skin reaction -- fever, sore throat, swelling in your face or tongue, burning in your eyes, skin pain, followed by a red or purple skin rash that spreads (especially in the face or upper body) and causes blistering and peeling.

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She stated nursing staff have been "talked to" about these issues but she confirmed there was no documentation of these discussions.



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Report date Number of violations

Nov. 15, 20122 (click for details) Read full report

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No incomplete reports available.



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RIVERSIDE GENERAL HOSPITAL ->

Report No. 1525

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RIVERSIDE GENERAL HOSPITAL

3204 ENNIS ST HOUSTON, TX 77004

Nov. 9, 2012

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on interview and record review, the facility 's Governing Body failed to ensure the facility adhered to its policy regarding Restraint/Seclusion usage for 2 of 7 sampled discharged patients (ID # 6, # 10). The facility failed to obtain physician orders for restraint (Patient ID # 6, # 11) and failed to include these episodes into the Quality Assurance Monitoring program.

Findings include:

Patient ID # 6

Record review on 11-09-12 of Patient ID # 6 's clinical record revealed she was [AGE] years old and admitted to the facility on on [DATE] with a diagnosis of Mood Disorder.

Review of facility " Significant Incident Report, " dated 03-12-12 read: " pt. (patient) ID # 6 offered to go to quiet room and refused. Code is called. Pt in day room. Pt attempted to swing at Staff ID # 11, but missed... Staff grabbed pt. and took to ground after she swung at him ...pt taken to ground by Staff ID # 11, where she hit her head ... "

Review of the physician orders for Patient ID # 6 failed to reveal a physician order for the personal restraint applied on 11-09-12. In addition, review of the facility Quality Assurance data for restraints, failed to reveal the reporting of this episode of personal restraint.

Patient ID # 10

Record review on 11-09-12 of Patient ID #10 's clinical record revealed he was [AGE] years old and admitted to the facility on on [DATE] with a diagnosis of Schizoaffective Disorder.

Review of facility " Significant Incident Report, " dated 05-26-12 read: " pt. (ID # 10) trying to attack staff. Pt taken down by staff ...later pt complained of shoulder pain ... " Record review showed x-ray disclosed a fractured clavicle; Patient ID # 10 was transported to a local hospital for evaluation and treatment. Patient ID # 10 returned to the facility the same day.

Review of the physician orders for Patient ID # 10 failed to reveal a physician order for the personal restraint applied on 11-09-12. In addition, review of the facility Quality Assurance data for restraints, failed to reveal the reporting of this episode of personal restraint. The facility policy required any injuries related to the use of restraint would be reported and reviewed.

Interview on 11-09-12 at 2:10 p.m. with the Director of Nursing (DON/ Staff ID #1), she stated the facility had not been considering the use of PMAB (Preventative Management of Aggressive Behavior) as a restraint. Upon review and discussion of the facility 's restraint/seclusion policy, the DON (ID # 1) acknowledged that use of a "physical take-down (using PMAB) " was considered a personal

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

restraint.

Record review in 11-09-12 of the facility policy titled "Seclusion and Restraint, "undated, read: "Definition:Restraint: an individual placed in restraint to be defined as personal, mechanical or any device which restrain a patient for medical ,behavioral and/or diagnostic reasons ...III. Orders. 1 ...b. All restraint and seclusion are applied and continued pursuant to an order by the physician, clinical psychologist, or other authorized licensed independent practitioner designee ,,,, "XII. QA and Performance Improvement: Data Collection is integrated into PI activities: Indicators: 1/ Staff or patient injury sustained while in seclusion or restraint. 2 orders "

Review of the facility preprinted form titled " Seclusion /Restraint Orders " revealed six (6) check off boxes for type of restraint, one of which was " Personal " restraint. Further review of the order form revealed a section that listed patient behaviors with " check off boxes. " The behaviors included: fighting staff; fighting with peers; threatening to fight staff, etc ... "

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RIVERSIDE GENERAL HOSPITAL RIVERSIDE GENERAL HOSPITAL

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Report date Number of violations

Nov. 9, 2012 1 (click for details) Read full report Aug. 6, 2012 4 (click for details) Read full report March 23, 20122 (click for details) Read full report

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METHODIST DALLAS MEDICAL CENTER ->

Report No. 1474

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METHODIST DALLAS MEDICAL CENTER

1441 NORTH BECKLEY AVENUE DALLAS, TX Nov. 6, 75203 2012

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on review of documents and interviews with staff, the facility failed to ensure care in a safe setting for 1 of 1 patient whose record was reviewed. Allegations of physical abuse of the elderly Patient #1 were reported and no occurrence report was filed; also, the facility does not have a procedure for investigating abuse allegations of elderly patients filed against hospital staff, which could affect patient safety.

Findings included:

An in-person interview was conducted the morning of 11/6/12 with Staff #2, Nurse Manager for the unit where Patient #1, an elderly individual, was inpatient. Staff #2 stated the patient's family member reported that Patient #1 appeared withdrawn, and the family member alleged that the patient was "handled roughly" by a Patient Care Technician (PCT), Staff #4. The Manager added that there was no evidence of abuse outwardly upon examination of Patient #1 and the PCT was removed from caring for the patient at the family member's request. The Nurse Manager stated that the allegations of physical abuse were not discussed with the PCT.

Review of a handbook given to new employees entitled, Risk Management, Your Important Role as a Methodist Employee, states under the section Occurrence Reporting, that "Anything out of the normal for a patient ...should prompt an Occurrence Report." No report was found documenting the allegations of "rough handling" by a Methodist employee, which had been reported to the employee's supervisor, Staff #2, by the patient's family member.

Review of the medical record for Patient #1 revealed that the patient was elderly and also had a psychiatric diagnosis. There was no documentation of the allegations of abuse. The patient remained stable with no complaints throughout the hospital stay. There was no documentation of bruising or other signs of abuse.

In-person interviews were conducted the morning of 11/6/12 in a facility conference room with the hospital Director of Quality and the hospital Risk Manager. The Quality Director, Staff #1, acknowledged that there was no occurrence report filed regarding the allegation of abuse of Patient #1 as reported to the unit Nurse Manager by the family member. The hospital Risk Manager, Staff #3 acknowledged that the hospital does not have a policy about how to proceed if an employee is accused of abusing an elderly patient.

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METHODIST DALLAS MEDICAL CENTER METHODIST DALLAS MEDICAL CENTER

1441 NORTH BECKLEY AVENUE DALLAS, TX 75203 | Voluntary non-profit - Other

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Report date Number of violations

Nov. 6, 20121 (click for details)
Feb. 7, 20122 (click for details)
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Incomplete reports

No incomplete reports available.



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Tag No: A0145

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WESTBURY COMMUNITY HOSPITAL, LLC ->

Report No. 1782

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WESTBURY COMMUNITY HOSPITAL, LLC 5556 GASMER HOUSTON, TX 77035 Oct. 31, 2012

VIOLATION: PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the facility failed to fully investigate one (1) allegation of verbal abuse of Patient ID # 22 and one (1) allegation of physical abuse of Patient ID # 23:

- 1. Patient ID # 22 documented allegations of verbal abuse by Mental Health Technician (MHT) # 20 on 09-22-12.
- 2. Patient # 23 documented allegations of physical abuse by MHT # 15 on 09-22-12 (reported by Patient # 21)

Findings include:

Intake ID # TX 984

Review of Intake # TX 984 revealed facility " self-reported " the following to Adult Protective Services (APS). APS forwarded the complaint to the Texas Department of State health Services (TDSHS) for investigation. The intake read: : ' two patients at the facility filed two complaints on a tech named () or () that allegedly hit a patient (name unknown) and was abusive to another patient (name unknown) ...Two patients stated this tech was verbally abusive to other patients and used foul language and was disrespectful to patients in psych hospital ...Acting Director of Nurses has knowledge of incident and names of individuals involved, including a housekeeper who allegedly witnessed the incident. ...Incident occurred on 09-22-12; reported to patient Advocate on 09-24-12 ... "

Interview on 10-31-12 at 8:35 a.m. with facility Patient Advocate ID # 24 she had no responsibility for investigation of abuse, neglect, exploitation; this was done by the Director of Nurses (DON) or the Risk Manager. She went on to say she documented complaints on the Patient /Employee Complaint Form, copied the form, and gave the original to the facility Risk Manager (ID # 25). If the issue involved allegations of Abuse, Neglect, Exploitation, she also reported it to APS.

Interview on 10-31-12 at 2:10 p.m. with the facility Risk Manager ID # 25 he stated the facility Patient Advocate (# 24) conducted all facility investigations including those involving Abuse, Neglect, and Exploitation. He stated the investigation would include: talking with the patient, removing alleged perpetrator form unit; reviewing (or completing) an occurrence report; patient/staff/ witness interviews and statements, assessment of patient, informing family and physician.

Patient # 22

Record review on 10-30-12 of Patient # 22 's admission information revealed she was [AGE] years old and involuntarily admitted to the facility on on [DATE] with diagnosis of Suicidal Ideation and history of Bipolar Disorder and Depression. Patient ID # 22 was discharged from the facility on 09-25-12.

On 10-30-12, record review of facility " Patient/Employee Complaint Form, " dated 09-22-12 completed by Patient # 22 revealed allegations of verbal abuse: " tech (first name only) refuses to help mescreaming and yelling at me and very hateful to me ... " The form was signed by Patient Advocate ID # 24 on 09-24-12 at 10: 00 a.m., on the line provided for " date resolved."

Review of an additional "Patient/Employee Complaint Form," dated 09-22-12 completed by a second patient (Patient ID # 21), corroborated Patient # 22 's complaint. This complaint read: "...tech (first name only) has been yelling and refusing to get people clothes and snacks....talked rude and disrespectful ... " this form also documented "patient afraid of retaliation by techs. "The form was signed by Patient Advocate ID # 24 on 09-24-12 at 9:50 a.m., on the line provided for "date resolved."

Neither the facility Patient Advocate (ID # 24) or Risk Manager (ID #25) was able to provide any documentation of an investigation that included assessment of patient, witness statements, interviews with patients and staff, occurrence reports, follow-up actions. Further review of Patient # 22 's clinical records failed to reveal any documentation related to patient 's allegation of verbal abuse.

When requested, facility provided the personnel file of Mental Health Technician (MHT) ID # 21, stating this was the only tech with the nickname described in the two (2) complaints. After several staff interviews, surveyors determined facility had incorrectly identified the tech involved; the actual Tech named in the complaints was MHT # 20. This was confirmed and acknowledged by Acting DON, ID # 4.

On 10-31-12, record review of facility grievance forms revealed an additional complaint had been documented against MHT # 20 on 10-26-12. The complaint was regarding MHT # 21 not allowing patient to talk and failing to help patient obtain pain medication in a timely manner.

Patient #23

Record review on 10-30-12 of Patient # 23 's admission information revealed she was [AGE] years old and involuntarily admitted to the facility on on [DATE] with diagnosis of Psychotic Disorder and history of Schizophrenia and Developmental Disorder. Patient # 23 was discharged from the facility on 09-21-12.

On 10-30-12, record review of facility " Patient/Employee Complaint Form, " dated 09-22-12 completed by Patient # 21 regarding allegations of physical abuse of a patient other than herself. The form read: "...I saw a tech (ID # 15) hit Patient (first name) for hiding a juice. The patient was crying ... " Additional information provided was the patient reported " a cleaning lady saw the incident and the patient 's name was (first name only) ... " The form was signed by Patient Advocate ID # 24 on 09-24-12 on the line provided for " date resolved."

Neither the faiclity Patient Advocate (ID # 24) or Risk Manager (ID #25) was able to provide any documentation of an investigation that included witness statements, interviews with patients and staff, occurrence reports, or follow-up actions.

On 10-30-12, interview at 11:45 a.m. with Patient Advocate (ID # 24) she stated she was unable to identify the full name of the patient involved or confirm the facility had assessed her or spoken with the patient. She went on to say she heard the tech involved was terminated.

Interview on 10-31-12 at 2:10 p.m. with facility Risk Manager (ID # 25) he was unable to identify the full name of the patient involved or confirm the facility had assessed her or made attempts to contact her post-discharge.

On 10-31-12, surveyors determined the full name of the patient (Patient ID # 23) from review of the facility daily census on 09-22-12 and supplied the name to the facility. Patient # 23 had been discharged the day before the allegation was documented.

Review of the personnel file of MHT # 15 's personnel file revealed she had been terminated on 09-26-12 by the DON. There was a statement in the file by MHT # 15, dated 09-24-12. The statement did not include denial of hitting Patient #23.

Surveyor was unable to interview the DON, as she was out of the country on vacation. The Acting DON (ID # 4) had no knowledge of either allegation of abuse involving Patient # 22 or Patient # 23.

Review of the facility " Master Occurrence Report Log " for 2012 failed to reveal that occurrence reports were written for the allegation of verbal abuse of Patient # 22 and allegation of physical abuse of Patient # 23, both reported on 09-22-12.

Review of facility policy titled " Abuse, Neglect and Exploitation Prevention-Adult and Children dated 05-2010, read: "8 ...c If an occurrence of unsafe behavior occurs the Charge Nurse will immediately implement a plan of action which includes ...Placing patient in private placed. the Nursing staff will complete an Occurrence Report for each patient involved in the occurrence within two (2) hours ...the nursing staff will: complete notification requirements (administration, physician, and family) within 2 hours ...the nursing staff will document the corrective action plan on the Occurrence Report and in the medical record,,,the Risk manager will investigate and report findings to the Administrator and Corporate Compliance for further action as needed ... "

*Note: facility was previously cited on 12-01-11 for a Condition Level deficiency: Condition of Participation: Patient Rights CFR 483.12 .The deficiencies cited were related to patient abuse and neglect prevention and investigation.

Tag No: A0468

VIOLATION: CONTENT OF RECORD - DISCHARGE SUMMARY

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the facility failed to ensure that 7 of 12 sampled discharged patient records (ID # 15, # 16, # 18, #19, #20, #21, and # 23) contained a Discharge Summary per facility policy.

Findings include:

On 10-31-12 record review of 12 sampled discharged patient records revealed the following 7 records lacked a physician 's Discharge Summary:

Patient ID # 15 was admitted to the facility on on [DATE] with a diagnosis of Schizoaffective Disorder. He was discharged from the facility on 09-10-12

Patient ID # 16 was admitted to the facility on on [DATE] with a diagnosis of Depression and ETOH (ethanol abuse). She was discharged from the facility on 09-11-12

Patient ID # 18 was admitted to the facility on on [DATE] with a diagnosis of Self Inflicted Wound; Schizoaffective Disorder. She was discharged from the facility on 09-06-12.

Patient ID # 19 was admitted to the facility on on [DATE] with a diagnosis of Schizophrenia. He was discharged from the facility on 09-15-

Patient ID # 20 was admitted to the facility on on [DATE] with a diagnosis of Suicidal ideation. He was discharged from the facility on 09-05-12

Patient ID # 21 was admitted to the facility on on [DATE] with a diagnosis of Suicide Attempt. She was discharged from the facility on 09-26-12

Patient ID # 23 was admitted to the facility on on [DATE] with a diagnosis of Psychotic Disorder. She was discharged from the facility on 09-21-12.

Interview on 10-31-12 at 11:30 a.m. with Medical Records Director ID # 27, she reported the Discharge Summary should be completed 3 weeks of discharge.

Review of facility policy titled " Discharge Summary, " revised 04/1, read: Discharge Summaries will be completed within the timeframe set forth in the Medical staff Rules ... "

Review of facility Medical Staff Rules & Regulations, revised October 2010 read: "F. Discharge Summary: A Discharge Summary shall be entered into the record of all patients hospitalized over 48 hours within twenty-one(21) days after discharge ... "

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5556 GASMER HOUSTON, TX 77035 | Proprietary

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Oct. 31, 2012 2 (click for details)
July 20, 2012 2 (click for details)
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No incomplete reports available.



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Report No. 1550

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SIERRA MEDICAL CENTER 1625 MEDICAL CENTER DR EL PASO, TX 79902

Oct. 30, 2012

VIOLATION: PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES

Tag No: A0122

Based on a review of facility policies, documentation, and interview, it was determined that the facility failed to ensure the grievance process was followed regarding time frames for response to a complaint.

Findings were:

Facility Based Policy entitled, " Grievance and Complaint Resolution " stated in part, " A. "Patient Grievance" is a formal or informal written or verbal complaint (when a verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient 's representative, regarding the patient 's care, abuse or neglect, patient harm, ...

V. Procedure

D. A response to the grievance will be provided within seven (7) business days. If the grievance will not be resolved, or the investigation not completed within 7 business days, the director/designee will inform the patient that the hospital is still working on it and will follow up with a written response within a stated number of days, not to exceed thirty (30) days ..."

Risk Management had documentation of several phone calls from the family of patient #1. On 07/10/12, in a phone call, the family expressed concerns over poor service.

The family of Patient #1 sent a letter to the facility 09/14/12 that stated in part, " ... From our understanding some internal action and peer review rating was given, which we were told is confidential information. Besides that, we do not understand what the final outcome of the review was, except that we could contact you ... My sister was released in a semi conscious state from your ER after having a Cat of her brain which we were told was normal. We want to know why 3 days later she was in a coma with no gag reflex due to a [DIAGNOSES REDACTED] the size of fist. We want to know what the final decision about her medical treatment was, what is to be done about what happened.

In a review of facility available documentation there was no written response provided related to the family's complaint/grievance within the time frame specified by facility based policy.

In an interview, Staff member #1 confirmed there was no written response to the complaint/grievance within the specified time frame.

VIOLATION: PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

http://www.hospitalinspections.org/report/1550[3/26/2013 11:24:23 AM]

Tag No: A0123

^{**}NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

Based on a review of facility policies, documentation, and interview, it was determined that the facility failed to ensure that with resolution of a grievance the patient and/or representative was provided a written notice of its decision that contained 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.

Findings were:

Facility Based Policy entitled, "Grievance and Complaint Resolution" stated in part,

"A. "Patient Grievance" is a formal or informal written or verbal complaint (when a verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient 's representative, regarding the patient 's care, abuse or neglect, patient harm, ...

V. Procedure...

I. Written notice of the hospital 's determination regarding the grievance will be communicated to the patient or patient representative in a understandable language and manner. The notice will contain:

1. The date of receipt of grievance;

- 2. The name of the hospital contact person and phone number;
- 3. The steps taken on behalf of the patient to investigate the grievance and date completed

4. The results of the grievance process and;

5. The date of completion.

J. The hospital 's response will include adequate information to address each and every item stated in the grievance. The response is not intended to be an exhaustive explanation of every action."

Risk Management had documentation of several phone calls from the family of patient #1. On 07/10/12, in a phone call, the family expressed concerns over poor service.

The family of Patient #1 sent a letter to the facility 09/14/12 that stated in part, " ...From our understanding some internal action and peer review rating was given, which we were told is confidential information. Besides that, we do not understand what the final outcome of the review was, except that we could contact you ...My sister was released in a semi conscious state from your ER after having a Cat of her brain which we were told was normal. We want to know why 3 days later she was in a coma with no gag reflex due to a [DIAGNOSES REDACTED] the size of fist. We want to know what the final decision about her medical treatment was, what is to be done about what happened."

In a review of available documentation there was no written notice of the facility's grievance resolution that contained 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 provided to the complainant. The letter from Patient #1's family specifically requested follow up regarding the results of the investigation.

In an interview, Staff member #1 confirmed there was no written notice of the facility's grievance resolution that contained 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 provided to the complainant.

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No incomplete reports available.



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Tag No: A0438

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PROVIDENCE MEMORIAL HOSPITAL ->

Report No. 1454

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PROVIDENCE MEMORIAL HOSPITAL 2001 N OREGON ST EL PASO, TX 79902 Oct. 29, 2012

VIOLATION: ADMINISTRATION OF DRUGS Tag No: A0405

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview, it was determined that facility staff failed to follow physician orders.

Findings were:

Facility policy entitled "Physician Orders: Receiving, Transcribing "stated the following: "Policy - Prompt and accurate transcription of the physician orders facilitates delivery of quality patient care ...Purpose - To outline the responsibilities in receiving, transcribing and noting of physician orders ...1. Orders written on the physicians order sheet will be acknowledged as soon as possible. "

Review of patient #1's medical record on 10/29/12 revealed the following:

- A " Physician Orders " sheet indicated that blood glucose checks " AC&HS " (before meals and at night), and an insulin sliding scale were ordered on [DATE] at 4:21 PM.
- The patient 's " Point of Care Testing " notes and medication administration records revealed the following: On the night of 7/9/12 no evidence of a blood glucose check was evident; according to the physician orders the patient should have had a blood glucose check that night.
- Ŏn the morning of 7/10/12 at 7:10 AM the patient 's blood glucose level was documented as 179 and no insulin was administered; according to the physician orders the patient should have received 2 units of insulin.

The above findings were confirmed in an interview with the Risk Manager on 10/29/12.

VIOLATION: FORM AND RETENTION OF RECORDS

Based on record review and interview, it was determined that the facility failed to ensure that nursing staff accurately documented notes in the medical record.

Findings were:

Facility policy entitled " Daily Documentation (Nursing Notes) ", reviewed on 10/29/12, stated the following: "Policy - Nursing documentation will be done each shift with reassessments occurring at change of shift, change of caregiver, change in condition, prn or per physician 's order ...1. Daily assessments and/or reassessments will be done at change of shift, change of caregiver, change in status, prn or per physician 's order. An RN must do an assessment/reassessment on patients at least every 24 hours."

Review of patient #1's record on 10/29/12 revealed that a nurse inaccurately documented patient discharge information in the medical

- record:
 The " Discharge Assessment: Discharge Summary " dated 7/11/12 at 10:47 AM indicated that the patient 's mode of discharge was by a "Wheelchair".
 A " Clinical Documentation-Nursing Note " dated 8/20/12 at 10:56 AM stated the following " It was noted in the discharge instructions that patient left via wheelchair because instructions were completed in computer before patient decided to get copy of labs. Patient left unit walking as he was directed to medical records to request desired information."

The above findings were confirmed in an interview with the Risk Manager on 10/29/12.

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Incomplete reports

No incomplete reports available.

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BAPTIST MEDICAL CENTER ->

Report No. 1482

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BAPTIST MEDICAL CENTER 111 DALLAS STREET SAN ANTONIO, TX 78205 Oct. 25, 2012

VIOLATION: ADMINISTRATION OF DRUGS Tag No: A0405

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview, there was no documentation available to confirm that nursing staff administered patient #1's vaccine as ordered by physician #1.

Findings included:

Record review on 10/16/12 of patient #1's medical chart revealed a physician's order written by physician #1, dated 04/19/12 at 0400 AM, that included but was not limited to the following: DTaP ([DIAGNOSES REDACTED], Tetanus and Pertussis) IM (Intrmuscular) times 1 now.

Record review of patient #1's medical chart did not reveal documentation of nursing staff administering the ordered vaccine.

Record review of patient #1's History and Physical, dated 04/19/12 at 0345 AM and completed by physician #1, revealed the following: "Patient #1 is a [AGE] year old female with past history of hypertension and anxiety, who presents to the Emergency Department complaining of some low grade fevers and infection of her thumb. She states that her cat bit her on the thumb and the tooth went through and through the flesh. She states that over the past several days, the wound has progressively become more painful and swollen and there is some red streaking starting to go up her arm. She is being admitted for IV antibiotics."

Interview by phone on 10/25/12 at approximately 10:00 AM with the Director of Risk Management revealed that she would review patient#1's chart to determine if there was written documentation of patient #1 receiving the DTaP vaccine. She confirmed the nursing staff should have documented the vaccine as given according to physician #1's order.

Record review of an email from Director of Risk Management, dated 10/25/12 at 6:49 PM confirmed the administration of the DTaP vaccine was not documented by nursing staff in patient #1's record.

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MEDICAL CENTER OF PLANO ->

Report No. 1546

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MEDICAL CENTER OF PLANO

3901 W 15TH ST PLANO, TX 75075

Oct. 23, 2012

Tag No: A0144

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on documentation and an in-person interview with the Director of Critical Care on the evening of 10/23/12 at the facility; the Governing body failed to ensure that all services were safely provided as patient number #1 had a documented allergy to latex. A latex Foley was placed into patient #1 on 06/16/12 in the Emergency Department.

Findings were: Review of emergency nurse progress notes stated; 6/16/12, 2230 Allergies Latex. 22:36 Identification band and allergy band placed on patient. 2315, 16 French Foley catheter placed.

An in-person interview was conducted with the Director of Critical Care on the evening of 10/23/12 at the facility it was confirmed that a

Foley containing latex was placed into patient # 1.

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Report No. 1512

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BAYLOR MEDICAL CENTER AT GARLAND

2300 MARIE CURIE DRIVE GARLAND, TX 75042

Oct. 22, 2012

Tag No: A0386

Tag No: A0457

VIOLATION: ORGANIZATION OF NURSING SERVICES

Based on review of documentation and interviews with facility staff, the facility failed to clearly delineate responsibilities for patient care as the facility procedure for bowel management system rectal tube insertion did not specify what staff could perform the procedure, contraindications to the procedure, or if a physician order was required. Registered Nurse (staff #1) placed a bowel management system rectal tube in patient #1 without a physician's order which resulted in a vaginal vault laceration in patient #1.

The findings were:

The facility procedure entitled "Mosby Skills - Bowel Management System (BMS)" with a revision date of September 2010 was reviewed on 10/22/12. The procedure did not specify what staff could perform the procedure, contraindications to the procedure or if a physician order was required for insertion of the bowel management system rectal tube.

The medical record of patient #1 was reviewed on 10/22/12. The ER (emergency room) nurses' note dated 8/17/12 1555 by registered nurse staff #1 reflected in part "Pt (patient) with full yellow liquid diaper. Cleaned pt and placed (size) 16 Foley cath (catheter) with sterile technique done. Rectal tube placed and filled reservoir with 45 cc (cubic centimeters) H2O (water). At 8/17/12 1900 "Report called to ICU nurse. Pt with no changes. NAD (no apparent distress) noted."

The Admission Physician Orders dated 8/17/12 6:35 pm written by physician staff #2 reflected in part "Insert Indwelling Urinary Catheter." The record did not contain an order for a rectal tube.

A GYN Progress Note dated 8/18/12 1200 by physician staff #3 reflected in part "In ER was noted to have profuse diarrhea. Rectal tube was inadvertently placed in vagina. On arrival to ICU, was noted to have vaginal bleeding and clotsVaginal vault laceration secondary to placement of rectal tube."

Staff #1 was interviewed on 10/22/12 at 12:50 pm and was asked if there was a physician's order for the rectal tube. Staff #1 stated it was a nursing intervention and no order was needed. Staff #1 stated ICU nurses at the facility put in rectal tubes as indicated without physician orders. Staff #1's personnel file was reviewed on 10/22/12 and reflected a previous assignment in the ICU.

The interim Chief Nursing Officer, staff #4, was interviewed on 10/22/12 at 2:10 pm. Staff #4 was asked what the facility policy was regarding if a physician order was required for a nurse to insert a rectal tube. Staff #4 stated a written policy could not be found that showed that either a physician order was required or was not required for the procedure. Staff #4 stated the practice in ICU was that nurses inserted rectal tubes using their nursing judgment without a physician order. Staff #4 also stated that invasive procedures involving inserting something in a body cavity usually required a physician order.

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

Based on review of documentation and interviews with facility staff, the facility failed to ensure that verbal orders were authenticated within

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48 hours as 8 of 21 verbal orders in the medical record of patient #1 were not authenticated within 48 hours.

The findings were:
The medical record of patient #1 was reviewed on 10/22/12. The record of patient #1 contained 21 verbal physician orders. 8 of the 21 verbal physician orders were not authenticated within 48 hours.

In an interview with staff #5 on 10/22/12 at 1:45 pm, staff #5 confirmed there were verbal orders in the record that were not authenticated within 48 hours.



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Report No. 1477

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SCOTT & WHITE MEMORIAL HOSPITAL

2401 31ST ST TEMPLE, TX 76508

Oct. 10, 2012

Tag No: A0395

VIOLATION: RN SUPERVISION OF NURSING CARE

Based on review of clinical records, hospital policies, and staff interviews, the hospital failed to ensure that a registered nurse properly supervised and evaluated the nursing care for each patient, as there was no documented evidence that patient was monitored with hourly rounding and there was no nursing documention of a fall, physican notification, or assessment of the patient post fall. Findings were:

Review of facility policy, Nursing Assessment, Reassessment and Admission, stated, in part, " 5. Reassessment of the patient 's needs may occur for many reasons including the following;

a. To evaluate the response to care, treatment, and services;

b. B. To respond to a significant change in status and/or diagnosis or condition;

c. C. To satisfy legal or regulatory requirements; d. D. To meet the time intervals specified by the institution;

e. E. To reevaluate pain at subsequent intervals based on the patient 's presenting needs.

6. Patient needs identified through the assessment and reassessment serve as the basis for an individual plan of care.
Review of facility policy, Nursing Documentation, stated, in part, "Reassessment is documented when the patient 's level of care changes, at change of shift, and as the patient 's condition warrants."

Patient #1 sustained a fall in the evening on 07/13/12 according to physician documentation. Event Progress note completed by the DO, dated 7/13/12 at 2001, stated, "called to patient room after she sustained a falling (sic) while trying to get to restroom. She fell on her bottom, hitting the left bottom cheek. She did not loose (sic) consciousness or hit her head. Also complaining of some low back pain that has been worsening as the day progressed.

Exam: Hematoma to left bottom. No broken skin, no redness, Tender to palpation. Deep palpation to secondary tissue not tender. No active bleeding. Slight tender to palpation suprapubic."

Review of Patient #1's medical record revealed, nursing assessments performed every shift on 07/12/12 through 07/13/12 indicating that Patient # 1 was identified as a fall risk. The Fall Risk Assessment for both days included " hourly rounds " with " yes " indicated. 2 Pain Assessments were completed on 07/13/12 at 21:49 and 22:49 stating the patient reported pain to the sacrum. According to nursing documentation, Patient #1 was transferred to the 5th floor on 07/13/12 at 2240. The Nursing Assessment performed upon transfer on 07/13/12 at 22:40, included the flowing integumentary notation " " Skin integrity- bruise-left gluteal ". Nursing Note date 07/13/12 at 22:48 stated, " Patient temp 100.4. Notified Dr. Brackman and informed of temp. New order for Motrin 600 mg PO X 1 NOW. Order noted. Request a X-ray to bruised area on left gluteal r/t fall. Dr. Brackman stated not at this time due to injury is to soft tissue and not to coccy or other bony primises (sic). No further orders at this time. " to soft tissue and not to coccyx or other bony primises (sic). No further orders at this time. "

A review of all nursing documentation for 07/13/12 and 07/14/12 revealed no documented description of the actual fall event which

occurred on the evening of 07/13/12. There was no documented notification of the physician or physical assessment of the patient post

In an interview with Staff member # 1, on 10/1012 at 1100, she stated that " hourly rounds " are currently included in the nursing assessment. The hourly rounds are not currently documented in the medical record, logged, or tracked by the facility.

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Report No. 1511

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BAYLOR MEDICAL CENTER AT GARLAND

2300 MARIE CURIE DRIVE GARLAND, TX 75042

Oct. 2, 2012

VIOLATION: OPERATING ROOM POLICIES

Tag No: A0951

Based on review of documentation, and an interview with the Chief Nursing Officer/Chief Operation Officer, the facility failed to maintain a safe standard of medical and patient care; patient # 1 sustained burns to the neck, ear, and shoulder during a surgical procedure on 07/31/12 at the facility.

Findings were:

Review of Skin Prep policy and procedure, revised 2011 stated, "To provide guidelines for preparation of operative sites. Purpose

prepare operative sites prior to all surgical procedures and render the operative site as free as possible from bacteria. Gentle preps should be done for all neck surgeries or suspicious lesions. Allow drying time for prep before draping. "
Review of Electrosurgical Safety, revised 2011 state, " purpose is to ensure safe functioning of the electrosurgical unit and to provide a safe exit for electrical current. Vi. When using flammable liquids directly on skin, allow time for evaporation before activation."
Review of facility documentation root cause and analysis 08/14/12 stated, " The choraprep may have not dried completely before the incision was made with the cauther. A large foam neck pillow was used to help support the head. Adequate padding behind the head was required to allow the head not to hang free. Patient was induced under anesthesia and when that was done patient was given 100% oxygen.'

Review of operative Report 08/01/12 stated, " Patient #1 was brought to the operation suite due to a significant cervical stenosis and fusion, patient # 1 had to have adequate padding behind the head to allow the head not to hang free, an incision was made and cautery was used to go through the fat, in the first seconds of cauterization patient # 1 was noted to have some burning sweet smell and then noted smoke.

In an in-person interview with the Chief Nursing Officer/Chief Operating Officer on the morning of 10/02/12 at the facility it was confirmed that patient # 1 sustained burns to the neck, ear, and shoulder during the surgical procedure on 07/31/12 at the facility.



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Tag No: A0396

Tag No: A1077

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BAPTIST MEDICAL CENTER ->

Report No. 1481

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BAPTIST MEDICAL CENTER 111 DALLAS STREET SAN ANTONIO, TX 78205 Sept. 25, 2012

VIOLATION: NURSING CARE PLAN

- 1. Based on reviews of medical records, policies and procedures, and staff interviews Baptist Medical Center Outpatient Endoscopy Lab failed to conduct a nursing assessment and develop a nursing care plan. The findings included:
- a. A review of the medical record conducted with staff members # 1 and # 2 on 9/25/12 at 10:00 in the hospital's conference room revealed the nursing staff failed to conduct a nursing assessment and develop a care plan to prevent the patient from falling out of bed. Available information from the patient's primary care physician including her diagnosis of "advanced dementia" and family members who accompanied the patient and capable of providing historical medical and injury information were not utilized until after the patient was injured.
- Endoscopy Lab revealed the nursing staff failed to perform basic fall prevention measures and there was no evidence the nursing staff conducted a nursing assessment prior to the planned outpatient procedure Esophagoscopy Gastroscopy Duodenoscopy (EGD) or updated nursing plan of care that incorporated the patient's history of recent falls
- nursing plan of care that incorporated the patient's history of recent falls.

 c. Staff interviews conducted with staff members # 3 and # 4 conducted on 9/25/12 at 11:45 a.m. in the Endoscopy Lab revealed they witnessed the patient fall onto the floor that resulted in the patient suffering fractures to the face and wrist as well as sutures to repair a laceration to the face. Both staff members also acknowledged the fall could have been prevented if the bed rails had been up and in the locked position. After their own review of the findings staff members #1 and #2 agreed the nursing staff failed to properly assess the patient and to develop and implement a nursing plan of care to meet the patient's needs.

VIOLATION: INTEGRATION OF OUTPATIENT SERVICES

- 1. Based on medical record reviews, reports, policies and procedures, and staff interviews Baptist Medical Center failed to integrate acceptable nursing standards of practice and patient safety measures in the outpatient departments offered by the hospital. The findings included:
- a. Review of the patient's medical record conducted on 9/24/12 and again on 9/25/12 with staff member # 1 in the hospital's conference room revealed the Endoscopy Lab nursing staff failed to conduct a comprehensive nursing assessment prior to performing an outpatient procedure capable
- of identifying the patient at a high risk for falls. Further reviews revealed there was also no evidence the staff utilized tools established by the hospital to develop and implement a nursing care plan to meet the patient's immediate and post procedure needs.
- b. A review of the hospitals policies and procedures and training reports conducted on 9/25/12 in the conference room with staff member # 1 revealed the nursing staff of the endoscopy lab were recently trained in assessing and implementing high risk fall preventive measures. Staff member # 1 acknowledged the hospital was actively expanding these standard measures for inpatient services to the outpatient departments and were approximately 90% complete.
- c. Interviews with staff members # 3 and # 4 conducted on 9/25/12 at 11:50 a.m. revealed they both failed to implement basic fall prevention measures, did not utilized established protocols to identify patients at an advanced risk for falls or post fall procedures.

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AHCJ unveils HospitalInspections.org



The Association of Health Care Journalists has launched hospitalinspections.org, a free, searchable news application that compiles thousands of federal inspection reports for hospitals around the nation since January 2011.

The move follows years of advocacy by AHCJ urging the government to release the deficiency reports in an

electronic format. Until now, reporters and the public had to file Freedom of Information Act (FOIA) requests to the Centers for Medicare and Medicaid Services (CMS) to obtain the documents, a process fraught with delays that can stymie timely public knowledge of problems at hospitals.

Health Journalism 2013

- See coverage of the conference
- Program

More than 750 people attended AHCJ's annual conference at the Seaport Boston Hotel and the adjacent Seaport World Trade Center.

Journalists participated in skill-building workshops and panel discussions. Many of them visited area research sites on Wednesday. Winners of the Awards for Excellence in Health Care Journalism were recognized at Saturday's

luncheon. On Sunday, the conference concluded with the association's traditional "How To" sessions. The conference featured world-class speakers, important news briefings and helpful sessions all aimed at aiding reporters, editors and news producers in better covering the latest health issues.

Secrets of pitching: Tips, tricks and insight into editors' minds



Recorded March 5

For freelancers and potential freelancers, pitching is job No. 1. AHCJ knows that; that's why every year, our annual Health Journalism conference offers Freelance PitchFest, which puts you face-to-face with some of the biggest health editors in the country. Members attending PitchFest know they have to be ready to make a good impression in minutes — and members who won't be attending the conference, but are busy freelancers, want to know more about pitching too. AHCJ has your back with a webcast on pitching health stories that sell,

featuring three top editors.

2012 winners named in top health journalism awards

An investigation revealing concerns about unnecessary treatments by private dental firms - along with stories showcasing the enormous financial toll of medical care and the cost of dying - were among the top winners of this year's Awards for Excellence in Health Care Journalism.



First-place awards also went to a series that investigated long-forgotten lead factories and the dangers they pose to nearby residents, coverage of the compounding pharmacy linked to the national outbreak of fungal meningitis, the toll obesity is taking on residents of one state and the effect of violence against those living with HIV.

Webcast on global aging issues

One key issue addressed at the recent World Economic Forum was the rapidly increasing global aging population; and how to prepare for its profound impact on global health, as well as the direct economic, social and political implications.

Global experts from the WEF Global Agenda Council on Ageing

Health Reform

Aging

Oral Health

Medical Studies

Other Topics

COVERING HEALTH An AHCJ blog

Snapshots from #ahcj13 | Tom Parks

Tom Parks, health editor at SmartBrief, Charlotte, N.C.: What is the most pressing health issue in your community? The rejection of Medicaid ...

Snapshots from #ahcj13 | **Rhonda Stewart**

Which Health Journalism 2013 session did Rhonda Stewart like best? Hint: It involves global health. The Health Journalism 2013 Conference might be ...

Funding a critical issue in strengthening oral health #ahcj13

Often overlooked in overall health is the importance of oral health. But 100 million Americans lack dental benefits, and in 2009, there were 830,000 ..

Using Twitter, LinkedIn to diversify your sources #ahcj13

At KQED Public Radio's The California Report in San Francisco. part of my job is to connect with communities across California and

Experts call for changing culture of youth sports to reduce dangerous injuries #ahcj13

Organizers of youth baseball leagues learned a simple truth over time that if they let a pitcher throw without any limits, he was more likely to ...



Reporting Guides



Recorded Feb. 27

presented a report outlining key challenges/opportunities associated with global aging, including how to improve healthy aging through the innovation of global health systems and

investment in long-term health options; as well as specific initiatives to seize the social and economic opportunity created by the aging population.

A recording of this webcast will be available soon.

Reporter's guide to health care antitrust issues

We don't normally think about local hospitals as cutthroat competitors seeking to put rivals out of business or operating monopolies that can charge whatever they wish because they've bought, intimidated or frightened away competition.

But anticompetitive behavior can exert real impact on health care pricing, access and quality of care.

As Mark Taylor tells us in this comprehensive tip sheet, antitrust issues are among the most underreported stories in health care. And that's a shame because, at their core, health care antitrust stories often include classic elements



Photo by afagen via Flickr

of conflict, greed, conspiracies, collusion and intense rivalry. Millions, even billions, of dollars are at stake. Find out what stories you might find in your community.

Tip sheet:

Caregiving comes to the forefront of issues around aging

The challenges of caregiving are getting new attention from AARP and the federal government as baby boomers struggle to assist their aging, ailing parents. A recent ad campaign featured caregivers screaming silently in frustration over responsibilities such as taking a parent to the doctor or dealing with medical bills, while AARP expanded its resource center on caregiving.

Now, Judith Graham and Eileen Beal share facts, studies, story ideas and lots of resources for reporters to cover caregiving issues. This is a big topic that will only continue to grow in importance as the baby boomers age.

'A Life Hijacked:' Project documents man's saga with Alzheimer's



Gary Rotstein

Gary Rotstein, the Pittsburgh Post-Gazette's age beat reporter, has been following and writing about Alan Romatowski, a man with early-onset Alzheimer's disease since July 2008. His series, updated each Thanksgiving weekend, is a long-running chronicle of Romatowski's experiences, his decline, the impact on his family and others, to show what so many American families increasingly experience among the 5 million-plus dementia cases.

Rotstein writes for AHCJ about how the project got started, how he's handled telling the family's story sensitively and the kinds of stories he has written about Romatowski and his family.



Daniel J.

Tips on covering medical studies on a deadline

Deadline in a few hours? "Don't panic" is bad advice. It's not even possible when deadline looms and nobody has called you back. Managing that hot little ball of panic is key. Think of it as a controlled nuclear reaction from which you can draw energy.

DeNoon

Award-winning health reporter Daniel J. DeNoon shares his straightforward strategy for reporting and writing a news story about a journal article while on deadline.

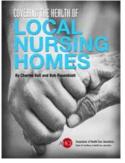
He has tips about what parts of the study to read first, how to find experts to comment, how many people to interview and how to convey the importance of your deadline to your sources

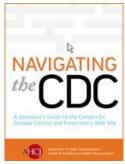
New resource will help reporters cover medical research

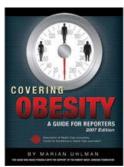
AHCJ has rolled out another Core Curriculum topic on its website. "Covering Medical

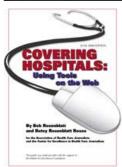


COVERING









Studies" is the fourth in a series of core topic subject areas making up the curriculum. It is one of at least a dozen key subject areas the organization believes today's health journalists will need to master to cover the beat well.

"Journalists are inundated daily with the latest medical studies," said Len Bruzzese, executive director of AHCJ and its Center for Excellence in Health Care Journalism. "AHCJ has long promoted the need to understand the essential building blocks of covering medical studies. At the same time, we have tried to teach that such coverage comes with a certain responsibility to keep this information in context. This core topic content will serve both demands."

Evaluate, report on quality of hospitals in your area

AHCJ offers hospital mortality and readmission data, which will allow you to tell your audience whether a hospital's rates are in line with national averages, significantly better or significantly worse. A special AHCJ webinar provided an introduction to this data, including ideas on how to use the data in your own area.

The federal survey that reflects patients' perspectives of hospital care has been updated on the AHCJ website. The spreadsheets that AHCJ offers allow you to analyze the top-rated hospitals — or lowest-rated hospitals — in your State-by-state breakdown of how patients rate hospitals, according to HCAHPS survey

Graphic via OpenHeatMap

Need help analyzing data? AHCJ has tip sheets to help, including "Finding patterns and trends in health data: Pivot tables in spreadsheets" and "Intro to investigating health data using spreadsheets." Links to the data and the relevant tip sheets are all on the Data page.



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AHCJ makes Nursing Home Compare data easier to analyze



Find stories with ready-to-use Hospital Compare data

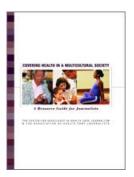
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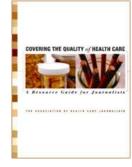


- Covering Medical Research
- Covering the Health of Local Nursing Homes
- · Navigating the CDC: A Journalist's Guide to the CDC Web Site
- Covering Obesity: A Guide for Reporters
- · Covering Hospitals: Using Tools on the Web

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AHCJ's training includes annual conferences, regional conferences, one-day workshops, panel discussions, webcasts, online training modules and more.

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The Association of Health Care Journalists offers a wide range of resources - many of which are available exclusively to members.

AHCJ publications include our quarterly newsletter, HealthBeat, as well as several guides to covering specific aspects of health and health care

Members share ideas and ask questions of fellow members on the AHCJ electronic mailing list. Tip sheets are prepared for our conferences and workshops, often offering sources and information about covering specific stories.

Contest entries are from the Awards for Excellence in Health Care Journalism, recognizing the best health reporting in print, broadcast and online media. We have links to past winners and information culled from questionnaires submitted with the entries about how each story was researched and written.

We include links to some recent reports and studies of interest to our membership, as well as links to Web sites relevant to health

Members and other journalists write articles specifically for AHCJ about how they have reported a story, issues that our members are likely to cover and other important topics.

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Associate Editor/Editor	iHealthBeat	Full- time	Washington, DC	02/20/13
Editor	QuantiaMD	Full- time	Waltham, MA	02/19/13
Editor-in-Chief	California HealthCare Foundation Center for Health Reporting	Full- time	Los Angeles, CA	02/14/13
Associate Editor	Cancer Today	Full- time	Philadelphia, PA	01/30/13
Senior Writer	American Hospital Association	Full- time	Chicago, ID	01/29/13
Editor, Chief	Medical Daily	Full- time	New York, NY	01/24/13
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Health Research Institute Director	PricewaterhouseCoopers LLP	Full- time	Dallas, TX	01/14/13

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Report No. 1476

on doing so is available here.

<u> SCOTT & WHITE MEMORIAL HOSPITAL</u> ->

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information

SCOTT & WHITE MEMORIAL HOSPITAL 2401 31ST ST TEMPLE, TX 76508

Sept. 19, 2012

VIOLATION: PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT

Tag No: A0145

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of documentation and interviews with staff, the facility failed to protect the rights of patient #1 to be free from physical abuse by a staff member. The facility also failed to follow their own policy.

Findings included:

Facility document entitled Patient Rights and Responsibilities with a revised date of 09/2012 stated, "I. Policy: The organization believes that patients have certain rights and responsibilities while under our care and service. These rights and responsibilities are codified in State and Federal regulations, as well as accreditation standards." Further review of the policy stated, "III. Procedure: A. The Patients have the right to: 16. Be treated with dignity, courtesy, consideration, and respect ... 18. Be free from neglect; exploitation; verbal, mental, physical, and sexual abuses; and/or harassment."

During the investigation that the staff member #1 hit patient #1 the following was revealed:

- 1. A review of the clinical record of Patient #1 revealed he was a 5 year old boy who presented to Scott & White hospital on [DATE]. He was scheduled to have a MRI with sedation.
- 2. Nurse's notes dated 07/11/2012 at 11:00am revealed the staff member #1 documented the patient and the mother arrived to the unit, vital signs were taken, child had nothing to eat by mouth, the nurse verified allergies and patient identification, and EMLA cream applied to 2 areas. The next nursing documentation was at 12:00pm when another nurse noted the IV was in the right hand and sedation was started at the bedside. There was no documentation in the patient's medical record that patient #1 was combative at any point during the admission.
- 3. Review of facility emails from nursing staff to staff members #6 and #7 revealed the nursing staff submitted to their supervisors their view of the incident. The staff members stated they witnessed staff member #1 "slap" or "swat" the hand of patient #1.
- 4. In in person interviews with staff members #2, #3, and #4, it was revealed the staff members witnessed staff member #1 "slap" or "swat" the hand of patient #1.

The above was confirmed in interviews with the administrative staff members #6 and #7 the afternoon of 9/19/2012.



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EAST TEXAS MEDICAL CENTER ->

Report No. 1488

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

EAST TEXAS MEDICAL CENTER 1000 SOUTH BECKHAM STREET TYLER, TX 75701 Sept. 5, 2012

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on document review and interview the facility failed to insure the daily hygiene needs of 1 of 1 patients was met.

On 9/6/2012 a written complaint was received to the investigating authority that patient #2 was found with feces between her legs with prescription ointment applied over the feces. Family reported this information was told to the shift nurse who stated she had seen it and reported it to the house supervisor. The staff nurse, having knowledge of the feces with the medicated ointment over it, did not provide hygiene services for the patient after she reported it to the house supervisor.

On 9/12/2012 a thorough review of the patient's Electronic Medical Record (EMR) revealed:

- Patient #2's respiratory status was maintained via ventilator.
 Patient #2 was maintained with sedation while on the ventilator and unable to make her needs known.
- no documentation personal hygiene, such as a bath, was provided.
 -The Braden scale found in the EMR recorded the patient was bed bound, incontinent of bowel and had a Foley catheter.
- -The EMR also revealed the patient was unable to turn herself and unable to meet her daily hygiene needs.
- -The EMR also recorded the patient had no skin break down upon admission other than a surgical incision and drainage of a facial abscess, however, patient #2 developed a stage II pressure ulcer on her right buttock, which required debridement.

On 9/12/2912 at 11:00 am, an interview with RN #3 confirmed no daily hygiene was recorded and the Braden scale reflect a dependent patient that was a high risk for skin break down. RN #3 confirmed the patient did in fact develop a stage II pressure ulcer on her Right buttock. RN #3 confirmed she was not aware of a policy for documentation of daily hygiene needs of the patient

On 9/13/2012 at 10:00 AM, an interview with RN #2 also confirmed the patient was discharge from the acute hospital to a long term acute hospital with a stage II pressure wound that was not present upon admission

VIOLATION: RN SUPERVISION OF NURSING CARE

Tag No: A0395

Tag No: A0144

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on document review and interview the facility failed to insure the Registered Nurse assessed and evaluated the needs of 1 of 1 patients identified.

On 9/12/2012, the Electronic Medical Records (EMR) of patient #2 was reviewed and the following was documented in the EMR:

-Pt #2 was admitted on [DATE] and the initial nursing assessment records the patient weighed 187 kilograms (kg) (1 kg = 2.2 pounds (lbs)), 187 kg x 2.2 lbs = 411.4 lbs, and had no skin break down other than the surgical wound to the right jaw.

- -The family members complain the patient had a foul odor during the first week after admission.
 -The first record of patient #2 skin break down is recorded in the EMR 8 days after admission, on 8/12/2012.
- -On 8/12/2012 the EMR for patient #2 records 3 areas of skin integrity compromise.
- -Left (Lt) breast skin fold 14 centimeters (cm) x 5 cm open and draining

- -Right (Rt) breast skin fold 14 cm x 3 cm open and draining
 -Right buttocks 16 CM x 14 cm open draining hematoma
 The EMR records nurses applied "skin barrier" (a heavy cream based ointment) to the skin folds of the patient's breast.
- -On 8/17/2012 the EMR recorded the following: -Lt and Rt breast improved with use of Nystatin powder.

The patient's Rt buttock continues to deteriorate without successful pressure reduction and on 8/19/2012 the patient's Rt buttock is debrided at the bedside by Physical Therapy (PT). The EMR recorded the resulting wound measures "11.5 cm in length".

On 8/21/12 patient #2 is transferred to a long term acute care facility and the EMR revealed the wound measures 12 cm x 8 cm with continued pressure necrosis visible on the photo.

On 9/5/2012 at 10:00 AM in the conference room RN #3 confirmed there was no documentation in the EMR that the nurses recorded any nursing intervention for pressure reduction and off loading other than a bariatric bed that offered some pressure relief.

Further discussion with RN#3 confirmed there was no recorded assessment, evaluation or interventions provided patient #2 for frequent episodes of fecal incontinence. There was no recorded skin care for daily hygiene. The nursing staff did not document the physician was notified of the patient's fecal incontinence, that was no longer formed, but had become liquid.

Tag No: A0396

Tag No: A0468

Tag No: A0952

VIOLATION: NURSING CARE PLAN

Based on record review and interview the facility failed to develop and keep current the nursing care plan for 1 of 1 patients identified.

On 9/5/2012, the electronic medical record (EMR) for patient #2 was reviewed. The EMR revealed the care plan was identified by topical reference only. There were no interventions located in the EMR for the following:

-Alteration in skin integrity established 8/4/2012 post op surgery for Incision and Drainage of abscess on right jaw line. Nothing was identified for the decubitus of right buttocks identified in the nurse's note on 8/12/2012 or beneath bilateral breast identified on 8/10/2012 in the nurses note. No nursing intervention or care plan updates were located in the EMR for patient #2.

On 9/5/2012 at 10:00 AM in the conference room, RN #3 confirmed there were no interventions or updates for patient #2 care plan.

On 9/5/2012 at 1:00 PM RN #2 confirmed there were no nursing interventions recorded or updates recorded on patient #2 care plan.

VIOLATION: CONTENT OF RECORD - DISCHARGE SUMMARY

Based on document review and interview the facility failed to insure a discharge summary was available on 1 of 1 patient medical record reviewed.

On 9/12/2012, the Electronic Medical Record (EMR) for Patient #2 was reviewed and no discharge summary was located in the EMR.

On 9/12/2012 at 10:00 AM in the conference room RN #3 confirmed no Discharge summary was to be found in the EMR.

VIOLATION: HISTORY AND PHYSICAL

Based on record review and interview the facility failed to insure a history and physical (H&P) was completed prior to surgery in 1 of 1 patient medical record reviewed.

On 9/5/2012, the Electronic Medical Record (EMR) was reviewed for patient #2. No H&P was located within the EMR for patient #2 who was seen in the Emergency Department (ED) on 8/4/2012 for painfull right mandibular facial area and subsequently taken to surgery for extraction of tooth #30 and Incision and Drainage of the underlying abscess.

On 9/5/2012 at 10:00 AM, RN #3 confirmed no H&P was located for patient #2 within the EMR.

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Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

No incomplete reports available.

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TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON ->

Report No. 1566

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

TEXAS HEALTH PRESBYTERIAN HOSPITAL **DENTON**

3000 N I-35 DENTON, TX

Aug. 30, 2012

76201

VIOLATION: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Tag No: A0308

This STANDARD was not met as evidenced by:

Based on interview and Contract Clinical Record review, The governing body did not ensure that a contractor of services furnished service that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services, which includes demonstrated involvement in its QAPI program, citing 3 of 3 reports for July 2012.

Findings included:

- 1. Monthly Environmental Testing Log for July 2012 revealed equipment # H11 microbial culture redrawn on 7/9/12 microbial culture results were >600 CFU/ml with a contamination level >200 CFU/ml. (Action level required for disinfection of equipment re-culture and Equipment pulled from service where possible). There is not a date recorded in the contractor log when the equipment was removed and replaced with back up equipment necessary for patient safety requirements.

 2. Monthly Environmental Testing Log for July 2012 revealed equipment # H20 microbial culture redrawn on 7/13/12 microbial culture results were >600 CFU/ml with a contamination level >200 CFU/ml. (Action level required for disinfection of equipment re-culture and
- Equipment pulled from service where possible). There is not a date recorded in the contractor log when the equipment was removed and replaced with back up equipment necessary for patient safety requirements.
- 3..Monthly Environmental Testing Log for July 2012 revealed equipment # R.O. 47(Reverse Osmosis) microbial culture redrawn on 7/9/12 microbial culture results were >600 CFU/ml with a contamination level >200 CFU/ml. (Action level required for disinfection of equipment re-culture and Equipment pulled from service where possible). There is not a date recorded in the contractor logs when the equipment was removed and replaced with back up equipment necessary for patient safety requirements.

During an interview with the contracted Chief Bio-Medical Technician, (Staff # 4) on 8-29-12 at 2:15 PM confirmed the above findings. The Chief Bio-Medical Technician stated he had not documented the date and replacement of back up equipment on contractor logs.

During an interview with the Quality Staff of the acute care facility, (Staff # 5) on 8/30/12 at 1040 AM confirmed that the above findings had not been received in a timely manner from the contracted service for the hospital QAPI team to trend, analize, and evaluate and that there is not a mechanism in place for the monthly review of QAPI from the contracted services with the hospital quality program.



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TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON

3000 N I-35 DENTON, TX 76201 | Voluntary non-profit - Private

View hospital's federal Hospital Compare record

Report date Number of violations

Aug. 30, 20121 (click for details) Read full report May 7, 2012 1 (click for details) May 19, 2011 3 (click for details) Read full report Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the

actual reports from CMS or your state health department.

Incomplete reports

No incomplete reports available.



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RIVERSIDE GENERAL HOSPITAL ->

Report No. 1524

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RIVERSIDE GENERAL HOSPITAL

3204 ENNIS ST HOUSTON, TX 77004

Aug. 6, 2012

VIOLATION: POSTING OF SIGNS

Tag No: A2402

Tag No: A2403

Based on observation and interview, the facility failed to post in the emergency department the required signage regarding patient rights with respect to examination and treatment for emergency medical conditions and women in labor.

Findings include:

TX # 074

On 08-06-12 at 10:30 a.m. during a tour of the facility's Emergency Department and patient entrances, observation failed to reveal required Emergency Medical Treatment and Labor Act (EMTALA) signage informing patients of their rights with respect to examination and treatment for emergency conditions and women in labor.

Interview on 08-06-12 at 3:00 p.m with Director of Nurses (DON) ID # 52, she stated the facility did have the required EMTALA signs posted but they must have been removed when the walls were painted. She went on to say she was aware of the requirement, as the emergency room had a Level IV trauma designation.

VIOLATION: HOSPITAL MUST MAINTAIN RECORDS

Based on record review and interview, the facility failed to maintain a medical record for 1 of 4 sampled patients (Patient ID # 4) who had been transferred to other facilities from the hospital 's ER.

Findings include:

TX # 074

On 08-06-12 review of the facility 's Emergency (ER) Log for 2011-2012 revealed four (4) patients were transferred to other facilities (Patient ID # 4, 7, 10, 12).

Further review of the ER Log revealed Patient ID # 4 was seen in the ER on 05-02-12. The documentation read: " codes blue ...OD/ opiate ...transferred to () Hospital at 11:40 a.m. ... "

Interview on 08-07-12 at 2:30 p.m. with the Director of Nurses (DON) ID # 52, she stated she was unable to locate the medical record for Patient ID # 4. She went on to say there was a record for this patient and a staff nurse had been working on it. " The DON reported the nurse was out on sick leave.

VIOLATION: MEDICAL SCREENING EXAM Tag No: A2406

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview the hospital failed to ensure 2 of 24 emergency room records reviewed contained a Medical Screening examination. (Patient ID# 's 9 and 14)

Findings include:

The following emergency room records failed to document an appropriate medical screen:

Patient ID# 9 (MDS) dated [DATE] at 4:29 p.m. with a laceration to the forearm status post fight. The Director of Nursing (ID# 52) triaged the patient, cleaned the wound and applied a dressing. The nurse also obtained verbal orders from a physician to administer the patient an antibiotic injection and a Tetanus shot. An appropriate medical screen was not documented in the patient 's record.

Record review of a policy titled "The Federal Emergency Medical Treatment and Active Labor Act " (EMTALA) stated "General: the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department ... "

The Director of Nursing (ID# 52) acknowledged 8/6/12 at

3 p.m. that not all patients receive a medical screening examination. The Director of Nursing stated only a physician is qualified to perform a medical screening examination.

Patient ID# 14 (MDS) dated [DATE] at 3:20 p.m. with complaints that she stepped on a nail. The Registered Nurse triaged the patient and obtained verbal orders from a physician to administer the patient a Tetanus shot. An appropriate medical screen was not documented in the patient 's record.

Tag No: A2409

VIOLATION: APPROPRIATE TRANSFER

Based on interview and record review, the facility failed to ensure an appropriate transfer for 4 of 4 sampled patients (Patient ID # 4, 7, 10, 12) transferred to other facilities from the hospital 's ER.

- 1. There was no documentation of physician certification of medical risks/benefit discussion of transfer (4 of 4 records).
- 2. No documentation of acceptance by receiving hospital or indication of medical information sent to receiving hospital (4 of 4 records).

Findings include:

TX # 074

On 08-06-12 review of the facility 's Emergency (ER) Log for 2011-2012 revealed four (4) patients were transferred to other facilities (Patient ID # 4, 7, 10, and 12) during this time period.

On 08-06-12, review of Patient ID#s 7, 10, 12 medical records failed to reveal a memorandum of Transfer (MOT); physician certification of medical risks/benefits of transfer; documentation of acceptance by receiving hospital, and indication of medical information sent to receiving hospital.

Patient ID # 10: seen in the facility ER on 02-27-12 with a diagnosis of diagnosis of Paranoid Schizophrenia. Patient ID # 10 was transferred to another hospital the same day at 6:15 p.m.

Patient ID #7: seen in the ER on 04-12-12: diagnosis Overdose /Seroquel; was transferred to () Hospital at 5:40 p.m. the same day.

Patient ID # 12: seen in the ER on 11-14-11: diagnsis of Head Injury: transferred to a local children 's hospital at 10:50 a.m. on the same day.

Per facility ER Log: Patient ID # 4: 05-02-12 (code blue), diagnosis Overdose; was transferred to () Hospital at 11:40 a.m. Surveyor was unable to review Patient # 4 's medical record, as facility could not locate it (see TAG A-2403).

Interview on 08-07-12 at 1:00 p.m. with the Medical Records Manager (ID # 55) she stated the MOTs were kept in the patient 's medical record.

Interview on 08-07-12 at 2:30 p.m. with the Director of Nurses (DON) ID # 52, she stated an MOT was required for each patient transferred from the facility to a different hospital. She went on to say it the MOT was located in the medical record and it contained documentation regarding physician certification of risk/benefit of transfer; acceptance by receiving hospital, and list of medical information sent to receiving hospital. The DON was unable to locate an MOT for Patients ID# 4, 7, 10, 12).

Review of facility policy titled "Transferring /Receiving Patient To/From Outside Facility," undated, read: "...5. The transferring physician shall secure a receiving physician and a receiving hospital that are appropriate to the medical needs of the patient ...Nursing: 2. Initiate and assist the physician in the completion of the "memorandum of transfer" ensuring that all area are completed ...8 make sure all components of the medical record have been xeroxed, including lab data, x-ray, electrocardiogram, and all documentation, requested by receiving facility or as requested by the physician ...10. The original copy of the MOT should be attached to the patient's transferring record and a copy forwarded to medical record and Nursing Administration ... "

Review of the facility form titled "Memorandum of Transfer" revealed spaces provided to document acceptance of receiving physician and hospital (name, date and time); patient diagnoses, medical record attachments; and signature line for physician transfer risk/benefit certification.



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Report No. 1540

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

TEXAS HEALTH HARRIS METHODIST HURST-EULESS-BEDFORD

1600 HOSPITAL PARKWAY BEDFORD, TX 76022 Aug. 6, 2012

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on review of documentation and an interview with staff # 1, the facility failed to ensure that services were provided in a safe manner; patient # 1 was found on the floor.

Findings were:

Review of documentation safety action learning tool (SALT) completed by staff # 2 stated, " The event was preventable and resulted in injury. The bed alarm was not checked prior to patient #1 being found on the floor. The phlebotomist came to the nurse's station to report that the patient was found on the floor."

Review of nurse and physician progress note 01/16/12 stated patient # 1 fell .

In an in-person interview with the supervisor staff # 3, at the time of the incident, on the afternoon of 08/06/12 at the facility, it was confirmed that the patient care technician staff # 4, did not reset the bed alarm and patient # 1 was found on the floor by the phlebotomist.



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1600 HOSPITAL PARKWAY BEDFORD, TX 76022 | Voluntary non-profit - Church

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Report date Number of violations

Aug. 6, 2012 1 (click for details)

March 21, 20124 (click for details)

Aug. 3, 2011 1 (click for details)

Feb. 11, 2011 2 (click for details)

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Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

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TEXOMA MEDICAL CENTER ->

Report No. 1516

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

TEXOMA MEDICAL CENTER

5016 S US HIGHWAY 75 DENISON, TX 75020

July 27, 2012

Tag No: A0043

VIOLATION: GOVERNING BODY

Based on interview and record review the hospital failed to ensure the medical staff monitored and evaluated inpatient medical care and appropriately intervened when a significant change in a patient's condition occurred. The hospital failed to:

- 1) Assess and provide medical interventions for 1 of 1 patient (Patient #2) who was not eating and/or drinking and lost 9 pounds in three days and required emergent transfer to the medical hospital for dehydration and renal failure.
- 2) Current and previously discharged inpatients (Patient #1, #2, #8 and #10's) blood pressures were not monitored and/or reassessed when blood pressure readings were either elevated and/or low. No interventions and/or documentation addressed patient changes of condition occurred.

Cross refer to tag 0049

VIOLATION: MEDICAL STAFF - ACCOUNTABILITY

Tag No: A0049

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the Hospital failed to ensure the medical staff provided quality of care for inpatient Psychiatric patients. The medical staff failed to evaluate and/or assess patient care needs which included: 1) Follow-up on elevated and/or low blood pressures for 4 of 4 patients (Patients #1,#2, #8, #10). 2) Assess and intervene for 1 of 1 patient (Patient #2) who was not eating and/or drinking which resulted in an emergent transfer to the medical hospital on [DATE] where (Patient #2) was placed in ICU (Intensive Care Unit) for dehydration and required renal dialysis. This failure placed all patients at risk for developing dehydration and/or complications related to either elevated and/or low blood pressure.

Findings included:

1) (Patient #2's) nursing admission assessment dated [DATE] timed at 02:00 AM reflected, "Blood pressure 170/80...ADL's (activities of daily living) cannot walk about home, cannot bathe/dress, cannot dress prepare meals, take medications, do housework...cannot brush own teeth...poor hygiene, confused poor short/long term memory..."

The nursing daily flow sheet dated 02/21/12 completed by the technician and signed by RN (Registered Nurse) Staff #20 reflected, breakfast refused, lunch refused and supper percent eaten left blank. The intake, voided and dietary supplement section was left blank.

The precaution sheet-vital sign log dated 02/21/12 reflected (Patient #2's) weight was "242 pounds."

The physician progress note dated 02/22/12 reflected, "Refused to eat and drink yesterday...per family this is out of character for patient..." No documentation was found which indicated the physician addressed and/or intervened.

The nursing daily flow sheet dated 02/22/12 completed by the technician and signed by RN Staff #20 reflected, breakfast refused, lunch refused and supper percent eaten 50%. The intake, voided and dietary supplement section was left blank.

The progress notes-nursing notes dated 02/23/12 timed at 12:15 PM reflected, "Pt (patient) appears more alert today...however, she is still lethargic, slurred speech and disheveled...provide safe therapeutic environment while assessing mental/physical status..."

The nursing daily flow sheet dated 02/23/12 completed by the technician and signed by RN Staff #20 reflected, breakfast 20%, lunch 10% and supper refused. The intake, voided and dietary supplement section was left blank.

The nursing daily flow sheet dated 02/24/12 completed by the technician and signed by RN Staff #16 reflected, breakfast 10%, lunch refused and supper left blank. The intake, voided and dietary supplement section was left blank and fluids were hand written in under the breakfast and the lunch section.

The 02/24/12 precaution sheet/vital sign log reflected, "08:00 AM B/P (blood pressure) 148/81...12:00 Noon B/P 85/48...18:00 PM B/P 84/59...weight 233.08 pounds..." (Patient #2) lost 9 pounds in three days. No documentation was found which indicated (Patient #2's) low blood pressure was addressed.

The nursing daily flow sheet dated 02/25/12 completed by the technician and signed by RN Staff #16 reflected, breakfast 0%, lunch 5% and supper 5%. The intake, voided and dietary supplement section was left blank.

The physician orders dated 02/25/12 timed at 14:40 PM reflected, "Push fluids, monitor for possible dehydration...at 20:29 PM transfer to the ER (emergency room) for eval (evaluation)..." No documentation was found which indicated fluids were pushed and/or ensure was provided for (Patient #2).

The progress notes-nursing notes dated 02/25/12 timed at 17:50 PM reflected, "Patient appears drowsy, won't open eyes up...poor appetite, poor po (by mouth) fluid intake...needs assistance with ADL's..provide a safe and therapeutic environment...at 20:50 PM the note continued...tech (technician) noted that client was cool to touch, unresponsive and unable to obtain pulse...B/P...respirations 40 and erratic...apical is weak...40 a minute...unresponsive to verbal/physical stimuli...unable to palpate B/P or obtain with stethoscope...oxygen saturation 81% and client is cold, color is white and pasty...orders received to transfer to ER (emergency room) for evaluation...client's family called regarding transfer and change in condition..."

(Patient #2's) medical record from Hospital B dated 02/25/12 timed at 21:06 PM reflected, "Lethargy...BUN (blood urea nitrogen) 90...creatinine 6.5...dehydration...volume depletion...acute renal failure...hypotension...at 21:30 PM B/P 95/52...22:22 PM B/P 70/48...placed in Trendelenburg position and increased fluids bolus...at 01:00 AM B/P 88/53..."

Hospital B's physician consult dated 02/28/12 reflected, "In the Behavioral Health, the patient was not eating and drinking and hence she was noted to be in an extremely obtunded state when she came into the emergency room ...upon arrival her blood pressure was 83/46...BUN of 90 and creatinine of 6.5...the patient has had one treatment of renal dialysis..."

On 07/19/12 at approximately 09:40 AM Staff #6 was interviewed. Staff #6 reviewed (Patient #2's) medical record. Staff #6 stated no nutritional screen was initiated on (Patient #2). Staff #6 stated the RN's are supposed to review the vital sign flow sheet and sign it. Staff #6 said the nursing staff should have addressed (Patient #2) not eating and/or drinking and provided interventions. Staff #6 said no interventions were provided for (Patient #2) when her blood pressure initially dropped.

On 07/19/12 at approximately 12:15 PM Staff #11 was interviewed. Staff #11 was asked to review (Patient #2's) medical record. Staff #11 said she saw (Patient #2) on 02/25/12 and informed the staff to push fluids and give ensure. Staff #11 said the nursing staff were not good about documenting vital signs and the information needed to care for the patient. Staff #11 stated the nursing staff does not always document and/or communicate important information so it can be followed-up on.

2) On 07/18/12 at approximately 03:55 PM a tour of the SCU (Stabilization Care Unit) was toured with Staff #3. The surveyor reviewed the technician's patient vital sign records. (Patient #8's) blood pressure reading at 06:00 AM on 07/17/12 was 98/56. The record did not indicate a second blood pressure was taken. Staff #6 was asked to review the vital sign log and the nursing note for 07/17/12. Staff #3 verified (Patient #8's) low blood pressure reading was not addressed and a recheck was not completed by Staff #17.

(Patient #8's) history and physical dated 07/11/12 reflected, "66 year old...multiple admissions here for bipolar with hallucinations, suicidal ideation and homicidal ideation...past medical history...hypertension, COPD (Chronic Obstructive Pulmonary Disease)..."

(Patient #8's) vital sign log dated 07/17/12 reflected, (Patient #8's) blood pressure was 98/56..." No further documentation was found which indicated (Patient #8's) blood pressure was re-checked and/or addressed by the RN Staff #17 and/or the physician was notified.

The interdisciplinary progress notes dated 07/17/12 reflected no documentation by Staff #17 which indicated (Patient #8's) low blood pressure reading was addressed.

The medical staff Bylaws dated 03/13/09 reflected, "Each department or service shall monitor and evaluate medical care on a retrospective, concurrent and prospective basis in all major clinical activities of the department or service...the monitoring and evaluation must at least include: the identification and collection of information about important aspects of patient care...identify important problems in patient care..."

3) (Patient #1's) "Medical Stability Attestation" document dated 02/03/12 and the "In-Patient Physician Orders" dated 02/03/12 reflected admitting diagnoses including Hypertension and Stroke. The patient's blood pressure was 195/117 according to the vital sign log dated 02/10/12 at 6:00 AM; an additional blood pressure reading of 193/117 was documented on 02/10/12 at 09:20 AM. No further blood pressure was documented.

The interdisciplinary progress notes dated 02/10/12 at 09:00 AM reflected that "(Patient #1) was still not feeling well..." The "Nursing Daily Flow Sheet" dated 02/10/12 reflected (Patient #1) was on medical concern precautions.

On 02/15/12 at 06:00 AM (Patient #1's) vital sign log reflected a blood pressure reading of 206/117. The only 02/15/12 entry on the "Progressive Nursing Notes" at 5:00 PM did not indicate any blood pressure concerns. The "Physician Daily Progress Notes" dated 02/15/12 at 10:35 AM did not mention (Patient #1's) blood pressure reading.

4) (Patient #10) was admitted on [DATE] with an admitting diagnoses including Major Depressive Disorder. The patient reported she had not eaten in 10 days. The "Psychiatric Evaluation" dated 07/11/12 reflected a "long history of depression and anorexia." The "History and Physical Consultation" dated 07/11/12 reflected an admission blood pressure of 100/75.

The "Vital Sign Log" dated 07/11/12 at 6:00 AM reflected (Patient #10) had a blood pressure of 106/75. Further blood pressure readings were 90/65 at 2:00 PM and 84/54 at 10:00 PM. The following day, on 07/12/12 (Patient #10's) blood pressure was 86/51 at 6:00 AM, 87/51 at 6:00 PM, and 81/51 at 10:00 PM. Eight hours later, on 07/13/12 at 6:00 AM, (Patient #10) had a blood pressure of 84/55. No further blood pressure readings were documented.

During an interview on 07/18/12 around 3:30 PM Staff #3 stated she could not find any additional blood pressure readings on 07/13/12 for (Patient #10). When requested by the surveyor to provide additional documentation, Staff #3 stated at that time, "There is no other blood pressure."

Tag No: A0115

Tag No: A0144

VIOLATION: PATIENT RIGHTS

Based on interview and record review the hospital failed to ensure the physical and medical needs of both discharged and/or current inpatients was provided. The hospital failed to ensure a safe environment was provided for patients who demonstrated a change in their medical condition as evidenced by the following:

- 1) Assessment and medical intervention was not provided for 1 of 1 patient (Patient #2) who was not eating and/or drinking and lost 9 pounds in three days. (Patient #2) required emergent transfer to the medical hospital for dehydration, low blood pressure and renal failure.
- 2) Current and previously discharged inpatient (Patient #1, #2, #8 and #10's) blood pressures were not monitored and/or reassessed when blood pressure readings were either elevated and/or low. No interventions and/or documentation addressed a patient change of condition occurred nor what care was provided for the 4 patients.
- 3) Equipment was not provided for 1 of 1 patient (Patient #1) with sleep apnea. (Patient #1) slept an average of 4.9 hours per night, missed the initial four days of therapy, and was sleepy during the day.

These failures placed all patients at risk for developing dehydration and/or complications related to either elevated and/or low blood pressure, and complications related to inadequate sleep.

Cross refer to Tag 0144

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the Hospital failed to ensure 4 of 4 patient's (Patient #1, #2, #8 and #10) received medical care in a safe setting and patient care needs were evaluated and/or assessed which included: 1) Follow-up on elevated and/or low blood pressures for 4 of 4 patients (Patients #1, #2, #8 and #10). 2) Assess and provide nursing interventions for 1 of 1 patient (Patient #2) who was not eating and/or drinking and lost 9 pounds in 3 days which resulted in an emergent transfer to the medical hospital 02/25/12 where (Patient #2) was placed in ICU (Intensive Care Unit) for dehydration and required renal dialysis. 3) Provide 1 of 1 patient (Patient #1) with equipment needed for sleep apnea. (Patient #1) slept an average of 4.9 hours per night, missed the initial four days of therapy, and was sleepy during the day.

This failure placed all patients at risk for developing dehydration and/or complications related to either elevated and/or low blood pressure, and complications related to inadequate sleep.

Findings included:

1) (Patient #2's) nursing admission assessment dated [DATE] timed at 02:00 AM reflected, "Blood pressure 170/80...ADL's (activities of daily living) cannot walk about home, cannot bathe/dress, cannot dress prepare meals, take medications, do housework...cannot brush own teeth...poor hygiene, confused poor short/long term memory..."

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The Education Department nursing meeting dated 04/27/12 reflected, "Patient weights are to be done on admission and twice a week unless otherwise ordered...intake and output..." The 05/31/12 nursing meeting reflected, "Post fall debriefing, document reviews..." The 06/28/12 nursing meeting reflected, "Nursing documentation (enhanced description of symptoms present..." The nursing meeting dated 06/28/12-07/13/12 reflected, "Dietary consult education..." No documentation was found which indicated assessment and follow-up on patient changes was conducted during the above training.

2) On 07/18/12 at approximately 03:55 PM a tour of the SCU (Stabilization Care Unit) was toured with Staff #3. The surveyor reviewed the technician's patient vital sign records. (Patient #8's) blood pressure reading at 06:00 AM on 07/17/12 was 98/56. The record did not indicate a second blood pressure was taken. Staff #6 was asked to review the vital sign log and the nursing note for 07/17/12. Staff #3 verified (Patient #8's) low blood pressure reading was not addressed and a recheck was not completed by Staff #17.

(Patient #8's) history and physical dated 07/11/12 reflected, "66 year old...multiple admissions here for bipolar with hallucinations, suicidal ideation and homicidal ideation...past medical history...hypertension, COPD (Chronic Obstructive Pulmonary Disease)..."

(Patient #8's) vital sign log dated 07/17/12 reflected, (Patient #8's) blood pressure was 98/56..." No further documentation was found which indicated (Patient #8's) blood pressure was re-checked and/or addressed by the RN Staff #17.

The interdisciplinary progress notes dated 07/17/12 reflected no documentation by Staff #17 which indicated (Patient #8's) low blood pressure reading was addressed.

3) (Patient #10) was admitted on [DATE] with an admitting diagnoses including Major Depressive Disorder. The patient reported she had not eaten in 10 days. The "Psychiatric Evaluation" dated 07/11/12 reflected a "long history of depression and anorexia." The "History and Physical Consultation" dated 07/11/12 reflected an admission blood pressure of 100/75.

The "Vital Sign Log" dated 07/11/12 at 6:00 AM reflected (Patient #10) had a blood pressure of 106/75. Further blood pressure readings were 90/65 at 2:00 PM and 84/54 at 10:00 PM. The following day, on 07/12/12 (Patient #10's) blood pressure was 86/51 at 6:00 AM, 87/51 at 6:00 PM, and 81/51 at 10:00 PM. Eight hours later, on 07/13/12 at 6:00 AM, (Patient #10) had a blood pressure of 84/55. No further blood pressure readings were documented.

During an interview on 07/18/12 around 3:30 PM Staff #3 stated she could not find any additional blood pressure readings on 07/13/12 for (Patient #10). When requested by the surveyor to provide additional documentation Staff #3 stated at that time, "There is no other blood pressure."

4) (Patient #1's) "Medical Stability Attestation" document dated 02/03/12 and the "In-Patient Physician Orders" dated 02/03/12 reflected admitting diagnoses included Hypertension and Stroke.

(Patient #1's) blood pressure was 195/117 according to the vital sign log dated 02/10/12 at 6:00 AM; an additional blood pressure reading of 193/117 was documented on 02/10/12 at 09:20 AM. No further blood pressure was documented. The interdisciplinary progress notes dated 02/10/12 at 09:00 AM reflected that "(Patient #1) was still not feeling well..." The "Nursing Daily Flow Sheet" dated 02/10/12 reflected (Patient #1) was on medical concern precautions.

On 02/15/12 at 06:00 AM (Patient #1's) vital sign log reflected a blood pressure reading of 206/117. The only 02/15/12 entry on the "Progressive Nursing Notes" at 5:00 PM did not indicate any blood pressure concerns. The "Physician Daily Progress Notes" dated

02/15/12 at 10:35 AM did not mention (Patient #1's) blood pressure reading.

(Patient #1's) psychiatric evaluation and nursing admission assessment, both dated 02/03/12 included a medical history of Asthma, Chronic Obstructive Pulmonary Disease, and Obstructive Sleep Apnea. The "Comprehensive Admission Screening" dated 02/03/12 reflected Patient #1 used a CPAP machine [to provide continuations positive airway pressure] and oxygen therapy. The document reflected (Patient #1) had been disabled with Congestive Heart Failure since 1996.

According to the "Group Notes" (Patient #1) did not attend group therapy on 02/04/12, 02/05/12, 02/06/12, and 02/07/12; on 02/13/12 (Patient #1) excused herself from the group with complaints she could not breathe. Then "Daily Nursing Flow Sheet" night shift documentation between 02/03/12 and 02/16/12 reflected (Patient #1) slept an average of 4.9 hours per night.

During an interview on 07/18/12 at 2:10 PM Staff #2 stated she could not find documentation that (Patient #1) CPAP was used.

The policy entitled, "Delivery Model" with a current effective date of 12/11 reflected, "The Modified Team Nursing Model (MTN)...supports the goal of providing holistic nursing care meeting the psychosocial, physical, and spiritual needs of a patient across the lifespan using the nursing process...the RN in Charge...ensures patient assessments are completed...collaborates with health care team members to ensure patient/family needs are met...nurse aide member...provides direct patient care under the supervision of the RN to include...data collection and documentation, to include height, weight, I/O (intake and output), vital signs...nutritional activities..."

Tag No: A0385

Tag No: A0392

VIOLATION: NURSING SERVICES

Based on interview and record review the hospital failed to ensure nursing services was adequately being supervised. Nursing services failed to provide the following:

- 1) Assess and provide medical interventions for 1 of 1 patient (Patient #2) who was not eating and/or drinking and lost 9 pounds in three days and required emergent transfer to the medical hospital for dehydration and renal failure.
- 2) Current and previously discharged inpatient (Patient #1, #2, #8 and #10's) blood pressures were not monitored and/or reassessed when blood pressure readings were either elevated and/or low. No interventions and/or documentation addressed a patient change of condition occurred
- 3) The hospital failed to provide adequate number of nursing personnel to provide assistance with ADL's (activities of daily living) for 2 of 2 patients (Patient #9 and #10). Patient's were not bathed and/or left with soiled clothes on.

Cross refer to Tag 0392 and 0395

VIOLATION: STAFFING AND DELIVERY OF CARE

The hospital failed to provide adequate number of nursing personnel to provide care to patients as needed to provided assistance with ADLs for 2 of 2 patients (Patient #9 and #10). (Patient #9) did not receive a bath for three days. (Patient #10) wore badly stained clothes on the unit.

Findings included:

1) Observations on 07/18/12 at 4:30 PM on the hospital's Acute Care Unit reflected, (Patient #9) was sitting in a wheel chair with an attached lap tray. The unit was malodorous. (Patient #9) wore a stained sweat shirt and complained she did not have a bath "in three days." Staff #8 verified (Patient's #9's) bath was three days ago.

The Interdisciplinary Progress Notes dated 07/09/12 at 10:00 PM and 07/09/12 at 10:50 AM reflected (Patient #9) was "dependent for ADLs." On 07/09/12 at 10:50 AM the notes reflected Patient #9's comment, "I am worried about my clothes."

2) (Patient #10) was observed on 07/20/12 at 9:03 AM curled up on the sofa next to the entrance way. The patient was disheveled, dressed in a plaid jacket with badly stained sleeves and front.

Observations on 07/20/12 at 9:05 AM on the hospitals Progressive Care Unit reflected a strong urine smell in the hallway across from the patient laundry room. A grey bucket with two towels was left underneath two chairs in the hallway.

On 07/20/12 at 9:10 AM Staff #3 agreed that there was an odor and verbalized the intention to call housekeeping.

During an interview on 07/19/12 at 3:45 PM Staff #12 stated patients did not get bathed or shaved due to the lack of staff. Staff #12 stated patients did not get their personal clothes washed and had to wear paper scrubs during visitation nor did patients get to go outside due to staffing issues.

On 07/19/12 at 5 PM Staff #14 stated that providing showers for patients was "extremely difficult" due to staffing issues. Before visitation, staff would "wipe them [the patients] down and spray some scents on them to make them smell good." Mental Health Technicians (MHTs) were taken off the unit "daily" to accommodate visits to outside groups or physician visits.

During an interview on 07/20/12 at 10:30 AM Staff #15 stated that nurses were left with up to 32 patients once the MHT "gets pulled..." Staff #15 stated "ADLs [activities of daily living] don't get done and they don't offer snacks."

On 07/20/12 at 11:41 AM an unidentified male patient was observed sitting at a table in front of a lunch tray in the otherwise empty day room. No staff assisted the patient. Staff #18 was observed in the closed door consultation room speaking with the physician. Upon surveyor inquiry, Staff #18 entered the day room and explained he gave report to the physicians during their unit visits as part of his job duties.

The policy entitled, "Delivery Model" with a current effective date of 12/11 reflected, "The Modified Team Nursing Model provides...comprehensive, compassionate and individualized nursing care in a manner that maintains the dignity, rights...of patients...it

supports the goal of providing holistic nursing care meeting the psychosocial, physical...needs of the patient..."

VIOLATION: RN SUPERVISION OF NURSING CARE

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the Hospital failed to ensure 4 of 4 RN's (Registered Nurses) (RN #15, #16, #17 and #20) evaluated and/or assessed patient care needs which included: 1) Follow-up on elevated and/or low blood pressures for 3 of 3 patients (Patient #2, #8, and #10). 2) Assess and provide nursing interventions for 1 of 1 patient (Patient #2) who was not eating and/or drinking and lost 9 pounds in 3 days. Patient #2's blood pressure dropped and resulted in an emergent transfer to the medical hospital 02/25/12. (Patient #2) was placed in ICU (Intensive Care Unit) for dehydration and required renal dialysis. This failure placed all patients at risk for developing dehydration and/or complications related to either elevated and/or low blood pressure.

Tag No: A0395

Findings included:

1) (Patient #2's) nursing admission assessment dated [DATE] timed at 02:00 AM reflected, "Blood pressure 170/80...ADL's (activities of daily living) cannot walk about home, cannot bathe/dress, cannot dress prepare meals, take medications, do housework...cannot brush own teeth...poor hygiene, confused poor short/long term memory..."

The nursing daily flow sheet dated 02/21/12 completed by the technician and signed by RN (Registered Nurse) Staff #20 reflected, breakfast refused, lunch refused and supper percent eaten left blank. The intake, voided and dietary supplement section was left blank.

The precaution sheet-vital sign log dated 02/21/12 reflected (Patient #2's) weight was "242 pounds."

The physician progress note dated 02/22/12 reflected, "Refused to eat and drink yesterday...per family this is out of character for patient..."

The nursing daily flow sheet dated 02/22/12 completed by the technician and signed by RN Staff #20 reflected, breakfast refused, lunch refused and supper percent eaten 50%. The intake, voided and dietary supplement section was left blank.

The progress notes-nursing notes dated 02/23/12 timed at 12:15 PM reflected, "Pt (patient) appears more alert today...however, she is still lethargic, slurred speech and disheveled...provide safe therapeutic environment while assessing mental/physical status..."

The nursing daily flow sheet dated 02/23/12 completed by the technician and signed by RN Staff #20 reflected, breakfast 20%, lunch 10% and supper refused. The intake, voided and dietary supplement section was left blank.

The nursing daily flow sheet dated 02/24/12 completed by the technician and signed by RN Staff #16 reflected, breakfast 10%, lunch refused and supper left blank. The intake, voided and dietary supplement section was left blank and fluids were hand written in under the breakfast and the lunch section.

The 02/24/12 precaution sheet/vital sign log reflected, "08:00 AM B/P (blood pressure) 148/81...12:00 Noon B/P 85/48...18:00 PM B/P 84/59...weight 233.08 pounds..." (Patient #2) lost 9 pounds in three days. No documentation was found which indicated (Patient #2's) low blood pressure was addressed.

The nursing daily flow sheet dated 02/25/12 completed by the technician and signed by RN Staff #16 reflected, breakfast 0%, lunch 5% and supper 5%. The intake, voided and dietary supplement section was left blank.

The physician orders dated 02/25/12 timed at 14:40 PM reflected, "Push fluids, monitor for possible dehydration...at 20:29 PM transfer to the ER (emergency room) for eval (evaluation)..."

The progress notes-nursing notes dated 02/25/12 timed at 17:50 PM reflected, "Patient appears drowsy, won't open eyes up...poor appetite, poor po (by mouth) fluid intake...needs assistance with ADL's..provide a safe and therapeutic environment...at 20:50 PM the note continued...tech (technician) noted that client was cool to touch, unresponsive and unable to obtain pulse...B/P...respirations 40 and erratic...apical is weak...40 a minute...unresponsive to verbal/physical stimuli...unable to palpate B/P or obtain with stethoscope...oxygen saturation 81% and client is cold, color is white and pasty...orders received to transfer to ER (emergency room) for evaluation..."

(Patient #2's) medical record from Hospital B dated 02/25/12 timed at 21:06 PM reflected, "Lethargy...BUN (blood urea nitrogen) 90...creatinine 6.5...dehydration...volume depletion...acute renal failure...hypotension...at 21:30 PM B/P 95/52...22:22 PM B/P 70/48...placed in Trendelenburg position and increased fluids bolus...at 01:00 AM B/P 88/53..."

Hospital B's physician consult dated 02/28/12 reflected, "In the Behavioral Health, the patient was not eating and drinking and hence she was noted to be in an extremely obtunded state when she came into the emergency room ...upon arrival her blood pressure was 83/46...BUN of 90 and creatinine of 6.5...the patient has had one treatment of renal dialysis..."

On 07/19/12 at approximately 09:40 AM Staff #6 was interviewed. Staff #6 reviewed (Patient #2's) medical record. Staff #6 stated no nutritional screen was initiated on (Patient #2). Staff #6 stated the RN's are supposed to review the vital sign flow sheet and sign it. Staff #6 said the nursing staff should have addressed (Patient #2) not eating and/or drinking and provided interventions. Staff #6 said the nurse did not intervene when (Patient #2's) blood pressure initially dropped.

On 07/19/12 at approximately 12:15 PM Staff #11 was interviewed. Staff #11 was asked to review (Patient #2's) medical record. Staff #11 said she saw (Patient #2) on 02/25/12 and informed the staff to push fluids and give ensure. Staff #11 said the nursing staff were not good about documenting vital signs and the information needed to care for the patient. Staff #11 stated the nursing staff does not always document important information so it can be followed-up on.

The Education Department nursing meeting dated 04/27/12 reflected, "Patient weights are to be done on admission and twice a week unless otherwise ordered...intake and output..." The 05/31/12 nursing meeting reflected, "Post fall debriefing, document reviews..." The 06/28/12 nursing meeting reflected, "Nursing documentation (enhanced description of symptoms present..." The nursing meeting dated 06/28/12-07/13/12 reflected, "Dietary consult education..." No documentation was found which indicated assessment and follow-up on

patient changes was conducted during the above training.

2) On 07/18/12 at approximately 03:55 PM a tour of the SCU (Stabilization Care Unit) was toured with Staff #3. The surveyor reviewed the technician's patient vital sign records. (Patient #8's) blood pressure reading at 06:00 on 07/17/12 was 98/56. The record did not indicate a second blood pressure was taken. Staff #6 was asked to review the vital sign log and the nursing note for 07/17/12. Staff #3 verified (Patient #8's) low blood pressure reading was not addressed and a recheck was not completed by Staff #17.

(Patient #8's) history and physical dated 07/11/12 reflected, "66 year old...multiple admissions here for bipolar with hallucinations, suicidal ideation and homicidal ideation...past medical history...hypertension, COPD (Chronic Obstructive Pulmonary Disease)..."

(Patient #8's) vital sign log dated 07/17/12 reflected, (Patient #8's) blood pressure was 98/56..." No further documentation was found which indicated (Patient #8's) blood pressure was re-checked and/or addressed by RN Staff #17.

The interdisciplinary progress notes dated 07/17/12 reflected no documentation by Staff #17 which indicated (Patient #8's) low blood pressure reading was addressed.

3) (Patient #10) was admitted on [DATE] with an admitting diagnoses including Major Depressive Disorder. The patient reported she had not eaten in 10 days. The "Psychiatric Evaluation" dated 07/11/12 reflected a "long history of depression and anorexia." The "History and Physical Consultation" dated 07/11/12 reflected an admission blood pressure of 100/75.

The "Vital Sign Log" dated 07/11/12 at 6:00 AM reflected (Patient #10) had a blood pressure of 106/75. Further blood pressure readings were 90/65 at 2:00 PM and 84/54 at 10:00 PM. The following day, on 07/12/12 (Patient #10's) blood pressure was 86/51 at 6:00 AM, 87/51 at 6:00 PM, and 81/51 at 10:00 PM. Eight hours later, on 07/13/12 at 6:00 AM, (Patient #10) had a blood pressure of 84/55. No further blood pressure readings were documented.

During an interview on 07/18/12 around 3:30 PM Staff #3 stated she could not find any additional blood pressure readings on 07/13/12 for (Patient #10). When requested by the surveyor to provide additional documentation, Staff #3 stated at that time, "There is no other blood pressure."

The policy entitled, "Delivery Model" with a current effective date of 12/11 reflected, "The Modified Team Nursing Model (MTN)...supports the goal of providing holistic nursing care meeting the psychosocial, physical, and spiritual needs of a patient across the lifespan using the nursing process...the RN in Charge...ensures patient assessments are completed...collaborates with health care team members to ensure patient/family needs are met...nurse aide member...provides direct patient care under the supervision of the RN to include...data collection and documentation, to include height, weight, I/O (intake and output), vital signs...nutritional activities..."



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No incomplete reports available.

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Report No. 1554

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

DOCTORS HOSPITAL

9440 POPPY DR DALLAS, TX 75218

July 24, 2012

VIOLATION: COMPLIANCE WITH LAWS

Tag No: A0021

Based on observation the facility failed to keep the fire door to the generator room closed.

The inspector observed, while accompanied by the Plant Manager during the hours of the inspection from 8:00 am to 9:45 am on 7/24/2012 that the fire doors going into the generator room had the closers removed and the doors were propped open. The doors must be self-closing. If the facility requires the doors to be open, they must be placed on hold opens that will release with activation of the fire alarm.

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

The branches of the emergency system shall be installed and connected to the alternate power source specified in 3-4.1.1.2 and 3-4.1.1.3 so that all functions specified herein for the emergency system shall be automatically restored to operation within 10 seconds after interruption of the normal source. - NFPA 99, 1999, 3-4.3.1

Based on observation the facility failed to properly maintain the emergency power system.

The inspector observed, while reviewing the generator documentation, with the Manager of Facility Services, the Chief Operating Officer, and the Manager Plant Operation during the hours of the inspection from 8:00 am to 9:45 am on 7/24/2012 that the following sequence of events had occurred.

- 1) On 6/12/2012 the monthly load test showed that the power from the generator was not transferring within the time period specified by the Code.
- 2) On 7/10/2012, the next monthly load test, the problem was still present.
- 3) On 7/13/2012 a Contractor was called to evaluate the problem. The Service Order showed that there was a bad AVR, automatic voltage regulator, and a new AVR was ordered.
- 4) On 7/15/2012, between approximately 5:15 and 7:00 pm the power from the electric utility failed, and the hospital had no emergency power because the AVR had completely failed.
- 5) On 7/16/2012 the AVR was replaced. The emergency power system was then tested and found to be in good working order.

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Incomplete reports

No incomplete reports available.



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HENDRICK MEDICAL CENTER ->

Report No. 1508

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HENDRICK MEDICAL CENTER

1900 PINE ABILENE, TX 79601

July 23, 2012

Tag No: A0083

VIOLATION: CONTRACTED SERVICES

Based on review of medical documentation and interview, it was determined that the facility governing body did not maintain responsibly for serviced furnished in the hospital, as evidence by failing ensure that bylaws, rules, and regulations were implemented and by the medical staff.

Findings were:

Facility policy & procedure titled Restraint Use stated, in part,

- " Physician Řesponsibilities
- 1. Restraint shall be ordered by a Licensed Independent Practitioner and used only when clinically indicated. PRN Restraint orders are not accepted.

A review of the clinical record for Patient # 1 revealed the following Physician Order, 06/19/12 at 0600, "Problem: Pulled PICC line out, IV pulled out. Attempted several times to get out of bed. May restrain for patient safety. " There was no time limit, start or stop time noted on this restraint order, making this a standing PRN restraint order.

Facility policy & procedure titled Nursing Documentation stated, in part,

- "Nursing Documentation:...
- 2. Monitor and record the following:
- ? Changes in patient 's condition

A review of the clinic record for patient #1 revealed a failure to properly document a fall that occurred on 06/15/12. According to documentation, "While on the floor, the patient fell, X-rays of the right lower extremity were ordered. X-rays revealed a right distal femur fracture.'

? It appears the fall resulting in the fractured right femur occurred around 1500 on 06/14/12 related to the time entered on the Physician/Professional Communication sheet. According to the Physician/ Professional Communication Note dated 6/14/12 the physician was notified of a "Significant Event" at 1515. There was no description of the significant event. The actions related to the communication were, "Stat xray of hip and right knew. Will contact Dr. Badylak and call if any changes to orders."

? There was no documented description of the significant event (fall). There was no follow up fall assessment, physical assessment, or pain assessment documented on the patient post fall.

Facility policy & procedure titled Fall Precautions stated, in part, "The Morse Fall Scale will be utilized to assess the patient's fall risk

factors upon admission, fall, change in status and discharge or transfer to a new setting."

? A review of the clinical record for Patient #1 revealed a Safety Assessment including Fall Risk Assessment completed upon their admission on 6/14/12 at 1300. This initial Fall Risk Assessment at 1500 indicating a low fall risk 25-50. A Safety Assessment at 1500 indicated she was WNL (within defined limits). Another Fall Risk Assessment is not completed in the medical record until 2131. During this assessment the patient received a score of 65 indicating a high fall risk. No other fall risk assessments were completed on 6/14/12. No fall assessment was document post fall per policy. There was no follow up fall assessment documented on the patient post fall.

Facility policy & procedure titled Pain Management stated, in part, " All patients will be assessed for pain on admission and reassessed as indicated by the patient 's condition:..

9. Frequency of assessment for pain should be determined based on individual patient needs. The patient will be assessed: ... ? Each shift ...

? After each analgesic according to onset and peak effect time.

10. Assessment and evaluation will be ongoing and consider the patient 's history, current condition and anticipated needs. If the patient is reporting pain, the following factors should be evaluated and documented and as indicated:

? Location

- ? Radiation
- ? Intensity (0-10) ? Onset

? Duration

? Patterns

- ? Assessment of pain at its least and worst
- ? Qualitative Characteristics ...
- ? Response to the Intervention
- ? Absence or presence of unrelieved pain at peak action time
- ? Absence or presence of dose-limiting side effects
- 14. Reassessment of the patient 's condition and response to pain medications will be made after the administration of each dose of pain medication. '

A review of the clinical record for Patient #1 revealed insufficient documentation of pain assessment (4 out of 7 times that pain medication

was administered) on the following days:
? On 6/14/12 at 1629 " Presence of Pain: complaints of pain/discomfort " of her right knee was noted by the nurse. The nurse did not document intensity of the pain. The Pain Management Interventions indicated " single medication modality ". The Pain Response to Interventions at 1816 noted pain improved, this does not appropriately document the patient s response to pain medication, nor does it note intensity.

? On 06/15/12 at 0944 " Presence of Pain: complaints of pain/discomfort " of her right leg was noted by the nurse, rated 6/10. The Pain Management Interventions indicated " Tylenol #3 300/30mg 1 tab PO " . The Pain Response to Interventions at 1020 noted " pain at acceptable level " , this does not appropriately document the patient 's response to pain medication, nor does it note intensity. ? On 06/19/12 at 0200 " Presence of Pain: complaints of pain/discomfort " of her right hip was noted by the nurse. The nurse did not document intensity of the pain. The note stated " Tylenol #3 given po for pain to rt hip " . No re-assessment of the patient 's condition and

response to the pain medication was documented.

? On 06/19/12 at 1015 " Presence of Pain: complaints of pain/discomfort " of her right leg was noted by the nurse, rated 10/10. The Pain Management Interventions indicated " single medication modality " . No re-assessment of the patient 's condition and response to the pain medication was documented.
? No documented pain assessment was recorded for Patient #1 status post fall on 06/15/12.

The governing body failing to maintain responsibly for furnished services in the hospital was confirmed in an interview with the Nurse Managers on the afternoon of 7/23/12 in the facility conference room.

Tag No: A0169

Tag No: A0353

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on review of medical documentation and interview it was determined that the facility failed to ensure that patient rights were maintained as evidence by the presence of a standing/PRN restraint order.

Findings were:

? A review of the clinical record for Patient #1 revealed the following Physician Order, 06/19/12 at 0600, "Problem: Pulled PICC line out, IV pulled out. Attempted several times to get out of bed. May restrain for patient safety. " There was no time limit, start or stop time noted on this restraint order, making this a standing PRN restraint order.

Facility policy & procedure titled Restraint Use stated, in part, "Physician Responsibilities

1. Restraint shall be ordered by a Licensed Independent Practitioner and used only when clinically indicated. PRN Restraint orders are not accepted. '

This standing PRN restraint order was confirmed in an interview with the Nurse Managers on the afternoon of 7/23/12 in the facility conference room.

VIOLATION: MEDICAL STAFF BYLAWS

Based on review of medical documentation and interview, it was determined that the facility failed to ensure that bylaws were enforced and carried out by medical staff to carry out their responsibilities.

Findings were:

Facility policy & procedure titled Restraint Use stated, in part, "Physician Responsibilities

1. Restraint shall be ordered by a Licensed Independent Practitioner and used only when clinically indicated. PRN Restraint orders are not accepted.

A review of the clinical record for Patient # 1 revealed the following Physician Order, 06/19/12 at 0600, "Problem: Pulled PICC line out, IV pulled out. Attempted several times to get out of bed. May restrain for patient safety. " There was no time limit, start or stop time noted on this restraint order, making this a standing PRN restraint order.

Facility policy & procedure titled Nursing Documentation stated, in part,

"Nursing Documentation:...

- 2. Monitor and record the following:
- ? Changes in patient 's condition

A review of the clinic record for patient #1 revealed a failure to properly document a fall that occurred on 06/15/12. According to documentation, "While on the floor, the patient fell, X-rays of the right lower extremity were ordered. X-rays revealed a right distal femur

? It appears the fall resulting in the fractured right femur occurred around 1500 on 06/14/12 related to the time entered on the Physician/Professional Communication sheet. According to the Physician/ Professional Communication Note dated 6/14/12 the physician was notified of a "Significant Event" at 1515. There was no description of the significant event. The actions related to the communication were, "Stat xray of hip and right knee. Will contact Dr. Badylak and call if any changes to orders.

? There was no documented description of the significant event (fall). There was no follow up fall assessment, physical assessment, or pain assessment documented on the patient post fall.

Facility policy & procedure titled Fall Precautions stated, in part, " The Morse Fall Scale will be utilized to assess the patient 's fall risk factors upon admission, fall, change in status and discharge or transfer to a new setting."
? A review of the clinical record for Patient # 1 revealed a Safety Assessment including Fall Risk Assessment completed upon their

admission on 6/14/12 at 1300. This initial Risk Assessment scored the patient at 50 indicating a low fall risk 25-50. A Safety Assessment at 1500 indicated she was WNL (within defined limits). Another Fall Risk Assessment is not completed in the medical record until 2131. During this assessment the patient received a score of 65 indicating a high fall risk. No other fall risk assessments were completed on 6/14/12. No fall assessment was document post fall per policy. There was no follow up fall assessment documented on the

Facility policy & procedure titled Pain Management stated, in part, " All patients will be assessed for pain on admission and reassessed as indicated by the patient 's condition:..

9. Frequency of assessment for pain should be determined based on individual patient needs. The patient will be assessed: ...

- ? After each analgesic according to onset and peak effect time.
- 10. Assessment and evaluation will be ongoing and consider the patient 's history, current condition and anticipated needs. If the patient is reporting pain, the following factors should be evaluated and documented and as indicated:
- ? Location? Radiation
- ? Intensity (0-10)
- ? Onset
- ? Duration
- ? Patterns
- ? Assessment of pain at its least and worst
- ? Qualitative Characteristics ...
- ? Response to the Intervention
- ? Absence or presence of unrelieved pain at peak action time
- ? Absence or presence of dose-limiting side effects
- 14. Reassessment of the patient 's condition and response to pain medications will be made after the administration of each dose of pain medication. "

A review of the clinical record for Patient # 1 revealed insufficient documentation of pain assessment (4 out of 7 times that pain medication was administered) on the following days:

- ? On 6/14/12 at 1629 " Presence of Pain: complaints of pain/discomfort " of her right knee was noted by the nurse. The nurse did not document intensity of the pain. The Pain Management Interventions indicated " single medication modality " . The Pain Response to Interventions at 1816 noted " pain improved " , this does not appropriately document the patient 's response to pain medication, nor does it note intensity.
- ? On 06/15/12 at 0944 " Presence of Pain: complaints of pain/discomfort " of her right leg was noted by the nurse, rated 6/10. The Pain Management Interventions indicated " Tylenol #3 300/30mg 1 tab PO " . The Pain Response to Interventions at 1020 noted " pain at acceptable level " , this does not appropriately document the patient 's response to pain medication, nor does it note intensity. ? On 06/19/12 at 0200 " Presence of Pain: complaints of pain/discomfort " of her right hip was noted by the nurse. The nurse did not document intensity of the pain. The note stated " Tylenol #3 given po for pain to rt hip " . No re-assessment of the patient 's condition and response to the pain medication was documented.
- response to the pain medication was documented.
 ? On 06/19/12 at 1015 " Presence of Pain: complaints of pain/discomfort " of her right leg was noted by the nurse, rated 10/10. The Pain Management Interventions indicated " single medication modality " . No re-assessment of the patient 's condition and response to the pain medication was documented.
 ? No documented pain assessment was recorded for Patient #1 status post fall on 06/15/12.

Tag No: A0395

The lack of enforcement of bylaws was confirmed in an interview with the Nurse Managers on the afternoon of 7/23/12 in the facility conference room.

VIOLATION: RN SUPERVISION OF NURSING CARE

Based on review of medical documentation and interview it was determined that the facility failed to ensure that a registered nurse evaluated the nursing care for each patient as evidence by lack of adequate assessment and documentation of patient care.

Findings were:

Facility policy & procedure titled Nursing Documentation stated, in part,

- "Nursing Documentation:...
- 2. Monitor and record the following:? Changes in patient 's condition "

A review of the clinic record for patient #1 revealed a failure to properly document a fall that occurred on 06/15/12. According to documentation,"While on the floor, the patient fell, X-rays of the right lower extremity were ordered. X-rays revealed a right distal femur fracture."

? It appears the fall resulting in the fractured right femur occurred around 1500 on 06/14/12 related to the time entered on the Physician/Professional Communication sheet. According to the Physician/ Professional Communication Note dated 6/14/12 the physician was notified of a "Significant Event" at 1515. There was no description of the significant event. The actions related to the communication were, "Stat xray of hip and right knee. Will contact Dr. Badylak and call if any changes to orders."

? There was no documented description of the significant event (fall). There was no follow up fall assessment, physical assessment, or

pain assessment documented on the patient post fall.

Facility policy & procedure titled Fall Precautions stated, in part, " The Morse Fall Scale will be utilized to assess the patient 's fall risk factors upon admission, fall, change in status and discharge or transfer to a new setting." ? A review of the clinical record for Patient # 1 revealed a Safety Assessment including Fall Risk Assessment completed upon their

admission on 6/14/12 at 1300. This initial Fall Risk Assessment scored the patient at 50 indicating a low fall risk 25-50. A Safety Assessment at 1500 indicated she was WNL (within defined limits). Another Fall Risk Assessment is not completed in the medical record until 2131. During this assessment the patient received a score of 65 indicating a high fall risk. No other fall risk assessments were completed on 6/14/12. No fall assessment was document post fall per policy. There was no follow up fall assessment documented on the

Facility policy & procedure titled Pain Management stated, in part, " All patients will be assessed for pain on admission and reassessed as indicated by the patient 's condition:..

9. Frequency of assessment for pain should be determined based on individual patient needs. The patient will be assessed: ...

- ? After each analgesic according to onset and peak effect time.
- 10. Assessment and evaluation will be ongoing and consider the patient 's history, current condition and anticipated needs. If the patient is reporting pain, the following factors should be evaluated and documented and as indicated:

? Location ? Radiation

- ? Intensity (0-10)
- ? Onset
- ? Duration
- ? Patterns
- ? Assessment of pain at its least and worst
- ? Qualitative Characteristics ...
- ? Response to the Intervention
- ? Absence or presence of unrelieved pain at peak action time
- ? Absence or presence of dose-limiting side effects
- 14. Reassessment of the patient 's condition and response to pain medications will be made after the administration of each dose of pain medication. "

A review of the clinical record for Patient # 1 revealed insufficient documentation of pain assessment (4 out of 7 times that pain medication was administered) on the following days:

- ? On 6/14/12 at 1629 " Presence of Pain: complaints of pain/discomfort " of her right knee was noted by the nurse. The nurse did not document intensity of the pain. The Pain Management Interventions indicated " single medication modality " . The Pain Response to Interventions at 1816 noted " pain improved " , this does not appropriately document the patient 's response to pain medication, nor does it note intensity.
- ? On 06/15/12 at 0944 " Presence of Pain: complaints of pain/discomfort " of her right leg was noted by the nurse, rated 6/10. The Pain Management Interventions indicated "Tylenol #3 300/30mg 1 tab PO". The Pain Response to Interventions at 1020 noted "pain at acceptable level", this does not appropriately document the patient's response to pain medication, nor does it note intensity.

 On 06/19/12 at 0200 "Presence of Pain: complaints of pain/discomfort" of her right hip was noted by the nurse. The nurse did not document in the patient stated "Tylenol #3 given po for pain to rt hip". No re-assessment of the patient's condition and response to the pain medication was documented.
- ? On 06/19/12 at 1015 " Presence of Pain: complaints of pain/discomfort " of her right leg was noted by the nurse, rated 10/10. The Pain Management Interventions indicated " single medication modality " . No re-assessment of the patient 's condition and response to the
- pain medication was documented.
 ? No documented pain assessment was recorded for Patient #1 status post fall on 06/15/12.

This lack of appropriate nursing care was confirmed in an interview with the Nurse Managers on the afternoon of 7/23/12 in the facility conference room.

VIOLATION: CONTENT OF RECORD - OTHER INFORMATION

Based on review of medical documentation and interview it was determined that the facility failed to ensure that all nursing notes, reports of treatment, and other information necessary to monitor the patient's condition were included in the medical record.

Tag No: A0467

Findings were:

Facility policy & procedure titled Nursing Documentation stated, in part,

"Nursing Documentation:...

- 2. Monitor and record the following:
- ? Changes in patient 's condition

A review of the clinic record for patient #1 revealed a failure to properly document a fall that occurred on 06/15/12. According to documentation, "While on the floor, the patient fell, X-rays of the right lower extremity were ordered. X-rays revealed a right distal femur

? It appears the fall resulting in the fractured right femur occurred around 1500 on 06/14/12 related to the time entered on the Physician/Professional Communication sheet. According to the Physician/ Professional Communication Note dated 6/14/12 the physician was notified of a "Significant Event" at 1515. There was no description of the significant event. The actions related to the communication were, "Stat xray of hip and right knee. Will contact Dr. Badylak and call if any changes to orders."

? There was no documented description of the significant event (fall). There was no follow up fall assessment, physical assessment, or pain assessment documented on the patient post fall.

Facility policy & procedure titled Fall Precautions stated, in part, "The Morse Fall Scale will be utilized to assess the patient's fall risk factors upon admission, fall, change in status and discharge or transfer to a new setting."

? A review of the clinical record for Patient # 1 revealed a Safety Assessment including Fall Risk Assessment completed upon their admission on 6/14/12 at 1300. This initial Fall Risk Assessment at 1500 indicating a low fall risk 25-50. A Safety Assessment at 1500 indicated she was WNL (within defined limits). Another Fall Risk Assessment is not completed in the medical record until 2131. During this assessment the patient received a score of 65 indicating a high fall risk. No other fall risk assessments were completed on 6/14/12. No fall assessment was document post fall per policy. There was no follow up fall assessment documented on the patient post fall.

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- ? Intensity (0-10)
- ? Onset
- ? Duration ? Patterns
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- ? Qualitative Characteristics ...
- ? Response to the Intervention
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 ? No documented pain assessment was recorded for Patient #1 status post fall on 06/15/12.

This lack of information necessary in the medical record to monitor the patient's condition was confirmed in an interview with the Nurse Managers on the afternoon of 7/23/12 in the facility conference room.

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METHODIST STONE OAK HOSPITAL ->

Report No. 1768

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METHODIST STONE OAK HOSPITAL

1139 E SONTERRA BLVD SAN ANTONIO, TX 78258

July 20, 2012

VIOLATION: NURSING CARE PLAN

Tag No: A0396

Based on record review and interview with facility staff and complainant, the facility failed to follow and/or update the nursing plan of care for one patient (patient #1) with a physician's order for a nasogastric (NG) tube, failed to implement the physician's order for placement of the NG tube, failed to note the physician's order for the NG tube in a timely manner, and failed to educate the patient and/or family member on the reasons for the use of and the consequences of not using the NG tube for patient #1 who had an admitting diagnosis of bowel obstruction.

The failed practice had the potential to affect all patients (unknown number) on the unit with an NG tube.

Findings included:

- 1. Record review on 07/18/12 of patient #1's History and Physical, dictated by physician #1 on 10/05/11 at 0925, revealed that "patient was an [AGE] year old man who comes in for just less than a day with history of abdominal pain. It was sharp and excruciating and occurred yesterday after eating. He has not had a bowel movement since Sunday and only had a small one at noon. He tried to give himself an enema, but that did not work. He has had some nausea and vomiting. He has NG tube in place. He had a CT scan of his abdomen showed patient with a nonspecific dilatation of the stomach and small intestine and small right inguinal hernia. Note, he does have a large amount of stool in the colon. Case of patient having constipation and probably obstipation with small bowel distention and dilation as well. Patient has a history of Meckel diverticulum with intra-abdominal hernia status post repair in 2010. Patient also with Parkinson and history of chronic constipation. Patient also with chronic kidney disease. Plan is for a soapsuds enema. We will start him on bowel regimen. We will have GI (gastrointerologist) see him. Continue supportive care. Continue prophylaxis. I will discuss this with the daughter."
- 2. Record review on 07/18/12 of patient #1's emergency room physician's telephone orders, dated 10/05/12 at 0350, included but was not limited to the following: "admit to med/surg, Dx (diagnosis) bowel obstruction, Diet: NPO (nothing by mouth), and NGT (nasogastric tube to intermittent with wall suction."
- 3. Record review on 07/18/12 to 07/19/12 of patient #1's clinical documentation record, dated 10/05/11 to 10/07/11, revealed the NG tube was identified as a problem/intervention on the nursing plan of care. Under goals, the plan of care documented the following: "1. The patient will receive care which reflects an ongoing process of interdisciplinary care based on their specific care needs. Coping responses to hospitalization will be assessed and addressed. 2. The patient and/or significant others can expect to be involved in the plan of care with attention to cultural and religious beliefs, privacy, and confidentiality. 3. The patient and/or other significant others will participate in the process of coordination of resources in preparation for discharge. 4. The patient and/or significant others will receive teaching about the nature of their health conditions, procedures, treatments, self-care and post discharge care. Verbalization of questions concerns will be encouraged. Patient education, which is an interactive, interdisciplinary teaching process is prioritized based on the ongoing assessment

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

of individual learning needs. 5. The patient and/ or significant others will have their environment and care managed to minimize risk to themselves and others. "

- 4. Record review on 07/18/12 of patient #1's clinical documentation record, dated 10/05/11 at 1105 AM and created by Registered Nurse (RN) #1 on 10/05/11 at 1831 PM revealed the following statement: "Per PCA (Patient Care Assistant) report, patient up to bedside commode and pulled out NG tube. Notified Dr. ______, (Physician # 1) per physician 's order, hold re-placing NG tube."
- 5. Record review on 07/19/12 of gastroenterologist 's (physician #2) order for patient #1, dated 10/05/11 at 1210 PM, included the following: Replace NG tube. The order was documented as entered into order system by clerical staff at 1250 PM. The order was documented as noted by RN # 1 at 1800 PM. In addition, beside the order for the placement of the NG tube was a small square. The other orders on the page were checked off. Review of physician #2's progress notes for patient #1, dated 10/05/11 at 1270 PM included the following notation under plan " NGT LIWS (NG tube low intermittent wall suction). "
- 6. Record review of clinical documentation record from 10/05/11at 1105 AM until 10/06/11 at 0053 AM revealed no further documentation by nursing staff regarding the NG tube. There was no documentation discussing why the order to replace the NG tube was not carried out. There was no documentation that a physician was notified regarding the order to replace the NG tube not being carried out. On 10/06/11 at 0053 and created in the clinical record on 10/06/11 at 0101 AM by RN #2 revealed the following: "Sleeping from 199 (corrected to 1900) until 2200, refused golightly and NG tube, daughter at bedside agreed with patient. Unable to swallow liquids without coughing. PO (by mouth) medications on hold. Dr. _____ (physician #3) on call for Dr. _____ (physician #2), notified, new orders received. Medicated with Zofran for abdominal discomfort, and with morphine for complaints of severe pain. Resting comfortable at this time, daughter at bedside. "There was no documentation in the clinical record of a discussion between patient #1and/or patient #1's daughter regarding why the NG tube was ordered and the possible consequences of not re-placing the NG tube. In addition, during the six hours between the written order by the gastroenterologist (physician #2) to replace the NG tube and the notation of the order by RN #2, there was no documentation by nursing staff that patient #1 and/or the patient #1's daughter was in agreement with not replacing the NG tube nor was there documentation that the gastroenterologist (physician #2) was aware the patient and/or the patient 's daughter did not want the NG tube replaced.

Continued review of patient #1's clinical documentation record revealed that on 10/06/11 at 0930AM and documented by RN #3 on 10/06/11 at 1357 PM revealed the following: " Dr. _____ (Physician #2) called by nurse and reported to the doctor that the NG tube remains out. Received order to keep patient NPO (nothing by mouth),and to hold PO (by mouth) medications. Received order to first give fleets enema, then changed to suppositories. Informed doctor of patient 's family 's concerns. Notified family of call to doctor. "

At 10/06/11 at 1030 AM and documented on 10/06/11 at 1400 by RN #3, " patient 's family assisted patient to side of bed, patient vomiting. Cleaned patient 's face with wash cloth. Family stated patient vomited a lot.: At 1100 AM, Dr. ______ (Physician #2) on the floor to see patient. Patient vomiting. Dr. _____ (Physician #2) asked for an NG tube and lubrication. Pulse ox placed on patient prior to placement of the NG tube."

At 1115 AM, "Dr. ____ (Physician #2) with patient when code called, Dr. Reported that patient stopped breathing. At 1145 AM, patient was transferred to ICU."

- 7. Record review on 07/18/12 of patient #1 's Death Summary, dated 10/11/11 at 1215 PM revealed the following statements by Physician #3: "He had an NG tube in place and patient removed it a couple of times while in the hospital. On the morning of October 6th (2011), the patient started vomiting, aspirated, and went into respiratory arrest. Required an emergent intubation and emergency service. Patient became hypotensive requiring vasopressors with Levophed. Patient was intubated, receiving total ventilatory respiratory support, on Levophed, was diagnosed with a status post pulseless electrical activity arrest, acute ST elevated MI, acute renal failure with profound metabolic lactic acidosis, aspiration pneumonia, and septic shock secondary to intra-abdominal catastrophe. On the early hours of October 7th, patient 's family requested do not ressussicate/do not intubate (DNR/DNI), and around 7:00 AM, patient was declared dead.
- 8. Interview on 07/18/12 at 11:00 AM with the Director of Risk Management revealed that she was familiar with the complaint regarding patient #1. She stated she has referred this case to Medical Peer Review. She further explained that whenever there was a complaint, part of the process was to refer to Medical Peer Review. She stated the next meeting for Medical Peer Review would be in August 2012. She stated she had acknowledged the complaint by sending a letter to the complainant.
- 9. Interview on 07/18/12 at 12:55 with RN #1 who worked the 7:00 PM shift revealed the following: She did not remember patient #1. She confirmed that when a square is beside a physician 's order that means she has not completed the order. She stated she would have gone over the physician 's orders that had not been completed with the next shift. She was unable to explain why there was a six hour difference between when the physician ordered the NG tube replaced and when she noted the order for the replacement.
- 10. Interview on 07/19/12 at 4:00 PM with the complainant revealed the following. She indicated she was the daughter of patient #1 and had stayed with patient #1 during a large part of his hospital stay. She stated that she had been with her father since late evening of 10/05/11 when she took him to the facility emergency room until the morning of 10/06/11 prior to the time he coded. She stated that on the morning of 10/05/11, she had initially agreed with patient #1 's wish to not have the NG tube in because he was uncomfortable when the NG tube was in place. She stated that later in the day sometime after 5:30 PM and into the night, she voiced concerns to the nursing staff regarding the amount of fluid coming from his mouth. She described it as "brown and stringy". She stated she knew the NG tube needed to go back in. She stated she was told by RN #2 that she needed an order to replace the NG tube and she would have to get in touch with a physician to get an order to replace the NG tube. The complainant recalled that she continuously asked RN#2 if she had heard from the physician regarding replacing the NG tube and was told she had not heard from the physician.
- 12. Interview on 07/18/12 at 7:00 PM with RN #2 who worked the 7:00 PM to 7:00 AM shift revealed that she recalled patient #1 and his daughter. She described his daughter as " demanding " . She stated that patient #1 and his daughter did not want the NG tube in place. She recalled that she documented they did not want the NG tube in place because she had spoken with the physician on call (physician #3) and he had instructed her to document their refusal of the NG tube. She indicated that if she had placed an NG tube in the patient, she would have had to " hold him down " . She stated that she did not remember patient #1's daughter asking her to contact a physician because she wanted the NG tube replaced. She confirmed that she contacted the physician on call after attempting to contact other physicians. She did not remember if she attempted to contact physician #2. She stated that she thought she had documented her unsuccessful attempts to contact a physician during the night. She was unable to recall a specific reason why she was attempting to contact a physician regarding patient #1.



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Tag No: A0450

Tag No: A2402

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WESTBURY COMMUNITY HOSPITAL, LLC ->

Report No. 1781

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

WESTBURY COMMUNITY HOSPITAL, LLC 5556 GASMER HOUSTON, TX 77035 July 20, 2012

VIOLATION: MEDICAL RECORD SERVICES

The facility failed to ensure that patient medical record entries were completed, timed, and dated per hospital policy for 8 of 21 sampled patients (Patient ID # 8, 10, 11, 12, 13, 15, 18, and 21).

The "Memorandum of Transfer" form was incomplete for the above-listed sampled patients.

Findings include:

Intake # TX 968:

Review of the "Memorandum of Transfer" (MOT) form for 21 sampled patients who had been transferred from the facility during June and July 2012 revealed the following:

- a. MOT for sampled Patients IDs # 12, 13, and 15 failed to include date and time " Accepting hospital secured by Transferring hospital " (Section A, question 8).
- b. MOT for sampled Patients IDs # 8, 12, 13 failed to include signature, title, and time of " Transferring hospital administration who contacted the receiving hospital. " (Section A, question 9).
- c. MOT for sampled Patients IDs# 10, 11, 18, 21 failed to include documentation of name, phone number, and address of " Next of Kin " and indication the Next of Kin was notified of the patient 's transfer. (Section A, question 3).

Interview on 07/20/12 at 3:00 p.m. with the Interim Director of Nursing (ID # 50) she stated all sections of the MOT form should be completed, including signatures, staff names, dates , and times. She went on to say that if a person had no " Next of Kin " or it was unknown, this should be documented in the " Next of Kin " section of the MOT and not be left blank.

Review of facility policy titled "Patient Transfer, "revised date 3/12, read: "...F. Memorandum of Transfer: 1. The hospital shall provide that a memorandum of transfer (MOT) be completed for every patient who is transferred..."

VIOLATION: POSTING OF SIGNS

Based on observation, interview and record review, the facility failed to conspicously post a sign indicating rights of individuals in emergency conditions.

Findings include:

Observation rounds conducted on 07/19/12 at 11:45 a.m. of the first floor intake area for all patients entering the facility revealed the

following:

The intake area has two entrances, one for the ambulance drop off/walk in and the one for walk-ins. On the two entrances there were postings (8 1/2 by 11) on each door which read " emergency room IS CLOSED TO THE PUBLIC. NO EMERGENCY PERSONNEL ARE AVAILABLE. IN CASE OF AN EMERGENCY, CALL 911. "

Interview with staff #57 (personnel roster/key #2) during the observation rounds on 07/19/12 at 11:00 am in the intake unit revealed "everyone comes through both doors and the main door is for the ambulance". "We see everyone that comes through those doors for some kind of treatment" and pointed at the "EMTALA" signs at both the waiting area and in the hallway on the board.

Observation on 07/20/12 at 12:00 p.m. with employee #51, Interim DON (personnel roster #2) revealed the two signs were still posted at the doors and this employee took the signs down and said that "people will misread it because we do see everyone that comes here, stabilize them or call 911 and then make appropriate transfer if we have to". Employee #51 did confirm that the signs are not the right signs.

Review of facility policy and procedure titled "EMTALA-Texas Signature dated 5/10 and revised 4/12 on 07/20/12 revealed the following: "The hospital must post signage that, at a minimum, meets the following requirements: "

as well as those individuals waiting to for examination and treatment in areas other than traditional emergency department (e.g., entrance, admitting area, waiting room, labor and delivery, treatment areas located on hospital property);

? " signage must be readable from anywhere in the area or at least twenty (20) feet ".



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Report No. 1561

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ST DAVID'S SOUTH AUSTIN MEDICAL CENTER

901 WEST BEN WHITE BLVD AUSTIN, TX July 17, 78704 2012

VIOLATION: PATIENT RIGHTS: CONFIDENTIALITY OF RECORDS

Tag No: A0147

Based on a review of documentation and interview, it was determined that the facility failed to ensure the right of patients to the confidentiality of his or her clinical record.

Findings were:

? Patient Kardex forms were received at Department of State Health Services (DSHS)via fax for 5 out of 7 patient medical records reviewed (Patients #1, 2, 3, 5, and 6). The Kardex form included the following personal health information: the patient medical record number, birth date, admitted, primary diagnosis, medical history, hospitals/surgery history, allergies, and diet order.

number, birth date, admitted, primary diagnosis, medical history, hospitals/surgery history, allergies, and diet order.

? SBAR (Situation, Behavior, Assessment, and Re-Assessment)Fax Reports were received at DSHS via fax for 2 out of 7 patient medical records reviewed (Patients # 4 and 7. The SBAR Fax Report included the following personal health information: patient name, age, sex, weight, height, chief complaint, admitting doctor, admission diagnosis, vital signs, allergies, medical history, medications administered in the emergency room, physical assessment information and other information.

? Several pages of handwritten SBAR (Situation, Behavior, Assessment, and Re-Assessment) notes were received at DSHS on 6 out of 7 patient medical records reviewed (patients # 1, 2, 3, 4, 5, and 6). The handwritten SBAR notes contained personal health information including input and output measurements, labs, and orders.

Facility policy & procedure titled Health Information Management stated in part "Paper Documents Containing PHI

A. Facilities must ensure that reasonable safeguards are in place to protect paper documents containing PHI:

1. to the extent feasible:

i. PHI should be removed from high visibility areas, even if those areas are not open to the public, and

ii. PHI should be maintained in a confidential manner in order to prevent workforce members and others that do not have a need to know from accessing such PHI.

iii. Documents must not be left unattended in areas accessible to the public (e.g., charts may not be left unattended on a counter that is open to the public).

iv. Access to areas containing PHI must be limited to authorized personnel.

2. Documents containing PHI must be disposed of securely (e.g., place PHI in shred bins not regular trash cans or recycle bins that will not be shredded). The facility must eliminate unnecessary regular trash cans. "

Facility Document titled Patient Rights stated in part, "Confidentiality of your health care information/medical records and communication, written or oral, between you and your healthcare providers except as otherwise provided for by law or contracts with your third party payer.

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	п
	The issues regarding the right to confidentiality of clinical records was confirmed in an interview with the Director of Quality Management on the afternoon of 7/16/12.

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SOUTH HAMPTON COMMUNITY HOSPITAL ->

Report No. 1757

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SOUTH HAMPTON COMMUNITY HOSPITAL

2929 SOUTH HAMPTON ROAD DALLAS, TX July 9, 75224 2012

VIOLATION: PATIENT RIGHTS: TIMELY REFERRAL OF GRIEVANCES

Tag No: A0120

Based on review of documentation and interview with staff, it was determined the facility failed to document any investigation of the concerns of patient #2 regarding the quality of care. The facility also failed to follow its own policies and procedures.

Findings included:

A review of facility policy entitled, "Patient Grievance Process," stated "To establish a process for prompt resolution of patient grievances to assure all patient concerns are addressed, resolved and follow-up is completed with the patient or patient's family in the most expeditious manner possible." Review of the policy revealed a definition for a concern and a grievance. The policy stated the definition for a "Concern: a written or verbal concern or objection from a patient, or the patient's designated representative, regarding the quality or appropriateness of patient care that can be effectively addressed and resolved by informal means without a formal grievance procedure or the necessity of providing a written response. Generally a concern can be solved quickly by the staff member receiving the concern." The policy stated the definition for a "Grievance: A written or verbal request by a patient or designated representative to have the facility formally review the patient's concern or objection about the quality or appropriateness of patient care. Generally a grievance would require an investigation and/or may require management level personnel to resolve the grievance. This grievance cannot be resolved promptly by staff present at the time of the grievance." Further review revealed "2. All grievances will be reviewed by the Sr. Clinical Coordinator and CNO no more than 3 weeks after the grievance is filed and the patient will receive a written notice of its decision ..." The policy also stated all grievances received post discharged requesting follow up will be documented on a Patient Concern Response form by the employee receiving the grievance. The form will to be forwarded to the Department/Clinical Director for investigation and resolution.

- 1. According to the complaint intake form, the patient's representative had dates and the names of the staff members who failed to file the complaint regarding the quality of care received. For example:
- a) On 12/15/2011, a telephone call to the facility operator was placed to notify the staff member the patient representative wanted to file a complaint. The facility operator directed the call to staff member #8. The patient representative stated staff member #8 initiated the complaint.
- b) On 12/21/2011 at 1:55pm, a telephone conversation with staff member #9 regarding the fall patient #2 sustained which caused possible rib fractures, Thoracentesis Procedure performed without the consent of the patient representative, and other concerns. The patient representative stated that staff member #9 would complete the complaint.
- c) On 12/29/2011, the patient representative stated a telephone call was placed to the unit manager at Windsor Gardens and South Hampton Community Hospital had not returned the telephone call.
- d) On 1/13/2012 and 1/24/2012, the patient representative followed up on the phone calls placed with staff member #9 and still had not received a returned call.
- 2. A review of the medical record of patient #2 revealed a face sheet (patient's personal information ie: address, billing information) which had a hand written note dated 12/21/2011. The staff member from South Hampton Community Hospital obtained the information from the unit manager of Windsor Gardens Nursing Home. The unit manager was calling for the representative of patient #2. The call was in regards to a fall patient #2 allegedly sustained at South Hampton Community Hospital. The unit manager was calling the facility to request information regarding the incident report.

In an in person interview on July 9, 2012 at approximately 1:30pm with staff member #1, it was confirmed that the facility failed to perform an internal investigation regarding the information obtained above. In the same interview staff member #1 stated there was no documentation the complaint was filed to the proper departments for investigation. In multiple interviews with staff members #1 and #2 on July 9, 2012, it was confirmed the facility had staff members who failed to perform their assigned duties and are no longer working for the facility.

VIOLATION: PATIENT RIGHTS: INFORMED CONSENT

Based on review of documentation and interview with staff, it was determined the nursing staff failed to evaluate the nursing care provided to patient #2.

Tag No: A0131

Tag No: A0132

Findings included:

Facility policy entitled, "Consent for Medical and Surgical Treatment," stated "2. Minors and Incompetent patients will be treated only upon obtaining consent based on protocol as outlined in this policy." In the General Comments section stated, "3. The patient/responsible party signs form to indicate that consent is given for stated procedure/treatment and which is understood along with risks and hazards. 6. The following definitions are given for clarification: Incompetent Adult- lacks ability to understand and appreciate the nature and consequences of a treatment decision including the significant benefits, harms of, and reasonable alternatives to proposed treatment decision." In the Disclosure and Consent section stated, "5. The Disclosure and Consent form will be ...I or (we) will be struck out; all blanks filled in correctly before the patient or his/her representative, and physician /nurse sign. 6. The physician's first and last name will be used on the Disclosure and Consent form. 7. All Disclosure and Consent forms must be witnessed by one person. This can be the Physician or a nurse who observes the patient or representative signing the form. 10. The consent form will be signed by the individual receiving care with following exceptions ...Incompetent patients. 15. It is the responsibility of the nurse in charge to review the informed consent and insure that proper procedure has been carried out."

Review of the medical record of patient #2 revealed the following:

Patient #2 was admitted from 12/6/2011 through 12/15/2011.

Physician documentation on 12/6/2011, 12/7/2011, and 12/13/2011revealed the patient had a past history of dementia (which is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior). Physician progress notes dated 12/14/2011 at 6:00pm stated patient #2 was confused when he stands up in the middle of the room. Nursing daily assessments revealed the patient was confused at times and responded to simple commands.

- 1. Facility document consent form for a PICC (Peripherally Inserted Central Catheter) line dated 12/9/2011 was signed by patient #2 and was incomplete. The local analgesic medication box was left blank. The section which stated the alternatives to the procedure and the probability of success which had been explained to the patient was left blank. Only the last name of the physician was on the consent form. The sections where the patient was to check a box on the consent form were all left blank.
- 2. The consent form dated 12/10/2011 for PICC line was signed by the patient's representative and had the necessary boxes checked. Only the last name of the physician was on the consent form.
- 3. Review of facility document entitled, "Disclosure and Consent Medical and Surgical Procedures," revealed a consent form dated 12/15/2011 at 9:30am to perform a thoracentesis. Patient #2 signed the consent form but the radiology technician dated the consent form. The consent form had only the name of the physician and was signed by the physician and the radiology technician. Facility policy stated the consent forms would have the first and last names of the physician and the witnessed by a nurse. The facility failed to follow its own policy.
- 4. Review of the radiology report dated 12/15/2011 revealed the physician dictated the informed consent was obtained. The report also stated "utilizing local anesthesia." Further review stated, "unsuccessful attempt at right-sided thoracentesis. Only small amount of Pleural effusion was present."

In multiple interviews on July 9, 2012 with staff member #1, the above was confirmed that the nursing staff failed to properly evaluate the quality of care for patient #2. In an interview with staff member #2 on July 9, 2012 at approximately 5:05pm, it was confirmed that the facility will review its own policies and procedures. In multiple interviews with staff members #1 and #2 on July 9, 2012, it was confirmed the facility had staff members who failed to perform their assigned duties and are no longer working for the facility.

VIOLATION: PATIENT RIGHTS: ADVANCED DIRECTIVES

Based on review of documentation and interview with staff, it was determined the facility failed to properly execute the patient's rights for advanced directives.

Findings included:

Review of the medical record of patient #2 revealed a history of dementia (which is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior.) Physician documentation revealed the patient had dementia. Nursing daily assessments revealed the patient was confused at times and responded to simple commands.

A review of facility document entitled "Notice to Patients Regarding Your Right To Make Advanced Health Care Decisions," revealed the form was signed by the patient's representative on 12/06/2011. The question, "Do you have a Durable Power of Attorney for Health Care," the patient's representative checked the box "yes." The facility failed to obtain a copy of the Durable Power of Attorney as evidence by there were no documents found in the medical record. There was no documentation the facility spoke with the patient's representative regarding obtaining a copy of the Durable Power of Attorney.

In multiple in person interviews on July 9, 2012 with staff member #1, it was confirmed that the facility failed to request and obtain a copy of the Durable Power of Attorney from the patient's representative.



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NORTHWEST TEXAS HOSPITAL ->

Report No. 1505

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NORTHWEST TEXAS HOSPITAL 1501 COULTER ROAD AMARILLO, TX 79106 July 5, 2012

VIOLATION: MEDICAL STAFF ACCOUNTABILITY Tag No: A0347

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on a review of documents and interviews with staff, the medical staff was not accountable to the governing body for the quality of the medical care provided to the patients.

Findings were:

A review of facility policy #III-E.29 titled INSOMNIA PROTOCOL states, in part, " POLICY STATEMENT: To establish consistency in prescribing patterns and to monitor the need and effectiveness of the short-term use of hypnosedative agents for patient in the hospital (excludes the Pavilion) ...2. Prescriber Responsibilities: ...a. Prescriber will initiate appropriate hypnosedative agent to be administered from the following available:

- ? Zolpidem 5 mg
- ? Temazepam 15 mg (<[AGE] years old) ? Temazepam 7.5 mg (>[AGE] years old)
- 4. Pharmacist Responsibilities: ...c. The pharmacist will be responsible for initiating the lowest dose of the agent prescribed by the physician, i.e., prescription written for " zolpidem 10 mg PO QHS PRN insomnia will be auto-substituted for " zolpidem 5 mg PO x 1 dose, may repeat an additional 5 mg PO x 1 in 30 minutes if needed for insomnia "; ...Auto-Substitutions: Orders written for the following hypnosedatives (PRN insomnia) will be substituted accordingly:
- ? zolpidem a 5 mg PO HS PRN insomnia: may repeat if necessary in 30 minutes (if age <[AGE] years old) ? zolpidem a 5 mg PO HS PRN insomnia (if age > or equal to [AGE] years old)

A review of NWT Medical Executive Committee meeting minutes (8-9-11) revealed, in part, the following documentation:

- " Minutes from the July 26th PTIC meeting were reviewed. The following was highlighted:
- ? Insomnia Protocol Conclusions/Recommendations/Action: The Medical Executive Committee reviewed the Insomnia Protocol and approved as submitted with no further action. "

In an interview with staff #7 on 7-3-12, he was unable to provide any documentation to show that the protocol had been communicated with staff #10.

The above was confirmed in an interview with the Chief Executive Officer, the Chief Nursing Officer and other administrative staff during the afternoon of 7-5-12 in the facility conference room.

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Tag No: A0171

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DENTON REGIONAL MEDICAL CENTER ->

Report No. 1536

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DENTON REGIONAL MEDICAL CENTER 3535 SOUTH I35 EAST DENTON, TX 76210 July 2, 2012

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on review of documents and interview with staff, the facility did not ensure that the orders for physical restraint were in accordance with the required limits for 2 of 5 patients whose records were reviewed. Patient #1 and Patient #2, both adults, were physically restrained for combative behavior requiring an order renewal every 4 hours; these orders were not obtained.

Findings were:

The hospital's restraint policy, entitled PATIENT RESTRAINT/SECLUSION, last approved in February 2012, states under the section entitled PROCEDURE, the RN assessment of a patient who may need restraints includes whether the patient understands that he/she should not remove medical devices, and/or whether or not the patient understands the need to remain immobile. The RN assessment also includes determining if a patient is exhibiting aggressive, combative, or destructive behavior that places the patient or staff in immediate danger. Section 5A outlines the requirements for physician orders for restraint needed for non-violent behavior, such as the need to remain immobile or to leave medical devices undisturbed. In these cases, the physician orders are required at least every 24 hours. To continue restraint beyond the initial order duration, the physician or Licensed Independent Practitioner (LIP) must see the patient and perform a clinical assessment to determine if continuation of restraint is necessary at least each calendar day. Section 5B outlines the requirements for physician orders for restraint for violent or self-destructive behavior; the order must not exceed 4 hours for adults, aged 18 years and older. To continue restraint or seclusion beyond the initial order duration, the RN determines that the patient is not ready for release and calls the ordering physician to obtain a renewal order that does not exceed 4 hours for adults.

Review of the medical record for Patient #1 revealed that the patient required the use of restraints for combative behavior from 5/13/2012 - 5/15/2012. Beginning at 2:40 pm on 5/13/12, nursing notes indicated that the patient was getting out of bed and wanting to leave. Patient #1 ripped all the EKG monitoring leads off and began to punch the sitter. Soft restraints were applied to arms and legs, and the physician was notified. Nursing notes for 5/14/12 state that the patient "continuously moves self in bed even in restraintsattempted to bite me while administering medicationpatient physically abusive. "On 5/14/2012, an order for non-violent restraints was written by the physician at 8:15 am. The 2nd restraint order for non-violent behavior was obtained the next morning, 5/15/12. The facility considered Patient #1 as a "non-violent" patient who needed restraints for "non-violent" behavior every 24 hours; therefore, orders for violent behavioral restraints were not obtained per facility policy: There was no initial order at the time of initiation of restraints the afternoon of 5/13/12, nor were there renewal orders every 4 hours based on nursing assessments of the need to continue the restraints.

Review of the medical record for Patient #2 revealed that the patient required restraints for combative behavior 4/28/2012 between the hours of 6:20 pm and 2:00 am, 4/29/12. Nursing notes indicate that at 6:20 pm on 4/28/2012, the patient was combative with physical aggression, and attempting to remove medical devices. At 7:20 pm, a " code yellow " was called because the patient was combative during nursing intervention and they required additional security staff. An initial physician order for non-violent restraint was obtained at the initiation of restraints for the duration of 24 hours, not the required 4 hours per combative behavioral restraint requirements.

These findings were acknowledged by the facility Vice President of Human Affairs and the Director of ICU in a joint in-person interview conducted the afternoon of 7/2/2012.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on review of documentation and interview with staff, the facility failed to ensure that staff monitored the physical and psychological well-being of 2 of 5 patients placed in restraints for combative behavior. Patient #1 and Patient #2 were placed in restraints and were not monitored every 20 minutes according to facility procedure.

Tag No: A0205

Findings were:

The hospital's restraint policy, entitled PATIENT RESTRAINT/SECLUSION, last approved in February 2012, states that restraints used for non-violent behavior, such as a patient who pulls at tubes and devices, must be monitored at least every 2 hours. For those patients in restraints for violent behavior, the policy does not specify the timeframe required for monitoring. The staff training documents state that that patients should be monitored three times an hour (every 20 minutes) if in behavioral restraints, including documenting any changes in behavior, signs of injury, the alternatives attempted, and the patient's readiness for release from restraint.

Review of the medical record for Patient #1 revealed that the patient required the use of restraints for combative behavior from 5/13/2012 - 5/15/2012. Beginning at 2:40 pm on 5/13/12, nursing notes indicated that the patient was getting out of bed and wanting to leave. Patient #1 ripped all the EKG monitoring leads off and began to punch the sitter. Soft restraints were applied to arms and legs, and the physician was notified. Nursing notes for 5/14/12 state that the patient "continuously moves self in bed even in restraintsattempted to bite me while administering medicationpatient physically abusive. "Review of restraint documentation indicates that Patient #1's restraint status was monitored every 2 hours while the patient was restrained 5/13/12-5/15/12, not every 20 minutes as required by facility procedure for patients placed in restraints due to combative or violent behavior.

Review of the medical record for Patient #2 revealed that the patient required restraints for combative behavior 4/28/2012 between the hours of 6:20 pm and 2:00 am, 4/29/12. Nursing notes indicate that at 6:20 pm on 4/28/2012, the patient was combative with physical aggression, and attempting to remove medical devices. At 7:20 pm, a " code yellow " was called because the patient was combative during nursing intervention and they required additional security staff. Review of restraint documentation indicates that Patient #2's restraint status was monitored every 2 hours while the patient was restrained for combative behavior, not every 20 minutes as required by facility procedure.

These findings were acknowledged by the facility Vice President of Human Affairs and the Director of ICU in a joint in-person interview conducted the afternoon of 7/2/2012.



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JPS HEALTH NETWORK ->

Report No. 1469

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JPS HEALTH NETWORK

1500 S MAIN ST FORT WORTH, TX 76104

June 20, 2012

VIOLATION: RN SUPERVISION OF NURSING CARE

Tag No: A0395

Based on review of documentation and interview with staff, it was determined the nursing staff failed to supervise and evaluate care on 3 of 10 medical records reviewed for patients who presented to the ED with cardiac symtoms. The nursing staff also failed to acknowledge physician orders in 8 of 10 patient medical records.

Findings included:

Review of facility policy entitled, "Patient Rights and Responsibilities" stated, "I. Patient Rights, The District has adopted the following statements of patient rights ...Considerate, dignified and respectful care, provided in a safe environment, free from all forms of abuse, neglect ..."

Review of facility policy entitled, "Nursing Documentation" stated "It is the policy of Department of Emergency Medicine (DEM) to provide specific guidelines for consistent documentation of nursing care. Further review revealed, "E. Nursing documentation will include: Documentation of other parameters such as ... Continuous Cardiac Monitoring ... F. Patient observations should be performed and documented as indicated by the patient's clinical status."

- 1. The medical record of patient #10 revealed the patient (MDS) dated [DATE] at 11:26am and had an abnormal EKG. The patient was transferred to bed in the Emergency Department (ED) at 11:36am. Documentation revealed the patient was not placed on a cardiac monitor until 11:58am when he was transferred to a room. The patient had a history of a heart attack and atrial fibrillation. The patient presented to ED with chest pain and was not monitored for a 22 minute time period which could have placed the patient's safety in jeopardy.
- 2. The medical record of patient #4 revealed the patient (MDS) dated [DATE] at 12:46am with swelling to the penis and lower legs for 3 days and had a history of atrial fibrillation. The EKG performed at 2:34am stated atrial fibrillation. Patient #4 was first transferred to an area in the ED without a cardiac monitor. Physician #6 at 4:07am documented the patient was in need of a monitored bed. Patient #4 was then transferred to an area from the ED waiting room that does not have cardiac monitors in the rooms. There was no documentation in the medical record the patient was on a cardiac monitor until 5:21am when the patient was transferred to another area in ED that had monitors in the room. The patient presented to ED with chest pain and was not monitored for a 4 hour and 15 minute time period which could have placed the patient's safety in jeopardy.
- 3. The medical record of patient #5 revealed the patient present to the ED with chest pain and shortness of breath on 12/28/2011 at 11:28pm and the patient left without being seen. Documentation revealed the nurse called the patient 13 minutes later and the patient did not answer. The patient presented to the ED with chest pain and there was no documentation the patient was triaged.
- 4. Review of 8 of 10 (#1, 2, 4, 6, 7, 8, 9, 10) medical records, the nurse failed to acknowledge physician orders. The nurse failed to sign,

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

date, and time the order sheet as the signature line was blank.

The above was confirmed in multiple interviews on 6/20/2012 with staff member #1 and #2. Staff member #14 stated in an interview on 6/20/2012 at 10:40am that nurse's must sign, date, and time all physician orders and that the issue had been discussed with them.

VIOLATION: QUALIFIED EMERGENCY SERVICES PERSONNEL

Based on review of documentation and interview with staff, it was determined the facility failed to adequately staff shifts to meet the patient needs.

Tag No: A1112

Findings included:

Staff member #2 stated in an interview on 6/19/2012 at 12:30pm the ED staff's 16 RN's per shift and in the projected new budget for 10/2012 they are increasing staffing to 20-23 RN's.

Review of Emergency Department (ED) staffing schedules revealed:

- 1. On 12/14/2011 shift 7:00pm-7:00am, there was the team leader absent and the staffing schedule did not have the name of the needed staff members to fill the positions needed. Also on 12/14/2011, in the yellow area which was critical care, there was 1 nurse scheduled to work in the critical care area during this shift. There was no clerk available in the yellow area. There was no documentation the facility filled the needed positions. These staffing issues were a potential for placing patient safety at risk.
- 2. On 12/28/2011 shift 7:00pm -7:00am there was 1 nurse absent, one nurse was working 7:00pm-12:00am, one tech was absent, there was no tech scheduled in the purple area which was the fast track, and there was no EKG tech scheduled. Documentation also revealed there were 14.8 Registered Nurse's (RN) and zero Licensed Vocational Nurse's (LVN) scheduled to work on this shift for the ED. There was no documentation the facility filled the needed positions. These staffing issues were a potential for placing patient safety at risk.
- 3. On 12/29/2011 shift 7:00am-7:00pm, there was the flow facilitator and a nurse absent. Also, the intake nurse was late. Documentation also revealed there were 13.8 Registered Nurse's (RN) and zero Licensed Vocational Nurse's (LVN) scheduled to work on this shift for the ED. There was no documentation the facility filled the needed positions. These staffing issues were a potential for placing patient safety at risk.
- 4. On 12/29/2011 shift 7:00pm-7:00am, the yellow area which was the critical care area did not have a tech. Documentation revealed there were 14.8 Registered Nurse's (RN) and zero Licensed Vocational Nurse's (LVN) scheduled to work on this shift for the ED. There was no documentation the facility filled the needed positions. These staffing issues were a potential for placing patient safety at risk.
- 5. On 12/30/11 shift 7:00pm-7:00am revealed there were 10.9 Registered Nurse's (RN) and one Licensed Vocational Nurse's (LVN) scheduled to work on this shift. There was no documentation the facility filled the needed positions. These staffing issues were a potential for placing patient safety at risk.

The above was confirmed in multiple interviews on 6/19-20/2012 with staff members #1 and #2.

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PARKLAND HEALTH AND HOSPITAL SYSTEM ->

Report No. 1463

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PARKLAND HEALTH AND HOSPITAL SYSTEM

5201 HARRY HINES BLVD DALLAS, TX 75235 June 15, 2012

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the hospital failed to ensure 1 of 1 patient (Patient #1) was provided a safe environment for both physical and emotional health. RN Staff #5 entered (Patient #1's) room on the morning of 05/03/12 at approximately 02:00 AM and is alleged to have performed a physical assessment which included (Patient #1's) genitalia. (Patient #1) was being treated for an infected finger and manual examination of the patients external genitalia was not consistent with the assessment or treatment of the patients presenting problem or primary diagnosis.

Findings included:

The physician note dated 04/17/12 timed at 18:55 PM reflected, "(Patient #1) is a [AGE] year old male...had an injury with rebar after a fall 5 days prior to admission. He noticed worsening swelling and purulent drainage on the right index finger...he came to the ED (Emergency Department) on 04/09/12...patient was taken to the OR (Operating Room)...there was some bony erosion at the dorsal aspect of the joint...x-ray findings suggestive of osteo[DIAGNOSES REDACTED] and septic arthritis...neck no cervical lymphadenopathy..."

The physician progress note dated 05/02/12 timed at 13:18 PM reflected, "Pain in finger with stretching and ROM (range of motion) exercises only...neck supple...stable..."

The nursing progress note documented by RN Staff #3 dated 05/02/12 timed at 18:52 PM reflected, "Report received from off going RN...Sheriff at bedside...at 19:35 PM initial assessment completed...pt stated pain in r (right) index finger...pain medication given...sheriff at bedside ...at 20:47 PM pt stated pain has been relieved...05/03/12 at 07:19 AM...report given to on coming RN..." No documentation was found which indicated relieving RN Staff #5 documented an assessment was completed on (Patient #1).

On 06/07/12 at 02:45 PM (Patient #1) was interviewed. (Patient #1) stated on the morning of 05/03/12 at about 02:00 AM RN Staff #5 entered his room and told him he needed to complete a physical assessment. (Patient #1) stated the nurse pulled the privacy curtain and said he needed to check his pulse in his neck, chest, and armpits. RN Staff #5 checked the nodes in his neck, axilla, and chest (lymph nodes) and said he needed to check the nodes in his groin as they were the same. (Patient #1) stated RN Staff #5 touched him "down there" (pointing to his privates). (Patient #1) stated RN Staff #5 made him feel uncomfortable. (Patient #1) stated RN Staff #5 fondled his privates. RN Staff #5 finished and left the room. (Patient #1) was asked if any nurse at the hospital had performed a similar assessment on him. (Patient #1) stated, "No only RN Staff #5." (Patient #1) stated he pushed the call bell a short time later and his nurse Staff #3 came into the room. (Patient #1) stated he informed RN Staff #3 that RN Staff #5 touched him inappropriately during an assessment. (Patient #1) stated RN Staff #5 did this to him previously on the morning of 04/26/12. (Patient #1) stated he did not say anything the first time because who would believe him he is an "inmate." (Patient #1) stated it upsets him still and struggles emotionally with this event. (Patient #1) stated no one assessed him after the event and/or provided any type of counseling.

On 06/07/12 at approximately 03:45 PM Staff #16 was interviewed. Staff #16 stated he was unaware until today (06/07/12) that (Patient #1) alleged one of the Hospital staff touched (Patient #1) in a sexual manner. Staff #16 stated he would be sure (Patient #1) received counseling services.

On 06/08/12 at 02:30 AM RN Staff #3 was interviewed by telephone. RN Staff #3 stated (Patient #1) was stable on her shift 05/02/12 07:00 PM to 05/03/12 07:00 AM. RN Staff #3 said she asked RN Staff #5 to relieve her for lunch break for thirty minutes at approximately 02:00 AM. RN Staff #3 stated she informed RN Staff #5 her patients were fine and just answer any call lights. RN Staff #3 stated a short time after she returned from her break (Patient #1) pushed his call light. RN Staff #3 said she asked (Patient #1) what he needed and (Patient #1) asked her if she instructed RN Staff #5 to do an assessment on him (Patient #1) during her break. RN Staff #3 said she told (Patient #1) "no." RN Staff #3 stated there was no reason for RN Staff #5 to do a physical assessment on (Patient #1). RN Staff #3 stated (Patient #1) informed her RN Staff #5 pulled the curtain around the bed and proceeded to check his neck, axilla, chest and then pulled his pants down and touched (Patient #1) in the patients (Patient #1) genitalia. RN Staff #3 stated RN Staff #5 did not report (Patient #1) had any problems while she was gone on break. RN Staff #3 said RN Staff #5 did not document anything pertaining to the assessment. RN Staff #3 said she reported the event to the Charge Nurse. RN Staff #3 was asked if she re-assessed the patient for bruises, marks and notified the physician. RN Staff #3 stated "No."

On 06/08/12 at 11:30 AM RN Staff #5 was interviewed by telephone. RN Staff #5 stated he knew (Patient #1) as he previously cared for him. On the morning of 05/03/12 RN Staff #5 stated he went into the patient's room at approximately 02:00 AM to do a focused assessment. RN Staff #5 stated he checked the patients neck, axilla and groin pulling his pants down checking the lymph nodes. RN Staff #5 stated (Patient #1's) lymph nodes were swollen. The surveyor asked RN Staff #5 the reason he assessed (Patient #1) pulling his pants down. RN Staff #5 said the patient had swollen lymph nodes. RN Staff #5 was questioned as to why he would assess a patient's groin area when the patient's affected and treated site was his finger. RN Staff #5 did not answer the question. Staff #5 was asked where his documentation was recorded in the medical record that the physician was notified. Staff #5 offered no explanation. RN Staff #5 was asked whether he assessed all his patient's in the above manner. RN Staff #5 stated, "No." RN Staff #5 was asked if (Patient #1) called for assistance utilizing his call bell during Staff #3's lunch break. RN Staff #5 said (Patient #1) did not request any assistance.

The Hospital policy entitled, "Assessment-Reassessment" with a revision date of 05/12 reflected, "All patients receiving inpatient...and appropriate follow-up assessments based upon their individual needs including physical, psychological...care and/or treatment provided by all health care professionals will be based on each patient's specific needs...each patient is to be reassessed according to the guidelines established by the clinical discipline and/or significant change in patient condition...all involved caregivers are responsible for communication of patient care needs ...focused assessment...in a focused assessment the nurse is "focusing" on a patient problem or complaint. A focused assessment is defined as a reassessment of one or more body systems in response to a new abnormal finding, an existing abnormal finding, or documentation of a previous abnormal finding that has returned to within defined limits..."

Tag No: A0395

VIOLATION: RN SUPERVISION OF NURSING CARE

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the hospital failed to ensure 1 of 1 patient (Patient #1) was evaluated and/or assessed by an RN after (Patient #1) verbalized RN Staff #5 entered his room on the morning of 05/03/12 at approximately 02:00 AM and reportably performed a physical assessment which included (Patient #1's) privates. (Patient #1) verbalized to RN Staff #3 that RN Staff #5 was sexually inappropriate with him. RN Staff #3 did not document the event, notify the physician and/or re-assess/evaluate (Patient #1's) physical and emotional status according to the hospital's own policy.

Findings included:

The physician note dated 04/17/12 timed at 18:55 PM reflected, "(Patient #1) is a [AGE] year old male...had an injury with rebar after a fall 5 days prior to admission. He noticed worsening swelling and purulent drainage on the right index finger...he came to the ED (Emergency Department) on 04/09/12...patient was taken to the OR (Operating Room)...there was some bony erosion at the dorsal aspect of the joint...x-ray findings suggestive of osteo[DIAGNOSES REDACTED] and septic arthritis...neck no cervical lymphadenopathy..."

The nursing progress note documented by RN Staff #3 dated 05/02/12 timed at 18:52 PM reflected, "Report received from off going RN...Sheriff at bedside...at 19:35 PM initial assessment completed...pt stated pain in r (right) index finger...pain medication given...sheriff at bedside...at 20:47 PM pt stated pain has been relieved...05/03/12 at 07:19 AM...report given to on coming RN..." There was no documentation RN Staff #3 completed an assessment of (Patient #1) after learning of an allegation of staff to patient sexual abuse.

On 06/07/12 at 02:45 PM (Patient #1) was interviewed. (Patient #1) stated on the morning of 05/03/12 at about 02:00 AM RN Staff #5 entered his room and told him he needed to complete a physical assessment. (Patient #1) stated the nurse pulled the privacy curtain and said he needed to check his pulse in his neck, chest, and armpits. RN Staff #5 checked the nodes in his neck, axilla, and chest (lymph nodes) and said he needed to check the nodes in his groin as they were the same. (Patient #1) stated RN Staff #5 touched him "down there" (pointing to his privates). (Patient #1) stated RN Staff #5 made him feel uncomfortable. (Patient #1) stated RN Staff #5 fondled his privates. (Patient #1) stated he reported this to RN Staff #3. (Patient #1) stated no one assessed him after the event and/or provided any type of counseling.

On 06/07/12 at approximately 03:45 PM Staff #16 was interviewed. Staff #16 stated he was unaware until today (06/07/12) that (Patient #1) alleged one of the Hospital staff touched (Patient #1) in a sexual manner. Staff #16 stated he would be sure (Patient #1) received counseling services.

On 06/08/12 at 02:30 AM RN Staff #3 was interviewed by telephone. RN Staff #3 stated (Patient #1) informed her Staff #5 pulled the curtain around the bed and proceeded to check his neck, axilla, chest and then pulled his pants down and touched (Patient #1) inappropriately in his privates.

On 06/08/12 at approximately 11:00 AM Staff #11 was interviewed. Staff #11 validated (Patient #1's) medical record did not contain any documentation that (Patient #1) was re-assessed after reporting an allegation of staff to patient sexual abuse.

On 06/08/12 at 11:30 AM RN Staff #5 was interviewed by telephone. On the morning of 05/03/12 RN Staff #5 stated he went into the patient's room at approximately 02:00 AM to do a focused assessment. RN Staff #5 stated he checked the patients neck, axilla and groin

pulling his pants down checking the lymph nodes. RN Staff #5 stated (Patient #1's) lymph nodes were swollen. RN Staff #5 was asked where his documentation was recorded in the medical record and/or the physician was notified. Staff #5 offered no explanation.

On 06/08/12 at approximately 01:15 PM M.D. #14 was interviewed. M.D. #14 was asked by the surveyor if he was aware of any problem with swollen lymph nodes and/or any report the patient alleged he was touched by a male nurse in a sexual manner. M.D. #14 stated none of the staff notified him regarding the above.

The Hospital policy entitled, "Assessment-Reassessment" with a revision date of 05/12 reflected, "All patients receiving inpatient...and appropriate follow-up assessments based upon their individual needs including physical, psychological...care and/or treatment provided by all health care professionals will be based on each patient's specific needs..."



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PARKLAND HEALTH AND HOSPITAL SYSTEM PARKLAND HEALTH AND HOSPITAL SYSTEM

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Report date Number of violations

June 15, 20122 (click for details) Read full report May 17, 2012 1 (click for details) Jan. 24, 2012 2 (click for details) Read full report Read full report Nov. 4, 2011 1 (click for details) Read full report July 1, 2011 2 (click for details) Read full report May 12, 2011 4 (click for details) Jan. 21, 2011 3 (click for details) Read full report Read full report

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Incomplete reports

Report date Number of incomplete reports Number of violations

May 8, 2012 1 2 April 2, 2012 1 Jan. 25, 20121 6 Sept. 9, 20111 July 21, 20111



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<u>TRUSTPOINT HOSPITAL</u> ->

Report No. 1767

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TRUSTPOINT HOSPITAL

4302 PRINCETON LUBBOCK, TX 79415

June 12, 2012

Tag No: A0049

VIOLATION: MEDICAL STAFF - ACCOUNTABILITY

Based on review of documentation and interview, it was determined that the facility 's governing body did not ensure that the medical staff gave quality care to all of its patients.

Findings were:

Facility policy entitled "Basic Medication Administration" stated in part "The following will be checked prior to medication administration:

- ? Right patient (two patient identifiers)
- ? Right drug
- ? Right dose
- ? Right route
- ? Right time

The patient 's hospital number and name on the identification bracelet should be compared with the name and number on the Medication Administration Record (MAR) before the drugs are administered. "

On 4/20/12, Patient # 1 was administered another patient 's medications. According to facility documentation, the nurse who administered the medications did not follow facility policy and procedure when giving medications.

In an interview with the Coordinator of Performance Improvement on 6/12/12, the above medical error was confirmed.

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on review of documentation and interview, it was determined that the facility failed to track all adverse events in its Quality Improvement meetings.

Findings were:

Facility policy entitled "Performance Improvement Plan" stated under "Objectives: "The objectives of Trust Point Hospital are to improve the quality of patient care, enhance appropriate utilization of resources, and to

reduce or eliminate unnecessary risks and hazards with in the facility by:

? Increasing the probability of desired patient outcomes by assessing and improving the processes that most affect those outcomes;
? Establishing priorities for investigation and resolution of issues and problems by addressing those with the greatest potential impact on

patient outcomes and satisfaction;

? Educating employees involved in patient care in assessing and improving processes which contribute to improved outcomes;

? Educating all employees in the basic concepts of performance improvement

? Integrating medical staff performance improvement activities whenever possible with those of the organization specifically with respect to

utilization review and risk management. "

Patient # 1 was given the wrong medications on 4/20/12. This adverse event had not been reported to the Coordinator of Performance Improvement until 6/12/12. The Quality Improvement team (QAI) was unaware of the event as well.

In an interview with the Chief Executive Officer and the Coordinator of Performance Improvement on 6/12/12, it was acknowledged that all adverse events should be reported to the Performance Improvement team for review and evaluation in a timely manner.

Tag No: A0405

VIOLATION: ADMINISTRATION OF DRUGS

Based on review of documentation and interview, it was determined that the facility failed to administer medications according to facility policy.

Findings were:

Facility policy entitled "Basic Medication Administration" stated in part "The following will be checked prior to medication administration:

- ? Right patient (two patient identifiers)? Right drug
- ? Right dose
- ? Right route ? Right time

The patient 's hospital number and name on the identification bracelet should be compared with the name and number on the Medication Administration Record (MAR) before the drugs are administered.

On 4/20/12, Patient # 1 was administered another patient 's medications. According to facility documentation, the nurse who administered the medications did not follow facility policy and procedure when giving medications.

In an interview with the Coordinator of Performance Improvement on 6/12/12, the above medical error was confirmed.

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4302 PRINCETON LUBBOCK, TX 79415 | Physican Ownership

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Report date Number of violations

June 12, 20123 (click for details) Read full report Nov. 9, 2011 1 (click for details) Feb. 9, 2011 1 (click for details) Read full report Read full report

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Incomplete reports

No incomplete reports available.



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MOTHER FRANCES HOSPITAL ->

Report No. 1491

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

MOTHER FRANCES HOSPITAL

800 EAST DAWSON TYLER, TX 75701

June 5, 2012

Tag No: A0144

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on document review and interview the facility failed to provide for the physical and emotional care of 1 of 1 patients reviewed.

On 6/5/2012 at 8:30 am in the conference room the patient's medical record was reviewed and revealed the following:

- Pt #1 was admitted through the Emergency Department (ED) on 1/2/2012 at 1920 hrs. The chief complaint retractable nausea, vomiting and dehydration. Abdomen soft, patient alert and oriented, calm and cooperative.

- Orders for pt #1 include routine Intra-venous (IV) Reglan and as needed (PRN) Maalox plus 30 milliliter (ML) every 6 hours, Zofran 4mg orally disintegrating tablet (ODT) every 4 hours and Phenergan 25 mg IV every 4 hours PRN nausea and vomiting (N/V) and Morphine 4 mg IV every 4 hours for pain.

- 1/2/2012 the following medications were documented as given.
 Pt #1 was given PRN Phenergan 25 mg at 2215 hrs
 Pt #1 was given PRN Maalox plus 30 ml by mouth at 0415 hrs and was immediately vomited back out.
 Pt #1 was given PRN Zofran 4 mg at 0020 hrs
 Pt #1 was given PRN morphine 4 mg at 0329 hrs
 1/3/2012 the 0705 RN patient assessment documents the pt as alert, oriented and abdomen distended.

- Pt #1 was given his first full nursing assessment for the beginning of the shift 1/3/2012
 Pt #1 was given PRN Phenergan 4 mg at 0910 hrs
 Pt #1 was give PRN Morphine 4 mg at 0910 hrs

- Pt #1 complained of (C/O) nausea, and indicates he feels like when he swallows it gets stuck mid chest. (There was no documentation this information was relayed to the physician)
- Pt #1 medical record does not reflect physician notification of reassessment of lack of effectiveness or pt relief of symptoms.
- Pt #1 C/O Nausea and pain but declines the nurses offer of another dose of Phenergan and Morphine.
- Pt's medical record dated 1/3/2012 documents the physician examined the patient, the medical record is not timed. The RN initiated the contrast for CT at 1630 hrs.
- Pt #1 C/O nausea PRN Phenergan given and oral contrast started
- Pt #1 unresponsive without pulse or respiration full code initiated.

An interview with Pt #1 wife revealed the following:

- Pt #1's wife requested a physician to examine her husband during the morning of 1/3/2012. _ Pt #1's wife indicated she was told by the
- RN that the physician's were making rounds and would get to him but there were many patient's to be seen.

 Pt #1's wife indicated that her husband through up "nearly constantly" but no one was there to help

 1/3/2012 at 1630 hrs Pt #1's wife stated that when the RN requested her husband drink the contrast fluid, she told the RN he had been throwing everything that went down, right back up, and that he could not drink the contrast fluid.
- Pt #1's wife stated the RN told her he needed to try to drink as much as possible
- Pt #1's wife was asked if the RN stayed in the room to insure her husband could safely swallow, Pt's #1's wife said "no"

- 1/3/2012 at 1700 Pt #1's wife ran into the hall way screaming for help. Pt had slumped over in chair with out pulse or respiration. -1/3/2012 1720 hrs pt transferred to Intensive Care Unit status post Cardiac Pulmonary Resuscitation with large volume aspiration and anoxic brain injury.

On 6/5/2012 at 1:30 PM the facility policy E-1 PATIENT ASSESSMENT AND REASSESSMENT. Policy 1.1...The assessment of the care and /or treatment needs of the patient is continuous throughout the patient's hospitalization . Procedure 2.4 a. Any significant change in the patient's diagnosis and/or condition necessitates an immediate re-assessment with changes in the plan if care reflecting the change in diagnosis or condition. 2.4 b. Patients are reassessed after treatment, therapy or education sessions to determine the effectiveness (extent of improvement) of the interventions undertaken by the health care team. 2.4 d. Routine reassessment should occur minimally every shift, and an in-depth reassessment should occur if patient changes level of care. 2.12 Reassessment of patient's needs is contingent on the urgency of the patient's condition and/or changes in the patient's condition. 2.13 The following factors are included in the assessment and reassessment of the patient: b. vital signs ...cardiac rhythm. c....fear, anxiety, support system, mental status coping mechanism...

The facility failed to insure that RN staff evaluated the emotional as well as physical condition of the patient. The facility failed to insure the RN met the needs of a [AGE] year old man who entered the hospital with dehydration secondary to a 24-48 hours complaint of nausea and vomiting. The patient continued to exhibit nausea and vomiting with the addition of abdominal distention and pain that went unrecognized as significant by the lack of documentation of the changes and assessment of the patient's condition. The facility failed to insure the RN re-assessed the patient after the 0705 shift assessment and reported the changes in the patient's condition to a physician prior to the 4:30 PM rounding by the physician. The facility failed to insure that RN re-evaluate the effectiveness of PRN medication that were given this patient who exhibited recurrent N/V/Pain.

Tag No: A0395

VIOLATION: RN SUPERVISION OF NURSING CARE

Based on record review and interview the facility failed to insure the registered nurse evaluated the care of 1 of 1 patients.

On 6/5/1012 at 9:00 AM in the conference room the medical record of patient (Pt) #1 was reviewed and revealed the following:

- 1/2/2012 at 1936 (7:36 pm) hours (Hrs) Pt #1 was first seen in the emergency department (ED)of the hospital.
- Pt #1's chief complaint was documented as nausea and vomiting (n/v) which began 24-48 before.
- 1/2/2012 at 2130 hrs pt #1 was admitted to the emergency admission (EAU) unit. The nurses narrative assessment documents the patient complained of (c/o) nausea during the assessment and the nurse paged the physician and requested medication for acid reflux. The assessment documents the patients abdomen is soft non-tender bowel sounds present in all 4 quadrants. Patient denies needs.
- -1/2/2012 2145 hrs physician's order from Dr#1 received- Maalox 30 milliliters(ML) Q6 (every 6 hours) prn (as needed) indigestion.
- -1/12/2012 at 2215 hrs the nurses narrative documentation records-nausea-phenergan 25mg given for nausea-Maalox given for indigestion-attempted to give medication-pt vomiting again-will continue to monitor.
- -1/2/2012 at 2250 hrs the nurses narrative assessment documents the patient is received to room 489-2 bowel sounds in all 4 quadrants abdomen soft. Pt c/o n/v med's (medications) given in EAU prior to receiving. will monitor every 1-2 hours.
- -1/3/2012 0015 hrs Pt c/o nausea see mar (Medication Administration Record)
- -1/3/2012 0250 hrs Pt c/o/ discomfort and pain to abdomen, Dr. #1 paged see pain flow sheet.
- -1/3/2012 0245 hrs physician's order from Dr. #1 Morphine 2-4 MG (milligrams) Q6 hrs PRN pain
- -1/3/2012 0700 hrs report IPOC (Interdisciplinary Plan of Care) discussed with nurse, no needs voiced
- -1/3/2012 0705 hrs shift assessment complete...Abdomen distended...
- -1/3/2012 0910 hrs pt c/o pain and nausea prn morphine/phenergan given.
- -1/3/2012 1100 hrs Pt stated when he swallows it feels like it gets stuck in mid chest. Pt c/o nausea as well.
- -1/3/2012 1310 hrs Pt c/o pain and morphine/phenergan offered, pt declines.

- 1/3/2012 1416 hrs- Physician #6 left orders for CT scan of abdomen/pelvis with PO and IV contrast as well as lab.
 -1/3/2012 1630 hrs PO (by mouth) contrast started, phenergan given for nausea.
 -1/3/2012 1700 hrs- Wife came out of room screaming for help Pt slumped over in chair code called. Pt had no pulse or respiration see

On 6/5/2012 at 11:00 am an interview with pt #1 wife revealed vomiting accompanied the patient's nausea. She stated she requested the RN contact the physician for pain medication because her husband was in pain. She stated the pain medication did not relieve the pain. She said the nausea medication did very little to relieve the nausea but seamed to make her husband agitated and as the day progressed he became very confused as well. She said that she told the Dr #6 as well as the nursing staff her husband could not hold old anything on his stomach. Both the Dr #6 and the RN told her that her husband needed to try to drink the contrast in order to complete the test.

On 6/5/2012 at 2:00 pm an interview with staff #9 revealed that the liquid contrast for a radiographic testing is two (2) 16 ounce bottles of liquid. After instruction has been given the patient and family the contrast is left at the bed side to be sipped on until consumed by the patient.

On 6/5/2012 at 1:30 PM the facility policy E-1 PATIENT ASSESSMENT AND REASSESSMENT. Policy 1.1...The assessment of the care and /or treatment needs of the patient is continuous throughout the patient's hospitalization . Procedure 2.4 a. Any significant change in the patient's diagnosis and/or condition necessitates an immediate re-assessment with changes in the plan if care reflecting the change in diagnosis or condition. 2.4 b. Patients are reassessed after treatment, therapy or education sessions to determine the effectiveness (extent of improvement) of the interventions undertaken by the health care team. 2.4 d. Routine reassessment should occur minimally every shift, and an in-depth reassessment should occur if patient changes level of care. 2.12 Reassessment of patient's needs is contingent on the urgency of the patient's condition and/or changes in the patient's condition. 2.13 The following factors are included in the assessment and reassessment of the patient: b. vital signs ...cardiac rhythm. c....fear, anxiety, support system, mental status coping mechanism...

The nurse failed to document with in a reasonable time, the evaluation of effectiveness of the PRN nausea medication that was given. The nurse failed to document the evaluation of the pain medication that was given. The nurse failed to document communication with the physician regarding the change in the patient's condition from "abdomen soft to abdomen distended". The nurse failed to evaluate the patient and act as an advocate on the behalf of the patient. There was no documentation the physician had been notified or any new order received between the start of the nurses shift at 0705 and when the physician made his after noon round as 1416 hrs.

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

Based on document review and interview the facility failed to insure physician's verbal orders were authenticated in a timely manner in 1 of 1 patient records reviewed.

Tag No: A0457

On 6/5/2012 at 1:00 pm in the conference room the medical record for patient #1 was reviewed and revealed two (2) verbal telephone orders were documented as received by nursing staff on 1/ and 1/3/2012 respectively. Both telephone orders were electronically signed and dated by physician #1 on 2/21/2012.

On 6/5/2012 at 1:30 PM in the conference room the Chief Nursing Officer confirmed the orders were electronically signed greater than 30 days after they were verbally given to the nursing staff.

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No incomplete reports available.



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Tag No: A0395

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TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS ->

Report No. 1526

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TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS

8200 WALNUT HILL LANE DALLAS, TX June 5, 75231 2012

VIOLATION: RN SUPERVISION OF NURSING CARE

Based on review of documentation and interview with staff, the facility failed to ensure that a registered nurse supervised and evaluated the nursing care for 1 of 1 patient whose record was reviewed. Physician orders for repositioning Patient #1 were not followed by nursing staff while the patient was on complete bed rest.

Findings were:

Patient #1 underwent surgery on 2/6/12, and the ICU physician's order was for the patient to be on complete bed rest following the surgery. The order included that the patient should be turned from side to back to side every 2 hours in order to maintain skin integrity. According to the nursing flow sheet, Patient #1 was not turned as ordered by the physician on 2/7/12 and 2/8/12. For example, on 2/7/12 the patient was placed on the right side at noon, and then every 2 hours until 8 pm, was documented as continuing to lie on the right side. On 2/8/12, Patient #1 was noted to be lying on the left side between the hours of 4 am to 7:30 am; there is no documentation of the patient's position at the 10 am entry. Again, on 2/13/2012, Patient #1 was placed on bed rest while in ICU. At 2:30 pm, the patient was on the left side and remained on the left side until 8 pm, according to the documentation. On 2/14/12, the patient was documented on the left side at noon, 2 pm, and 4 pm.

These findings were acknowledged by Staff #2, Quality Improvement Coordinator, during a review of Patient #1's electronic medical record the afternoon of 6/5/12.



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TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS TEXAS HEALTH PRESBYTERIAN HOSPITAL DALLAS

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No incomplete reports available.



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FOREST PARK MEDICAL CENTER ->

Report No. 1769

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FOREST PARK MEDICAL CENTER

11990 NORTH CENTRAL EXPRESSWAY UNKNOWN, TX None

June 5, 2012

Tag No: A0457

Tag No: A0468

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

Based on review of documents and interview with staff, the facility failed to ensure that all verbal orders were authenticated within 48 hours for 1 of 1 patient whose record was reviewed. Patient #1's medical record contained telephone orders issued by practitioners involved in the patient's care; however, they were not authenticated within 48 hours.

Findings were:

Review of the medical record of Patient #1 revealed multiple telephone orders that were not authenticated within 48 hours by the practitioner or another practitioner involved in the patient's care. Between the dates of 9/22/11 and 9/29/11, there were in excess of 50 telephone orders not authenticated within 48 hours. For example, on 9/22/11, a telephone order was received by a physician at 3:49 am. While the order was signed by the physician, it was not dated or timed; therefore, it could not be verified if the order was authenticated within 48 hours. On 9/23/2011, a physician issued a telephone order at 11:20 pm. It was electronically signed on 10/27/11 at 7:41 pm, over a month after it was issued.

The facility Medical Staff Rules and Regulations, last approved by the Governing Board in January 2012, contain a section entitled ORDERS SECTION. Rule #6 states "Telephone and Verbal orders are authenticated with the time frame specified by law and regulation. By CMS regulation, these orders must be signed within forty eight (48) hours."

These findings were acknowledged by the facility Chief Executive Officer in an in-person interview conducted the morning of 6/5/2012.

VIOLATION: CONTENT OF RECORD - DISCHARGE SUMMARY

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of documents and interview with staff, the facility failed to include a discharge summary with outcome of hospitalization, disposition of care and provisions for follow-up care for 1 of 1 patient whose record was reviewed. Patient #1 was transferred to another hospital on [DATE], and there was no discharge summary included in the electronic medical record at the time of the survey, 6/4/2012.

Findings were:

The facility Medical Staff Rules and Regulations, last approved by the Governing Board in January 2012, state under the section entitled DISCHARGE SUMMARY, rule #34, " A discharge summary shall be dictated on all medical records of patients hospitalized more than 48 hours."

Review of the medical record for Patient #1 revealed that the patient was admitted to Forest Park Medical Center on 9/21/11 for elective revision of past weight-loss surgeries. Patient #1 was transferred for a higher level of care on 9/30/11; the patient was hospitalized for 9 days and there was no discharge summary included in the electronic medical record.

This finding was acknowledged by the facility Chief Executive Officer in an in-person interview conducted the morning of 6/5/2012.

VIOLATION: OPERATIVE REPORT

Based on review of documents and interview with staff, the facility failed to ensure that operative reports were dictated as required in the hospital's Medical Staff Rules and Regulations for 1 of 1 patient whose record was reviewed. Patient #1 had two surgeries at the facility, and the full operative reports were not dictated until approximately a month following the surgeries.

Tag No: A0959

Findings were:

The facility Medical Staff Rules and Regulations, last approved by the Governing Board in January 2012, under the section entitled SURGICAL CARE SECTION rule #4, state that "Operative reports must be dictated in the medical record immediately after the surgery and shall contain a description of the findings, the technical procedures used, any specimens removed, the postoperative diagnosis, and the name of the primary surgeon and assistant surgeons, and filed in the medical record as soon as possible after surgery."

Review of the medical record for Patient #1 revealed that the patient had surgery while inpatient at the facility. The operative report was not dated as to when the surgery occurred, but other progress notes in the record indicate the surgery was performed 9/27/11 by physician staff #3. While there was a handwritten operative note on the chart, the full operative report was dictated by staff #3 on 11/1/2011, 35 days after the surgery was performed.

Review of another operative report for Patient #1 revealed that the surgeon, staff #3, did not include the date of the surgery in the report; however, progress notes identify the date of surgery as 9/29/12. While there was a handwritten operative note on the chart, the full operative report was dictated by staff #3 on 11/1/2011, 33 days after the surgery was performed.

These findings were acknowledged by the facility Chief Executive Officer in an in-person interview conducted the morning of 6/5/2012.

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Incomplete reports

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Report No. 1582

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

SOUTHWEST SURGICAL HOSPITAL

1612 HURST TOWN CENTER DRIVE HURST, TX 76054

2012

May 30,

Tag No: A2400

Tag No: A2406

VIOLATION: COMPLIANCE WITH 489.24

Based on record review and interview, the facility did not comply with 42 CFR ?489.24, Special Responsibilities of Medicare Hospitals in emergency cases, in that, the facility did not provide an appropriate medical screening examination within the capability of the hospital's emergency department to 1 of 1 patient (Patient #1) who presented at the ER (emergency room) on 04/16/12. The facility did not abide by their policy.

(Cross Refer to Tag A 2406)

VIOLATION: MEDICAL SCREENING EXAM

Based on record review and interview, the facility did not provide an appropriate medical screening examination within the capability of the hospitals' emergency department to 1 of 1 patient (Patient #1) who presented at the ER (emergency room) on 04/16/12. Patient #1 experienced convulsions and apnea (suspension of external breathing) and 911 was called. When the ambulance arrived the EMS (emergency medical services) personnel took ownership of Patient #1. The facility did not abide by their policy.

Findings included:

Patient #1 presented in the ER and was triaged at 8:20 PM on 04/16/12. The chief complaint was pain on the right upper side of the chest, low back, and legs. At 8:37 PM, Physician #6 conducted his assessment. Within 60 to 90 seconds of his assessment, the patient began U.E. (upper extremity) tonic-clonic convulsion, had foam at mouth, and an episode of brief apnea. "I bagged her with an Ambu bag, checked her to have positive radial pulse, and she soon regained spontaneous breathing. Our nurse called an aide to call 911 for assistance...EMS (emergency medical services) arrived shortly. I ordered Labetalol and Ativan, but IV (intravenous) access was not available...At 2100, I spoke with Facility B emergency department (ED) Physician #1 to inform him of the developments."

The "Physician Order Sheet" indicated the following were ordered: at 8:40 PM "IV saline lock access; "at 8:45 PM "Labetalol 5 mg IV and Ativan 0.5 mg IV." The physician noted beside the written orders "not done prior to EMS transfer."

The "Additional Progress Notes" written by Physician #6 indicated "...Our nurse called aide to call 911 for assistance...EMS arrived shortly. I ordered Labetalol and Ativan, but IV (intravenous) access was not available...EMS staff deferred my request for IV and meds (medications) ...due to risk of seizure; (EMS) stated would start IV enroute ..."

In an interview on 05/30/12 at 10:25 AM via phone, Physician #6 (the attending ER physician on 04/16/12) stated Personnel #5 asked if she needed to call EMS. "Due to limited manpower, I told her to call. The EMS came in 2-3 minutes after. One of the EMS talked to the patient's family and took over the scene. I reported to one of the EMS that the patient had seizures." The EMS personnel stated the patient will be transferred to Facility B for stroke evaluation. "I did not believe this was a stroke but I did not protest. I would be happy with Facility C, they evaluate stroke also."

In an interview on 05/29/12 at 1:55 PM via phone, Personnel #5 (the attending ER nurse on 04/16/12) stated she was present when Physician #6 conducted the assessment. Shortly thereafter, the patient began convulsing. The RN stated the physician "bagged the patient" and verbally ordered "to start an IV and give Labetalol, and Ativan." She asked the physician if he wanted her to call 911. The physician told her to do it. The RN instructed the nursing assistant to call 911 and informed the in-patient nurse to help in the ER. The RN stated that she was fixing to gather her supplies to start an IV when the EMS came and took over the patient's care. The RN stated that she did not have time to start an IV and administer the medications as ordered.

Subject/ Policy: "EMTALA guidelines for Emergency Department Services (Emergency Medical Treatment and Active Labor Act)" revised 10/2010 required "All patients shall receive a medical screening exam that includes providing all necessary testing and on-call services within the capability of the hospital..."



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Tag No: A0123

Tag No: A0396

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BAPTIST MEDICAL CENTER ->

Report No. 1480

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

BAPTIST MEDICAL CENTER 111 DALLAS STREET SAN ANTONIO, TX 78205 May 24, 2012

VIOLATION: PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION

1. Based on reviews of an incident report, policies and procedures, and staff interviews Baptist Medical Center failed to follow its established policies and procedures to conduct complaint investigations and notify the complainant in writing of the results of the investigation.

The findings included:

a. A review of the complaint conducted on 5/23/12 at 9:30 a.m. in the conference room with the director of risk management of Baptist Health System revealed the administrative director spoke to the complainant via telephone and he complained his wife had fallen and the nursing staff was unaware of the incident until he returned and found her on the floor. He also informed her, he had already complained to the nurses about the interruption in her tube feeding, the lack of response to the call bell, and the lack of hourly rounding by the nursing staff. Based on her verbal apology on the day of the incident she assumed the issue was resolved. No evidence was provided the complainant was contacted on the results of an investigation.

b. A review of grievance/complaint policy and procedures and an interview with the administrator on 5/24/12 at 11:30 a.m. in the conference revealed she could not provide evidence of compliance with hospital procedures to inform the complainant in writing of the

results, how the investigation was conducted or when it was completed.

VIOLATION: NURSING CARE PLAN

- 1. Based on reviews of medical records, policies and procedures, and staff interviews Baptist Medical Center nursing staff failed to update nursing care plans relative to current nursing assessments and medical plans. The findings included:
- a. A review of the medical record conducted on 5/24/12 at 10:30 a.m.in the hospital's conference room revealed the patient was classified as a high risk for falls based on an assessment conducted in the Emergency Department on 3/4/12/ at 6: 26 p.m. The patient scored a 21
- on an assessment in which a score of greater than 10 is considered a high risk. According to the emergency department record the risk factors the patient had included: (i) unsteady, (ii) on pain medication, (iii) had a recent fall, (iv) weakness, and (v) assistive device. b. Upon admission and transfer to unit 3W the patient was essentially downgraded and placed on basic fall prevention based on an initial assessment conducted on 3/5/12 at 09:15 a.m. using the Baptist Health System approved "Hendrich II Fall Risk Assessment Tool". Between 3/5/12 and until the patient was injured due to a fall on 3/8/12 her risk assessments fluctuated between high risk and risk specific without any escalating intervention plans by the nursing staff or in the nursing plan of care contrary to the established policies and procedures. At the time of the fall the patient did not have a bed alarm on and had not been visited by the nursing staff for at least an hour.
- c. Interviews conducted on 5/24/12 at 11:00 a.m. with the nursing staff involved in the patient's care revealed the day of the incident 3/8/12 the patient used the call bell three times and no one responded to answer to the bell verbally or responded to her room. The patient's husband and son had left her to get lunch and they were the first to find her on the floor with an injury to her arm. No evidence was provided to support the basic fall prevention plan that included hourly rounding was performed. No evidence the high risk fall plan for patients scoring a 5 or greater is flagged as "priority" for call light response at the nurses 'station had been enacted. No evidence of risk specific intervention plan for addition of a bed alarm to indicate when the patient was out of bed until after the fall.

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NORTH AUSTIN MEDICAL CENTER ->

Report No. 1573

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NORTH AUSTIN MEDICAL CENTER

12221 MOPAC EXPRESSWAY NORTH AUSTIN, TX May 24, 78758 2012

VIOLATION: CONTRACTED SERVICES

Tag No: A0083

Based on a review of documentation, the governing body failed to be responsible for services furnished in the hospital.

Findings were:

A review of facility policy and procedure titled Interpreters and Adaptive Aids states, in part, 'Hearing Impaired: 1) Sign-Language Interpreter-Staff will contact Communication by Hand at (512) 467-1917 when an interpreter is needed.

Review of the clinical record of patient #1 revealed that the patient was deaf but no interpreter was contacted. The following documentation indicated that interpretive services were needed:

? The Emergency Medical Services Patient Care Report states, "pot is also deaf and a significant amount of anxiety is related to her inability to communicate with personnel onscene.

? The Physician's emergency room Report states, "Evaluation limited bypt is deaf.. History limited by a language barrier."

? The Nursing Progress Notes state, "The initial plan of care for this patient includes an assessment with eforts to address the patient's anxiety;'

The above was confirmed in an interview with the Chief Nursing Officer and the Director of Quality on the afternoon of 5-24-12 in the Administrative conference room.

VIOLATION: PATIENT RIGHTS: NOTICE OF RIGHTS

Tag No: A0117

Based on a review of the clinical record, the hospital failed to inform the patient of her patient rights.

Findings were:

During a review of the clinical record for patient #1, it was revealed that the patient was deaf. Further review of the clinical record revealed no effort on the part of the facility to obtain an American Sign Language Interpreter so that the patient could be informed of her rights in her primary language.

The above was confirmed in an interview with the Chief Nursing Officer and the Director of Quality on the afternoon of 5-24-12 in the administrative conference room.

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NORTH AUSTIN MEDICAL CENTER NORTH AUSTIN MEDICAL CENTER

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Tag No: A0057

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SHELBY REGIONAL MEDICAL CENTER ->

Report No. 1577

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SHELBY REGIONAL MEDICAL CENTER 602 HURST STREET CENTER, TX 75935 May 18, 2012

VIOLATION: GOVERNING BODY Tag No: A0043

Based on observation, record review and interview, the hospital did not have an effective governing body that was legally responsible for the conduct of the hospital. The hospital's Board of Directors did not provide the hospital's Governing Board with the authority to ensure that the hospital services provided complied with all applicable conditions of participation and standards as follows:

- A. The governing body failed to follow the hospital's Governing Body rules and regulations in appointing a Chief Executive Officer (Administrator).(Cross refer to findings at A057, Chief Executive Officer);
- B. The governing board failed to ensure that diagnostic laboratory services were available to meet the needs of the patients who were provided care in the hospital's emergency department and/or admitted to the hospital. (Cross Refer to findings A0576, Laboratory Services);
- C. The governing board failed to ensure that the hospital had an effective ongoing hospital wide quality assessment performance improvement program. (Cross refer to findings at A0263, Quality Assurance and Performance Improvement.)

During the follow-up visit 5/17/12 through 5/18/12, it was determined that Governing Body remains non-compliant. Based upon record review and interview:

- A. The governing body failed to follow the hospital's Governing Body rules and regulations in appointing a Chief Executive Officer (Administrator).(Cross refer to findings at A057, Chief Executive Officer);
- B. The governing board failed to ensure that diagnostic laboratory services were available to meet the needs of the patients who were provided care in the hospital's emergency department and/or admitted to the hospital. (Cross Refer to findings A0576, Laboratory Services);
- C. The governing board failed to ensure that the hospital had an effective ongoing hospital wide quality assessment performance improvement program. (Cross refer to findings at A0263, Quality Assurance and Performance Improvement.)

VIOLATION: CHIEF EXECUTIVE OFFICER

Based on interview with the hospital's "Owner / Board of Director" (Staff #25) and 4 members of the Governing Board (Staff #2, Staff #4, Staff #12, and Staff #13) and review of the hospital document titled, "Rules and Regulations of the Governing Board ", the hospital's governing board failed to follow the governing board rules and regulations when "owner / Board of Director" appointed the hospital's chief executive officer

(Administrator) without the approval of the Governing Board.

Findings were:

- 1. Review of " Rules and Regulations of the Governing Board " revealed the following:
 "Article IX, Administrator, Section 1. Appointment. The Board of Directors or its designee shall appoint a Administrator of the Hospital (referred to herein as the " Hospital Administrator ") in accordance with such criteria as may be adopted by the Board of Directors subject to approval by the Governing Board ".
- 2. Review of the document titled, "Memorandum" dated January 30, 2012 from the hospital "Owner/Board of Director" (Staff # 25), with the subject line, "Administrator", addressed to the medical staff and the hospital employees, revealed the following announcement: "Please welcome Mr. (Staff #1) as "Hospital's "new Administrator."
- 3. During the investigation, the survey team requested the "Governing Board Minutes" for the meetings conducted November 14, 2011 and February 28, 2012. The minutes were not provided to the surveyors to review during the investigation survey.
- 4. During a phone interview on 03/13/2012 at approximately 3:30PM, the surveyor asked Staff #25 if Staff #1 had been approved by the Governing Board. Staff #25 responded:

Yes, (Staff #2) who serves as Chairman of the Governing Board had taken care of the approval of Staff #1 as the Administrator.

- 5. An interview with the corporate CEO (Staff #2) who serves as Chairman of the Governing Board on 03/12/2012 at 3:00PM in the Administrator 's office revealed Staff #1 was appointed and approved by Staff #25 as the Administrator. Staff #2 reported he had just met Staff #1 at the facility on 03/09/2012 and was not present at the 02/28/2012 Governing Body Meeting . Staff #2 then confirmed that Staff #1 had been functioning as the Hospital Administrator effective 01/30/2012.
- 6. Based on interview, Staff #1 confirmed he had not met Staff #2 until 03/09/2012.
- 7. During an interview on 03/08/2012 at approximately 3:00PM, the survyor asked Staff # 4 if the new Administrator had been approved by the Governing Body. Staff #4 replied " No."
- 8. In an interview with Governing Board Member (Staff #12) on 03/12/2012 at 12:30PM in the Administrator 's office, it was revealed that Staff #1 was present at the 02/28/2012 Governing Board Meeting Staff #12 was asked if the Governing Body approved Staff #1 as the Administrator, Staff #12 stated "No".
- 9. Interview with Governing Board Member (Staff #13) on 03/12/2012 at 2:00PM revealed that Staff #13 was present at the 02/28/2012 Governing Board Meeting. The surveyor asked Staff #13 if the Governing Body approved Staff #1 as the Administrator. Staff #13 replied "No "

During the follow-up visit 5/17/12 through 5/18/12, it was determined that the facility remained non-compliant. Based on interview and record review, the facility failed to supervise and provide mentoring to the Administrator. As part of the arrangement for the appointment of the new Administrator by the Governing Board, as revealed in the meeting held 04/20/2012, the corporate CEO was to be in the facility two to three times per week for the purpose of providing guidance to the newly appointed Administrator.

Review of the facility 's plan of correction revealed the following statement: "The Governing Board will follow the hospital 's Governing Board rules and regulations by appointing an Administrator at special called Governing Board meeting, which will be monitored by the CEO."

A review of the special called Governing Board meeting minutes held 4/20/12 revealed the following documentation word for word, "Board Member #14 noted that after reading the plan of corrections that the hospital submitted to the State and the Governing Board Bylaws, it is apparent the responsibility that the members of the Governing Board have. Board Member #14 asked if the hospital has insurance coverage on the Governing Board. Staff #4 noted that the hospital does not have any D&O (Director and Officer) insurance. Board Member #15 made the comment that people sue companies with deep pockets and then name the Board also. CEO (staff #2) indicated that he would speak with Board of Director #16 and we would get some insurance for the Board.

According to the Governing Board Bylaws Article IX, Section 1 states the Board of Directors or its designee shall appoint an Administrator of the hospital in accordance with such criteria as may be adopted by the Board and subject to approval by the Governing Board. Section 2 states the appointed Administrator shall have the

knowledge and skills necessary to perform the duties required of the Hospital's senior leader. Among other criteria, education and relevant experience are improvement qualifications. CEO (staff #2) indicated that he had received Staff #1 (administrator) resume and thus shared it with the members of the Board. Board Member #14 asked Staff #1 (administrator) what was the experience he had to be the Administrator. Staff #1 (administrator) noted that he has a Masters degree in English Literature from the School of Modern Languages, Literatures and Cultures in Pakistan and a Bachelors degree in English, Economics and Behavioral Sciences in Pakistan. Staff #1 (administrator) noted that he has successfully completed course of instruction in Health Careers Core from McFatter Technical Center (Florida) as well as a certificate in computer science from Whiddon Roger Technical Center. Staff #1 (administrator) has also attended the following courses: Principals of Business Management, Introduction to Personal Management and Management Skill for Institutional Development. Staff #1 was an Administrator at Chatha Memorial Hospital in Pakistan for ten years.

CEO (staff #2) requested Staff #6 (quality manager) and Staff #1 (administrator) step out of the meeting so the Governing Board could discuss this issue. Members of the Governing Board noted that they had not been included in the process to select an Administrator and questioned why

the last one left. Communication issues have come up and the future of the hospital is at stake - we need a strong Administrator and felt that they could approve him. CEO (staff #2) indicated that he has been Administrator and could be here two to three days a week hut

Indicated that he has been Administrator and could be here two to three days a week hut somebody needs to be here daily. The Administrator needs to have a degree in hospital administration and they need to have experience, If the new Administrator does not have these, he will not stand a chance. The hospital has a lot of problems and needs good communication. Communication 101 would solve a lot of issues. One Board member stated that he could not judge Staff #1 (administrator) personally and it might be ok if he has OJT (on the job training) but to be a good Administrator, one must be proactive and there are a lot of issues that needs the attention of an Administrator. Board Member #15 suggested that Board of Director #16 come to the next Governing Board meeting and discuss with the Board the plans he has for the hospital.

One Board member noted that Staff #1 (administrator) could possibly handle the day to day operations but we are not dealing with a smooth running facility which brings us back to basics and what we are facing is the hospital needs someone to get us past these issues.

Staff #1 (administrator) doesn't have the expertise, he is a pleasant gentleman and he can probably do some things for us but according to the plan of correction the hospital has a cease order in 60 days. CEO (staff #2) noted that the hospital will have a full inspection shortly. The Administrator needs to get up to speed and bring the hospital up as well.

It is an alarming situation with the Laboratory, very serious that labs were not being done and were not identified and fixed at the time. The Board should have been notified of the problem. The hospital needs to have somebody that knows what needs to be done and get it

done - and not a yes man.

If Staff #1 (administrator) is going to be the Administrator and get his experience from OJT, then he needs the right person under him helping him with issues The Board noted that they have been talking about the Laboratory and the difference between now and then is the Laboratory had a full-time Supervisor that handled all the problems. Staff #1 (administrator) could be Administrator as long as he had the correct personnel in each Department. The hospital does not need employees that only want their paychecks. It was suggested that Staff #1 be under 90 day review and the hospital get serious and get somebody to help Staff #1 or get somebody with credentials. One member of the Board requested a stipulation: that the hospital hires a Laboratory Supervisor that will work 8a -5p to solve the problems in the Laboratory and turn it around. The Board suggested that maybe an RN could evaluate the problems and then troubleshoot. The Board cannot solve any problems unless we change -we need to change.

The Board noted that Staff #1 (administrator) could be appointed as Administrator and they could evaluate him in 90 day and emphasize that he needs to hire a full-time Laboratory Supervisor (either an RN or MT) in 14 days and the outcome of the full State survey would

also be a part of his evaluation. '

During an interview on 05/18/2012 at 2:15 pm, the CEO confirmed he reassured the Governing Board, if the Administrator (staff #1) was approved as Administrator, the CEO would provide support two to three day a week. The interview confirmed the CEO had not made a visit to the facility since the Governing Board meeting held 04/20/2012.

VIOLATION: QAPI **Tag No:** A0263

Based on document review and by interview, the hospital's governing body failed to develop, implement, or maintain an effective hospital wide quality assessment and performance improvement program: Findings were:

A. Based on document review and by interview, the following hospital departments did not report outcomes to the Quality Program:

- 1. Materials Management,
- 2. Plant Operations,
- 3. Dietary
- 4. Medical Records,
- 5. Nursing,
- 6. Cardiopulmonary,
- 7. Pharmacy,
- 8. Surgery,
- Laboratory,
 Physical Therapy,
- 11. Linen /Laundry Services
- 12. Maintenance,
- 13. Admitting,
- 14. Emergency Services,
- 15. Housekeeping,
- Radiology

(Refer to findings at A0265, QAPI Health Outcomes)

- B. identifies and report medical errors to the Quality Assurance Committee. (Refer to findings at A0266, QAPI Medical Errors)
- C. Based on document review and by interview, the hospital laboratory failed to have a process in place to correct patient care issues found from the data being tracked in the Laboratory department which could cause an adverse event to a patient. (Refer to findings at A0267, QAPI Quality Indicators)
- D. Based on document review and interview, the hospital did not have an effective system in place to collect QAPI data from hospital departments with which to monitor the effectiveness and safety of services and quality of care provided. (Refer to findings at A0275, QAPI Quality of Care)
- E. Based on interviews and record review the facility failed to share the Governing Boards expectations for the Quality Improvement Process Improvement Program (QAPI) with the Department Managers. (Refer to findings at A0309, Executive Responsibilities)

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on record review and interview the facility failed to ensure Materials Management, Plant Operations, Dietary, Housekeeping, Medical Records, Nursing, Radiology, Respiratory, Pharmacy, Laboratory, Therapy Services, Linen /Laundry, and Surgery departments were reporting outcomes to the Quality Program.

Review of the Quality Assurance /Performance Improvement Meetings minutes dated November 23, 2011 and February 10, 2012 revealed no evidence that Materials Management, Plant Operations, Dietary, Housekeeping, Medical Records, Nursing, Radiology, Respiratory, Pharmacy, Laboratory, Physical Therapy, Linen /Laundry, and Surgery were reporting quality outcomes. Quality meetings were being held, but there was no documentation of actions that would resolve the problems found by the departments with the data collected by the departments to promote healthy outcomes for patient care and safety.

Interview with the Staff #6 on 3/9/2012 at 2:30 PM in the survey office confirmed there were no quality outcomes being reported to the Performance Improvement Committee from the departments.

On re-visit of the complaint survey on 05/17/2012-05/18/2012 the facility continued to be out of compliance with the following:

Based on record review and interview the facility failed to ensure Admitting, Maintenance, Materials Management, Plant Operations, Emergency, Dietary, Housekeeping, Medical Records, Nursing, Radiology, Cardiopulmonary, Risk Management, Pharmacy, Laboratory, Physical Therapy, Linen /Laundry, and Surgery departments were reporting outcomes to the Quality Program.

Review of the Quality Assurance /Performance Improvement Meetings minutes dated April 13, 2012, revealed no evidence that Admitting, Maintenance, Materials Management, Plant Operations, Emergency, Dietary, Housekeeping, Medical Records, Nursing, Radiology, Cardiopulmonary, Risk Management, Pharmacy, Laboratory, Physical Therapy, Linen /Laundry, and Surgery were reporting quality outcomes. A Quality Assurance Committee meeting the problems to the problems are allocated by the detailed by the details and the problems are allocated by the details and the problems. found by the departments with the data collected by the departments to promote healthy outcomes for patient care and safety. This was the only Quality Assurance Meeting held since the last survey on March 12, 2012.

Interview with the Staff #6 on 3/17/2012 at 2:30 PM in the Director of Nurses' office confirmed there were no quality outcomes being reported to the Performance Improvement Committee from the departments.

VIOLATION: LABORATORY SERVICES

Based on document review and by interview, the hospital failed to maintain or have available, adequate laboratory services to meet the needs of patients.

Tag No: A0576

Findings were:

A. Based on document review and by interview, the hospital failed to have laboratory services available either directly or through a contractual agreement with a certified laboratory that meets part 493 of this chapter (1) lack of appropriate reagents required to perform ordered diagnostic testing;

- (2.) malfunctioning analyzers requiring repair and(3.) instructions from hospital Owner / Board of Directors to not refer CKMB testing to other laboratories. (Refer to findings at A0582, Adequacy of Laboratory Services)
- B. Based on document review and by interview, results of diagnostic tests ordered by emergency room physicians deemed necessary for assessing the cardiac condition of patients presenting to the Emergency Department with cardiac related symptoms were not available in accordance with the laboratory policy and procedure. (Refer to findings at A0583, Emergency Laboratory Services)
- C. Based on document review and by interview the facility failed to accurately perform laboratory tests ordered by the attending physician citing 10 of 39 medical records reviewed. (Refer to findings at A584, Written Description of Services)

During the follow-up visit 5/17/12 through 5/18/12, it was determined that Laboratory Services remains non-compliant. Based upon record review and interview, the facility failed to provide leadership and supervision for lab services.

Review of the facility 's plan of correction revealed the following statement: "A. The Governing Board will empower the Administrator through the Laboratory Supervisor to order appropriate regents required to perform diagnostic testing and repair non-functioning analyzers requiring repair and to follow practitioner 's orders. The CEO will monitor these activities."

A review of the special called Governing Board meeting held 4/20/12 revealed, " It is an alarming situation with the Laboratory, very serious that labs were not being done and were not identified and fixed at the time. The Board should have been notified of the problem.

The hospital needs to have somebody that knows what needs to be done and get it done - and not a yes man. If Staff #1 is going to be the Administrator and get his experience from OJT, then he needs the right person under him helping him with issues The Board noted that they have been talking about the Laboratory and the difference between now and then is the Laboratory had a full-time Supervisor that handled all the problems. Staff #1 could be Administrator as long as he had the correct personnel in each Department. The hospital does not need employees that only want their paychecks. It was suggested that Staff #1 be under 90 day review and the hospital get serious and get somebody to help Staff #1 or get somebody with credentials. One member of the Board requested a stipulation: that the hospital hires a Laboratory Supervisor that will work 8a -5p to solve the problems in the Laboratory and turn it around. The Board suggested that maybe an RN could evaluate the problems and then troubleshoot. The Board cannot solve any problems unless we change -we need to change.

The Board noted that Staff #1 could be appointed as Administrator and they could evaluate him in 90 day and emphasis with him that he

needs to hire a full-time Laboratory Supervisor (either an RN or MT) in 14 days and the outcome of the full State survey would also be a part of his evaluation. "

An interview with Staff #1 revealed there had not been a Laboratory Supervisor hired to work 8am till 5pm, as requested by the Governing Board per meeting held 04/20/2012. No evidence of the facility actively recruiting a Laboratory Supervisor was provided by staff #1.

During an interview on 05/18/2012 at 2:15 pm, it was confirmed the CEO reassured the Governing Board, if the Administrator (staff #1) was approved as Administrator the CEO would provide support two to three day a week. The interview confirmed the CEO had not made a visit to the facility since the Governing Board meeting held 04/20/2012.

Tag No: A0582

VIOLATION: ADEQUACY OF LABORATORY SERVICES

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview the facility failed to

A. ensure emergency laboratory services were available to meet the needs of the patients who were provided care at the facility emergency room and/or as an in-patient. Citing 18 of 39 patient medical records reviewed. (Medical records reviewed for patient #1 thru #39).

B. The facility also failed to ensure the Laboratory department had a contract with the hospital where patient lab specimens had been taken to obtain lab results.

A. Findings include: Review of medical records for patients #1 thru #39 was conducted on 3/8/2012, 3/9/2012, and 3/12/2012.

Review of medical record for patient #1 revealed on 2/28/2012 patient was admitted to room 103 A . Review of Physician Orders dated 2/28/2012 at 3:25 pm revealed order for Basic Metabolic Panel (BMP) to be drawn in am. Review of BMP results dated 2/29/2012 revealed at 12:15 pm a notation written per staff #23, "Where is the rest of my BMP? Lytes??". Electrolytes received and reviewed per staff #23 on 2/29/2012 at 1:05 pm. No documentation found in medical record to explain missing electrolyte panel results. Physician order dated 3/1/2012 written at 8:55 am revealed order for STAT Creatine Kinase (CK), Creatine Kinase Myocardial Band (CKMB), and Troponin. Lab results dated 3/1/2012 and printed at 9:52 am revealed results for CK and Troponin. No results found for CKMB in medical

Review of medical record for patient #2 revealed patient arrived to emergency room on [DATE] at 6:15 pm with complaint of (c/o) vomiting and diarrhea. Review of orders written per Physician Assistant (PA) revealed order for following labwork: Complete Blood Count (CBC), CK, CKMB, Comprehensive Metabolic Panel (CMP), Troponin, and Urinalysis (UA). Results found for all labwork ordered with exception to the CKMB.

Review of medical record for patient #3 revealed patient arrived to emergency room on [DATE] at 10:15 pm with c/o chest pain radiating to both arms. Review of orders written per emergency room (ER) physician revealed order for following labwork: Pro-Brain natriuretic peptide (Pro-BNP), CBC, CK, CKMB, Prothrombin Time (PT), Partial thromboplastin time (PTT), and Troponin. Results found for all labwork with exception to CKMB, PT, and PTT.

Review of medical record for patient #9 revealed the patient arrived to emergency room on [DATE] at 6:15 pm with c/o heart palpitations. Review of orders written per ER physician revealed order for following labwork: B-NP, CBC, CK, CKMB, CMP, and Troponin. Results found for all labwork ordered with exception to the CKMB.

Review of medical record for patient #10 revealed the patient arrived to emergency room on [DATE] at 4:21 pm with c/o "he stopped breathing". Review of orders written per ER physician revealed order for following labwork: Blood Cultures x2, CBC and CMP. Results found for all labwork ordered with exception to the Blood Cultures x2. No documentation found to confirm Blood Cultures were collected and/or result found on chart.

Review of medical record for patient #19 revealed the patient arrived to emergency room on [DATE] at 8:23 pm with c/o seizure. Review of orders written per ER physician revealed order for following labwork: CBC, CK, CKMB, PT, PTT, and Troponin. Results found for all labwork ordered with exception of CKMB, PT, and PTT. No documentation found to confirm these labs were drawn as ordered. Review of medical record for patient #22 revealed the patient admitted to room 103 B on 2/27/2012. Admit orders reveal Diagnostic Studies ordered as follows: CBC, Fasting Blood Sugar (FBS), CK, CKMB every 6 hours x3, Troponin, BNP, Blood Cultures X2, and UA. Results found for all labwork ordered with exception of CKMB every 6 hours x3. No documentation found to confirm this labwork was

drawn as ordered.

Review of medical record for patient #24 revealed the patient arrived to emergency room on [DATE] at 1:39 am with c/o shortness of breath all day. Review of orders written per ER physician revealed order for following labwork: CBC, Pro-BNP, CK, CKMB, PT, PTT, and Troponin. Results found for all labwork ordered with exception of CKMB, PT, and PTT. No documentation found to confirm these labs were drawn as ordered.

Review of medical record for patient #25 revealed the patient arrived to the emergency room on [DATE] at 3:05 pm with c/o bilateral arm pain-feels like I'm having a heart attack. Review of orders written per ER physician revealed order for following labwork: CBC, Pro-BNP, CK, CKMB, PT, and Troponin. Results found for all labwork ordered with exception of CKMB. No documentation found to confirm CKMB was drawn as ordered.

Review of medical record for patient #26 revealed the patient arrived to the emergency room on [DATE] at 11:19 am with c/o shortness of breath and sharp pain. Review of orders written per ER physician revealed order for following labwork: Amylase, CBC, CK, CKMB, CMP, Lipase, and Troponin. Results found for all labwork ordered with exception of CKMB. No documentation found to confirm CKMB was drawn as ordered.

Review of medical record for patient #27 revealed the patient arrived to the emergency room on [DATE] at 8:00 pm with c/o chest pain x30 minutes. Review of orders written per ER physician revealed order for following labwork: Amylase, CBC, CK, CKMB, CMP, Lipase, and UA. Results found for all labwork ordered with exception of CKMB. No documentation found to confirm CKMB was drawn as ordered. Review of medical record for patient #28 revealed the patient arrived to the emergency room on [DATE] at 12:20 am with c/o chest pain. Review of orders written per ER physician revealed order for following labwork: CBC, Pro-BNP, CK, CKMB, CMP, PT, PTT, Troponin, and UA. Results found for all labwork ordered with exception of CKMB, PT, PTT, and UA. No documentation found to confirm these labs were drawn and/or collected as ordered.

Review of medical record for patient #29 revealed the patient arrived to the emergency room on [DATE] at 12:09 pm with c/o syncopal episode. Review of orders written per ER physician revealed order for following labwork: CBC, CK, CKMB, CMP, and Troponin. Results found for all labwork ordered with exception of CKMB. No documentation found to confirm CKMB was drawn as ordered.

Review of medical record for patient #31 revealed the patient arrived to the emergency room on [DATE] with c/o involved in motor vehicle accident. Review of orders written per ER physician revealed order for following labwork: amylase, CBC, Pro-BNP, CK, CKMB, CMP, PT, PTT, Troponin, and UA. Results found for all labwork ordered with exception of PT and PTT. No documentation found to confirm these labs were drawn and/or collected as ordered.

Review of medical record for patient #33 revealed the patient arrived to the emergency room on [DATE] at 7:05 am with c/o I need my head checked out. Review of orders written per ER physician revealed order for following labwork: CBC, BNP, CK, CKMB, CMP, PT, PTT, Troponin, Lipase, and UA. Results found for all labwork ordered with exception of PT and PTT. No documentation found to confirm these labs were drawn and/or collected as ordered.

Review of medical record for patient #34 revealed the patient arrived to the emergency room on [DATE] at 3:40 pm with c/o shortness of breath and hands tingling. Review of orders written per ER physician revealed order for following labwork: CBC, BNP, CK, CKMB, CMP, FBS, D-Dimer, INR, PT, PTT, Troponin, and UA. Results found for all labwork ordered with exception of PTT. No documentation found to confirm these labs were drawn and/or collected as ordered.

Review of medical record for patient #37 revealed the patient arrived to the emergency room on [DATE] at 10:15 pm with c/o chest pain. Review of orders written per ER physician revealed order for following labwork: CBC, Pro-BNP, CK, CKMB, CMP, PT, PTT, and Troponin. Results found for all labwork ordered with exception of CKMB, PT and PTT. No documentation found to confirm these labs were drawn and/or collected as ordered. Review of Physician order written 2/28/2012 revealed order written for patient admit including order for labwork: CK, CKMB, Troponin every 6 hours x3. No results for CKMB that was ordered on [DATE] and/or 2/28/2012 found on chart. No results found for third set of cardiac enzymes ordered every 6 hours x3.

Review of medical record for patient #38 revealed the patient arrive to the emergency room on [DATE] at 7:11 pm with c/o chest pain x1 hour. Review of orders written per ER physician revealed order for following labwork: CBC, BNP, CK, CKMB, CMP, and UA. Results found for all labwork ordered with exception of CKMB. No documentation found to confirm these labs were drawn and/or collected as ordered.

Shelby Regional Medical Center-Laboratory Policy manual

Reviewed date: 11/12/2011 Policy Number: Lab 1.17 Stat Laboratory Tests and Results

I. Policy

Laboratory tests to be performed on an emergency basis STAT must be written upon the request of a member of the medical staff, those physicians, and nurse practitioner of the medical staff who have authorization to request such support services to the extent permitted by law, and other person authorized by the hospital and licensed to engage in direct treatment of patients.

II. Procedure

- 1. STAT laboratory tests are to be ordered due to clinical necessity of test result information. Clinical necessity includes, but may not be limited to:
- A. Tests results necessary in establishing a diagnosis for the patient, the delay of which may result in lack of the provision of necessary treatment requited to stabilize the patient's physical condition.
- B. Test results necessary in the determination of implementation or revision of treatment for the patient, the delay of which may result in lack of the provision of treatment required to stabilize the patient's physical condition.
- 2. The following laboratory test have been established for STAT ordering purposes:
- A. CBC with differential
- B. BMP
- C. Cardiac Profile
- D. BNP E. D-Dimer
- F. CMP
- G. Individual Electrolyte levels
- H. Liver profile
- I. Known toxic medication levels(phenytoin levels, etc.)
- J. Urine drug screen
- K. Strep Test
- L. Influenza screening
- M RSV
- 3. Those individuals approved to order laboratory tests may request any laboratory test that is able to be returned on a STAT basis, as a STAT return, based on his/her clinical judgement- if STAT return is expected to benefit the care of the patient. However, these individuals are encouraged to follow the necessity rationale as outlined in this policy. Unnecessary ordering of STAT laboratory testing will be monitored as a performance improvement process measure by the Clinical laboratory Department.
- A. All orders for STAT laboratory testing will be forwarded to the Clinical Laboratory immediately upon receipt of the order.
- B. The Clinical Laboratory will obtain the appropriate patient specimen if this has not been obtained by Nursing, physician or other clinical staff, within 15 minutes of receipt of STAT request.
- C. All STAT request result will be forwarded tot he requesting unit with in one hour, after receipt of STAT request by the Clinical

Laboratory.

A phone interview with Staff #14 on 03/09/2012 at approximately 10:00AM with another surveyor present, and lab staff #16, #21, and #33 present was conducted. Staff #14 identified himself as the lab supervisor. Staff #14 was asked if he was aware there were 64 unprocessed tubes of blood (specimens) being held in the lab refrigerator with physicians ' orders requesting the cardiac lab test (CKMB ' s). Staff #14 responded, " No. " Staff #14 was asked if he had instructed the lab staff to ignore the physicians' orders and not process the lab specimens for CK-MB. Staff #14 responded "No." Staff #14 was told there were multiple interviews stating the Staff #14 had instructed lab staff to ignore the physician's order and not process the CKMB's. Staff #14 changed his previous answers given in the interview and reported he was aware of the unprocessed labs and he had instructed staff to ignore the physicians' orders. Staff #14 reported he was instructed by Staff #1 and Staff #25 to ignore the physicians' orders and not process the CKMB's.

B. An interview with staff # 16 on 3/8/2012 at 12:00 PM revealed patients' specimens were being taken to the hospital which is 30 miles away, when reagents are unavailable to test the patient's blood.

An interview with staff #4 on 3/12/2012 at 10:00 AM confirmed the hospital did not have a contract with the hospital where patient lab specimens had been taken to obtain test results.

During the follow-up visit 5/17/12 through 5/18/12, it was determined that Laboratory Services remains non-compliant. Based upon record review and interview, the facility failed to provide leadership and supervision for lab services.

Review of the facilities plan of correction revealed the following statement: " A.The Administrator will empower the Laboratory Supervisor to perform diagnostic testing according to Laboratory policy as ordered by the ER practitioners for assessing the cardiac condition of patient presenting to the ED with cardiac related symptoms and the CEO will monitor these activities. "

An interview with Staff #1 revealed there had not been a Laboratory Supervisor hired to work 8am till 5pm as requested by the Governing Board per meeting held 04/20/2012. No evidence was provided by staff #1 of the facility actively recruiting a Laboratory Supervisor.

Tag No: A0583

During an interview on 05/18/2012 at 2:15 pm, it was confirmed the CEO had not made a visit to the facility since 04/20/2012.

VIOLATION: EMERGENCY LABORATORY SERVICES

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review, observation, and interview the facility failed to

A. ensure emergency laboratory services were available to meet the needs of the patients who were provided care at the facility emergency room and/or after admission as an in-patient. Citing 18 of 39 patient medical records reviewed. (Medical records reviewed for patient #1 thru #39.)

B. The facility laboratory also failed to complete lab test ordered by the physicians to meet the needs of the patients who were provided care at the emergency room and/or admitted to the hospital.

Findings include: Review of medical records for patients #1 thru #39 was conducted on 3/8/2012, 3/9/2012, and 3/12/2012.

Review of medical record for patient #1 revealed on 2/28/2012 patient was admitted to room 103 A . Review of Physician Orders dated

2/28/2012 at 3:25 pm revealed order for Basic Metabolic Panel (BMP) to be drawn in am. Review of BMP results dated 2/29/2012 revealed at 12:15 pm a notation written per staff #23, "Where is the rest of my BMP? Lytes??". Electrolytes received and reviewed per staff #23 on 2/29/2012 at 1:05 pm. No documentation found in medical record to explain missing electrolyte panel results. Physician order dated 3/1/2012 written at 8:55 am revealed order for STAT Creatine Kinase (CK), Creatine Kinase Myocardial Band (CKMB), and Troponin. Lab results dated 3/1/2012 and printed at 9:52 am revealed results for CK and Troponin. No results found for CKMB in medical record.

Review of medical record for patient #2 revealed patient arrived to emergency room on [DATE] at 6:15 pm with complaint of (c/o) vomiting and diarrhea. Review of orders written per Physician Assistant (PA) revealed order for following labwork: Complete Blood Count (CBC), CK, CKMB, Comprehensive Metabolic Panel (CMP), Troponin, and Urinalysis (UA). Results found for all labwork ordered with exception to the CKMB.

Review of medical record for patient #3 revealed patient arrived to emergency room on [DATE] at 10:15 pm with c/o chest pain radiating to both arms. Review of orders written per emergency room (ER) physician revealed order for following labwork: Pro-Brain natriuretic peptide (Pro-BNP), CBC, CK, CKMB, Prothrombin Time (PT), Partial thromboplastin time (PTT), and Troponin. Results found for all lab work with exception to CKMB, PT, and PTT.

Review of medical record for patient #9 revealed the patient arrived to emergency room on [DATE] at 6:15 pm with c/o heart palpitations. Review of orders written per ER physician revealed order for following labwork: B-NP, CBC, CK, CKMB, CMP, and Troponin. Results found for all labwork ordered with exception to the CKMB.

Review of medical record for patient #10 revealed the patient arrived to emergency room on [DATE] at 4:21 pm with c/o "he stopped breathing". Review of orders written per ER physician revealed order for following labwork: Blood Cultures x2, CBC and CMP. Results found for all labwork ordered with exception to the Blood Cultures x2. No documentation found to confirm Blood Cultures were collected and/or result found on chart.

Review of medical record for patient #19 revealed the patient arrived to emergency room on [DATE] at 8:23 pm with c/o seizure. Review of orders written per ER physician revealed order for following labwork: CBC, CK, CKMB, PT, PTT, and Troponin. Results found for all labwork ordered with exception of CKMB, PT, and PTT. No documentation found to confirm these labs were drawn as ordered. Review of medical record for patient #22 revealed the patient admitted to room 103 B on 2/27/2012. Admit orders reveal Diagnostic Studies ordered as follows: CBC, Fasting Blood Sugar (FBS), CK, CKMB every 6 hours x3, Troponin, BNP, Blood Cultures X2, and UA. Results found for all labwork ordered with exception of CKMB every 6 hours x3. No documentation found to confirm this labwork was drawn as ordered.

Review of medical record for patient #24 revealed the patient arrived to emergency room on [DATE] at 1:39 am with c/o shortness of breath all day. Review of orders written per ER physician revealed order for following labwork: CBC, Pro-BNP, CK, CKMB, PT, PTT, and Troponin. Results found for all labwork ordered with exception of CKMB, PT, and PTT. No documentation found to confirm these labs were drawn as ordered.

Review of medical record for patient #25 revealed the patient arrived to the emergency room on [DATE] at 3:05 pm with c/o bilateral arm pain-feels like I'm having a heart attack. Review of orders written per ER physician revealed order for following labwork: CBC, Pro-BNP, CK, CKMB, PT, and Troponin. Results found for all labwork ordered with exception of CKMB. No documentation found to confirm CKMB was drawn as ordered.

Review of medical record for patient #26 revealed the patient arrived to the emergency room on [DATE] at 11:19 am with c/o shortness of breath and sharp pain. Review of orders written per ER physician revealed order for following labwork: Amylase, CBC, CK, CKMB, CMP, Lipase, and Troponin. Results found for all labwork ordered with exception of CKMB. No documentation found to confirm CKMB was drawn as ordered.

Review of medical record for patient #27 revealed the patient arrived to the emergency room on [DATE] at 8:00 pm with c/o chest pain x30 minutes. Review of orders written per ER physician revealed order for following labwork: Amylase, CBC, CK, CKMB, CMP, Lipase, and UA. Results found for all labwork ordered with exception of CKMB. No documentation found to confirm CKMB was drawn as ordered. Review of medical record for patient #28 revealed the patient arrived to the emergency room on [DATE] at 12:20 am with c/o chest pain. Review of orders written per ER physician revealed order for following labwork: CBC, Pro-BNP, CK, CKMB, CMP, PT, PTT, Troponin, and UA. Results found for all labwork ordered with exception of CKMB, PT, PTT, and UA. No documentation found to confirm these labs were drawn and/or collected as ordered.

Review of medical record for patient #29 revealed the patient arrived to the emergency room on [DATE] at 12:09 pm with c/o syncopal episode. Review of orders written per ER physician revealed order for following labwork: CBC, CK, CKMB, CMP, and Troponin. Results found for all labwork ordered with exception of CKMB. No documentation found to confirm CKMB was drawn as ordered. Review of medical record for patient #31 revealed the patient arrived to the emergency room on [DATE] with c/o involved in motor vehicle accident. Review of orders written per ER physician revealed order for following labwork: amylase, CBC, Pro-BNP, CK, CKMB, CMP, PT, PTT, Troponin, and UA. Results found for all labwork ordered with exception of PT and PTT. No documentation found to confirm these labs were drawn and/or collected as ordered.

Review of medical record for patient #33 revealed the patient arrived to the emergency room on [DATE] at 7:05 am with c/o I need my head checked out. Review of orders written per ER physician revealed order for following labwork: CBC, BNP, CK, CKMB, CMP, PT, PTT, Troponin, Lipase, and UA. Results found for all labwork ordered with exception of PT and PTT. No documentation found to confirm these labs were drawn and/or collected as ordered.

Review of medical record for patient #34 revealed the patient arrived to the emergency room on [DATE] at 3:40 pm with c/o shortness of breath and hands tingling. Review of orders written per ER physician revealed order for following labwork: CBC, BNP, CK, CKMB, CMP, FBS, D-Dimer, INR, PT, PTT, Troponin, and UA. Results found for all labwork ordered with exception of PTT. No documentation found to confirm these labs were drawn and/or collected as ordered.

Review of medical record for patient #37 revealed the patient arrived to the emergency room on [DATE] at 10:15 pm with c/o chest pain. Review of orders written per ER physician revealed order for following labwork: CBC, Pro-BNP, CK, CKMB, CMP, PT, PTT, and Troponin. Results found for all labwork ordered with exception of CKMB, PT and PTT. No documentation found to confirm these labs were drawn and/or collected as ordered. Review of Physician order written 2/28/2012 revealed order written for patient admit including order for labwork: CK, CKMB, Troponin every 6 hours x3. No results for CKMB that was ordered on [DATE] and/or 2/28/2012 found on chart. No results found for third set of cardiac enzymes ordered every 6 hours x3.

Review of medical record for patient #38 revealed the patient arrive to the emergency room on [DATE] at 7:11 pm with c/o chest pain x1 hour. Review of orders written per ER physician revealed order for following labwork: CBC, BNP, CK, CKMB, CMP, and UA. Results found for all labwork ordered with exception of CKMB. No documentation found to confirm these labs were drawn and/or collected as ordered.

Shelby Regional Medical Center-Laboratory Policy manual

Reviewed date: 11/12/2011 Policy Number: Lab 1.17 Stat Laboratory Tests and Results

Policy

Laboratory tests to be performed on an emergency basis STAT must be written upon the request of a member of the medical staff, those physicians, and nurse practitioner of the medical staff who have authorization to request such support services to the extent permitted by law, and other person authorized by the hospital and licensed to engage in direct treatment of patients.

II. Procedure

1. STAT laboratory tests are to be ordered due to clinical necessity of test result information. Clinical necessity includes, but may not be

limited to:

- A. Tests results necessary in establishing a diagnosis for the patient, the delay of which may result in lack of the provision of necessary treatment requited to stabilize the patient's physical condition.
- B. Test results necessary in the determination of implementation or revision of treatment for the patient, the delay of which may result in lack of the provision of treatment required to stabilize the patient's physical condition.
- 2. The following laboratory test have been established for STAT ordering purposes:
- A. CBC with differential
- B. BMP
- C. Cardiac Profile
- D. BNP
- E. D-Dimer F. CMP
- G. Individual Electrolyte levels
- H. Liver profile
- I. Known toxic medication levels(phenytoin levels, etc.)
- J. Urine drug screen
- K. Strep Test
- L. Influenza screening
- M. RSV
- 3. Those individuals approved to order laboratory tests may request any laboratory test that is able to be returned on a STAT basis, as a STAT return, based on his/her clinical judgement- if STAT return is expected to benefit the care of the patient. However, these individuals are encouraged to follow the necessity rationale as outlined in this policy. Unnecessary ordering of STAT laboratory testing will be monitored as a performance improvement process measure by the Clinical laboratory Department.
- A. All orders for STAT laboratory testing will be forwarded to the Clinical Laboratory immediately upon receipt of the order.
- B. The Clinical Laboratory will obtain the appropriate patient specimen if this has not been obtained by Nursing, physician or other clinical staff, within 15 minutes of receipt of STAT request.
- C. All STAT request result will be forwarded tot he requesting unit with in one hour, after receipt of STAT request by the Clinical

A phone interview with Staff #14 on 03/09/2012 at approximately 10:00AM with another surveyor present, and lab staff #16, #21, and #33 present was conducted. Staff #14 identified himself as the lab supervisor. Staff #14 was asked if he was aware there were 64 unprocessed tubes of blood (specimens) being held in the lab refrigerator with physicians ' orders requesting the cardiac lab test (CKMB's). Staff #14 responded, " No. " Staff #14 was asked if he had instructed the lab staff to ignore the physicians' orders and not process the lab specimens for CK-MB. Staff #14 responded "No." Staff #14 was told there were multiple interviews stating the Staff #14 had instructed lab staff to ignore the physician's order and not process the CKMB's. Staff #14 changed his previous answers given in the interview and reported he was aware of the unprocessed labs and he had instructed staff to ignore the physicians' orders. Staff #14 reported he was instructed by Staff #1 and Staff #25 to ignore the physicians' orders and not process the CKMB's.

B. During the tour on 3/8/2012 of the Lab and the emergency room, it was reported by staff #5, #6, #7, #17, #19, #21, #22, and #27, the facility does not have the capabilities of testing PTT (partial thromboplastin time is a blood test that looks at how long it takes for blood to clot. It can help tell if patient has a bleeding or clotting problem.) In the emergency room, surveyor observed a posting that read "LAB; ER Trauma Panel consist of CBC, UA, UDS, ETOH, AMYLASE, CMP, CKMB, TROPONIN, PT, PTT, SERUM PREGANCY." On 3/12/2012 at 9:00 AM confirmed with the emergency room Physician and ER staff nurses #6, #7, and #8 the lab specimens are drawn, but not all lab test will be completed.

Staff members #5, #6, #7, #17, #19, #21, # 22, and #27, interviewed during the tour at various times confirmed the PTT's are ordered and drawn, but the facility does not have the capabilities of running the PTT test.

On 3/8/2012 at 12:00 PM in the Lab refrigerator observed 34 patients' specimen in a rack (not frozen) (64 total specimens). When questioned Lab staff members #17, #19, and #21, (present at the time specimens were observed) what are these specimens for? The answer was we are waiting for reagent supplies to run CK-MB (CKMB- Creatine Kinase Myocardial Band) (Creatine phosphokinase MB isoenzyme Cardiology A CK isoenzyme usually in acute MI) (CK-MB levels, along with total CK are tested in persons who have chest pain to diagnose whether they have had a heart attack, since a high total CK could indicate damage to either the heart or other muscles, CK-MB helps to distinguish between these two sources.) Observed the 39 patient blood tubes were from 12/16/2011 thru 3/5/2012. During the interview with the lab members it was discussed that reagents had arrived in the facility on 3/1/2012 and specimens were still present in the refrigerator, each lab staff reported we have to save the reagents for the ER patients (who are more critical) because we will run out of reagent supplies again by the time the weekend arrives. Staff members reported staff #14 instructed them not to send CK-MB's out to the other labs. Posted on the computer in the lab was a note *Note* No Send out on CK-MB's. The staff members reported the blood tubes still present are CK-MB's the physicians have ordered when the patients were admitted to the hospital and some of the specimens are from the emergency room admits when the reagents were not available. Lab staff #17, #19, and #21 reported, if the emergency room physician insisted on having a CK-MB test, then a staff member will take the serum to the hospital which is 30 miles away by courier. Lab staff members reported the main chemistry machine has been broken for three months.

In the emergency room, surveyor observed a posting that read "LAB; Cardiac Work- Up consist of CMP, CBC, CK, CK-MB, TROPONIN, BNP." On 3/12/2012 at 9:00 AM confirmed with the emergency room Physician and ER staff nurses #6, #7, and #8 the lab specimens are drawn, but not all lab test will be completed.

An interview with ER staff #7 on 3/12/2012 at 9:00 AM stated "when the emergency room shift starts, I call the lab to see what tests are available for the day."

During the follow-up visit 5/17/12 through 5/18/12, it was determined that Laboratory Services remains non-compliant. Based upon record review and interview, the facility failed to provide leadership and supervision for lab services.

Review of the facilities plan of correction revealed the following statement: " A. The Administrator will empower the Laboratory Supervisor to ensure emergency Laboratory Services are available 24 hours a day to meet the needs of the patients who are provided care in the ED and/or after admission as an inpatient, which will be monitored by the CEO. B. The Administrator will empower the Laboratory Supervisor to ensure Laboratory Services are completed on all Laboratory test(s) that are ordered by the practitioner to meet the needs of the patients who are provided care in the ED and/or after admission as an inpatient, which will be monitored by the CEO. "

An interview on 05/17/2010 at 2:00pm, Staff #1 revealed there had not been a Laboratory Supervisor hired to work 8am till 5pm, as requested by the Governing Board per meeting held 04/20/2012. No evidence of the facility actively recruiting a Laboratory Supervisor was provided by staff #1.

During an interview on 05/18/2012 at 2:15 pm, it was confirmed the CEO had not made a visit to the facility since 04/20/2012.

VIOLATION: WRITTEN DESCRIPTION OF SERVICES

Based on record review and interview the facility failed to accurately perform laboratory tests ordered by the attending physician citing 10 of 39 medical records reviewed. (Reviewed medical records for patients #1 thru #39)

Tag No: A0584

Findings include:

Review of medical records for patients #1 thru #39 were conducted on 3/8/2012, 3/9/2012, and 3/12/2012.

Review of medical record for patient #5 revealed on 3/6/2012 at 3:17 pm blood was collected and a Pro-BNP was analyzed by the lab. Documentation of lab results found in the medical record. No documentation found to verify the Pro-BNP was ordered by the physician.

Review of medical record for patient #6 revealed on 3/6/2012 at 9:50 pm blood was collected and a Troponin and Pro-BNP was analyzed by the lab. Documentation of the lab results found in the medical record. No documentation found to verify the Troponin and Pro-BNP were ordered by the physician.

Review of medical record for patient #12 revealed on 2/25/2012 at 3:30 am blood was collected and tests for H. Influenza A was analyzed by the laboratory personnel. Documentation of lab results found on the chart. No documentation found to verify the H. Influenza A was ordered by the physician.

Review of medical record for patient #21 revealed on 3/3/2012 at 5:00 pm blood was collected an a BMP was analyzed by the lab. Documentation of the lab results found in the medical record. No documentation found to verify the BNP was ordered by the physician.

Review of medical record for patient #22 revealed on 2/27/2012 at 4:52 pm urine was collected and sent to the lab for a urinalysis. Documentation of the lab results found in the medical record. No documentation found to verify the urinalysis was ordered by the physician.

Review of medical record for patient #23 revealed on 2/17/2012 at 11:50 am blood was collected and the following lab test were done: CMP, CBC, CK, Pro-BNP, and Troponin. Documentation of results found in the medical record. No documentation found to verify the labwork was ordered by the physician.

Review of medical record for patient #28 revealed on 2/22/2012 at 12:30 am specimen for H. Pylori was collected and analyzed by lab

personnel. Documentation of lab results found in the medical record. No documentation found to verify the lab test for H. Pylori was ordered by the physician.

Review of medical record for patient #36 revealed on 2/29/2012 at 4:28 pm urine was collected and sent to the lab for a urinalysis. Documentation of the lab results found in the medical record. No documentation found to verify the urinalysis was ordered by the physician.

Review of medical record for patient #38 revealed on 3/5/2012 at 4:45 am urine was collected and sent to the lab for a urinalysis. Documentation of the lab results found in the medical record. No documentation found to verify the urinalysis was ordered by the

Review of medical record for patient #39 revealed on 2/6/2012 at 2:20 pm blood was collected and sent to the lab for a potassium level. Documentation of the lab results found in the medical record. No documentation found to verify the potassium level was ordered by the physician.

Interview with staff #6 on 3/9/2012 at 11:00 am confirmed the he labwork done on the patients did not have an documentation of an order in the medical record.

Abbreviations and Definitions:

BMP-Basic Metabolic Panel

BNP- B-Type Natriuretic Peptide (The level of BNP in the blood increases when heart failure symptoms worsen, and decreases when the heart failure condition is stable.)

CBC- Complete Blood Count

CK-Creatine Kinase

CKMB- Creatine Kinase Myocardial Band (Creatine phosphokinase MB isoenzyme Cardiology A CK isoenzyme usually? in acute MI) (CK-MB levels, along with total CK </understanding/analytes/ck>, are tested in persons who have chest pain to diagnose whether they have had a heart attack </understanding/conditions/heart-attack>. Since a high total CK could indicate damage to either the heart or other muscles, CK-MB helps to distinguish between these two sources.)

CMP- Comprehensive Metabolic Panel.

D-Dimer- D dimer is a protein fragment that is found in the blood after someone has had a blood clot

FBS- Fasting Blood Sugar

Pro-BNP (B-type natriuretic peptide (BNP) and amino-terminal pro-BNP (NT-proBNP) plasma levels are commonly high at the early phase of septic shock and have been suggested to be prognostic markers for this condition) PT- Prothrombin Time (A blood clotting test)

PTT- Partial thromboplastin time (blood test that measures the time it takes your blood to clot)

UA- Urinalysis (Urinalysis is the physical, chemical, and microscopic examination of urine)

Troponin- (Troponin level is a type of blood test used to check for damage to the heart)

Shelby Regional Medical Center: Laboratory Policy Manual

Reviewed date: 11/12/2011 Policy number 1.1

Mission

The mission of the Clinical Laboratory of Shelby Regional Medical Center is to provide the highest quality of care and superior customer service. This well be achieved through:

1.0 Ongoing development, implementation, and evaluation of quality control methods appropriate to each department.

2.0 Testing performed efficiently and accurately.

3.0 Continuous evaluation and revision of current laboratory procedures.

The Clinical Laboratory at Shelby Regional Medical Center will provide the highest quality of service to the hospital's medical staff by encouraging it's personnel to continuously update its educational and laboratory experience and to utilize only precise and accurate methods and equipment. The Clinical Laboratory will always provide the medical staff with competent reliable laboratory testing. Objective

Main Objective:

1.0 To efficiently and accurately perform the test ordered by the attending physician.

Continuing Objective

1.0 Ongoing development, implementation and evaluation of quality control methods appropriate to each department.

2.0 Continuous evaluation and revision of current laboratory procedures; introduction of new procedures as they are available and adaptable tot he needs of the hospital.

3.0 Clinical Laboratory personnel will participate in continuing education program in order to update their knowledge of laboratory theory and practice.

4.0 Encourage laboratory personnel to hold membership in MLT/MT-AMT, ASCP, and other professional organizations.

During the follow-up visit 5/17/12 through 5/18/12, it was determined that Laboratory Services remains non-compliant. Based upon record review and interview, the facility failed to provide a written list of lab services provided by the facility to the medical staff.

Review of the facilities plan of correction revealed the following statement: "The Administrator will empower the Laboratory Supervisor to provide the Medical Staff with a written description of services provided by the Laboratory, which will be monitored by the CEO."

Multiple requests were made of the lab staff, the Director of Quality, and the Director of Nursing to review the written list that would be provided to the medical staff of laboratory services provided. No document was provided to the surveyors for review.

An interview with Staff #1 revealed there had not been a Laboratory Supervisor hired to work 8am till 5pm, as requested by the Governing Board per meeting held 04/20/2012. No evidence of the facility actively recruiting a Laboratory Supervisor was provided by staff #1.

During an interview on 05/18/2012 at 2:15 pm, it was confirmed the CEO had not made a visit to the facility since 04/20/2012.

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on record review and interview the Laboratory department failed to monitor, measure, analyze, and track quality indicators and /or occurrences that have occurred in the department and report to the Quality Assurance /Performance Improvement committee.

Review of records titled "Quality Assurance /Performance Improvement Meetings" dated November 23, 2011 and February 10, 2012 revealed no evidence the Laboratory department had chosen indicators (specific to the department) to report to Quality Assurance /Performance Improvement Committee.

Interview with the Staff #6 on 3/9/2012 at 2:30 PM in the survey office confirmed the Laboratory had not chosen indicators and/or reported quality patient care issues or occurrences to the Quality Assurance /Performance Improvement Committee. Staff #6 also confirmed the Lab Department had never submitted any type of Quality reports to the committee.

On re-visit of the complaint survey on 05/17/2012-05/18/2012 the facility continued to be out of compliance with the following:

Based on record review and interview the Laboratory department failed to have a process in place to correct patient care issues found from the data being tracked in the Laboratory which could cause an adverse event to a patient.

Review of records titled "Quality Assurance /Performance Improvement Meetings" dated April 13, 2012 revealed " The data for the Laboratory is for the month of March 2012. Available 0% threshold is 100%. The plan of correction noted that during the month of March the Laboratory did not have any reagents for the PT/INR machine. The laboratory will continue to trend the data. " The Quality Assurance program has no documented processes in place to take action to prevent patient harm.

Interview with the Staff #6 on 3/17/2012 at 2:30 PM in the Director of Nurses' office confirmed the Quality Assurance program has no process in place to take action on the data collected to prevent patient harm.

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on record review and interview the Board of Directors failed to provide the Governing Board with the authority to identify opportunities for improvement and changes to improve the quality of patient care in the facility.

Review of the Quality Assurance /Performance Improvement Meetings minutes dated November 23, 2011 and February 10, 2012 revealed no evidence that Materials Management, Plant Operations, Dietary, Housekeeping, Medical Records, Nursing, Radiology, Respiratory, Pharmacy, Surgery, Laboratory, Physical Therapy, and Linen /Laundry Services were reporting quality improvement with the data that had been collected. Quality meetings were being held, but there was no documentation of actions that would resolve the problems found by the departments with the data collected to promote healthy outcomes for patient care and safety.

Interview with the Staff #6 on 3/9/2012 at 2:30 PM in the survey office confirmed there were no quality improvements from the departments being reported to the Performance Improvement Committee and being reviewed by the Governing Board.

On re-visit of the complaint survey on 05/17/2012-05/18/2012 the facility continued to be out of compliance with the following:

Based on document review and interview, the hospital did not have an effective system in place to collect QAPI data from hospital departments with which to monitor the effectiveness and safety of services and quality of care provided.

Review of the Quality Assurance Committee Meeting minutes dated April 13, 2012 revealed no evidence that the following departments reported quality improvement from the data collected:

- Materials Management,
- 2. Plant Operations,
- 3. Dietary,
- 4. Medical Records.

- 5. Nursing,
- 6. Cardiopulmonary,
- 7. Pharmacy,
- 8. Surgery,
- 9. Laboratory.
- 10. Physical Therapy,
- 11. Linen /Laundry Services
- 12. Maintenance,
- 13. Admitting,
- 14. Emergency Services,
- 15. Housekeeping,
- 16. Radiology,

Interview with the Staff #6 on 5/17/2012 at 2:30 PM in the Director of Nurses' office, confirmed there were no quality improvement action plans reported to the Quality Assurance Committee by the hospital departments and therefore the improvement plan had not been reviewed by the Governing Board.

Tag No: A0309

VIOLATION: EXECUTIVE RESPONSIBILITIES

Based record review and interview the Board of Directors failed to provide the Governing Board with the authority to ensure that an ongoing program for hospital wide quality improvement was defined, implemented, and maintained.

Finding were:

1. Review of the Shelby Regional Medical Center Rules and Regulations of the Governing Board Article VIII Governing Board Operational:

Section 5. Performance Improvement (P1). "The Governing Board shall require the Medical Staff and staffs of the Hospital departments/services to implement and report on the activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying opportunities to improve patient care, and for identifying and resolving problems. The Governing Board, through the Hospital Administrator, shall support these activities and mechanisms. The Governing Board shall provide for resources and support systems for the quality assessment and improvement and risk management functions related to patient care and safety. The Governing Board shall consider and, if necessary, act upon the results reported from P1 activities, which activities shall strive to satisfy the following objectives: (i) quality patient care provided by members of the medical and allied professional staffs, employees of the Hospital and all others who provide patient care services at this Hospital, (ii) use of planned and systematic procedures to objectively assess the quality of care provided, (iii) implementation of corrective action when problems or opportunities for improvement are identified, and (iv) the provision of one level of patient care throughout the Hospital."

- 2. Review of records titled Governing Board Meeting revealed no documentation of any Governing Board meetings at which expectations from implemention of the Quality Assurance/Performance Improvement program at the facility were discussed.
- 3. Interview with the Staff #4 on 3/12/2012 at 2:30 PM in the survey office confirmed the document reviewed by the surveyor was the notebook that contained the Governing Board Meetings. The notebook contained no documentation of Quality Assurance/Performance Improvement program activities discussed at the Governing Board Meetings. Surveyor was informed that meetings at which the quality improvement of patient care was discussed occurred on November 23, 2011 and February 28, 2012.

During the follow-up visit 5/17/12 through 5/18/12, it was determined that remains non-compliant. Based upon record review and interview, the facility failed to provide the Managers and Medical Staff the expectations set by the Governing Body to prvide and monitor quality of

Review of the facilities plan of correction revealed the following statement: " 2. The Governing Board will set expectations from the implementation of the QAPI program at the hospital. The expectations will be shared with the Managers and Medical Staff as well as be monitored by the CEO.

Interviews held on 05/17/2012 at approximately 3:00 pm with Staff #4, Staff #6 and Staff #5 all confirmed there had been no meeting or information shared with manager as it relates to the Governing Board expectations for QAPI.

During an interview on 05/18/2012 at 2:15 pm, it was confirmed the CEO had not made a visit to the facility since 04/20/2012.

VIOLATION: QAPI MEDICAL ERRORS

Based on record review and interview the facility failed to identify and report medical errors to the Quality Assurance Committee.

Review of the Quality Assurance /Performance Improvement Meetings minutes dated April 13, 2012, revealed no evidence medical errors were being reported to the Quality program.

Tag No: A0266

Interview with the Staff #6 on 3/17/2012 at 2:30 PM in the Director of Nurses' office confirmed medical errors were not being reported to the Quality Assurance Committee.

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Incomplete reports

Report date Number of incomplete reportsNumber of violations Oct. 5, 20121 9



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PARKLAND HEALTH AND HOSPITAL SYSTEM ->

Report No. 1462

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

PARKLAND HEALTH AND HOSPITAL SYSTEM

5201 HARRY HINES BLVD DALLAS, TX 75235

May 17, 2012

Tag No: A0144

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the hospital failed to ensure a safe environment was provided for both hospital personnel and 1 of 1 patient (Patient #1). (Patient #1) arrived in the hospital's main ED (Emergency Department) with a loaded gun in her purse. (Patient #1) was transferred to the Psychiatric ED where hospital personnel delayed a search/scan of the patient and her belongings prior to being assessed. This failure placed all patients and hospital personnel within the vicinity of (Patient #1) at risk for injury.

Findings included:

(Patient #1's) main emergency services encounter record reflected, "arrival date 04/24/12 at 02:03 AM...escorted by EMS...emergent...bipolar; off medications..."

The Main ED nursing note dated 04/24/12 at 03:18 AM reflected, "Pt (patient) presents with depression and reports being off medications times 5 days and has been drinking excessive ETOH (alcohol)...pt appears flat, tearful, depressed and paranoid but cooperative and pleasant with staff...sitter at bedside for safety..."

The Psychiatric Services Patient Log for 04/24/12: reflected, "(Patient #1) arrived on the Psychiatric ED unit at 06:15 AM..."

The Psychiatric ED nursing note dated 04/24/12 timed at 09:28 AM reflected, "Late entry for 07:00 AM ...pt found to have a gun in her purse. Pts (patient's) gun was a 38 caliber revolver...police called to confiscate the weapon...Dr. notified...charge nurse notified..."

The Psychiatric ED nursing note dated 04/24/12 timed at 10:34 AM reflected, "This [AGE] year old female was escorted to psych ED by a nurse and a police officer. The patient was taken into the family room by (Staff #7), as there was a pt in the intake room. I joined the interview and the patient admitted she had been "drinking way too much last night. It was a stupid thing to do." She had told the Dr. that she had recently moved back to...had ended a 12 year relationship, is not currently employed and she feels stressed because she doesn't know anyone in the area. The patient is calm, but tearful...denies suicidal, homicidal ideations...she was somewhat upset when the Dr. told her she would need to stay in the psych ER until her alcohol level dropped at or below 80 and that this would be several hours from now. She asked to speak to someone else...Dr. left to get attending who also informed her of the need for her to remain until she became legally sober...the patient left the family room and went into the intake room across the hallway...the patient's vital signs were taken...Psych Tech was asked to secure her belongings while I got the patient a cup of water. I gave the patient a large cup of ice water and left the intake area to give a hand off report to the oncoming shift..." No documentation was found which indicated a search and scan was completed upon arrival to the psychiatric ED unit and/or prior to being assessed.

The Psychiatric ED nursing note dated 04/24/12 timed at 07:00 AM reflected, "Patient found to have a gun in her purse...patient's gun was a 38 caliber revolver...police called to confiscate the weapon... notified of situation. Dr...notified of situation...charge nurse notified of the

situation..."

On 05/04/12 at 16:00 PM Staff #1 was interviewed. Staff #1 stated (Patient #1) arrived in the ED via ambulance. He stated patients are not searched when they come through the ambulance entrance. The patient was seen in the main ED and then sent to the psychiatric ED. He stated during the search and scan the technician found a loaded 38 caliber gun.

On 05/16/12 at 09:30 PM Staff #4 was interviewed by phone. Staff #4 stated he did not remember who brought the patient into the unit and put her in the interview room without being searched and scanned. Staff #4 stated when he went into the room (Patient #1's) purse was on the desk. Staff #4 said he began to do a property check and found the gun. Staff #4 stated he reported this to nurse. Staff #4 stated patients are frequently brought into the interview room before they are searched and scanned especially if they are voluntary. Staff #4 stated males could not search females it had to be same sex. Staff #4 stated four male technicians and two female nurses worked the morning of 04/24/12. Staff #4 said when there are no female technicians the female nurses are supposed to do the search/scan.

On 05/17/12 at 10:40 AM, the surveyor interviewed Staff #5. Staff #5 stated he had come on duty a little early on 04/24/12. Staff #5 said the patient was in the interview room with her purse on the other side of the desk. Staff #5 stated Staff #6 gave him report. Staff #5 stated the tech informed him the patient had a gun in her purse. He stated the police was notified and management was notified. Staff #5 stated Staff #6 did not follow procedure. The patient was not searched and scanned, nor were her belongings secured before she made it into the interview room. Staff #5 said the male technician could not do the search/scan as he was a male and (Patient #1) was female.

On 05/17/12 at 01:56 PM Staff #7 was interviewed. Staff #7 stated when (Patient #1) arrived the attending physician told her to take the patient in the family room as the interview room had a patient in it. Staff #7 stated she took Patient #1 in the room. Staff #7 said (Patient #1) had her purse with her. Staff #7 stated Staff #6 joined her approximately 10 minutes later in the interview room with (Patient #1). Staff #7 said she was aware search/scan was completed on patients but did not know when it was to be completed as part of the procedure. Staff #7 stated from the family room Staff #6 took (Patient #1) into the interview room. Staff #7 said she found out later (Patient #1) had a gun in her purse.

The Department of Clinical Staff Services Educational Event Record dated 04/24/12, 04/27/12, 04/30/12 and 05/01/12: reflected, "Given the incident happening 04/24/12 morning...it is important the patient property is secured...before the patient enters in the ante room for assessment...next the patient should be searched and scanned...the search and scan protocol should be done on each and every patient without fail. Once the search and scan is complete the admission process can continue...our goal is to keep the patient and staff safe..."

The Patient Search and Scan Policy with a revision date of 02/12: reflected, "In order to provide a safe environment for patients, staff, and visitors all individuals and belongings are searched and scanned at entry to the Psychiatric Emergency Services Department...a systematic search by the RN or technician, utilizing a hand-held metal detector (wand)...a systematic search by the RN or technician, who performs a pat down on a same sex patient ...belonging search...a systematic search by the RN or technician all belongings the patient brings to the department...visual inspection precedes physical search...on presentation the patient is physically separated from any bags, suitcases, purses, or other containers...access to these items is not permitted until the belongings search is completed...the search is done by the same sex staff..."



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Report No. 1501

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MEMORIAL HERMANN HOSPITAL SYSTEM

1635 NORTH LOOP WEST HOUSTON, TX 77008

May 16, 2012

VIOLATION: RN SUPERVISION OF NURSING CARE

Tag No: A0395

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Complaint TX 142

Based on interview and record review nursing services failed to supervise / evaluate the care of 1 of 6 patient records reviewed (Patient ID# 1). Patient ID# 1 experienced a change in condition and nursing services failed to notify a physician and failed to document assessment of vital signs / neurological assessments per physician orders.

Findings include:

PATIENT ID# 1

Record review of the physician emergency room notes dated 3/9/12 at 9:19 p.m. stated " Chief Complaint: Altered mental status, weakness left leg, sometime after 5:45 p.m., onset unknown. Patient has no real concerns. Past history includes cerebral vascular accident with left leg weakness, diabetes, hypertension, and dementia. Patient admitted [DATE] to 2/6/12 for Right Cerebral Vascular Accident post TPA treatment. (Tissue Plasminogen Activator). Alert and disoriented. Subtle speech changes sisters say at baseline. CT scan of brain shows no acute intracranial abnormality, unchanged from 2/4/12. This seems to be a TIA (transient ischemic attack) due to unsure onset and TIA would not do or consider TPA. Spoke with case management and meet inpatient criteria. Clinical Impression: TIA.

Record review of a History and Physical dated 3/10/12 stated "Reason for admission: Left leg weakness. This is a [AGE] year old African-American male with history of hypertension, [DIAGNOSES REDACTED], prior history of CVA (cerebral vascular accident), dementia who presented to the emergency room with sudden onset of left leg weakness, unable to stand and walk... Initial brain CT scan was unremarkable. "

Record review of initial physician orders dated 3/10/12 at 6:36 a.m. stated "Vital signs every 4 hours." Another physician order dated 3/12/12 at 3:30 p.m. stated " Neurological vital signs every 4 hours.

Record review of nursing assessments revealed the following: 3/10/12 at 7 a.m. " Initial Nursing Assessment " alert, some confusion and disorientation, not oriented to time, cooperative, clear speech. Unsteady gait.

3/11/12 at 8:09 a.m. " Confusion, disorientation, weakness, alert, not oriented to time, calm, speech clear, extremity movement unequal. " 3/12/12 at 8:00 p.m. " Confused, disoriented, alert, unable to follow directions, calm, speech clear, Extremities equal,

3/13/12 at 8 a.m. " Confusion, disorientation, weakness, alert, not oriented to time, affect appropriate, slurred speech, unequal extremity movements.

The patient developed a change in condition (slurred speech) on 3/13/12 at 8 a.m. and the nursing notes failed to document if a physician was notified.

A Speech Therapist note dated 3/13/12 at 1:41 p.m. stated "It was noted that the patient had slurred speech today, when on Saturday he just had some mild distortions ...Patient also could not move his left arm, which he was able to do on Saturday ...Patient 's sister stated that she noticed a change since yesterday with the left sided weakness. Nurse was notified to let MD know about patient 's change in status and that a consult with the neurologist and an MRI may be warranted. She verbalized understanding. A note was also left in the chart for the MD. Consider MRI brain to rule out extension to original CVA."

Record review of nursing notes 3/13/12 and 3/14/12 revealed no documentation that a physician had been notified regarding the change in the patient 's condition.

Nursing notes on 3/14/12 failed to document scheduled vital signs at 10 a.m. as ordered by the physician every 4 hours.

A physician progress note 3/14/12 at 10:33 a.m. stated "Last evening increased weakness to left, now with flaccid weakness left arm and leg. Rule out infarct right hemiphresis, will get STAT repeat MRI brain."

Nursing notes 3/14/12 at 12 p.m. stated "Lethargic, oriented x3, behavior calm but flat, slurred speech, extremity movement unequal."

A Radiology report dated 3/14/12 at 12:05 p.m. stated "Brain without contrast MRI Impression: Moderate to large acute / sub-acute right territory infarction, new since prior MRI dated 3/10/12. Findings reported to patient 's nurse at time of dictation to be relayed to referring physician."

Nursing notes 3/14/12 failed to document scheduled vital signs at 2 p.m. as ordered by the physician every 4 hours.

Nursing notes 3/14/12 failed to document scheduled neurological assessments at 4 p.m. as ordered by the physician every 4 hours.

Nursing notes 3/14/12 documented normal vital signs at 4:37 p.m.

Nursing notes 3/14/12 at 5:35 p.m. stated " Rapid response team called " increase in slurred speech. " The patient was subsequently moved to the intensive care unit.

The patient stabilized and was discharged [DATE] to a rehabilitation hospital.

Interview 5/16/12 at 1:20 p.m. with patient care nurse (ID# 53) revealed she was the patient care nurse for patient ID# 1 on 3/13 and 3/14/12. The nurse stated that if the speech therapist notified her of changes in the patient 's condition she would have notified the physician. The nurse further stated she did not document this information in the patient 's record.

The Administrative Director (ID# 50) acknowledged 3/16/12 at 1:30 p.m. that the patient care nurse should have documented the patient 's vital signs / neurological assessments every 4 hours as ordered and should have also documented that a physician was notified when the patient 's condition changed (slurred speech) on 3/13/12.



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Feb. 22, 2012 1 (click for details)
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We add full report
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Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

Report date Number of incomplete reportsNumber of violations Jan. 21, 20111



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BAYLOR MEDICAL CENTER AT WAXAHACHIE ->

Report No. 1520

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

BAYLOR MEDICAL CENTER AT WAXAHACHIE

1405 W JEFFERSON ST WAXAHACHIE, TX May 15, 75165 2012

VIOLATION: LICENSURE OF PERSONNEL Tag No: A0023

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of facility documentation, and an interview with the Care Accreditation Coordinator it was confirmed that CPR (cardiopulmonary resuscitation) certification for the emergency technician and the certified physician assistant had expired.

Review of policy Basic Life Support, review dated 03/2010 stated, "Hospital employees involved in direct patient care should be certified in Basic Life Support according to American Heart Association Standards. Certification must be renewed every 2 years."

Review of the personnel files revealed CPR certification had expired on [DATE] for the emergency technician and CPR certification for the certified physician assistant had expired on ,d+[DATE].

In an interview with the Care Accreditation Coordinator at the facility on the afternoon of 05/15/12 at 3:15 pm, it was confirmed that CPR (cardiopulmonary resuscitation) certification for the emergency technician and certified physician assistant had expired.

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BAYLOR MEDICAL CENTER AT WAXAHACHIE **BAYLOR MEDICAL CENTER AT WAXAHACHIE**

1405 W JEFFERSON ST WAXAHACHIE, TX 75165 | Voluntary non-profit - Other

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Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

No incomplete reports available.



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MEDICAL CENTER OF PLANO ->

Report No. 1545

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

MEDICAL CENTER OF PLANO

3901 W 15TH ST PLANO, TX 75075

May 15, 2012

Tag No: A0186

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on review of documentation and interviews, the facility failed to ensure the documentation of alternatives or other less restrictive interventions attempted.

Findings were:

Facility policy & procedure titled Patient Restraint stated, in part,

" 12. Documentation Requirements:

The medical record contains documentation of:

- a. Assessment for risk for restraint
- b. Restraint alternatives implemented
- c. Determination of effectiveness/ineffectiveness of restraint alternatives ... "

On 5/14/12, the medical chart for Patient # 1 was reviewed there was no documentation of the two physical restraints staff member # 6 implemented with the patient. There was no documentation describing the patient's behavior and the intervention used.

This lack of documentation was confirmed in an interview on 5/15/12 with the Chief Nursing Officer.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on review of documentation and interviews, the facility failed to ensure the documentation of the patient's condition or symptoms that warranted the use of restraint..

Findings were:

On 5/14/12, the medical chart for Patient # 1 was reviewed there was no documentation of the patient's condition or symptoms that warranted the use of restraint.

This lack of documentation was confirmed in an interview on 5/15/12 with the Chief Nursing Officer.

VIOLATION: GOVERNING BODY

Based on observations, document review and interviews with facility staff, the governing body failed to be responsible for ensuring that hospital policies and procedures were implemented and followed by hospital staff resulting in the following deficient practices:

Findings were;

http://www.hospitalinspections.org/report/1545[3/26/2013 11:39:34 AM]

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Tag No: A0187

Tag No: A0043

- 1. Patient's Rights to safety was violated according to hospital policy & procedure titled "Patient Restraint" because staff did not initiate restraint properly as trained; Cross refer to A0194.
- 2. A patient was restrained without a physician's order in violation of hospital policy and procedure titled "titled"; Cross refer to A0115.
- 3. Medical records were not completed. Cross refer to A0168, A0185, A0186, A0187, A0188, and A0438.

VIOLATION: PATIENT RIGHTS

Tag No: A0115

Tag No: A0144

Tag No: A0145

Tag No: A0159

Based on a review of available documentation, observations in the facility, and staff interviews, the facility failed to ensure that each patient's rights were protected and promoted.

Findings were:

The facility did not ensure that patients were cared for in a safe environment, and failed to ensure that patient restraints were properly applied per policy and ordered by a physician.

- 1. Based on a review of hospital policy and medical record review, the hospital failed to follow policy to ensure the safety of patients. Cross refer to A0144 and A0145.
- 2. Based on interviews and review of documentation the facility failed to correctly identify a restraint as any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. Cross refer to A0159.
- 3. Based on interviews and review of documentation the facility failed to properly monitor and evaluate a patient that was restrained. Cross refer to A0175, A0179.

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on review of documentation and interviews, the facility failed to ensure the patient's right to receive care in a safe setting.

Findings were:

Patient #1 was placed in two physical restraints on 2/9/11 with no restraint orders or documentation of the restraints present in the medical record.

Staff member # 6 utilized improper restraint technique on the patient described in a written statement as " I grabbed patient from behind, around her neck and took her to the ground " and in interview as " grabbed her from behind with a choke hold. "

Staff member # 9 who was involved in the restraint had not received training in restraint technique at the time of the incident.

This lack of ensuring the patient's right to receive care in a safe setting was confirmed in an interview on 5/15/12 with the Chief Nursing Officer.

VIOLATION: PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT

Based on review of documentation and interviews, the facility failed to ensure the patient was free from all forms of abuse or harassment.

Findings were:

Patient # 1 was placed in two physical restraints on 2/9/11 with no restraint orders or documentation of the restraints present in the medical record.

Staff member # 6 utilized improper and forceful restraint technique on the patient described in a written statement as " I grabbed patient from behind, around her neck and took her to the ground " and in interview as " grabbed her from behind with a choke hold. "

This lack of ensuring the patient's right to be free from all forms of abuse or harassment was confirmed in an interview on 5/15/12 with the Chief Nursing Officer.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on a review of documentation and interview the facility failed to correctly identify a restraint as any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

Findings were:

Facility policy & procedure titled Patient Restraint Appendix D: Definitions stated, in part, " A. Physical restraint: Any Manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body to include immobilization or reduction of the ability of a patient to move his or her arms, legs, or head freely is considered a physical restraintUnder this definition, many commonly used facility devices and practices could meet this definition of restraint (e.g., tucking in sheets very tightly, use of side rails, to prevent patient from voluntarily getting out of bed, holding a patient to prevent movement ...E. Physical Holds: ...Holding a patient in a manner that restricts the patient's

movements against the patient's will is considered restraint. "

Review of facility paperwork revealed a written statement by staff member # 6 regarding and describing an incident between him and Patient #1 stated, in part, " Patient threw cell phone on ground and came at me. Patient 's significant other tried to stop her and she got around him and grabbed her boots that were in the chair and threw them at me. They hit me in the face and I saw stars. I then grabbed patient and threw her to the bed so she would not come after me. Patient kicked and scratched, got away, and came after me again. I grabbed patient from behind, around her neck and took her to the ground. Security showed up and grabbed her.

A facility Incident Report completed by staff member # 9 on 2/9/11 stated, in part, " On Wednesday, February 9th, 2011 at approximately 1145 I, (staff member # 9) responded to a radio call for security to ER room 7 stat. Upon arrival I observed ER Tech (staff member # 6) holding Patient (#1) in a restraint position with her arms plat to the floor. I took control of the situation, with a continued restraint on the Patient: (referring to patient #1 by pame) because she was still being compating." Patient: (referring to patient #1 by name) because she was still being combative.

In an interview on 5/15/12, staff member # 6 described the events of 2/9/11 involving patient # 1 as follows, "She picked her boots up and slammed them into my face. She shattered my glasses which cut my nose and my cheek. That staggered me back a little. She turned to grab something, her purse bag on the bed. I pushed him (the boyfriend) out of the way. I grabbed her wrestled her to the ground. She was kneeling on ground holding onto the bed. She reached for her purse 2nd time. I grabbed her hand and grabbed her from behind with a choke hold around her neck back down off the side of the bed to the floor. She wanted to get up and get her purse. The boyfriend pushed me off of her. She jumped up and went for the purse again. I stopped her again and we wrestled. I wrestled her back ground on the floor away from the bed and the purse. At that time security showed up. He grabbed one end and I had the other end of her. When he (Security) grabbed her I let go. '

On 5/14/12, the medical chart for Patient # 1 was reviewed and no physician order or any documentation was present for the above described physical restraint.

In an interview with staff member # 4 on 5/16/12 she acknowledged she did not obtain any physician orders for a restraint involving Patient # 1.

This inappropriate use of restraint was confirmed in an interview with Chief Nursing Officer on 5/15/12.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on review of documentation and interviews, the facility failed to utilize restraint in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient according to hospital policy.

Tag No: A0168

Tag No: A0175

Findings were:

Facility policy & procedure titled Patient Restraint stated, in part,

- " 5. Order for Restraint
- a. An order for restraint must be obtained from an LIP/physician who is responsible for the care of the patient prior to the application of the restraint. The order must specify clinical justification for the restraint, the date and time ordered, the duration of use, the type of restraint to be used and behavior-based criteria for release ...
- d. When a LIP/physician is not available to issue a restraint order, an RN with demonstrated competency may initiate restraint use based upon face-to-face assessment of the patient. In these emergency situations, the order must be obtained during the application or immediately (within minutes) after the restraint is applied ...
- 5B. Order for Restraint with Violent or Self Destructive Behavior
- a. Physician orders for restraint must be time limited, must specify clinical justification for the restraint/seclusion, the date and time ordered, duration of restraint/seclusion uses, the type of restraint, and behavior-based criteria for release ...

A written statement dated (2/9/11 at 1351) and an interview (on 5/15/12) with staff member # 6 indicate that on 2/9/11 he physically restrained Patient # 1 2- 3 times before staff member # 9 arrived to assist.

A written statement by staff member # 9 on 2/9/11 indicates he observed the restraint and assisted staff member # 6 in physically restraining patient #1 upon his arrival to Room #7.

On 5/14/12, the medical chart for Patient # 1 was reviewed and no physician order or any documentation was present for the above described physical restraint.

In an interview with staff member # 4 on 5/16/12 she acknowledged she did not obtain any physician orders for a restraint involving Patient # 1.

This use of restraint without an order from a physician or other licensed independent practitioner was confirmed in an interview with Chief Nursing Officer on 5/15/12.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on review of documentation and interviews, the facility failed to ensure the condition of a patient who is restrained is monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.

Findings were:

Facility policy & procedure titled Patient Restraint stated, in part,

- 7. Monitoring the Patients in Restraints
- a. Patients are assessed by an RN immediately after restraints are applied to assure safe application of the restraint ... 9. Face-to-face assessment by a Physician or LIP:
- a. A face-to-face assessment by a physician or LIP, RN or physician assistant with demonstrated competence, must be done within one

hour of restraint/seclusion initiation or administration of medication to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others ...

Facility policy & procedure titled Patient Restraint Appendix A: Training Requirements stated, in part, " A. Direct Care Staff Staff will demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment and providing care for a patient in restraint or seclusion. Training will be provided to all staff designated as having direct patient care responsibilities (the facility to list), including contract or agency personnel. In addition, if hospital security guards or other non-healthcare staff (the facility to list) assist direct care, or other non-healthcare staff (the facility to list) assist direct care staff, when requested in the application of restraint or seclusion, the security guards, or other non-healthcare staff (as defined by the facility) are also expected to be trained and able to demonstrate competency in the safe application of restraint and seclusion. Training will occur:

1. Before performing restraint application, implementation of seclusion,

monitoring, assessment and providing care of patient in restrain or seclusion,

2. As part of orientation, and "

On 5/14/12, the medical chart for Patient # 1 was reviewed there was no documentation of the two physical restraints staff member # 6 implemented with the patient. There was also no documented monitoring of the patient while restrained in the medical chart.

A review of personnel records revealed that staff member #6 was up to date on his restraint training. Staff member #9 who participated in restraining patient # 1 was not current in his training and had not received any restraint training at the time of the incident. Staff member # 1 confirmed staff member # 9's lack of restraint training in the date of the incident, in an interview on 5/14/12

This lack of proper monitoring of the patient and lack of up to date training for staff involved in the restraint was confirmed in an interview on 5/15/12 with the Chief Nursing Officer.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on review of documentation and interviews, the facility failed to ensure the patient was seen within 1 hour after the initiation of the intervention to evaluate the patient's immediate situate, reaction to the intervention and medical/behavioral condition.

Tag No: A0179

Tag No: A0185

Tag No: A0188

Findings were:

Facility policy & procedure titled Patient Restraint stated, in part,

" 9. Face-to-face assessment by a Physician or LIP:
a. A face-to-face assessment by a physician or LIP, RN or physician assistant with demonstrated competence, must be done within one of restraint/seclusion initiation or administration of medication to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others ...

On 5/14/12, the medical chart for Patient # 1 was reviewed there was no documentation of the two physical restraints staff member # 6 implemented with the patient. There was no documented face to face assessment of the restrained patient within 1 hour after the initiation of the intervention.

This lack of documentation was confirmed in an interview on 5/15/12 with the Chief Nursing Officer.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on review of documentation and interviews, the facility failed to ensure the documentation of the restrained patient s behavior and the intervention used.

Findings were:

Facility policy & procedure titled Patient Restraint stated, in part, "5B. Order for Restraint with Violent or Self Destructive Behavior

- a. Physician orders for restraint must be time limited, must specify clinical justification for the restraint/seclusion, the date and time ordered, duration of restraint/seclusion uses, the type of restraint, and behavior-based criteria for release ... 12. Documentation Requirements:

The medical record contains documentation of: ...

- b. Restraint alternatives implemented
- c. Determination of effectiveness/ineffectiveness of restraint alternatives
- d. Second tier review for need of restraint
- e. Order for restraint and any renewal orders for restraint
- f. Restraint application ...

On 5/14/12, the medical chart for Patient # 1 was reviewed there was no documentation of the two physical restraints staff member # 6 implemented with the patient. There was no documentation describing the patient's behavior and the intervention used.

This lack of documentation was confirmed in an interview on 5/15/12 with the Chief Nursing Officer.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on review of documentation and interviews, the facility failed to ensure the documentation of the patient's response to the intervention.

Findings were:

On 5/14/12, the medical chart for Patient # 1 was reviewed there was no documentation of the patient's response to the interventions that occurred on 2/9/11.

This lack of documentation was confirmed in an interview on 5/15/12 with the Chief Nursing Officer.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on review of documentation and interviews, the facility failed to ensure the patient's right to safe implementation of restraint or seclusion by trained staff.

Tag No: A0194

Tag No: A0438

Findings were:

Facility policy & procedure titled Patient Restraint Appendix A: Training Requirements stated, in part, "A. Direct Care Staff Staff will demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment and providing care for a patient in restraint or seclusion. Training will be provided to all staff designated as having direct patient care responsibilities (the facility to list), including contract or agency personnel. In addition, if hospital security guards or other non-healthcare staff (the facility to list) assist direct care, or other non-healthcare staff (the facility to list) assist direct care staff, when requested in the application of restraint or seclusion, the security guards, or other non-healthcare staff (as defined by the facility) are also expected to be trained and able to demonstrate competency in the safe application of restraint and seclusion. Training will occur:

1. Before performing restraint application, implementation of seclusion, monitoring, assessment and providing care of patient in restrain or seclusion,

2. As part of orientation, and '

Staff member # 6 utilized improper restraint technique on the patient described in a written statement as " I grabbed patient from behind, around her neck and took her to the ground " and in interview as " grabbed her from behind with a choke hold. "

Staff member # 9 who was involved in the restraint had not received training in restraint technique at the time of the incident. Staff member # 1 confirmed staff member # 9's lack of restraint training, on the date of the incident, in an interview on 5/14/12

This lack of ensuring the patient's right to safe implementation of restraint or seclusion by trained staff was confirmed in an interview on 5/15/12 with the Chief Nursing Officer.

VIOLATION: FORM AND RETENTION OF RECORDS

Based on review of documentation and interviews, the facility failed to maintain a complete medical record for patients.

Findings were:

Patient #1 had no documentation of the two physical restraints staff member #6 placed her in. No narratives of the restraint events, physician orders, or monitoring sheets were present in the medical record. The facility considered this chart complete at the date of review.

This lack of complete documentation in the patient's medical chart was confirmed in an interview on 5/15/12 with the Chief Nursing Officer.

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<u>UNITED REGIONAL HEALTH CARE SYSTEM -></u>

Report No. 1455

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

UNITED REGIONAL HEALTH CARE SYSTEM

1600 11TH STREET WICHITA FALLS, TX May 10, 76301 2012

VIOLATION: ADMINISTRATION OF DRUGS

Tag No: A0405

Based on review of records and interview with staff, the facility failed to ensure that drugs and biologicals were administered in accordance with the orders of the practitioner responsible for the care of 1 of 1 patient whose record was reviewed. Patient #1 had orders for IV fluids on 1/15/2012; however did not receive the fluids that day.

Findings were:

Review of the medical record for patient #1 revealed a physician order dated 1/15/2012 at 6:37am for Dextrose 5% Water Infusion 1000 ml with IV Additives of Sodium Bicarbonate and Potassium Chloride. Per the Medication Administration Record (MAR), the nursing staff did not administer the IV fluids as ordered. This finding was confirmed in a telephonic interview with staff #12, the facility Patient Safety Coordinator the morning of 5/24/12.

VIOLATION: GOVERNING BODY

Tag No: A0043

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of documents and interviews with staff, the facility Governing Body failed to be responsible for the conduct of the hospital, as services furnished in the hospital did not comply with all applicable Conditions of Participation and Standards. The rights of patient #1 were violated, as medical and nursing staff did not follow proper procedures in ordering and monitoring physical restraint of the patient during 2 inpatient admissions in January 2012, and the facility did not protect the right of the patient to refuse treatment. Additionally, the patient did not receive IV fluids as ordered..

Findings were:

Review of the medical records of patient #1 revealed that the patient was admitted to the facility on [DATE] - 1/12/12 and again 1/14/12 - 1/20/12. The medical records for both stays reported that patient #1 had self-inflicted an abdominal stab wound the previous July and subsequently underwent a laparotomy and a colon resection. Both January admissions were due to the patient's tearing open the abdominal incision and probing with fingers and other instruments, creating infection. During both admissions, the patient was physically restrained for violent, self-harming behavior. The patient expired during a 3rd inpatient admission, 2/2/12 - 2/3/12.

1. Review of the patient 's record for the admission 1/2/12 - 1/12/12 revealed that only 2 physician orders were written for physical restraints over a total of 7 days that the patient was in restraints. During the admission 1/14/12 - 1/20/12, only 2 orders were written for physical restraints for patient #1 over a total of 7 days the patient was restrained. Restraint policy states that orders for patients in restraints for violent, self-harming behavior must be renewed every 4 hours up to 24 hours, then a new order must be obtained. The

physicians did not order restraints per facility policy, entitled Use of Restraint Policy, last approved by the facility governing body in June of 2009, and did not exhibit a working knowledge of the restraint policy and procedure. Cross refer to tags A0171 and A0176 for additional information.

- 2. Review of the patient 's record for the admission 1/2/12 1/12/12 revealed that the nursing staff did not monitor the patient while in restraints according to facility policy. For example, on 1/8/2012, Patient #1 was in physical restraints and a nursing assessment was performed at 9:17am. The next restraint assessment was performed approximately 4 hours later, at 1:25pm. During the admission 1/14/12 1/20/12, patient #1 was placed in physical restraints on 1/14/2012 at 7:39pm; the order stated it was for Behavioral Emergency. Progress notes revealed patient #1' restraint was first assessed by a registered nurse on 1/15/2012 at 6:00am, 9 ? hours after the patient was restrained. The next restraint assessment was on 1/15/2012 at 7:45pm. Facility policy, entitled Use of Restraint Policy, last approved by the facility governing body in June of 2009, states that patients in restraint for violent, self-harming behavior must be monitored every 15-30 minutes. Cross refer to tag A0175 for additional information.
- 3. Patient #1 requested to leave against medical advice (AMA), and was not allowed to leave. There is no further documentation that the hospital explained the risks of leaving AMA.Cross refer to tag A0131 for additional information.
- 4. The facility utilizes a form entitled REPORT OF DEATH. This form contains sections to be filled out if the patient died in restraints or within 24 hours of restraint. The forms for patients #1-#12 were reviewed; these 12 patients all died in restraint or within 24 hours of restraint. None of these patients' deaths were reported to CMS. Cross refer to tag A0214 for additional information.
- 5. Patient #1 did not receive IV fluids as ordered by the physician on 1/15/12. Cross refer to tag 0405 for additional information.

VIOLATION: PATIENT RIGHTS Tag No: A0115

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of documents and interviews with staff, the facility failed to be protect and promote the rights of patient #1, as medical and nursing staff did not follow proper procedures in ordering and monitoring physical restraint of the patient and the facility did not protect the right of the patient to refuse treatment.

Findings were:

Review of the medical records of patient #1 revealed that the patient was admitted to the facility on [DATE] - 1/12/12 and again 1/14/12 - 1/20/12. The medical records for both stays reported that patient #1 had self-inflicted an abdominal stab wound the previous July and subsequently underwent a laparotomy and a colon resection. Both January admissions were due to the patient's tearing open the abdominal incision and probing with fingers and other instruments, creating infection. During both admissions, the patient was physically restrained for violent, self-harming behavior. The patient expired during a 3rd inpatient admission, 2/2/12 - 2/3/12.

- 1. Review of the patient's record for the admission 1/2/12 1/12/12 revealed that only 2 physician orders were written for physical restraints over a total of 7 days that the patient was in restraints. During the admission 1/14/12 1/20/12, only 2 orders were written for physical restraints for patient #1 over a total of 7 days the patient was restrained. Restraint policy, entitled Use of Restraint Policy, last approved by the facility governing body in June of 2009, states that orders for patients in restraints for violent, self-harming behavior must be renewed every 4 hours up to 24 hours, then a new order must be obtained. The physicians did not order restraints per facility policy and did not exhibit a working knowledge of restraint policy and procedure. Cross refer to tags A0171 and A0176 for additional information.
- 2. Review of the patient's record for the admission 1/2/12 1/12/12 revealed that the nursing staff did not monitor the patient while in restraints according to facility policy. For example, on 1/8/2012, Patient #1 was in physical restraints and a nursing assessment was performed at 9:17am. The next restraint assessment was performed approximately 4 hours later, at 1:25pm. During the admission 1/14/12 1/20/12, patient #1 was placed in physical restraints on 1/14/2012 at 7:39pm; the order stated it was for Behavioral Emergency. Progress notes revealed patient #1's restraint was first assessed by a registered nurse on 1/15/2012 at 6:00am, 9 ? hours after the patient was restrained. The next restraint assessment was on 1/15/2012 at 7:45pm. Restraint policy states that patients in restraint for violent, self-harming behavior must be monitored every 15-30 minutes. Cross refer to tag A0175 for additional information.
- 3. Patient #1 requested to leave against medical advice (AMA), and was not allowed to leave. There is no further documentation that the hospital explained the risks of leaving AMA.Cross refer to tag A0131 for additional information.
- 4. The facility utilizes a form entitled REPORT OF DEATH. This form contains sections to be filled out if the patient died in restraints or within 24 hours of restraint. The forms for patients #1-#12 were reviewed; these 12 patients all died in restraint or within 24 hours of restraint. None of these patients' deaths were reported to CMS. Cross refer to tag A0214 for additional information.

Tag No: A0131

VIOLATION: PATIENT RIGHTS: INFORMED CONSENT

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of documents and interview with staff, the facility failed to ensure the right to refuse treatment for 1 of 1 patient whose record was reviewed. Patient #1 requested to leave against medical advice (AMA), and was not allowed to leave.

Findings were:

The facility policy entitled PATIENT RIGHTS AND RESPONSIBILITIES states under section PATIENT RIGHTS #6 that the patient has the right to refuse treatment as permitted by law and regulations, and if the treatment is refused the patient will receive other needed and available care.

Review of the medical record for patient #1 revealed that the patient was admitted to the facility on [DATE] and discharged [DATE]. Physician progress notes written 1/15/2012 stated that the patient wanted to leave against medical advice but the facility would not grant him that privilege unless they had a court order or a directive from the state hospital. There is no further documentation that the hospital explained the risks of leaving AMA or contacted staff at NTSH.

Tag No: A0171

These findings were confirmed in a telephonic interview conducted on 5/18/12 with staff #12, facility Patient Safety Coordinator.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of documents and interview with staff, the facility did not ensure that the orders for physical restraint were in accordance with the required limits for 1 of 1 patient whose records were reviewed. Patient #1 was physically restrained during 2 inpatient stays for violent and self-destructive behavior, and the orders for restraint were only written 4 times; the patient remained in restraints a total of 14 days throughout the inpatient stays.

Findings were:

Review of the medical record for the first January 2012 admission revealed that patient #1, [AGE], was admitted to the facility on [DATE] at 11:51pm and was discharged [DATE] at 8:25pm. Review of the patient's History & Physical (H&P) dated 1/2/2012 indicated the patient was a resident of a state facility for people with mental illness. The report also stated patient #1 self-inflicted an abdominal stab wound the previous July and subsequently underwent a laparotomy and a colon resection. This admission on 1/2/2012 was due to the patient's tearing open the incision and probing with fingers and other instruments, creating infection. The H&P also stated the physician's assessment was sepsis, anterior abdominal wound infection, cellulitis, campylobacter infection, borderline personality disorder, and history of multiple self inflicted abdominal stab wounds. The H&P also reported patient #1 had factitious disorder, the psychiatric condition in which a patient deliberately produces or falsifies symptoms of illness for the sole purpose of assuming the sick role. Patient #1 was placed in restraints 1/6/12 due to violence and intent for self-harm, not only for medical reasons, such as pulling tubes. For example, on 1/8/2012 at 7:01am, the nurse documented the patient stabbed the abdominal wound with a toothbrush. Also on 1/8/2012 at 5:45pm, the nurse documented that patient #1 had removed the wrist restraints and was agitated with "fists balled up" yelling at the sitter "Touch me, so I can knock the shit out of you!!" The nurse documented on 1/8/2012 at 10:30pm patient #1 became very agitated, clenching fists, and security was called. Patient #1 had to have a procedure to remove the toothbrush from the abdomen. Additionally the nurse documented on 1/9/2012 at 8:36 pm that the patient was angry, combative, and belligerent; was medicated with Ativan and Benadryl, and was in 4 point restraints. Further review revealed the nurse documented on 1/10/2012 at 6:51am, the patient was agitated, belligerent and combative when awak

A physician restraint order dated 1/6/2012 at 9:12am stated "Acute Med/Surg, bilateral hands, monitor at least every 2 hours, mittens due to patient having the feeling to hurt himself." Further review revealed a restraint order dated on 1/8/2012 at 7:22am for "Acute Med/Surg, monitor at least every 2 hours." The reason for the restraints was "High Risk: causing significant disruption of treatment (tubes, lines), stabbing himself." The restraint order did not specify the type of restraints to use and did not specify the extremities to be restrained. There were no further physician orders for restraint during this hospitalization , although restraints were documented by nursing and medical staff daily through the date of discharge, 1/12/2012.

Patient #1 was readmitted to the facility on [DATE], due to tearing at the abdominal incision while at his residence. The patient was discharged on [DATE]. The admitting physician documented in the History and Physical (H&P) report that the patient had a "24cm incision wound extending from umbilicus to the left side of the abdomen. It is extremely tender with purulent discharge."

Patient #1 was placed in physical restraints per physician staff # 8 on 1/14/2012 at 7:39pm; the order stated it was for Behavioral Emergency, as the patient was considered a high risk of injury to self or others. The physician documented the behavior that led to the restraints was "self inflicted wound at abdomen." The restraint type was both upper and lower extremities. There was no documented renewal of the restraint order. The patient was in restraints 1/15, 1/16, 1/17 with no order. On 1/18/2012 at 11:18am, physician staff #13 ordered restraints for "Acute Med/Surg," to be monitored every 2 hours for the significant disruption of treatment (tubes, lines). The restraint order included mittens bilaterally. Nursing and medical progress notes continue to indicate that patient #1 was still in restraints for behavioral issues. For example, physician progress notes dated 1/15/2012 at 1:00am state that the physician informed the patient that restraints were needed at all times to prevent further self-inflicted damage to the abdominal wound. Additionally, in the Restraint Documentation portion of the medical record, the nurse stated "both upper extremities; wrist/ankle, agitated, protection of lines, protection of abdominal dressing, violence/self harm potential-close obs (observation) required."

The hospital policy regarding use of restraint, entitled Use of Restraint Policy, last approved by the facility governing body in June of 2009 outlines the requirements for physician intervention in the use of restraints. Under the section, entitled ORDERING OF RESTRAINT FOR VIOLENT OR SELF DESTRUCTIVE BEHAVIOR, the policy states that each order for restraint used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient may only be obtained and renewed in accordance with the following limits up to a total of 24 hours: Up to four (4) hours for adults [AGE] and older. The policy states that " if restraint is discontinued prior to the expiration of the original order, a new order must be obtained prior to reinstating the use of restraint. At the end of the time frame, if the continued use of restraint to manage violent or self-destructive behavior is deemed necessary based on an individualized patient assessment, another order is required. When the original order is about to expire, a Registered Nurse (RN) must contact the physician or other LIP, report the results of his or her most recent assessment and request that the original order be renewed. Whether or not an onsite assessment is necessary prior to renewing the order is left to the discretion of the physician or other LIP in conjunction with a discussion with the RN who is overseeing the care of the patient.

In an in-person interview on 5/8/2012 at 11:05am, physician staff # 8 stated patient #1 had been admitted multiple times to the facility. Physician staff # 8 recalled that patient #1 would place different items in the abdominal wound which caused sepsis. The physician stated restraints were ordered on [DATE] for behavioral emergency, but the intent was to order the "regular" restraint because the patient was manipulating the wound. Physican staff # 8 did not know there was a difference between the Behavioral restraint order and the Acute Med/Surg restraint order.

In concurrent in-person interviews conducted on 5/7-8/2012, the facility Vice President of Nursing and Clinical Services, staff # 1 and the

Director of Quality Management, staff #2 confirmed that patient #1's physicians failed to follow proper policies and procedures for restraint orders during both hospitalization s in January 2012..

Tag No: A0175

Tag No: A0176

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of documents and interview with staff, the facility staff failed to monitor the condition of 1 of 1 restrained patient whose record was reviewed. Pt #1 was in physical restraints for violent self-harming behavior, but was not monitored at the interval determined by hospital policy.

Findings were:

The hospital's policy regarding use of restraint, entitled Use of Restraint Policy, last approved by the facility Governing Body in June of 2009, outlines the requirements for monitoring a patient placed in restraints for violent or self-destructive behavior. Under the section entitled ONGOING MONITORING AND ASSESSMENT OF A PATIENT IN RESTRAINT, each patient must be monitored every 15-30 minutes, including checking the patient's vital signs, hydration and circulation; the patient's level of distress and agitation; and skin integrity. This assessment shall also determine if the patient continues to require restraints. The staff training document entitled ADULT RESTRAINTS states on page 1 that patients in restraints for violent or self-destructive behavior should be monitored every 15-30 minutes.

Review of the medical record of patient #1 revealed that the patient was admitted to the facility on [DATE] - 1/12/12 and again 1/14/12 - 1/20/12. The patient was a resident of a state facility for people with mental illness. The history and physical (H&P) report also stated patient #1 had self-inflicted an abdominal stab wound the previous July and subsequently underwent a laparotomy and a colon resection. Both admissions were due to the patient's tearing open the abdominal incision and probing with fingers and other instruments, creating infection. During both admissions, the patient was physically restrained for violent, self-harming behavior.

During the first admission, patient #1's physician ordered physical restraints on 1/6/12 at 9:12 am. In the "Restraints" section of the medical record, the nurse documented on 1/8/2012 at 7:30am the patient was in both upper and lower restraints. Further review revealed the behavior requiring the restraints was "agitated; violence/self harm potential, close obs (observation) required." On 1/8/2012 a nursing assessment was performed at 9:17am and the next restraint assessment was performed approximately 4 hours later, at 1:25pm. The patient was monitored approximately every 2 hours while in restraints until 1/11/2012 at 6:00pm. The nurse did not reassess patient #1 while in restraints 1/11/2012 after 6:00pm; however, the medical record contained documentation in progress notes that the patient remained in restraints. The next reassessment of restraints was on 1/12/2012 at 8:00am. There was no documentation for the reason patient #1 was in restraints during the assessments of 8:00am, 10:00am, 12:00pm, 2:26pm, and 4:00pm. The last documented restraint assessment was done at 8:00pm prior to patient #1's discharge on 1/12/12 at 8:25pm. While there were medical interventions documented during the time patient #1 was in restraints, the assessment elements and the timeframe required for a patient in restraints for behavioral issues was not followed.

During the 2nd admission, patient #1 was placed in physical restraints per physician staff #8 on 1/14/2012 at 7:39pm; the order stated it was for Behavioral Emergency. Progress notes revealed patient #1 was first assessed by a registered nurse on 1/15/2012 at 6:00am. The next assessment was on 1/15/2012 at 7:45pm. The nurse then reassessed the patient again at 11:00pm and documented 4 point restraints (both upper and lower extremities). Documentation in the medical record on 1/16/2012 indicated that the patient was reassessed at 12:00am, 2:12am, and 6:00am. Following this, the nurses reassessed the patient approximately every 2 hours and documented restraints until 1/18/2012 at 4:00am. The next reassessment was on 1/18/2012 at 8:00am, 4 hours later. The nurse documented on 1/18/2012 at 7:50pm the patient had "both upper extremities; secured/tied mitten; 4 point." The documentation indicated that the patient continued to remain in restraints and was reassessed approximately every 2 hours until 1/19/2012 at 4:30am. The patient was discharged [DATE]. While there were nursing interventions documented during the time patient #1 was in restraints, the assessment elements and the timeframe required for a patient in restraints for behavioral issues was not followed.

In concurrent in-person interviews conducted on 5/7-8/2012, the facility Vice President of Nursing and Clinical Services, staff #1 and the Director of Quality Management, staff #2 confirmed that nursing staff failed to follow proper policies and procedures for monitoring patient #1 while in restraints during both hospitalization s.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of documents and interview with staff, the facility failed to ensure that physicians and other licensed independent practitioners (LIP) have a working knowledge of the use of restraints for 1 of 1 patient whose record was reviewed. Patient #1's practitioners did not order physical restraints or perform evaluations as required for patients in restraints for behavioral issues.

Findings were:

The hospital's policy regarding use of restraint, entitled Use of Restraint Policy, last approved by the facility governing body in June of 2009, states in the section entitled, PHYSICIAN EDUCATION & TRAINING ON THE USE OF RESTRAINT, that at a minimum, physicians and other LIPs authorized to order restraint must have a working knowledge of this policy regarding the use of restraint. This training may include, but not necessarily be limited to, the following: a patient's rights regarding the use of restraint; prohibitions on such use; ordering requirements; requirements and time frames for patient assessment.

Review of the medical record of patient #1 revealed that the patient was admitted to the facility on [DATE] - 1/12/12 and again 1/14/12 - 1/20/12. The patient was a resident of a state facility for people with mental illness. The history and physical (H&P) report stated patient #1 had self-inflicted an abdominal stab wound the previous July and subsequently underwent a laparotomy and a colon resection. Both January 2012 admissions were due to the patient's tearing open the abdominal incision and probing with fingers and other instruments,

creating infection. During both admissions, the patient was physically restrained for violent, self-harming behavior. Patient #1 was physically restrained during 2 inpatient stays for violent and self-destructive behavior, and the orders for restraint were only written 4 times; the patient remained in restraints a total of 14 days throughout the inpatient stays.

Further review of the medical record of patient #1 revealed that physician staff #8 was involved in the patient's care. In an in-person interview on 5/8/2012 at 11:05am, physician staff #8 stated patient #1 had been admitted multiple times to the facility. Physician staff #8 recalled that patient #1 would place different items in the abdominal wound which caused sepsis. The physician stated restraints were ordered on [DATE] for behavioral emergency, but intended to be for the "regular restraint" because the patient was manipulating the wound. Physician staff #8 did not know there was a difference between the Behavioral restraint order and the Acute Med/Surg restraint order.

In concurrent in-person interviews conducted on 5/7-8/2012, the facility Vice President of Nursing and Clinical Services, staff # 1 and the Director of Quality Management, staff #2 confirmed that patient #1's physicians failed to follow proper policies and procedures for restraint orders during both hospitalization s.

Tag No: A0214

VIOLATION: PATIENT RIGHTS: SECLUSION OR RESTRAINT

Based on review of documents and interview with staff, the facility failed to report to the Center for Medicare and Medicaid Services (CMS), deaths associated with the use of restraints, for 12 of 12 patients whose records were reviewed.

Findings were:

The hospital's policy regarding use of restraint, entitled Use of Restraint Policy, last approved by the facility governing body in June of 2009, includes a section entitled REPORTING OF DEATHS DUE TO USE OF RESTRAINT. In this section, the hospital states it must report to the Center for Medicare and Medicaid Services (CMS) each death that occurs while a patient is in restraints; each death that occurs within 24 hours after the patient has been removed from restraint; and each death known to the hospital that occurs within 1 week after restraint where it is reasonable to assume that the use of restraint contributed directly or indirectly to a patient's death. Each death must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death. Staff must document in the patient's medical record the date and time the death was reported to CMS."

The facility utilizes a form entitled REPORT OF DEATH. This form contains sections to be filled out if the patient died in restraints or within 24 hours of restraint. The forms for patients #1-#12 were reviewed; these 12 patients all died in restraint or within 24 hours of restraint. None of these patients' deaths were reported to CMS.

In concurrent in-person interviews conducted on 5/7-8/2012, the facility Vice President of Nursing and Clinical Services, staff #1 and the Director of Quality Management, staff #2 confirmed that CMS (Center for Medicare and Medicaid Services) was not notified of deaths associated with restraints for patients #1-#12



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No incomplete reports available.

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TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON ->

Report No. 1565

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON 3000 N I-35 DENTON, TX 76201 May 7, 2012

VIOLATION: FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE

Tag No: A0724

Based on observation of the emergency department during a tour with the assistant director of nursing on 5/7/12, the area was dusty, and chairs and beds had ripped covers, with items not being and in an acceptable condition.

Findings were:

On 5/7/12 the emergency department was observed during a tour with the assistant nursing director and the following were noted - Six sheets were observed to have stains, or tape and/or used cardiac leads adhering to them when they were delivered from the laundry service. The sheets do not appear to be clean on observation and with the tape and leads stuck the cleanliness is in question.

-There were seven visitor chairs that were observed to have rips and tears in the covers, these items cannot be cleaned with the broken areas.

-In the trauma room the pull down lights were observed to be dusty, and the bottom of the bariatric bed was observed to be covered with a one inch layer of dust. This is an infection control problem.

-In the Gynecology room the patient chair was observed to have six rips in the covering and this could not be cleaned effectively.

All of the above were confirmed in interview on 5/7/12 with the assistant nursing director.



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EMERUS HOSPITAL ->

Report No. 1772

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

EMERUS HOSPITAL

26791 HIGHWAY 380 UNKNOWN, TX None

April 30, 2012

VIOLATION: EMERGENCY ROOM LOG

Tag No: A2405

Based on record review and interviews, the hospital did not maintain a central log for 1 of 1 patient (Patient #3), that included the refusal of medical treatment by Patient #3's mother, after being told he had a non-emergent condition.

Findings included:

ED Central Log:

The computerized ED Central Log documented Patient #3, on his visit to the ED at Hospital A on Saturday, 04/14/12, was triaged at 9:02 AM by Personnel # 4, the ED registered nurse (RN). Chief Complaint: Asthma Attack - SOB (shortness of breath), Diagnosis: Asthma, Disposition type noted as Patient #3 left AMA (against medical advice), and time to Disposition: 31 minutes. The ED Central Log did not document the acuity/triage level for Patient #3, that determined his condition to be "non-emergent," and/or that Patient # 3's mother had refused medical treatment after being told he was "non-emergent."

refused medical treatment after being told he was "non-emergent."

The dispositions included on the hospital's Central Log were either "discharged to Home or Self Care; or AMA (Against Medical Advice)," and did not include the regulatory required "refused treatment" category.

ED Medical Record:

The hospital's financial "Prompt Pay Price Listing," form, had been included in the ED medical record, which showed a grid of the number and types of services provided to patients, according to ED triage levels, and the associated price for that level. This form, that had Patient # 3's name and personal information sticker attached, had the \$1,200.00 fee circled at the Level 4 emergency room Visit, and indicated a Triage Level 4/Less Urgent (Code ED 4), as the determined condition of this patient.

Posting of Signs:

The surveyor observed the required signs were posted in the admission area, regarding the EMTALA requirements for emergency medical conditions, and included a statement that indicated "this hospital does not participate in the Medicaid program," also required by regulation.

Interviews:

In a telephone interview at 3:00 PM on 04/30/12 with the nurse, Personnel # 4, she confirmed she had performed the initial triage assessment on Patient #3's admission to the ED. When asked why she had not documented Patient #3's acuity/triage level during her assessment, she said that "they had just gone to computerized charting in January 2012, and that she keeps forgetting to do it, as it is located somewhere else in the computerized records." She also verified that after her initial triage assessment, Patient #3 received a medical screening exam by the ED physician, Personnel #3, who had determined that Patient #3 did not have an emergency condition.

In a telephone interview at 4:25 PM on 04/30/12 with the ED physician (Personnel #3), he confirmed his documented MSE, that included mild wheezing, and that Patient #3 was in no dire distress. He stated that he does a MSE on all ED patients, and if he determines that it is not an emergency medical condition, and they are able to treat the patient in their ED, he had been instructed to inform patients or their families of the "Prompt Pay Charges" based on acuity triage level. He confirmed that Patient #3 was at an acuity triage Level 4/Less Urgent, and that he had only documented this "Code ED 4," associated with patient condition severity level on the financial form. He also said that when he informed Patient #3's mother that Patient #3 was non-emergent, afterward he had told her that the ED visit could be

\$1,200.00. He said he had ordered breathing treatments and prednisone to treat the patient, but that she had refused medical treatment.

Policies & Procedures:

Review of the hospital's Policies & Procedures required the following process for assessing the severity of the chief complaint, and assigning acuity levels according to their triage categories. This process documents Levels 1 and 2 as emergency medical conditions, and Levels 3, 4, and 5 as non-emergency conditions.

-The hospital Referral of Care Guidelines policy, dated 05/01/11, noted that "the triage nurse performs a rapid or comprehensive triage assessment ...and assigns a triage category." "Once the nurse has assigned a triage level to the patient the QMP (qualified medical professional) ie. Physician, will perform a MSE (Medical Screening Exam) ...and when completed there are two alternative outcomes: (a) ...the patient is determined to have a potential emergency medical condition, or (b) ...the patient is determined to NOT have an emergency medical condition, ...and the Patient Registration staff will provide the following alternative of care options to the patient ...? Stay and continue to utilize the resources of the Emergency Department and accept financial responsibility for their decision, or ? Receive Referral of Care options to seek care and treatment from an alternative source ..."

-The hospital Triage Medical Screening Exam policy, dated 05/01/11, noted that "all patients presenting to the Emergency Department are assessed rapidly to determine the severity of the presenting chief complaint ...acuity is assigned to each patient during the initial assessment." "Triage categories are: Level 1/Resuscitative, Level 2/Emergent, Level 3/Urgent, Level 4/Less Urgent, and Level 5/Non-Urgent."

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Incomplete reports

No incomplete reports available.



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Report No. 1771

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

EMERUS HOSPITAL 16000 SOUTHWEST FREEWAY SUGAR LAND, TX 77479

April 27, 2012

Tag No: A0043

Tag No: A0385

VIOLATION: GOVERNING BODY

Based on interview and record review the hospital failed to have an effective governing body. The governing body failed to ensure nursing services were organized according to hospital policy.

Refer to Condition of Participation: Nursing Services 482.23

Findings include:

Record review of the "Medical Staff By-Laws" dated 1/20/11 stated "Purposes: (b) serve as the primary means for accountability to the Governing Body for the quality and appropriateness of the professional performance and ethical conduct of its Members as well as of all Allied Health Professionals, and to strive for quality patient care ...The Medical Executive Committee is responsible for reviewing and reporting to the Governing Body on the following topics: ...(f) patient safety;..(h) performance improvement; (i) program evaluations / outcomes; (j) quality of care ...'

The President (ID# 51) of the Hospital acknowledged 4/27/12 at 3:45 p.m. the hospital needed to improve nurse staffing to meet the regulatory requirements. The President stated the Hospital had recently hired Registered Nurses for the inpatient unit.

Record review of " Medical Executive Committee Meeting " minutes dated 1/6/12 and 3/28/12 revealed no discussion regarding inpatient nurse staffing.

NURSING REASSESSMENT OF PATIENT ID# 1

Medical record review revealed Patient ID# 1 's condition deteriorated on 2/15/12 and the Registered Nurse failed to properly assess the patient (vital signs were not reassessed / documented regularly per policy). After the initial Triage vital signs were taken at 10:38 a.m. the patient 's vital signs were not reassessed again for 6 hours and 22 minutes when the patient was admitted to the medical unit (5 p.m.). The patient coded at 6:05 p.m.

The Chief Medical Officer (ID# 52) evaluated the incident of patient ID# 1 on a "Nonconformity Report " that identified the following " It was noted a patient was moved to the inpatient side without having a dedicated nurse for the inpatient unit and the emergency room. The ER nurse continued to provide appropriate care to both the inpatient and outpatient sides of the hospital. Our policy requires that a dedicated nurse be present on the inpatient unit at all times when there are patients admitted to the unit. At no time was the care of the patient compromised. "The "Correction" stated "The nurse managers at the hospital have been informed of the nursing requirements for the inpatient unit. We are working towards maintaining full-time nurse staffing for the inpatient side. "

VIOLATION: NURSING SERVICES

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Complaint Intake TX 333

Based on observation, interview and record review the hospital failed to provide a organized nursing services and failed to ensure nursing services were supervised by a registered nurse in each department on 2/15/12, 3/3/12, 3/4/12, 3/6/12, 3/9/12, 3/10/12 and 3/11/12 (The emergency room and the In-patient unit).

- 1) The hospital failed to ensure the Chief Nursing Officer (CNO# 53) manages appropriately to assure patients are supervised and provided quality services by Registered Nurses. The CNO failed to ensure the nursing department established a nurse staffing committee that meets quarterly according to their policy. (The Chief Nursing Officer is only present 1 and 1/2 days per week at the hospital managing Nursing services)
- 2) The hospital failed to ensure a registered nurse was assigned to supervise each department, the emergency department and the inpatient medical unit. (On February 15th, 2012 the hospital nursing staff only consisted of one registered nurse covering 2 (two) in-patients (ID # ' s 1 and 5) on the medical unit and the nurse was also responsible for the emergency department) Patient ID# 1 coded (arrested) on the in-patient unit on this date and a Registered Nurse was not available during this time if a patient presented to the emergency department.
- 3) The Hospital failed to ensure a registered nurse was immediately available to supervise a Licensed Vocation Nurse caring for inpatients on the medical unit 3/4/12, 3/9/12, 3/10/12 and 3/11/12. Hospital nursing staffing consisted of a Registered Nurse assigned to the emergency department and only a Licensed Vocational Nurse assigned to care for in-patients on the medical unit on these dates. On 3/10/12 inpatient ID# 6 was found unresponsive by a Licensed Vocational Nurse caring for the inpatient.
- 4) The Hospital failed to ensure emergency room patients were Triaged by a Registered Nurse according to their Triage Policy on 2/15/12 (Patient ID# 4 and 5), 3/3/12 (Patient ID# 8). Emergency Medical Technicians and Radiology Technicians were noted to be performing Triage nursing assessments on patients presenting to the emergency room.
- 5) The Hospital failed to ensure that a Registered Nurse appropriately evaluated the changing condition of Patient ID# 1 per their policy. The patient 's condition deteriorated on 2/15/12 and the Registered Nurse failed to properly assess the patient (vital signs were not reassessed per policy).

Findings include:

Observation 4/26/12 at 9:30 a.m. revealed Emerus Hospital has a four bed in-patient medical unit and a 24-hour emergency room . Hospital services provided include Emergency Services and in-patient services that do not require operating room services or intensive care services. Laboratory and radiology services (x-ray and CT scan) are also provided at this hospital.

CHIEF NURSING OFFICER

Interview 4/27/12 at 12:30 p.m. with the Chief Nursing Officer (CNO# 53) revealed he typically spends 1 and ? days a week at Emerus Hospital. The CNO stated that he is also a Regional Representative for a hospital system in San Antonio and divides his time. The CNO acknowledged that the Governing Board thought having one staff Registered nurse in the hospital at all times met the regulatory requirements of a Registered Nurse being immediately available to supervise care in the emergency department and the in-patient unit.

Interview 4/27/12 at 9:30 a.m. with the Chief Nursing Officer revealed the hospital does not have a Nurse Staffing Committee that meets quarterly per their facility policy.

Record review of a job description titled " Chief Nursing Officer " stated " Major Duties / Critical Task: Organizes, directs, manages, and coordinates various departments, programs and services related to managing resources, assuring quality services, and managing cases...

Record review of a policy titled "Nursing Advisory Committee Staffing Plan" dated 5/1/11 stated "Purpose: The Nursing Services Department of our hospital supports the provision of quality patient care in a safe, cost-effective manner by appropriately using qualified and skilled personnel. The Advisory Committee is established in accordance with Health and Safety Code 161.031-161.033 to solicit and receive input from nurses on the development, on-going monitoring and evaluation of the staffing plan. The committee will be representative of multiple areas of nursing. The Advisory Committee will meet at least quarterly. The Advisory Committee will report to the Board of Directors at least annually."

REGISTERED NURSE SUPERVISION:

Record review of the hospital staffing assignment for February 15th, 2012 on the 7 a.m. to 7 p.m. shift revealed the following staff members: A physician, a Registered Nurse, an emergency room technician, and a radiology technician. The Registered Nurse (ID# 57) was the only Nurse in the hospital responsible for two in-patients and the emergency room department.

Record review of patient record # 's 1 and 4 revealed they were admitted to the in-patient unit on 2/15/12. Patient ID# 1 was admitted at 5 p.m. and Patient ID# 4 was admitted at 5:40 p.m. Patient ID# 1 nursing notes at 6:05 p.m. stated " called to bedside by Radiology technician, patient climbing out of bed sank to the floor, patient found with weak thready pulse, code called. The patient was subsequently transferred to another hospital and later died .

According to the Nursing Admission Assessment Patient ID# 1 was admitted [DATE] at 5:00 p.m. The History and Physical dated 2/15/12 at 2:18 p.m. stated " Chief Complaint: Left ankle / foot swelling / redness for the past one week, shortness of breath, cough, blood-tinged sputum for 1 day. Impression: 1) Left ankle and foot cellulitis 2) Pneumonia 3) Type 2 diabetes 4) Hypertension.

Patient ID# 4 was admitted [DATE] at 5:40 p.m. The physician orders stated the diagnoses were "Left Arm / Shoulder Pain."

Interview on 4/26/12 at 1:30 p.m. with the Registered Nurse (ID# 57) working on February 15, 2012 on the 7 a.m. to 7 p.m. shift revealed she was the only Registered Nurse in the hospital caring for 2 in-patients and the emergency room when patient ID# 1 coded on the in-patient unit. The nurse stated the hospital had been waiting for a staffing agency to find another nurse to cover the in-patient unit. The

Nurse further stated that fortunately there were no current patients in the emergency room when the patient arrested.

Record review of a policy titled " Nursing Advisory Committee staffing Plan " dated 5/1/11 stated " Staffing and Delivery of Care: There will be adequate number of Registered Nurses and other personnel to provide nursing care to all patients. An RN will be immediately available to assist and supervise patient care as well as to respond to emergency situations.

LICENSED VOCATIONAL NURSE

Record review of a nursing assignment schedule for February and March 2012 revealed a Registered Nurse was not assigned to the inpatient care unit. On March 30th and 31st a Licensed Vocational Nurse was assigned to the inpatient unit.

Record review of in-patient medical record # 's 6, 7, 8, and 14 revealed these in-patients were being supervised / cared for by a Licensed Vocational Nurse (ID# 66). According to the hospital nurse staffing sheets 3/4/12, 3/9/12, 3/10/12, and 3/11/12, a Registered Nurse was assigned to the emergency department for these dates but the hospital did not have a Registered Nurse assigned to supervise the inpatient unit.

A Licensed Vocational Nurse (ID# 66) was supervising the in-patients on the medical unit per the nursing notes on the following dates, 3/4/12 (Patient ID# 8), 3/9/12 (Patient ID# ' s 7 and 14), 3/10/12 (Patient ID# ' s 6 and 14,

3/11/12 (Patient ID# 14).

The Chief Nursing Officer verified 4/27/12 at 3 p.m. that the in-patient unit was only staffed by a contract agency Licensed Vocational Nurse on the above dates. The CNO stated a Registered Nurse was assigned to the emergency room on these dates.

Patient ID# 6 was admitted on [DATE] with diagnoses of Pulmonary Embolism per the Physician Admission orders. The Triage record stated the patient was awake, alert and oriented. The in-patient nursing notes for patient ID# 6 dated 3/10/12 at 8 a.m. by a Licensed Vocational Nurse (LVN #66) stated " Doctor called back at bedside, patient not responding to verbal but is responding to painful stimuli. "At this time the LVN was also caring for another in-patient (ID# 14). The hospital did not have a Registered Nurse assigned to the inpatient unit on 3/10/12 during this incident. According to the nursing notes the patient was moved to the emergency room and intubated. The patient was transferred to another hospital. The transfer summary by the physician stated " Acute respiratory failure, altered mental status, pulmonary embolism, hyperkalemia, status post intubation. "

NURSING TRIAGE

Record review of a policy titled "Triage Medical Screening Exam" dated 5/1/11 stated "Responsibility: Registered Nurses ...Triage Assessment - The dynamic process of sorting, prioritizing, and assessing the patient and is performed by a qualified Registered Nurse at the time of presentation and before registration.

Record review of emergency room patient record ID# 's 4, 5, and 8 revealed the nursing triage assessment was performed by Emergency Medical Technicians and Radiology Technicians

Record review of patient ID# 4 dated 2/15/12 at 2:15 p.m. revealed that the nursing triage of this patient was completed by an Emergency Medical Technician (ID# 59). The Emergency Medical Technician listed the complaint as " Shoulder pain, numbness, Body Pain, and Dizzy.

Record review of patient ID# 5 dated 2/15/12 at 6:54 p.m. revealed that the nursing triage of this patient was completed by a Radiology Technician (ID# 60). The Radiology Technician listed the complaint as " Urinary Tract Infection, Possible Allergic Reaction.

Record review of patient ID# 8 dated 3/3/12 at 9 p.m. revealed that the nursing triage of this patient was completed by a Radiology Technician (ID# 65). The Radiology Technician listed the complaint as " Sickle Cell crisis. "

The Chief Nursing Officer acknowledged 4/27/12 at 3 p.m. that only Registered Nurses should be completing Triage assessments per the hospital policy.

NURSING REASSESSMENT OF PATIENT ID# 1

Patient ID# 1 's condition deteriorated on 2/15/12 and the Registered Nurse failed to properly assess the patient (vital signs were not reassessed / documented regularly per policy). After the initial Triage vital signs were taken at 10:38 a.m. the patient 's vital signs were not reassessed again for 6 hours and 22 minutes when the patient was admitted to the medical unit (5 p.m.). The patient coded at 6:05

Record review of the medical record for patient ID# 1 dated 2/15/12 revealed: This [AGE] year old male patient presented to the emergency room [DATE] at 10:43 a.m. The emergency room nursing triage record listed the complaint as " swollen feet and legs. " The patient was classified as " 4 Urgent. " The nursing notes stated " Past Medical History includes: cardiac history, coronary artery disease, diabetes, hypertension, pulmonary disease, pulmonary embolism, and gallstones. Surgical history listed knee, heart stents x 2. The triage notes stated presenting problem stated "Foot / ankle injury - pain swelling. Feet swelling last week, then states he fell down stairs, but unable to give a day or time. Slurred speech, sleepy, falling asleep between triage questions, doesn't answer triage questions. "Vital signs were assessed at the time of triage at 10:38 a.m. (BP 99/75, Pulse 102, Respirations 20, Oxygen saturation 96)

Per the nursing notes the patient 's condition deteriorated during the day:

11:00 a.m. Nursing notes stated "Unsteady gait, confused, lethargic, uncooperative, oriented to person and place. Skin dusky in color. Skin inspection includes redness to left foot, swelling to calf and ankle 3+. No vitals signs were documented.

12:05 p.m. Nursing notes stated " Patient was uncooperative, patient sleepy and would not sit still during the procedure. Patient did not want to lay down. " No vital signs were documented.

12:26 p.m. Nursing notes stated " Patient was uncooperative, patient too sleepy, would not stand still, too woobly, unable to perform lateral x-ray, had to perform repeat anterior posterior in wheelchair as patient unable to stand still. MD informed. Patient tolerated procedure with difficulty, too sleepy, having trouble following instructions. " No vital signs were documented.

1:00 p.m. Nursing notes stated " Oxygen therapy indicated for desaturation, oxygen therapy indicated for respiratory distress, Oxygen saturation 93%, 2 liters oxygen given, via nasal cannula applied, follow-up: after procedure oxygen saturation 99%, breath sounds clear. " No vital signs were documented.

2:18 p.m. The admitting physicians History and Physical stated " The History and Physical stated " Impression: 1) Left ankle and foot cellulitis 2) Pneumonia 3) Type 2 diabetes 4) Hypertension. "

3:06 p.m. emergency room physician notes stated "Pulse tachycardic, Respiratory rate increased. Patient alert and oriented to person, place and time. Rhonchi present to the right lower lobe. Edema present, to bilateral lower extremities, pitting, +2 pitting edema bilateral lower extremities. "No vital signs were documented.

5:00 p.m. Nursing notes stated "Patient was admitted . Edema present, dependent, +3 pitting, Speech is slurred, patient very drowsy, unaware of time, day, erratic behavior, confusion, rates pain as 9 (on a scale of 0-10) but cannot specify area where pain is. Vital signs were assessed: BP 118/76, HR 89, RR 22, Temp 98.1, O2 sat: 99 on room air. "

5:55 p.m. Nursing notes stated " Patient was uncooperative, climbing in and out of bed, over the side rails, very agitated, physician notified of above findings. " No vital signs were documented.

6:00 p.m. Nursing notes stated " Patient climbed out of bed over side rails, pulling on IV line, taking off his gown, patient repositioned and sitting up in bed. " No vital signs were documented.

6:05 p.m. Nursing notes stated " Called to bedside by Radiology technician, patient climbing out of bed sank to the floor, patient found with weak thready pulse, code called. Patient with no vital signs, showing pulseless electrical activity. "

Record review of a policy titled "Patient Assessment dated 5/1/11 stated Policy: The facility nurses shall initiate accurate and ongoing assessment of the physical, nutritional, psychosocial and cultural needs of patients within the facility. Procedure: Patients will be reassessed regularly throughout their course of treatment to determine their response to treatment."

Interview 4/26/12 at 1:30 p.m. with Registered Nurse (ID# 57) caring for patient ID# 1 on 2/15/12 revealed the patient became increasingly confused that day and " soiled " in a corner of the emergency treatment room he was in so she decided to move him to an in-patient room which had a bathroom at 5 p.m. The nurse stated upon admission to the inpatient room the patient was not on a cardiac monitor or a telemetry monitor.

The Chief Nursing Officer acknowledged 4/27/12 at 12:30 p.m. that the standard of care was to reassess urgent emergency room patients every two hours and that would include taking and documenting vital signs.

Tag No: A0386

Tag No: A0392

Tag No: A0393

VIOLATION: ORGANIZATION OF NURSING SERVICES

Based on observation, interview and record review the hospital failed to provide an organized nursing service.

Refer to 482.23 Condition of Participation: Nursing Services

VIOLATION: STAFFING AND DELIVERY OF CARE

Based on observation, interview and record review the hospital failed to have adequate numbers of licensed registered nurses to provide nursing care to all patients as needed.

Refer to 482.23 Condition of Participation: Nursing Services

VIOLATION: RN/LPN STAFFING

Based on observation, interview and record review the hospital failed to ensure nursing services were supervised and evaluated by a Registered Nurse at all times.

Refer to 482.23 Condition of Participation: Nursing Services

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April 27, 20125 (click for details)

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CHRISTUS SPOHN HOSPITAL CORPUS CHRISTI ->

Report No. 1471

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CHRISTUS SPOHN HOSPITAL CORPUS 600 ELIZABETH STREET CORPUS CHRISTI, April 5, CHRISTI TX 78404 2012

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based upon reviews of thefacility's policies and procedures, clinical records, and interviews with the facility's staff, the facility's staff failed to provide a safe setting.

- 1. Reviewed clinical records and facility policies and procedures and found that staff failed to provide a complete assessment as required
- by current standards of practice for the condition the patient was treated for.

 2. Interviewed Director of Quality and Licensed Clinical Social Worker who could not find evidence of a complete assessment as required by the current standards of practice, they both agreed that the assessment was not completed.

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based upon reviews of the Facility's policies and procedures, Quality Assurance records, and interviews with the facility's staff, the facility is not currently measuring or tracking quality indicators as they relate to proper assessments as requried by current standards of practice.

Findings:

- 1. Reviewed quality assurance data and could not find evidence of faciltiy currently tracking quality indicators related to the completion of required assessments that are required under current standards of practice.
- 2. Interviewed Director of Quality and Director of Case Managment, both agreed that the facility could not provide evidence of tracking quality indicators that measure or analyze the completion of required assessments are required by current standards of practice.

VIOLATION: NURSING CARE PLAN

Tag No: A0396

Based upon reviews of the facility's policies and procedures, clinical records, and interviews with the facility's staff, the facility staff failed to keep current a nursing care plan.

Findings:

1. Reviewed clinical record and could not find a current care plan that included the discharge planning of the patient, to include planning for discharge to meet post-hospital needs.

2. Interviewed Director of Quality and she agreed that the facility's staff failed to complete and keep current a nursing care plan to include
complete assessment for the condition the patient was treated for, and also failed to provide post-hospital needs assessment. Staff could
not provide evidence of compliance with this regualtion.

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CHRISTUS SPOHN HOSPITAL CORPUS CHRISTI CHRISTUS SPOHN HOSPITAL CORPUS CHRISTI

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Report date Number of incomplete reports Number of violations June 1, 20121

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BAYLOR REGIONAL MEDICAL CENTER AT PLANO ->

Report No. 1584

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BAYLOR REGIONAL MEDICAL CENTER AT 4700 ALLIANCE BOULEVARD PLANO, TX April 3, 75093 2012

VIOLATION: RN SUPERVISION OF NURSING CARE

Tag No: A0395

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of documentation and interview with staff, it was determined that nursing staff failed to follow a physician's order to be notified if pain control was ineffective for patient #1.

Findings included:

A review of the medical record revealed patient #1 was admitted for uncontrolled pain after having back surgery on 12/12/11.

A review of the medical record revealed there was a physician's order dated on 12/12/2011 at 2:20pm. This order stated, "Notify staff member #2/staff member #1 if...pain not controlled with medications." The orders were signed by staff member #1. Staff member #2 was the surgeon for patient #1.

A review of the medical record revealed staff member #2 ordered on [DATE] at 11:00am "DC /heplock IV's (intravenous) ...DC PCA (Pain Controlled Analgesia)..., Lortab 7.5 mg/500 po (by mouth) q6 h (every 6 hours) PRN (as needed) pain..." At 12:00pm, a staff physician order revealed, "DC IVF (Intravenous Fluids)."

A review of the medical record revealed a telephone order dated 12/14/2011 at 3:00pm from physician #3 revealed "Dilaudid 1 mg IV q4 (every 4 hours) PRN, Dilaudid 2-4 mg po q6 (every 6 hours) PRN." Noted by a nurse and signed off by staff member #3 on 12/27/2011.

There was no documentation found in the medical record of patient #1 or provided to the surveyor to indicate that the nursing staff notified staff member #1 or staff member #2 that the patient was having problems with pain control as specified by the physician order dated 12/12/11.

In a telephonic interview on 4/3/12 at approximately 4:30pm with staff member #1, it was confirmed that the nursing staff did not notify either staff member #1 or staff member #2 that patient #1 was having problems with pain control. Staff member #1 stated staff member #2 wants to be notified when patients are having problems with pain control. Staff member #1 stated staff member #2 wants to manage the patients pain medications.

In an interview with staff member #4 on 4/3/12 at approximately 5:15pm, the above was confirmed. It was also confirmed in the same interview that staff member #2 did have the order to be notified if patient #1's pain was not controlled with pain medication. Staff member #1 or staff member #2 was not notified and pain medication was prescribed to patient #1 without the consultation of staff member #1 or staff member #2. Staff member #4 also stated the nursing staff was now aware that staff member #2 wants to be notified when any patients are having problems with pain control.

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BAYLOR REGIONAL MEDICAL CENTER AT PLANO **BAYLOR REGIONAL MEDICAL CENTER AT PLANO**

4700 ALLIANCE BOULEVARD PLANO, TX 75093 | Voluntary non-profit - Other

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No incomplete reports available.



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ST DAVID'S SOUTH AUSTIN MEDICAL CENTER ->

Report No. 1560

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ST DAVID'S SOUTH AUSTIN MEDICAL CENTER

901 WEST BEN WHITE BLVD AUSTIN, TX April 2, 78704 2012

VIOLATION: CONTRACTED SERVICES

Tag No: A0083

Based on observation and a review of documentation, the governing body failed to be responsible for all services furnished in the hospital.

Findings were:

Review of facility policy CC-015 titled, "Discharge of the Patient from the Hospital" states, in part, "Once the physician's order for discharge is received, the patient's nurse or his/her designee will: ...13. Accompany or call for a volunteer to accompany the patient to the vehicle of transportation. 14. Assist the patient to transfer to the vehicle as needed."

During the review of the clinical record for patient #1, documentation reveals that the discharge instructions, as well as warnings and medication instructions were provided and reviewed with the patient. Documentation states, "The patient was discharged home and unaccompanied at time of discharge. The patient left the Emergency Department ambulatory."

The above was confirmed in an interview with the Director of Quality Outcomes Management on the afternoon of 4-2-12 in the facility conference room.



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RIVERSIDE GENERAL HOSPITAL ->

Report No. 1523

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RIVERSIDE GENERAL HOSPITAL 3204 ENNIS ST HOUSTON, TX 77004

March 23, 2012

VIOLATION: RN SUPERVISION OF NURSING CARE

Tag No: A0395

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, record review, and interview the facility failed to evaluate the safety needs of patients with history of sexual acting out and sexual abuse. Citing two patients #s 1 and 2, named a complaint investigation.

Findings

Observation on 3/22/12 at 11:34 am on the Adolescent Unit revealed in the boys patient care area there was a room with six(6) beds, one room with two(2) beds and another room with one (1) bed.

The rooms with one and two beds shared a common bath room that opened on either side into each room. When the bathroom doors are not locked then patients from either room had access to the other room. Patient (# 1) and Patient (# 2) were assigned to these rooms. Both boys had history of inappropriate sexual behavior. Both boys were on standard monitoring by unit staff.

Review of admission assessment record for Patient (# 1) revealed he was a [AGE] years old admitted to the facility on [DATE] with history of behavior disorder, aggressive especially towards males. He had history of sexual abuse and there were allegations that he himself sexually abused others.

He was assessed as not being able to take responsibility for his actions. The patient was placed on routine fifteen minutes monitoring.

Further review of the nurses 'notes dated 1/14/12 and 1/18/12 there were several documentation that the Patient (#1) kept going to the other boys 'rooms at nights although he was instructed not to.

Review of nurses 'notes dated 1/24/12 documented that the patient stated he had two sexual assault charges pending against him.

Review of Behavior Health Technician observation sheet dated 2/3/12 made the following documentation at 2:45pm: "Patient in rest room with a peer, had him pinned down, staff stopped him ".

There was no nursing documentation of the incident on the patient 's clinical record.

Patient # 2

Review of admission assessment record for Patient (# 2) revealed he was an eight (8) year old, admitted to the facility on [DATE] with history of Mood Disorder, Suicidal Ideation and aggressive ineffective coping skills. He had frequent conflict with others, afraid to be in a room alone. Had recent increase in aggression and agitation. The patient had history of physical abuse by his father who broke his femur at [AGE] months old and he was locked in dark closet.

Patient (#2) was placed in a room with adjoining bathroom to Patient (#1) 's room.

Review of Social worker notes dated 1/25/12 documented that Patient (# 2) was having hallucinations regarding hearing voices at nights telling him to come with him and they scare him.

Nurses notes dated 1/26/12 documented the patient complains of hearing voices and seeing shadows in his room.

There was nursing documentation dated 1/27/12 at 8:45 am that the patient was telling the Physician that he is afraid of the dark, afraid of shadows and thinks that people are out to get him. The patient was frequently coming to staff to say that peers are trying to hurt him. The patient always tattle-telling on other peers. Encouraged patient to focus on himself and learn to use his coping skills and relaxation technique.

There was no nursing documentation that Patient # 2 was questioned regarding these incidents.

Review of Behavior Health Technician observation sheet dated 2/3/12 made the following notation at 2:45pm:

" Patient in rest room pinned down by a peer "

There was no nursing documentation of the incident on the patient 's clinical record.

Review of Social Worker notes dated 2/10/12 revealed information that prior to this incident the treatment team for Patient (# 2) had observed sexually acting out behavior exhibited by the patient and that there was a concern that he might have been sexually assaulted in the past '

This behavior was never documented in the patient 's clinical record. There was no documentation in the patient 's record that the inappropriate behavior was communicated to other team members.

During an interview on 3/22/12 on the Adolescent at 11:50 am with Staff #50 Registered Nurse, she stated the Technicians make rounds every fifteen minutes on the unit. The facility had electronic monitoring that did not monitor inside the patient rooms. According to the Nurse she was not on duty at the time of the incident.

During an interview on 3/22/12 on the Adolescent at 2:15 pm with Staff #51, Chief Nursing Officer, she stated the Nurses did not evaluate that the patients had a shared bath room and should have been separated or more closely monitored.

Tag No: A0701

VIOLATION: MAINTENANCE OF PHYSICAL PLANT

Based on observation and interview the facility failed to ensure patients were cared for in a clean and sanitary environment.

Findings:

Observation on 3/22/12 between 11:25 am and 12:15 pm on the Adult patient unit and the Adolescent patient unit at the facility the following observations were made:

The floors in the patients 'rooms were dirty. There was built up dirt and dust in the corners of the floor.

There were missing floor tiles in rooms and loose floor tiles in bath rooms. Chipped paint from walls and doors.

Ceiling and wall vents had heavy built up of dust with dust webs.

The window ledges in all patient rooms were heavy with dust and dust webs including the bars on the windows.

Observation on 3/22/12 at 11:34 am on the Adolescent unit revealed several items of clothing on the floor in the boy 's rooms.

During an interview on 3/22/12 with the Nurse in charge of the unit she stated she was not able to tell if the clothing on the floor were clean or dirty. According to the Nurse the children put their clothes on the floor because there was no receptacle to store their clean or soiled clothing.

During an interview on 3/22/12 at 12:35 pm with Housekeeping Supervisor she stated it was difficult to clean the bars on the windows. According to the Assistant Administrator who was on rounds with the Surveyor, some cleaning need to be done, she further stated the facility was aware of the needed repairs and had some plans that were pending.



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WEST HOUSTON MEDICAL CENTER ->

Report No. 1541

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WEST HOUSTON MEDICAL CENTER 12141 RICHMOND AVE HOUSTON, TX 77082 March 23, 2012

VIOLATION: PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT Tag No: A0145

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the facility failed to ensure that all 14 patients residing on the Geri-Psych Unit were free from possible abuse and neglect:

A hospital Social Worker (#71) received knowledge of possible abuse of a discharged Patient (#1) by a CNA (#65) who was currently employed. The facility failed to investigate this allegation.

Findings include:

Intake # TX 262

Review of the clinical record of Patient # 1 revealed she was [AGE] years old and had been admitted to the facility on on [DATE]. Her medical history included the following: Depressive Disorder, Suicidal Ideation, Hypertension, and Cerebral Vascular Accident (CVA/ "stroke"). Patient # 1 was assessed as aphasic with right-sided weakness.

Further review of a History & Physical, dated 03-19-12 read Patient # 1 was "very depressed but cooperative ... able to communicate by writing ... She understands very well ... "Patient # 1 had been admitted to the hospital geropscyh unit due to increased depression concerning her grandson 's suicide 3-4 months prior. Patient # 1 was discharged from the hospital on02-16-2012 and returned to the nursing home.

Interview (telephone) on 03-23-12 at 4:00 p.m. with hospital social worker (Staff # 71) reported that on 03-08-12 she telephoned a local nursing home where Patient # 1 currently resided and inquired about her planned return to the hospital 's geropsych unit. She went on to say the nursing home 's social worker returned the call on 03-09-12 and said Patient # 1 would not be returning to the hospital 's Geropsych Unit because "something had happened there that scared her. "Staff # 71 said the nursing home social worker told her "Patient # 1 said a male Certified Nurse Aide (CNA/ ID # 65) touched her inappropriately while giving her a shower. "Staff # 71 went on to say she was unsure whether to report this as alleged abuse because she did not hear it directly from Patient # 1. Staff # 71 said she left a telephone message and text for the Interim Director (ID # 72), as well as a handwritten note about allegation of abuse. Review of Social Worker (ID # 71) personnel file revealed she was hired on 06-21-2010 and last received Abuse, Neglect, Sexual Abuse training on 07-21-2011.

Interview (telephone) on 03-23-12 at 5: 15 p.m. with Interim Geropsych Unit Director(ID # 72) he reported he had no knowledge of the allegations that Patient # 1 had possibly been abused by CNA # 65. He denied receiving any messages or texts regarding this issue.

Interview on 03-23-12 at with Interim Geropsych Manager (Staff # 52) she stated CNA # 65 was currently employed on the Geropscyh Unit and worked the night shift.

Review of the current Geropscyh Unit patient roster revealed there were currently 14 inpatients on the unit.

Interview on 03-23-12 at 5:20 p.m. with the hospital Risk Manager (# 51), she stated this alleged abuse should have reported and investigated using the established hospital process.

Review of facility policy titled " Abuse, Neglect, Exploitation (Suspected) of Adult, Elderly or Disabled person, reviewed 11/10, read: " Policy: (facility) will respond quickly and effectively to any actions or behaviors that may be construed as abuse, neglect, or exploitation ...1. The licensed employee who observed the suspected abuse will initiate the reporting process by: A. Notifying and discussing with director or Nursing Supervisor... "



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TEXAS HEALTH HARRIS METHODIST HURST-EULESS-BEDFORD ->

Report No. 1539

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

TEXAS HEALTH HARRIS METHODIST HURST-EULESS-BEDFORD

1600 HOSPITAL PARKWAY BEDFORD, TX 76022 March 21, 2012

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on interviews and record review, the hospital failed to provide care in a safe environment for 1 of 1 patient (Patient #1) whose blood specimen was processed under a different patient name (Patient #2) raising concerns regarding Patient #1 having a heart attack.

Findings included:

Patient #1's medical record reflected she was admitted to the hospital's main ED on 02/01/12 at 8:27 PM. An order was written on 02/01/12 at 8:40 PM for a blood sample to be drawn for tests including cardiac enzymes. The diagnosis documentation dated 02/02/12 at 12:21 AM reflected an "elevation of cardiac enzymes - could be a lab error." The discharge summary dated 02/03/12 at 12:32 PM reflected patient #1's "initial cardiac enzymes drawn in the ER were elevated but this was later thought to be a lab error."

Patient #2's medical record reflected he was admitted to the Hospital's ED on 01/18/12 at 12:37 PM with a diagnoses of Coumadin toxicity and chest pain.

During an interview on 03/20/12 at 12:40 PM Hospital Personnel #3 stated that the process of printing out a patient label and computerized lab requisition "did not happen in this case [Patient #1] and the lab person printed out a requisition with the wrong patient name."

Hospital Personnel #8 stated during an interview on 03/20/12 at 1:20 PM that if a patient specimen came to the lab without a requisition sticker, lab personnel would go into the system and pick the patient and physician order. For Patient #1 "they picked the wrong patient."

Hospital Personnel #1 was asked during an interview on 03/21/12 at 10:45 AM whether she was aware of hospital policy requiring staff to place the lab requisition sticker on the specimen tube before sending it to the lab to be processed; she stated "no."

Hospital Personnel #8 was interviewed again on 03/21/12 at 2:40 PM and stated the "sample was collected on the wrong patient unless there was an extra tube [of specimen]."

Review of the Hospital Policy Nursing 03-003 dated 09/10 reflected the expectation to "obtain the lab generated bar code label and verify test and times with the physician orders...collect the ordered specimen...and attach barcode label...to the specimen tubes."

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on interviews and record review, the hospital failed to set priorities for it's performance improvement activities in that it did not focus on problem prone areas. The hospital had 239 incidents of specimen labeling errors within 14 months including 1 of 1 patient (Patient #1) whose blood specimen was processed by lab services under a different patient name (Patient #2) raising concerns regarding Patient # 1 having a heart attack.

Findings included:

Patient #1's medical record reflected she was admitted to the hospital's main ED on 02/01/12 at 8:27 PM. An order was written on 02/01/12 at 8:40 PM for a blood sample to be drawn for tests including cardiac enzymes. The diagnosis documentation dated 02/02/12 at 12:21 AM reflected an "elevation of cardiac enzymes - could be a lab error." The discharge summary dated 02/03/12 at 12:32 PM reflected patient #1's "initial cardiac enzymes drawn in the ER were elevated but this was later thought to be a lab error."

Patient #2's medical record reflected he was admitted to the Hospital's ED on 01/18/12 at 12:37 PM with a diagnoses of Coumadin toxicity and chest pain.

During an interview on 03/20/12 at 12:40 PM Hospital Personnel #3 stated that the process of printing out a patient label and computerized lab requisition "did not happen in this case [Patient #1] and the lab person printed out a requisition with the wrong patient name."

During an interview on 03/20/12 at approximately 12:50 PM Hospital Personnel #3 stated the hospital had 45 incidents of "labeling errors" in January and February 2012, due to "requisition [sheets] not being sent with specimens" by nurses. Hospital Personnel #3 stated a total of 194 incidents of "specimen labeling errors" were reported in 2011.

Hospital Personnel #8 stated during an interview on 03/20/12 at 1:20 PM that if a patient specimen came to the lab without a requisition sticker, lab personnel would go into the system and pick the patient and physician order. For Patient #1 "they picked the wrong patient."

Hospital Personnel #10 stated during an interview on 03/21/12 at 9:15 AM the lab processed an ICU patient's blood with ED Patient #1's identifying information. Hospital Personnel #10 stated lab technicians "sometimes" called the ED and told staff they "had blood and no orders."

During an interview on 03/21/12 at 12:40 PM Hospital Personnel #12 stated the hospital had identified the problem of mislabeled specimen a year ago but "process improvement measures were not implemented" such as the use of the portable sample collection and label printing device.

Quality Assurance documentation reflected a 53 percent increase in specimen labeling errors in January and February 2012 compared to the same time in 2011.

The Hospital Policy Nursing 03-003 dated 09/10 reflected the expectation to "obtain the lab generated bar code label and verify test and times with the physician orders...collect the ordered specimen...and attach barcode label...to the specimen tubes."

Tag No: A0386

Tag No: A1103

VIOLATION: ORGANIZATION OF NURSING SERVICES

The Hospital failed to provide a well-organized nursing service in the hospital's main Emergency Department (ED) for 1 out of 1 patient (Patient #1) whose blood specimen was collected by nursing personnel in the ED for lab processing. The specimen was not labeled per hospital policy which resulted in the lab processing Patient #1's blood specimen under a different patient's name (Patient #2).

Findings included:

Patient #1's medical record reflected she was admitted to the hospital's main ED on 02/01/12 at 8:27 PM. An order was written on 02/01/12 at 8:40 PM for a blood sample to be drawn for tests including cardiac enzymes. The diagnosis documentation dated 02/02/12 at 12:21 AM reflected an "elevation of cardiac enzymes - could be a lab error." The discharge summary dated 02/03/12 at 12:32 PM reflected patient #1's "initial cardiac enzymes drawn in the ER were elevated but this was later thought to be a lab error."

Patient #2's medical record reflected he was admitted to the Hospital's ED on 01/18/12 at 12:37 PM with a diagnoses of Coumadin toxicity and chest pain.

During an interview on 03/20/12 at 12:40 PM Hospital Personnel #3 stated that the process of printing out a patient label and computerized lab requisition "did not happen in this case [Patient #1] and the lab person printed out a requisition with the wrong patient name."

Hospital Personnel #8 stated during an interview on 03/20/12 at 1:20 PM that if a patient specimen came to the lab without a requisition sticker, lab personnel would go into the system and pick the patient and physician order. For Patient #1 "they picked the wrong patient."

Hospital Personnel #10 stated during an interview on 03/21/12 at 9:15 AM the lab processed an ICU patient's blood with ED Patient #1's identifying information. Hospital Personnel #10 stated lab technicians "sometimes" called the ED and told staff they "had blood and no orders."

Hospital Personnel #1 was asked during an interview on 03/21/12 at 10:45 AM whether she was aware of hospital policy requiring staff to place the lab requisition sticker on the specimen tube before sending it to the lab to be processed; she stated "no."

Review of the Hospital Policy Nursing 03-003 dated 09/10 reflected the expectation to "obtain the lab generated bar code label and verify test and times with the physician orders...collect the ordered specimen...and attach barcode label...to the specimen tubes."

VIOLATION: INTEGRATION OF EMERGENCY SERVICES

Based on interviews and record review, the hospital failed to integrate its Emergency Department services with other departments of the hospital for 1 of 1 patient (Patient #1) whose blood specimen was processed by laboratory (lab) services under a different patient name (Patient #2) raising concerns regarding Patient # 1 having a heart attack.

Findings included:

Patient #1's medical record reflected she was admitted to the hospital's main ED on 02/01/12 at 8:27 PM. An order was written on 02/01/12 at 8:40 PM for a blood sample to be drawn for tests including cardiac enzymes. The diagnosis documentation dated 02/02/12 at 12:21 AM reflected an "elevation of cardiac enzymes - could be a lab error." The discharge summary dated 02/03/12 at 12:32 PM reflected patient #1's "initial cardiac enzymes drawn in the ER were elevated but this was later thought to be a lab error."

Patient #2's medical record reflected he was admitted to the Hospital's ED on 01/18/12 at 12:37 PM with a diagnoses of Coumadin toxicity and chest pain.

During an interview on 03/20/12 at 12:40 PM Hospital Personnel #3 stated that the process of printing out a patient label and computerized lab requisition "did not happen in this case [Patient #1] and the lab person printed out a requisition with the wrong patient name."

Hospital Personnel #8 stated during an interview on 03/20/12 at 1:20 PM that if a patient specimen came to the lab without a requisition sticker, lab personnel would go into the system and pick the patient and physician order. For Patient #1 "they picked the wrong patient."

Hospital Personnel #10 stated during an interview on 03/21/12 at 9:15 AM the lab processed an ICU patient's blood with ED Patient #1's identifying information. Hospital Personnel #10 stated lab technicians "sometimes" called the ED and told staff they "had blood and no orders."

The Hospital Policy Nursing 03-003 dated 09/10 reflected the expectation to "obtain the lab generated bar code label and verify test and times with the physician orders...collect the ordered specimen...and attach barcode label...to the specimen tubes."

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RANKIN HOSPITAL MEDICAL CLINIC ->

Report No. 1586

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RANKIN HOSPITAL MEDICAL CLINIC 1105 ELIZABETH UNKNOWN, TX None March 21, 2012

VIOLATION: UNSPECIFIED CATEGORY Tag No:

Based on staff interviews and review of the medical record for patient #1 the facility failed to ensure that bathing and physical therapy activities were documented as having been performed.

Findings were:

Review of the record for patient #1 revealed that there were only 4 of 63 days in which a shower or bath was documented as having been completed. There was no documentation of any of the physical therapy exercises performed during this same time. Interview with the administrator in the workroom on 3/20/12 confirmed these findings.



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No incomplete reports available.



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NORTH CYPRESS MEDICAL CENTER ->

Report No. 1761

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NORTH CYPRESS MEDICAL CENTER

21214 NORTHWEST FREEWAY CYPRESS, TX 77429

March 21, 2012

Tag No: A0395

VIOLATION: RN SUPERVISION OF NURSING CARE

Based on , record review and interview the facility failed to ensure staff evaluate the safety needs of patients by adhering to the facility's fire responsibility protocol # EC.5.10.4.b dated 4/2011 . This failed practice resulted in adverse patient event. Citing all 24 patients on Unit 2.

Findings:

Review of complaint narrative TX 147 revealed information that on 12/13/11 a visitor smelled smoke on unit two (2) and informed two unit staff of the incident. The complainant documented staff did not do a thorough search and there was a fire in a patient's room resulting in a patient sustaining burns and other patients inhaled smoke.

During an interview on 3/21/11 at 9:40 am at the facility with Staff # 50 Registered Nurse she stated a visitor told her there was the smell of smoke and that it was coming from room # 2305. according to the Staff she did look into the room and two other patient's rooms and although she smelled smoke she did not see anything. The staff stated she did not report the smell of smoke or the visitor's concern to the other staff on the unit and she did not sound the fire alarm.

She went to the Lunch room on break for a few minutes when she heard the alarm of fire. The fire was in room 2305.

During an interview with Staff # 51 Patient Care Technician she stated the visitor told her that there was a smell of smoke, according to the Staff she smelt smoke checked the stairwell and patient rooms in the area she was working but did not see any smoke. According to the Staff she thought the smoke might have come form some visitors clothing who were near the stairwell. According to Staff # 51 she reported the information to the Nurse but she did not activate the fire alarm.

During the interviews they staff stated they did not activate the fire alarm because they did not see fire or smoke.

Review of the facility's Fire Policy # EC.5.10.4.b dated 4/2011 gave the following information:

" In order to assure the safety of patients, visitors, and staff, a standard response to fire, or to the potential of fire, defined plans are required. This fire plan describes the standard response for all staff within the hospital to an activation of the Fire Alarm or to conditions that indicate the presence of a fire in the area."

The staff on the unit were informed of the potential for a fire and they failed to activate the fire alarm system per protocol.

VIOLATION: NURSING CARE PLAN Tag No: A0396

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review, and interview, the facility failed to develop a patient plan of care that instructs patient on safety precautions while on oxygen therapy. This failed practice had the potential to adversely affect all patients on the unit receiving oxygen therapy. Citing three of three patients receiving oxygen therapy, patient 3s (1, 2 and 3).

Findings:

Review of Physician 's history and physical dated 12/10/11 for Patient # 1 revealed the [AGE] year old patient was admitted on [DATE] with admitting diagnosis of Chronic Obstructive Pulmonary Disease (COPD). There was documentation that her mental status was evaluated as being alert and oriented times three (person, time, and place). The patient was bed bound. Review of nurses 'notes dated 12/12/11 revealed the patient was placed on oxygen therapy via nasal canulae. There was no documentation that the danger of smoking or using fire apparatus while on oxygen was discussed with the patient/family.

Review of nurses notes dated 12/13/11 documented the patient tried to light a cigarette while in bed with her oxygen canulae in place, the action resulted in a flash fire which burned her face.

Patient # 2

Review of physician 's History and Physical dated 11/29/11 revealed the [AGE] year old patient was admitted on [DATE] intubated and on a vent due to respiratory failure.

Review of nurses 'notes revealed the patient was taken off the ventilator on 12/4/11 and placed on oxygen via nasal canula. The patient was on oxygen therapy until 1/2/12.

There was no documentation that the danger of smoking or using fire apparatus while on oxygen was discussed with the patient/family.

Patient #3

Review of physician 's History and Physical dated 11/29/11 revealed the [AGE] year old patient was admitted on [DATE] with dyspnea and increasing shortness of breath. The patient also had Chonic Obstructive Pulmonary Disease and was on oxygen at home via nasal canula. The patient had history of smoking in the past.

Review of nurses 'notes dated 12/12/11 revealed the patient was placed on oxygen via nasal canula until discharge on 12/14/11. There was no documentation that the danger of smoking or using fire apparatus while on oxygen was discussed with the patient/family.

Review of the facility 's safety plan revealed no information that smoking or using flame while oxygen is in use could spark a fire.

During an interview on 3/21/12 at 10:35 am with facility 's Nurse Administrative staff they stated there was no policy that addresses fire hazard while using oxygen in patients 'rooms.

Review of the facility 's Smoking policy # EC.02.01.03 dated 2/2011 revealed information that patient would be informed of the facility 's no smoking policy, review of the information given to patient 's on admission only inform patients of the health risks of smoking.

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Incomplete reports

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Tag No: A0395

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MEDICAL CENTER OF ARLINGTON ->

Report No. 1552

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MEDICAL CENTER OF ARLINGTON 3301 MATLOCK ROAD ARLINGTON, TX 76015 March 13, 2012

VIOLATION: PATIENT RIGHTS: TIMELY REFERRAL OF GRIEVANCES Tag No: A0120

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on documentation, and an interviews with the facility staff, it was determined that the facility failed to complete an occurrence report on patient #1, for leaving the facility against medical advice.

Findings were:

Review of the medical record of patient #1, revealed that patient #1 was admitted to the facility on [DATE] and left against medical advice on 01/18/12.

Review of progress note 01/18/12 per the Nurse Practitioner stated, "Patient called her daughter and left against medical advice because she felt that I was accusatory, rude, and refused an explanation for the rationale, for her treatment modality."

Review of Policy # PCSO40, Against Medical Advice/Elopement, Leaving, without Treatment, revised 05/11. AMA/ELOPEMENT 7. "An occurrence report is completed on all AMA's/elopements and sent to the Department Director."

In a telephonic interview conducted with the Family Nurse Practitioner on 03/13/12 at 2:20 pm at the facility, it was confirmed that an occurrence report had not been completed for patient #1, who was admitted to the facility on [DATE] and left against medical advice on 01/18/12.

In an interview with the Vice President of Quality on the afternoon of 03/13/12 at the facility, it was confirmed that an occurrence report had not been completed for patient #1 who was admitted to the facility on [DATE] and left against medical advice on 01/18/12.

VIOLATION: RN SUPERVISION OF NURSING CARE

Based on review of facility documentation, policies, and an interview with the Quality Improvement Coordinator, it was determined, the nursing staff failed to change the dressing of patient # 2 each shift, as ordered by the physician.

Findings were:

Review of the medical record patient #2, revealed an exploratory laparotomy was performed on 11/04/11 with findings of ischemic right colon and a right colectomy was performed. The physician ordered 11/07/11 stated "Can change abdominal dressing q (every) shift with dry gauze".

Review of the clinical documentation record 11/10/11 and 11/11/11 revealed the dressing was not changed each shift, as ordered by the physician.

Review of facility policy, Diagnostic and Therapeutic Orders of Medical Staff: Acknowledgement, Coordination and Implementation #

PCSO24, stated, "registered nurses will coordinate the implementation of the physician's orders. Physicians' orders for patient care are processed in a timely manner to ensure that each patients needs are assessed and met. Based on each patient's presenting needs, orders are prioritized and implemented."

In an interview with the Quality Improvement Coordinator on the afternoon of 03/13/12, clinical records 11/10/11 and 11/11/11 were offered to the surveyor, revealing the dressing had been changed on 11/10/11 and 11/11/11. No other documentation was offered to the surveyor indicating that the dressing had been changed each shift as ordered by the physician.

Tag No: A0817

VIOLATION: DISCHARGE PLAN

Based on review of documentation, and an interview with the director of 1 East, it was determined, the facility failed to follow their own policy; patient #2 and his wife were not given discharge instructions for care of the abdominal incision.

Findings were

Review of facility policy # PC8017, Discharge Planning, II, stated " It is the policy at MCA, based upon patient admission requirements and assessments, the registered nurse initiates discharge planning on admission, writes an ongoing discharge plan, makes referrals to the case manager/social worker and coordinates discharge planning with the patient case manager, and family throughout the hospitalization. Prior to discharge, any post-discharge continuing nursing care needs are assessed and noted in the medical record."

Review of the patient clinical discharge education 11/11/11 revealed there was no documentation instructing the patient #2 and his wife on the care of the incision.

In an in-person interview with director of 1 East on the afternoon of 03/13/12, it was confirmed the facility failed to provide discharge instructions to patient #2 and his wife, for care of the abdominal incision.

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DALLAS REGIONAL MEDICAL CENTER ->

Report No. 1557

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DALLAS REGIONAL MEDICAL CENTER

1011 NORTH GALLOWAY AVENUE MESQUITE, TX 75149

March 13, 2012

VIOLATION: PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION

Tag No: A0123

Based on review of documentation and interview with staff, it was determined the facility failed in its resolution of the grievance as evidenced by the complainant did not receive written notice of the resolution.

Findings included:

A review of facility policy# PC-41 entitled, "Complaints, Patients, and Families" revealed "Purpose: To provide a mechanism to receive and respond to patient and/or family complaints concerning quality of care of any other issues." Further review stated, "1.b. Complaints may be via telephone, verbally, or in writing." The policy also stated, "3. Each patient or family making a significant complaint will receive a response from the respective department and/or administration."

A review of policy # HW-20 entitled, "Complaint/Grievance Resolution process," revealed "The Director of Risk Management shall operate and maintain the hospital's grievance mechanism designed to process and resolve patient complaints and formal grievances while maintaining a comprehensive record of complaints presented to Dallas Regional Medical Center." The policy also stated, "A written complaint is ALWAYS considered a grievance, whether from an inpatient ...or their representative regarding the patient care provided." The policy also stated that an Email or fax was considered "written." In the section "Receipt of Complaints" stated "B. 2. Grievances require written notice (response) to the patient within (7) days. The written response will contain the name of the hospital contact person and identify the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process and the date of completion ...If the grievance is not resolved within seven (7) days and if investigation is not complete or if corrective action is still being evaluated, the hospital's response should address that the hospital is still working to resolve the complaint and that the hospital will follow-up with another written response within (7) business days..." Further review revealed "C. 1. Upon receipt of complaint from patient or patient representative, the department receiving shall date the complaint and attach to a Patient/Customer Feedback Form ...5. Identify appropriate response to the patient ...8. Risk Management/Administration designee to provide oversight to all written letter responses."

In multiple interviews with staff member #3, on 3/12/2012, it was confirmed patient #1 did not receive a written notice from the facility regarding the grievance filed. Staff member #3 stated the facility was not aware a grievance was filed until the surveyor asked the staff member #3 if a grievance was received by the facility. The facility located the grievance on 3/12/2012 and it was determined the grievance was reported to the facility on [DATE].

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**



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Incomplete reports

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Tag No: A0273

Tag No: A0701

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SHELBY REGIONAL MEDICAL CENTER ->

Report No. 1576

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SHELBY REGIONAL MEDICAL CENTER 602 HURST STREET CENTER, TX 75935 March 12, 2012

VIOLATION: PROGRAM SCOPE, PROGRAM DATA

Based on record review and interview the Laboratory department failed to collect data and submit to the Quality Assurance /Performance Improvement Committee.

Review of records titled "Quality Assurance /Performance Improvement Meetings" dated November 23, 2011 and February 10, 2012 revealed no evidence the Laboratory department had collected any type of data related to patient care issues or occurrences to the Quality Assurance /Performance Improvement Committee.

Interview with the Staff #6 on 3/9/2012 at 2:30 PM in the survey office confirmed there was no data being reported to the Quality Assurance /Performance Improvement Committee from the Laboratory department.

VIOLATION: MAINTENANCE OF PHYSICAL PLANT

Based on observation, record review, and interview the facility failed to repair a collapsing floor and malfunctioning grease trap in the dietary department. This has the potential for harm to all dietary employees working in the kitchen area with risk for injury and exposure to infectious waste.

Findings include:

Touring the dietary department on 3/8/2012 at 12:00 noon revealed on entrance into the kitchen area the grease trap was observed. The metal plate was in place, but all screws to secure the plate to the floor were missing. The floor surrounding the grease trap appeared to slope slightly the entire circumference of the grease trap.

Interview with staff #32 on 3/8/2012 at 12:15 pm in the dietary department confirmed the grease trap was not properly secured to the floor. Advised that the last incident of the grease trap backing up and flooding the entire kitchen area was last 11/2011. In 2/2012 the grease trap was vacuumed out as part of routine maintenance to try and prevent it from backing up and flooding the kitchen again. Staff #32 also confirmed the grease had been an on-going problem due to the age of the facility. She also advised that from time to time very foul odors were emitted from the drain pipes in the kitchen floor into the entire kitchen area.

Shelby Regional Medical Center Explanation of Repair Needs

Date: 2/3/2011

Problem: Grease trap in the kitchen has rusted out and is allowing mud to mix with the grease.

Rationale for Repair:

1) The substructure for the floor in the kitchen (the dirt under the floor) is being sucked out with the grease every time the trap is cleaned. This has been a problem for 3-5 years. There is a hole that has to be getting bigger every time we clean the trap, thus leaving the possibility of a structural failure of the floor and casing substantial damage to the kitchen and possible environmental damage to the soil

around the trap.

2) If the kitchen is shut down due to environmental problems, the whole facility could be shut down until it meets code again. We have a quote in place from Nacogdoches Sheet Metal to install a new trap. The quote also has a quote to repair the main sewer line going from the hospital to the street. It has roots growing into it and has potential to collapse and totally block the flow of sewage from the hospital to the street.

Both issues need to be addressed as quickly as possible.

E-mail received by staff #3 from Liquid Environmental Shreveport La. Dated July 13, 2011 at 4:29 pm.

Thanks for taking the time to visit with me today on the phone about the condition of your grease trap. As you are aware your grease trap is in extremely poor condition, so much so the walls have caved in and my service tech is sucking up dirt and rocks from under your building each time we service your trap. If this continues the danger of your floor loosing enough support from the surrounding area is real enough to cause the floor around your grease trap to completely cave in. If this were to happen when an employee was walking past the trap it could produce disastrous results for your hospital.

In addition to the safety concerns caused by the very poor condition of your grease trap there's always the possibility of the local pretreatment inspector making a surprise visit to check on the trap. With the condition your trap is in not only could the hospital be forced to pay a fine, the inspector could also issue a cut-off notice which would allow the hospital to discharge any water to the city until the trap was replaced.

It is my strong recommendation that the hospital replace there trap in question as soon as possible in order to avoid any of the many safety or regulatory dangers associated with a trap in such poor condition. You are due for service now and I would love to coordinate that service around the replacement of your trap.

Bids for replacement of grease trap was reviewed and revealed the following:

Nacogdoches Sheet Metal and Plumbing, Ltd. dated 3/10/2099

To: Shelby Regional Medical Center

Nacogdoches Sheet Metal and Plumbing Ltd is pleased to replace existing grease interceptor to new Jonespec GT-27-2-50 polyethylene. Price includes saw-cut and busting out of flooring. No concrete work or floor repairs included in quote.

Total Price......\$10,995.00 +tax

No pavement, concrete, or floor covering quoted.

Bid from Nacogdoches Sheet Metal and Plumbing, Ltd. dated 1/5/2011 revealed the following:

To: Shelby Regional Medical Center

Nacogdoches Sheet Metal and Plumbing, Ltd is please to quote the removal of the grease interceptor in the kitchen. We will tie onto the grease line and run thru the kitchen, across hall to the outside, and set a 750 gallon grease trap and tie-in. We will leave the grease trap and run a line toward the front of the hospital and tie-into the existing sewer line. We will have the concrete

busted up, poured back, and tile replaced where we have to run new line in kitchen and hall.

Total Price.....\$21,869.00

Note: This bid does no include any dust clean-up. Any repairs of underground utilities that are not marked. No landscaping, asbestos

Alternate: To replace the sewer line in front of the hospital on South side about 80 feet out to the bad spot. ADD.......\$3883.00. One-half of total bill is due up front, and balance due upon completion of job.

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MEDICAL CENTER OF PLANO ->

Report No. 1544

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

MEDICAL CENTER OF PLANO

3901 W 15TH ST PLANO, TX 75075

March 6, 2012

VIOLATION: PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES

Tag No: A0122

Based on review of documents and interview with staff, the facility failed to ensure that the time-frame for response to a patient grievance was in accordance with facility policy for 1 of 1 patient whose record was reviewed.

Findings were:

Facility policy 900-RI-165, entitled Patient Grievance and Complaint Resolution Process, last reviewed in January 2011, states that a grievance is defined as a written complaint letter from patients or their representative. The Patient Grievance Committee is responsible for review and resolution of the grievance. Upon receipt of the grievance, hospital Health Care Improvement (HCI) staff will investigate and communicate with complainants who file cases involving risk and/or quality of care issues. A written response is to be sent to the complainant no later than 30 days after the complaint is filed; if the investigation takes longer than 30 days, the complainant will be notified of the anticipated date of completion.

A review of a facility Guest Relations report revealed that a complainant, the spouse of Patient #1, submitted a written grievance on 1/14/2012. An in-person interview with the Vice President of Health Care Improvement was conducted the afternoon of 3/6/12 in a facility conference room. According to the Vice President, the response letter did not go out to the complainant until 3/6/2012, which was 51 days after receipt of the letter of complaint. The complainant was not informed by the 30th day that the investigation response would take longer than 30 days.



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ST JOSEPH REGIONAL HEALTH CENTER ->

Report No. 1456

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

ST JOSEPH REGIONAL HEALTH CENTER 2801 FRANCISCAN DR BRYAN, TX 77802 March 5, 2012

VIOLATION: MEDICAL STAFF BYLAWS Tag No: A0353

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on document review and interview the hospital failed to insure the medical staff followed the rules and regulations as stated in the medical staff policies in 1 of 1 patient record reviewed.

On 3/5/2012 as 9:00 AM in the quality meeting room the medical record for patient #1 was reviewed and revealed following physician entries into the record:

- -Pt #1 presented to the Emergency Department (ED) on 8/14/2011 at 1040 hours (hr) with a two (2) day history of nausea, vomiting and diarrhea .
- -Pt #1's representative signed "No Advanced Directive" on Section 11 "Advanced Directive", of the Admission Patient Rights sheet dated 8/14/2011 at 9020 Hrs.
- -Pt #1 had a history of significant alcohol use and had been drinking beer heavily.
- -Upon evaluation in the ED, Pt #1 was found to be hypotensive with a blood pressure (B/P) of 90/60
- -Pt #1 was given intravenous (IV) fluids in the ED for a total of three (3) liters.
- -Pt #1 B/P stabilized in the ED.
- -Pt #1 primary diagnosis upon admission was as follows:
- -sepsis due to urinary tract infection
- -presumed infectious gastroenteritis
- -acute kidney failure
- -Pt #1 secondary diagnosis upon admission were as follows:
- -history of [DIAGNOSES REDACTED]
- -coronary artery disease
- -history of hypertension
- -history of colon cancer
- -ED documented Pt #1 as full code status.
- -8/14/2011 1415 hr Pt #1 was admitted to the telemetry floor.
- 8/14/2011 1415 hr the telemetry unit physician's order indicated, by an "x", Pt #1 was code status Do Not Resuscitate (DNR)
- -8/14/2012 1415 hr all other physician admission orders are documented by a check mark rather than an "x"
- -8/14/2011 1415 hr Pt #1 was receiving IV antibiotics.
- -4/15/2011 1257 hr physician's order for Pt #1 records clear liquid diet a tolerated
- -4/15/2012 1823 hr physician orders record "charge nurse to pronounce pt"

Nursing documented the following:

- -8/14/2011 2012 hr received report from previous shift. No complaints, no distress will monitor call light within reach.
- -8/15/2011 0020 hr Respirations even and unlabored.

- -8/15/2011 0423 hr Respirations even unlabored on 2 liters of oxygen, denies distress
- -8/15/2011 0735 hr Tylenol for head ache/fever
- -8/15/2011 1402 hr B/P 88/52 Doctor #11 notified of B/P, no further orders
- -8/15/2011 1839 hr Pt very restless, change in mental status, increase oxygen to 5 L per nasal cannula charge nurse notified (documentation does not reflect physician was notified)
- -8/15/ 1842 hr code blue canceled due to DNR status, unable to get B/P and Doctor #11 notified, family here. Pt's daughter here refusing to talk with Doctor #11
- -8/15/2011 1918 hrs Patient asystole, charge nurse pronounced Pt, Doctor #11 gave telephone order.

On 3/5/2012 at 10:00 AM in the quality meeting room policies were reviewed and revealed the following:

- -Policy No 41. Death, Determination and pronouncing by Registered Nurses within the hospital. -RN's may determine and pronounce patient death if ALL of the following criteria are met:
- 1. Death is expected
- 2. The physician had written a current "Do Not Resuscitate" order, AND there is documentation in the progress notes that the physician and family agree on the DNR status and
- 3. The patient is not on artificial life support.
- A review of progress notes did not reveal any entry by the physician addressing the DNR status.

On 3/5/2012 at 2:15 PM in the quality meeting room an interview occurred with staff #3,# 4 and #5.

- -The physician's were asked if the patient's death was expected.
- -The consensus was no.
- -The physician's were asked about the DNR order.
- -After conversation regarding the DNR order, the policy was discussed and the lack of progress notation to support the DNR was brought to the attention of the physician's.

On 3/5/2012 at 2:00 PM an interview with staff #7 revealed the following:

- -Staff #7 stated The family was involved but the children were demanding. The daughter was a registered pharmacy technician and wanted to know everything.
- -Staff #7 stated the spouse had been at Pt #1 bed side all day.
- -Staff #7 stated the daughter had very different expectations from what she understood the patient's desires were.
- -Staff #7 stated the patient declined to have her B/P check frequently "she only wanted what she wanted"
- -When staff #7 was questioned about the lack of documentation to reflect the patient's desire Staff #7 stated "we don't put it in the nurses notes because we are only going to do what the patient and Doctor want".

After review of documentation and interviews, the facility failed to insure physician documentation in a progress note indicating both he and the family had discussed and agreed upon a Do Not Resuscitate order. Without the progress note the patient remained a full code status. No resuscitation was attempted. Without the progress note the Registered Nurse could not pronounce the patient as dead. The facility did not follow policy #41.

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ST JOSEPH REGIONAL HEALTH CENTER ST JOSEPH REGIONAL HEALTH CENTER

2801 FRANCISCAN DR BRYAN, TX 77802 | Voluntary non-profit - Church

View hospital's federal Hospital Compare record

Report date Number of violations

March 5, 20121 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

No incomplete reports available.



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GULF COAST MEDICAL CENTER ->

Report No. 1506

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

GULF COAST MEDICAL CENTER 10141 US 59 NORTH WHARTON, TX 77488 March 1, 2012

VIOLATION: QAPI Tag No: A0263

Based on record review and interview the facility failed to provide documented evidence that an evaluation and analysis was conducted following an adverse patient outcome resulting in the death of a patient.

The facility failed to ensure patients leaving the facility for higher level of care were evaluated prior to transfer to ensure optimum health and quality of care is maintained during the transfer.

The facility failed to implement its quality policy to ensure adverse occurrences are evaluated and analyzed in an effort to improve and maintain quality of care and patient safety. Citing two(2) of two(2) patients identified in a complaint investigation TX 002 and TX 003.

Findings:

Review of complaint narative revealed allegations that on two occassions when two transferred patients arived at Hospital S from Hospital G, the patients were immediately assessed to be in critical condition requiring advanced cardiac life support when report from Hospital G and transport documentation reflected the patients were stable for transport.

(Refer to 482.21(a)(2) for details.).

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview the facility failed to provide documented evidence that an evaluation and analysis was conducted following an adverse patient outcome resulting in the death of a patient.

The facility failed to ensure patients leaving the facility for higher level of care were evaluated prior to transfer to ensure optimum health and quality of care is maintained during the transfer.

The facility failed to implement its quality policy to ensure adverse occurrences are evaluated and analyzed in an effort to improve and maintain quality of care and patient safety. Citing two(2) of two(2) patients identified in a complaint investigation TX 002 and TX 003.

Findings:

Review of complaint narative revealed allegations that on two occassions when two transferred patients arived at Hospital S from Hospital G, the patients were immediately assessed to be in critical condition requiring advanced cardiac life support when report from Hospital G

and transport documentation reflected the patients were stable for transport.

Review of the facility's curent policy titled Patient Safety Plan dated 8/11 documented the following information:

"The Patient Safety Program is an essential part of the hospital 's mission of providing exceptional care and services in a safe environment " . The purposes and objectives of this program are to:

Promote a patient safe environment through review of high-risk patient care processes, collection and analysis of adverse patient incident data, and routine investigation of significant adverse events.

Develop proactive patient safety risk reduction strategies based on the National Patient Safety Goals, Sentinel Events Alerts and other related guidelines or best practices.

Aggregate patient safety related data and information to improve professional and organizational performance with a focus on processes and systems.

Provide staff education related actual and potential medical and health care errors and utilize the knowledge gained to improve patient safety.

There was no evidence the facility investigated the circumstances surrounding two transferred patient complaints sent to the facility to by a receiving hospital. The patients were transferred in October 2011 and December 2011.

Review of clinical record for Patient (# 1) dated 10/4/11-10/7/11.

Review of demographic data revealed twenty (20) years old Patient (# 1) was 39 weeks pregnant with her first child.

Review of admission nursing notes revealed the following information:

On 10/4/11 at 6:40 am she was admitted to the hospital slabor and delivery suite for induction of labor.

There was documentation that the patient voided 80 cc (cubic centimeter) of yellow urine which tested with a trace of protein and 2+ of ketone. She had edema 1+ on both lower extremities up to her knees. Her hematology report dated 10/4/11 documented Patient (#1) had a Hemoglobin level of 7.3

Intravenous(IV) line was inserted and at 0723 bolus of Dextrose 5% Lactaid Ringers solution was administered. Cytotec 100 mcg was administered orally to induce labor.

Between the hours of 08:00 am and 12:27 pm on 10/4/11 Patient # 1 was started on oxygen via face mask. An amniotomy was done (artificial rupture of membranes) and she was given 4(four) milligrams of Zofran IV (Intra Venous) push.

Nurses 'notes at 08:30 made documentation that the patient complained of feeling cold, nauseous and that she was coughing and spitting up pink tinge mucous. There was documentation that the Obstetrician was aware. At 11:50 the patient complained of pain and an epidural was started, she voided 30 cc of urine. (Bolus IV fluid infusing since 07:30).

Further review revealed between 12:30 and 16:15 the patient 's blood pressure was dropping and remained with systolic 80-90 and diastolic in the 50s. Her heart rate remained elevated at 116-129. documented vital signs at 1315 blood pressure 90/50

There was documentation that Patient # 1 was having occasional episode of cough and spitting up pink tinge mucous.

Patient # 1 had a Foley catheter placed on 10/4/11 at 12:51.

At 16:50 the Foley was discontinued with 100 cc of dark urine in bag. IV fluid was still infusing.

Further review of the nurses 'notes revealed Patient #1 delivered a live male infant at 17:05 on 11/4/11. Blood pressure was 100/56, pulse 131, respiration 22. Placenta was delivered at 17:09 and the patient lost 600 cc of blood.

Patient #1 was transfused two units of packed Red Cells. There was documentation that the blood was transfused rapidly. The first unit started at 17:24 and the second unit started at 17:45. (Infused less than 30 minutes). Intra Venous fluid 500 mills bolus was also infusing.

Vital signs at that time were as follows: Blood pressure 80/31, heart rate 116, respiration 22, ten (10) Liters of oxygen via nasal catheter with oxygen saturation at 86%.

There was documentation that the patient was still coughing and spitting up pink tinge mucous. The second unit of blood was completed at 18:00. Foley catheter was re-inserted.

At 18:04 a portable chest x-ray was ordered. Oxygen saturation was 92% with oxygen via face mask. Blood pressure still very low (70/45). The patient complained of increased difficulty breathing, she was still coughing. Her color was pale; she had normal saline infusing at 30 cc (cubic centimeters) an hour.

At 18:20 Lactaid Ringers solution was infusing at 100 cc an hour. Her urinary out put was very low 45 cc (she received 1500ccs of fluid since 17:24).

Review of radiology report revealed a chest x-ray done on 10/4/11 at 6:15 pm. Reason for examination, cough.

diagnosis is [DIAGNOSÉS REDACTED]

Findings: There is mild Cardiomegaly with mild central vascular congestion. There are air space opacities throughout the right lung, most prominently in the right lower lung.

There is also left retro cardiac opacity. No pleural effusion or pneumothorax. No acute bony abnormality.

Impression: Opacities throughout the right lung as well as Left retro cardiac opacity, which may represent multifocal pneumonia or pulmonary edema.

Mild cardiomegaly with mild central vascular congestion

Review of nurses notes dated 10/4/11 revealed at 19:00 Patient (#1) was transferred to the Intensive Care Unit (ICU). She was on 10 liters of oxygen (O 2) via non re-breather mask. O 2 saturation was 86%. Blood pressure 128/64, pulse 132.

Review of Physician notes dated 10/4/11 documented the physician was consulted for respiratory distress and pneumonia. The physician summarized his findings as follows:

"the patient is in respiratory distress, afebrile, blood pressure 128/74, pulse 140-150 sinus tachycardia, oxygen saturation 70% -90% on non rebreather mask.

Lungs: bibasilar rales with ronchi on right side all the way up. Rales in the left base. Increased respiratory rate and effort. Heart: tachycardia but regular. Bilateral pedal edema (1+). The patient was saying she wanted to sit up because she could not breathe". The physician's plan was for intubation and multiple medications

Review of ICU nursing documentation timed at 1930-00:00 revealed the following information:

No other time was noted on the narrative. There was documentation that the physicians were aware of the patient 's condition and orders were administered per prescribed order.

There was documentation that the physician placed a central line. The patient remained pale, she was afebrile, normal saline was infusing at 200 cc an hour. There were decreased breath sounds to the right side, she was restless, still coughing, had orange color secretions. Oxygen saturation in the 70-80s.(normal oxygen saturation is 100% on room air).

Propofol (sedative) was administered for light sedation. She was orally intubated and a nasogastric tube was placed.

The nurses 'notes documented that a portable x-ray was done. IV fluid was infusing at 200 cc an hour. Urinary output from 19:30 to midnight was 55 cc and from midnight to morning was 20 cc, physician aware.

Review of physician's notes dated 10/5/11 at 4:15 pm gave the following information:

"we tried to do pressure control ventilation unfortunately with this the patient desatted even further and could not tolerate. I increased the PEEP to 20 with the inverse ratio ventilation.

At the same time we increased her rocuronium. She was already on maximum dose of diprivan. With this her O 2 saturation started to slowly rise. She is currently holding at around 90% o2 saturation. blood pressure is 99/70 and heart rate around 135. She is on levophed at maximum dose, neo-synepherine at 40 mcg/kg/minute and vasopressin.

Lungs remain unchanged. It doesn 't' t sound as bad as what is seen on chest x-ray. She is now completely paralyzed.

Current ventilator settings: include "assist control rate of 18, tidal volume of 500, Fi02 of 100, PEEP(Positive End Expiratory Pressure) of 20 and peak flow of 25".

Review of Nurses notes dated 10/5/11 - 10/6/11 revealed documentation that Patient (# 1) remained sedated with increasing respiratory distress. She was suctioned copious amount of orange colored secretion. Her oxygen saturation fluctuated, heart rate in the 120s with low blood pressure. Urinary output remained low. The patient also developed low grade fever (100.5).

Nurse 's notes dated 10/7/11 at 07:15 documented that the patient was received sedated and paralyzed. She was still intubated and on a vent with PEEP at 12. She was on multiple IV medications.

Review of the Memorandum of Transfer (MOT) dated 10/7/11 revealed the facility requested Emergency Medical Personnel, Ventilator, Monitor and IV pumps. The patient was to be transferred for higher level of care due to respiratory distress.

On 10/7/11 at 12:00 there was documentation that a call was received from Hospital S, that the patient was accepted for admission. Report was called to Hospital S, and the facility 's contracted ambulance service was called.

There was documentation that at 13:00 the patient was transported out by the ambulance service. At that time her blood pressure was 122/77 and pulse 122, vasopressin 0.04 units per minute, ativan 2 mg an hour, normal saline at 100 cc an hour, Fentanyl at 25 mcg an hour and oxygen saturation at 92%. There was no documentation that the patient went out on a ventilator. There was no mention of the patient 's level of consciousness when she left the unit.

Review of physician orders revealed there were no documented physician 's instructions for the transfer.

Review of Intensive Care Unit (ICU) nurses notes dated 10/7/11 at 14:00 documented the patient was back on the unit due to decrease in oxygen saturation to 40 per EMS. Bag was initiated and the patient returned to room 808.

On arrival vital signs were as follows: blood pressure 112/76, pulse 129, respiration 31, pulse Oximetry 96% on ambu bag. The patient was placed back on the respirator at previous settings". No mention of the patient's level of consciousness.

When the patient returned to the ICU there was documentation of medication changes per verbal order. There was no documentation that the physician evaluated the patient 's condition after she returned to the ICU.

Further review of the nursing documentation revealed there were three entries on the document all timed at 16:00 with the following information:

- (1)16:00: patient transferred out by EMS to Hospital S with blood pressure of 100/73, pulse 117, respiration 23, oxygen saturation 100% with current ventilator setting settings.(last documentation on vent settings was on 10/7/11 at 0715).
- (2)1600: 'diprivan drip at 3 mcg, levophed drip at 16 mcg/min, arterial line to RRA good waveform peripheral nerve stimulator 44". Pupils

sluggishly reactive, sclera edema, no facial grimace to sternal rub.

Vasopressin drip at 0.04 units/min Normal saline 100ccan hour Po 2 saturation 100%. Nail bed blanching well, elevate head of bed, general swelling to body. Urine dark yellow, Sinus tachycardia.

(3)1600: Auscultated for breath sound, crackles present bilateral, O 2 saturation 100%. EMS here, family to follow.

There was no documentation of the patient's level of consciousness or wether or not she was stable for transfer. There was no documentation on the patient's respiratory status and the type of respiration support used to transport the patient from the facility to the accepting hospital. There was no documentation of the amount of oxygen support the patient was on.

Review of clinical record at Hospital S.

Review of the Patient's information flow sheet at Hospital S revealed Patient (#1) arrived at the facility on 10/7/11 at 16:52 and was placed in room 207 on the Intensive Care Unit.

Nurses 'notes documented the patient was received from Hospital G accompanied by ambulance attendants. The patient was being bagged by EMT.

The Ambulance attendants told nursing staff that when the patient was placed on the ventilator she was desaturating and the balloon on the Endo Tracheal Tube (ETT) was deflated to make bagging easier.

On 10/7/11 at 17:02 blood pressure dropped in the 50s and heart rate 55. Two physicians on the floor rushed to the patient 's room.

The Levophed drip was increased. While attempting to check for Carotid pulse, noted patient 's neck and upper chest with subcutaneous emphysema.

Physician at bedside, stat chest X-ray ordered. A- line on right wrist with poor wave form, unable to obtain blood pressure, no pulse audible or palpable.

At 17:12 Patient(#1) was received with ETT(Endo Tracheal Tube) Pilot deflated. Pilot Cuff re-inflated. Ventilator initialized, then 100% Ambu Bag used for Cardio Pulmonary Resuscitation (CPR).

History and Physical dated 10/7/11 by Physician D at Hospital S documented that when the patient arrived at Hospital S, she was hypoxic and dropped her oxygenation. She was also hypotensive. They could not feel her pulse initially and CPR was started right away. She regained her pulse but was also found to have subcutaneous emphysema; she was connected to a ventilator, although she had a very high peak pressure, the stat chest x-ray done at that time showed bilateral large pneumothorax. Bilateral chest tubes were placed immediately at the bedside.

She was on norepinepherine and vasopressin drip, she was given multiple rounds of epinephrine, atropine and CPR was resumed. Through out the course she remained in PEA (Pulseless Electrical Activity). CPR continued for more than an hour the patient never regained her pulse and despite all the efforts there was no change in her status. The patient was pronounced dead at 6:20 pm on October 7, 2011.

Review of Radiology Report at Hospital S documented the following information: Chest examinationDATED 10/7/11

- 1. There are large bilateral pneumothroaces. The lungs are partially collapsed as a result of the pneumothroaces limiting evaluation of the lung parenchyma. No pneumothorax is seen. There is subcutaneous emphysema in the neck and right chest wall.
- 2. Impression: large bilateral pneumothroaces. (information was urgently communicated to the clinical team)
- 3. Subcutaneous emphysema
- 4. endotracheal tube tip approximately 2 cm to the carina.

Review of EMS first report

Review of EMS run sheet revealed the following information:

Arrived on location to find patient sedated and on ventilator. Diagnosis was [DIAGNOSES REDACTED]]).

Patient was on multiple drips, vasopressin, levophed, propofol, fenrtanyl, and normal saline. Patient was moved from bed and placed on portable vent with setting of RR 22, Vt-500,100% O 2. Peak pressure-50.

When patient was moved to EMS vent noted pink fluid in tube. Suction patient 's tube with little return. As the patient was loaded into the ambulance the monitor started to beep. The SPo2 was dropping, the vent was working properly. EMT got help from ER Nurse, EMT staff told the Nurse they had to take the patient back to the ICU to be re-evaluated.

The patient was unloaded from the ambulance and taken to the ER, when EMT staff started to use BMV(bag mask valve) to ventilate the patient with great success, the patient 's saturation went to the high 90s. Patient(#1) was taken back to the ICU and placed on bed (8). Care was transferred to the unit 's nurses.

There was no documentation on the nurses or physicians' notes at Hospital G that the EMT took the patient to their emergency room and what intervention if any was performed by hospital personnel.

Second report

Patient was being transferred to Hospital S, for need of a Pulmonologist for ARDS([DIAGNOSES REDACTED]). The patient was on a ventilator and on multiple IV medications. Patient 's nurse stated that the patient 's O 2 saturation has been 100% for a long time.

"Moved patient from bed to stretcher. Patient was taken off of ICU 's ventilator and ventilation. Bag Mask Valve (BMV) was started by EMT. Loaded patient into ambulance".

The EMT documented they unloaded the patient from the ambulance and took her to the ER at Hospital S(should have taken patient to the ICU, because the patient was a direct admission).

Staff in ER wanted to register the patient. EMT documented that they told ER staff to take the patient quickly to her room because of the lack of oxygen. The portable cylinder could hold 1000 pounds of oxygen. and the patient was receiving 15 liters an hour.

The report documented that Respiratory Therapist at Hospital S told the EMT they were bagging the patient too slowly and took over the bagging.

The patient was still on the monitor the patient was transferred on. Nurses and physicians were in attendance trying to find a pulse they could not, and CPR was started.

Patient # 2

Review of nurses 'notes dated 12/14/11 documented patient was admitted to the unit at 1810 from the emergency room. She was alert; the patient was hypotensive (low blood pressure) and had generalized edema of the whole body. Patient had multiple whelps on body but no skin breakdown.

Review of nurses notes dated 12/17/11 at 1930 revealed the following information:

Received patient obtunded. Open eyes to sternal rub, makes grunting sound.

12/18/11 at 0745 patient received lethargic, eyes opened at times. Right groin triple lumen site healthy. Pupils remain unequal.

Physician's progress notes dated 12/18/11 documented the patient to be transferred to Hospital S today.

Nurses ' notes on 12/18/11 at 0830 documented " spoke with nurse at Hospital S, clinical report regarding transfer given to the nurse; she will call when a bed is ready '.

Nurses ' notes dated 12/18/11 at 12:00 blood pressure 91/50, rechecked and confirmed. Physician informed new order received and initiated. Started normal saline bolus 250 wide open at 12:10, blood pressure dropped to 72/55. Patient was asymptomatic and when asked how she feels mumbled " okay " . Pupils remain unchanged.

At 12:30 blood pressure 117/50, no sign or symptom of respiratory distress noted.

Called transfer center to check on status, nurse stated the patient was accepted but still awaiting a bed.

At 15:00 no changes in neurological status, pupils still unequal, sluggish, altered mental status, no seizure activity noted. Received call from the transfer center. Report given at 15:45.

Review of the facility 's Memorandum of Transfer (MOT) dated 12/18/11 revealed a request was made for EMS, O 2, EKG, IV and EMT Personnel.

Further review of the nurses notes dated 12/18/11 revealed documentation that at 16:30 the patient left the unit by stretcher with EMS without incident.

There was no documentation that the physician evaluated the patient after her drop in blood pressure. No documented vital signs or assessment at time of transfer.

No documentation that Patient (#2) was transferred with the required medical equipment that was requested to ensure optimum medical stability during the transfer. There was no documentation from 0745 to 16:30 when the patient left the unit that she was receiving oxygen.

There was no documentation regarding her oxygen saturation status. On admission there was documentation that the patient had edema of her entire body, there was no mention in the nurses noted dated 12/18/11 between the hours of 07:45 and 16:30 when she left the unit.

Patient is a [AGE] year old lying in bed responsive to verbal stimuli only. ICU nurse stated that the patient had been admitted because of neurological changes. Patient on O 2 at 2 LPM with oxygen saturation in the 90s.

According to the nursing staff that was normal for her. IV with Clinimix. Patient was transported to the ICU without incident. Condition remains unchanged.

Review of Discharge Summary from Hospital S dated 2/29/12 documented:

Patient # 2 was transferred from Hospital G on 12/18/11 to be treated for [DIAGNOSES REDACTED] The transferring staff told the facility that the patient was hemodynamically stable at the time of transfer. On arrival at Hospital S, the patient was hypotensive (low blood pressure), and was in respiratory distress.

There was also bleeding from the central venous catheter site. emergency room (ER) physician was called in and the patient was intubated and a new central line was placed. The bleeding was controlled.

During an interview on 3/1/12 at 10:15 am with Staff # 52 RN that transferred the patient, she stated she could not re call if the patient was transferred on ventilator or not. She reviewed the record but was not able to tell whether or not the patient left the unit on a ventilator.

During an interview on 3/1/11 at 9:30 am with Physician # 53(Hospitalist) he stated the patient was initially in his care and was taken over by physicians from his group. The physician stated a transfer order should have been written. He further stated the patient was not stable enough to be transferred prior to the time she was transferred. (The patient's stability was never evaluated prior to transfer).

During an interview on 2/29/12 at 3:00 pm with Physician # (50) Obstetrician she stated there was a breakdown in communication, she was not informed when the patient was being transferred from the facility. The physician stated she would have ensured the patient was appropriately transferred to the receiving hospital.

Physician (# 50) stated the patient should have been transferred by air ambulance instead of ground transport especially after the patient desaturated and had to be returned to the unit.

During an interview on 2/29/12 at 1:35 pm with the Chief Nursing Officer she stated she wanted the patient to be transferred by air ambulance but the order was for ground ambulance. The Chief Nursing officer also stated "Administrative personnel were not aware until after the fact that the patient was transferred out without the ventilator. She further stated patients like those did not do well with bagging "

During the interview with the Chief Nursing Officer (CNO) she stated an official root cause analysis was not conducted. She also stated a Peer review was not done because all the physicians involved felt Patient # (1) had an amniotic embolus and if that was the case nothing could be done for her.

According to the CNO an unofficial review of the record was done and some issues with documentation was identified, she further stated there was no official analysis of the record and no plans were implemented.

During an interview on 3/1/12 at 11:35 am with the Director of the ambulance service, he gave the following information:

The Ambulance Service did not have PEEP (Positive End Expiratory Pressure) capability on their ventilators. The request was made for a vent, PEEP capability was not ordered.

During the interview on 3/1/12 at 11:25 am with the Director of the Ambulance Service he stated the EMT personnel initially took the patient from the unit on a portable vent. When EMT personnel arrived downstairs to the ambulance the patient began to desaturate, her oxygen saturation dropped and they had to get the ER personnel to assist. After two hours had elapsed the EMT personnel were called to transport the patient. There was a discussion with Nurses on the floor and the EMT and nurses decided that since the patient did well on the BVM with PEEP the patient would be transported with the BVM instead of the ventilator.

(There was no assessment by the physician to determine the patient's respiratory status and the type of respiratory support that was needed for the transfer).

VIOLATION: DISCHARGE PLANNING

Based on record review, and interview the facility failed to implement its discharge policy and procedure to ensure critically ill patients who required specialized life saving intervention at another facility was transferred to that facility in a timely manner with the necessary life sustaining equipment needed to maintain the patient in optimal condition during the transfer process;

Tag No: A0799

Tag No: A0837

The facility's physicians and nurses failed to evaluate and develop a plan of care for the patients prior to transfer to determine the appropriate care, and equipment needed during the transfer, citing two patients identified in complaint investigation TX 002 & TX 003 patient #s 1 and 2.

Findings:

Review of complaint narative revealed allegations that on two occassions when two transferred patients arived at Hospital S from Hospital G, the patients were immediately assessed to be in critical condition requiring advanced cardiac life support when report from Hospital G and transport documentation reflected the patients were stable for transport.

(Refer to 482.43(d) fo details.)

VIOLATION: TRANSFER OR REFERRAL

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review, and interview the facility failed to implement its discharge policy and procedure to ensure critically ill patients who required specialized life saving intervention at another facility was transferred to that facility in a timely manner with the necessary life sustaining equipment needed to maintain the patient in optimal condition during the transfer process;

The facility's physicians and nurses failed to evaluate and develop a plan of care for the patients prior to transfer to determine the appropriate care, and equipment needed during the transfer, citing two (2) of two (2) patients identified in a complaint investigation TX 002 & TX 003 patient #s 1 and 2.

Findings:

Review of complaint narative revealed allegations that on two occassions when two transferred patients arived at Hospital S from Hospital G, the patients were immediately assessed to be in critical condition requiring advanced cardiac life support when report from Hospital G and transport documentation reflected the patients were stable for transport.

Review of the facility's Current Discharge Planning Policy # 900-326 revised 5/08 documented the following information:

"Discharge Planning will be integrated with the interdisciplinary department to assure collaboration of services of discharge planning. Discharge Planning will ensure that the patient will be assisted in regaining optimum level of functioning by identifying the patients' continuing physical, emotional, symptom management (for example: pain, nausea, dysphasia) housekeeping, transportation, social and other needs and arranges for services to meet them.

The relationship of Discharge Planning with other departments is as follows:

The physician will make referrals for discharge planning needs and make recommendations for the plan of care. He/She is responsible for written orders for same.

Documentation

Communication between appropriate disciplines regarding the discharge planning process will be documented on the physician progress notes. This mechanism serves as a means of communication with the physician and other members of the healthcare team any clinical/financial /psychological issues related to discharge. Patient and family education is documented on the discharge summary. The discharge instruction sheet is given to the patient at the time of discharge and a copy is retained in the medical record".

Review of clinical record for Patient (# 1) dated 10/4/11-10/7/11.

Review of demographic data revealed twenty (20) years old Patient (# 1) was 39 weeks pregnant with her first child.

Review of admission nursing notes revealed the following information:

On 10/4/11 at 6:40 am she was admitted to the hospital slabor and delivery suite for induction of labor.

There was documentation that the patient voided 80 cc (cubic centimeter) of yellow urine which tested with a trace of protein and 2+ of ketone. She had edema 1+ on both lower extremities up to her knees. Her hematology report dated 10/4/11 documented Patient (# 1) had a Hemoglobin level of 7.3

Intravenous(IV) line was inserted and at 0723 bolus of Dextrose 5% Lactaid Ringers solution was administered. Cytotec 100 mcg was administered orally to induce labor.

Between the hours of 08:00 am and 12:27 pm on 10/4/11 Patient # 1 was started on oxygen via face mask. An amniotomy was done (artificial rupture of membranes) and she was given 4(four) milligrams of Zofran IV (Intra Venous) push.

Nurses 'notes at 08:30 made documentation that the patient complained of feeling cold, nauseous and that she was coughing and spitting up pink tinge mucous. There was documentation that the Obstetrician was aware. At 11:50 the patient complained of pain and an epidural was started, she voided 30 cc of urine. (Bolus IV fluid infusing since 07:30).

Further review revealed between 12:30 and 16:15 the patient 's blood pressure was dropping and remained with systolic 80-90 and diastolic in the 50s. Her heart rate remained elevated at 116-129. documented vital signs at 1315 blood pressure 90/50

There was documentation that Patient # 1 was having occasional episode of cough and spitting up pink tinge mucous.

Patient # 1 had a Foley catheter placed on 10/4/11 at 12:51.

At 16:50 the Foley was discontinued with 100 cc of dark urine in bag. IV fluid was still infusing.

Further review of the nurses 'notes revealed Patient #1 delivered a live male infant at 17:05 on 11/4/11. Blood pressure was 100/56, pulse 131, respiration 22. Placenta was delivered at 17:09 and the patient lost 600 cc of blood.

Patient #1 was transfused two units of packed Red Cells. There was documentation that the blood was transfused rapidly. The first unit started at 17:24 and the second unit started at 17:45. (Infused less than 30 minutes). Intra Venous fluid 500 mills bolus was also infusing.

Vital signs at that time were as follows: Blood pressure 80/31, heart rate 116, respiration 22, ten (10) Liters of oxygen via nasal catheter with oxygen saturation at 86%.

There was documentation that the patient was still coughing and spitting up pink tinge mucous. The second unit of blood was completed at 18:00. Foley catheter was re-inserted.

At 18:04 a portable chest x-ray was ordered. Oxygen saturation was 92% with oxygen via face mask. Blood pressure still very low (70/45). The patient complained of increased difficulty breathing, she was still coughing. Her color was pale; she had normal saline infusing at 30 cc (cubic centimeters) an hour.

At 18:20 Lactaid Ringers solution was infusing at 100 cc an hour. Her urinary out put was very low 45 cc (she received 1500ccs of fluid since 17:24).

Review of radiology report revealed a chest x-ray done on 10/4/11 at 6:15 pm.

Reason for examination, cough.

diagnosis is [DIAGNOSES REDACTED]

Findings: There is mild Cardiomegaly with mild central vascular congestion. There are air space opacities throughout the right lung, most prominently in the right lower lung.

There is also left retro cardiac opacity. No pleural effusion or pneumothorax. No acute bony abnormality.

Impression: Opacities throughout the right lung as well as Left retro cardiac opacity, which may represent multifocal pneumonia or pulmonary edema.

Mild cardiomegaly with mild central vascular congestion

Review of nurses notes dated 10/4/11 revealed at 19:00 Patient (#1) was transferred to the Intensive Care Unit (ICU). She was on 10 liters of oxygen (O 2) via non re-breather mask. O 2 saturation was 86%. Blood pressure 128/64, pulse 132.

Review of Physician notes dated 10/4/11 documented the physician was consulted for respiratory distress and pneumonia. The physician

summarized his findings as follows:

"the patient is in respiratory distress, afebrile, blood pressure 128/74, pulse 140-150 sinus tachycardia, oxygen saturation 70% -90% on non rebreather mask.

Lungs: bibasilar rales with ronchi on right side all the way up. Rales in the left base. Increased respiratory rate and effort. Heart: tachycardia but regular. Bilateral pedal edema (1+). The patient was saying she wanted to sit up because she could not breathe". The physician's plan was for intubation and multiple medications

Review of ICU nursing documentation timed at 1930-00:00 revealed the following information:

No other time was noted on the narrative. There was documentation that the physicians were aware of the patient 's condition and orders were administered per prescribed order.

There was documentation that the physician placed a central line. The patient remained pale, she was afebrile, normal saline was infusing at 200 cc an hour. There were decreased breath sounds to the right side, she was restless, still coughing, had orange color secretions. Oxygen saturation in the 70-80s.(normal oxygen saturation is 100% on room air).

Propofol (sedative) was administered for light sedation. She was orally intubated and a nasogastric tube was placed.

The nurses 'notes documented that a portable x-ray was done. IV fluid was infusing at 200 cc an hour. Urinary output from 19:30 to midnight was 55 cc and from midnight to morning was 20 cc, physician aware.

Review of physician's notes dated 10/5/11 at 4:15 pm gave the following information:

"we tried to do pressure control ventilation unfortunately with this the patient desatted even further and could not tolerate. I increased the PEEP to 20 with the inverse ratio ventilation.

At the same time we increased her rocuronium. She was already on maximum dose of diprivan. With this her O 2 saturation started to slowly rise. She is currently holding at around 90% o2 saturation. blood pressure is 99/70 and heart rate around 135. She is on levophed at maximum dose, neo-synepherine at 40 mcg/kg/minute and vasopressin.

Lungs remain unchanged. It doesn 't' t sound as bad as what is seen on chest x-ray. She is now completely paralyzed.

Current ventilator settings: include "assist control rate of 18, tidal volume of 500, Fi02 of 100, PEEP(Positive End Expiratory Pressure) of 20 and peak flow of 25".

Review of Nurses notes dated 10/5/11 - 10/6/11 revealed documentation that Patient (# 1) remained sedated with increasing respiratory distress. She was suctioned copious amount of orange colored secretion. Her oxygen saturation fluctuated, heart rate in the 120s with low blood pressure. Urinary output remained low. The patient also developed low grade fever (100.5).

Nurse 's notes dated 10/7/11 at 07:15 documented that the patient was received sedated and paralyzed. She was still intubated and on a vent with PEEP at 12. She was on multiple IV medications.

Review of the Memorandum of Transfer (MOT) dated 10/7/11 revealed the facility requested Emergency Medical Personnel, Ventilator, Monitor and IV pumps. The patient was to be transferred for higher level of care due to respiratory distress.

On 10/7/11 at 12:00 there was documentation that a call was received from Hospital S, that the patient was accepted for admission. Report was called to Hospital S, and the facility 's contracted ambulance service was called.

There was documentation that at 13:00 the patient was transported out by the ambulance service. At that time her blood pressure was 122/77 and pulse 122, vasopressin 0.04 units per minute, ativan 2 mg an hour, normal saline at 100 cc an hour, Fentanyl at 25 mcg an hour and oxygen saturation at 92%. There was no documentation that the patient went out on a ventilator. There was no mention of the patient 's level of consciousness when she left the unit.

Review of physician orders revealed there were no documented physician 's instructions for the transfer.

Review of Intensive Care Unit (ICU) nurses notes dated 10/7/11 at 14:00 documented the patient was back on the unit due to decrease in oxygen saturation to 40 per EMS. Bag was initiated and the patient returned to room 808.

On arrival vital signs were as follows: blood pressure 112/76, pulse 129, respiration 31, pulse Oximetry 96% on ambu bag. The patient was placed back on the respirator at previous settings". No mention of the patient's level of consciousness.

When the patient returned to the ICU there was documentation of medication changes per verbal order. There was no documentation that the physician evaluated the patient 's condition after she returned to the ICU.

Further review of the nursing documentation revealed there were three entries on the document all timed at 16:00 with the following information:

(1)16:00: patient transferred out by EMS to Hospital S with blood pressure of 100/73, pulse 117, respiration 23, oxygen saturation 100% with current ventilator setting settings.(last documentation on vent settings was on 10/7/11 at 0715).

(2)1600: 'diprivan drip at 3 mcg, levophed drip at 16 mcg/min, arterial line to RRA good waveform peripheral nerve stimulator 44". Pupils sluggishly reactive, sclera edema, no facial grimace to sternal rub.

Vasopressin drip at 0.04 units/min Normal saline 100ccan hour Po 2 saturation 100%. Nail bed blanching well, elevate head of bed, general swelling to body. Urine dark yellow, Sinus tachycardia.

(3)1600: Auscultated for breath sound, crackles present bilateral, O 2 saturation 100%. EMS here, family to follow.

There was no documentation of the patient's level of consciousness or wether or not she was stable for transfer. There was no documentation on the patient's respiratory status and the type of respiration support used to transport the patient from the facility to the

accepting hospital. There was no documentation of the amount of oxygen support the patient was on.

Review of clinical record at Hospital S.

Review of the Patient's information flow sheet at Hospital S revealed Patient (#1) arrived at the facility on 10/7/11 at 16:52 and was placed in room 207 on the Intensive Care Unit.

Nurses ' notes documented the patient was received from Hospital G accompanied by ambulance attendants. The patient was being bagged by EMT.

The Ambulance attendants told nursing staff that when the patient was placed on the ventilator she was desaturating and the balloon on the Endo Tracheal Tube (ETT) was deflated to make bagging easier.

On 10/7/11 at 17:02 blood pressure dropped in the 50s and heart rate 55. Two physicians on the floor rushed to the patient 's room.

The Levophed drip was increased. While attempting to check for Carotid pulse, noted patient 's neck and upper chest with subcutaneous emphysema.

Physician at bedside, stat chest X-ray ordered. A- line on right wrist with poor wave form, unable to obtain blood pressure, no pulse audible or palpable.

At 17:12 Patient(#1) was received with ETT(Endo Tracheal Tube) Pilot deflated. Pilot Cuff re-inflated. Ventilator initialized, then 100% Ambu Bag used for Cardio Pulmonary Resuscitation (CPR).

History and Physical dated 10/7/11 by Physician D at Hospital S documented that when the patient arrived at Hospital S, she was hypoxic and dropped her oxygenation. She was also hypotensive. They could not feel her pulse initially and CPR was started right away. She regained her pulse but was also found to have subcutaneous emphysema; she was connected to a ventilator, although she had a very high peak pressure, the stat chest x-ray done at that time showed bilateral large pneumothorax. Bilateral chest tubes were placed immediately at the bedside.

She was on norepinepherine and vasopressin drip, she was given multiple rounds of epinephrine, atropine and CPR was resumed. Through out the course she remained in PEA (Pulseless Electrical Activity). CPR continued for more than an hour the patient never regained her pulse and despite all the efforts there was no change in her status. The patient was pronounced dead at 6:20 pm on October 7, 2011.

Review of Radiology Report at Hospital S documented the following information:

Chest examination dated 10/7/11

- 1. There are large bilateral pneumothroaces. The lungs are partially collapsed as a result of the pneumothroaces limiting evaluation of the lung parenchyma. No pneumothorax is seen. There is subcutaneous emphysema in the neck and right chest wall.
- 2. Impression: large bilateral pneumothroaces.(information was urgently communicated to the clinical team)
- 3. Subcutaneous emphysema
- 4. endotracheal tube tip approximately 2 cm to the carina.

Review of EMS first report

Review of EMS run sheet revealed the following information:

Arrived on location to find patient sedated and on ventilator. Diagnosis was [DIAGNOSES REDACTED]]).

Patient was on multiple drips, vasopressin, levophed, propofol, fenrtanyl, and normal saline. Patient was moved from bed and placed on portable vent with setting of RR 22, Vt-500,100% O 2. Peak pressure-50.

When patient was moved to EMS vent noted pink fluid in tube. Suction patient 's tube with little return. As the patient was loaded into the ambulance the monitor started to beep. The SPo2 was dropping, the vent was working properly. EMT got help from ER Nurse, EMT staff told the Nurse they had to take the patient back to the ICU to be re-evaluated.

The patient was unloaded from the ambulance and taken to the ER, when EMT staff started to use BMV(bag mask valve) to ventilate the patient with great success, the patient 's saturation went to the high 90s. Patient(#1) was taken back to the ICU and placed on bed (8). Care was transferred to the unit 's nurses.

There was no documentation on the nurses or physicians' notes at Hospital G that the EMT took the patient to their emergency room and what intervention if any was performed by hospital personnel.

Second report

Patient was being transferred to Hospital S, for need of a Pulmonologist for ARDS([DIAGNOSES REDACTED]). The patient was on a ventilator and on multiple IV medications. Patient 's nurse stated that the patient 's O 2 saturation has been 100% for a long time.

"Moved patient from bed to stretcher. Patient was taken off of ICU 's ventilator and ventilation. Bag Mask Valve (BMV) was started by EMT. Loaded patient into ambulance".

The EMT documented they unloaded the patient from the ambulance and took her to the ER at Hospital S(should have taken patient to the ICU, because the patient was a direct admission).

Staff in ER wanted to register the patient. EMT documented that they told ER staff to take the patient quickly to her room because of the lack of oxygen. The portable cylinder could hold 1000 pounds of oxygen. and the patient was receiving 15 liters an hour.

The report documented that Respiratory Therapist at Hospital S told the EMT they were bagging the patient too slowly and took over the bagging.

The patient was still on the monitor the patient was transferred on. Nurses and physicians were in attendance trying to find a pulse they could not, and CPR was started.

Patient # 2

Review of nurses 'notes dated 12/14/11 documented patient was admitted to the unit at 1810 from the emergency room. She was alert; the patient was hypotensive (low blood pressure) and had generalized edema of the whole body. Patient had multiple whelps on body but no skin breakdown.

Review of nurses notes dated 12/17/11 at 1930 revealed the following information:

Received patient obtunded. Open eyes to sternal rub, makes grunting sound.

12/18/11 at 0745 patient received lethargic, eyes opened at times. Right groin triple lumen site healthy. Pupils remain unequal.

Physician 's progress notes dated 12/18/11 documented the patient to be transferred to Hospital S today.

Nurses ' notes on 12/18/11 at 0830 documented " spoke with nurse at Hospital S, clinical report regarding transfer given to the nurse; she will call when a bed is ready '.

Nurses ' notes dated 12/18/11 at 12:00 blood pressure 91/50, rechecked and confirmed. Physician informed new order received and initiated. Started normal saline bolus 250 wide open at 12:10, blood pressure dropped to 72/55. Patient was asymptomatic and when asked how she feels mumbled " okay " . Pupils remain unchanged.

At 12:30 blood pressure 117/50, no sign or symptom of respiratory distress noted.

Called transfer center to check on status, nurse stated the patient was accepted but still awaiting a bed.

At 15:00 no changes in neurological status, pupils still unequal, sluggish, altered mental status, no seizure activity noted. Received call from the transfer center. Report given at 15:45.

Review of the facility 's Memorandum of Transfer (MOT) dated 12/18/11 revealed a request was made for EMS, O 2, EKG, IV and EMT Personnel.

Further review of the nurses notes dated 12/18/11 revealed documentation that at 16:30 the patient left the unit by stretcher with EMS without incident.

There was no documentation that the physician evaluated the patient after her drop in blood pressure. No documented vital signs or assessment at time of transfer.

No documentation that Patient (#2) was transferred with the required medical equipment that was requested to ensure optimum medical stability during the transfer. There was no documentation from 0745 to 16:30 when the patient left the unit that she was receiving oxygen. There was no documentation regarding her oxygen saturation status. On admission there was documentation that the patient had edema of her entire body, there was no mention in the nurses noted dated 12/18/11 between the hours of 07:45 and 16:30 when she left the unit.

Patient is a [AGE] year old lying in bed responsive to verbal stimuli only. ICU nurse stated that the patient had been admitted because of neurological changes. Patient on O 2 at 2 LPM with oxygen saturation in the 90s.

According to the nursing staff that was normal for her. IV with Clinimix. Patient was transported to the ICU without incident. Condition remains unchanged.

Review of Discharge Summary from Hospital S dated 2/29/12 documented:

Patient # 2 was transferred from Hospital G on 12/18/11 to be treated for [DIAGNOSES REDACTED] The transferring staff told the facility that the patient was hemodynamically stable at the time of transfer. On arrival at Hospital S, the patient was hypotensive (low blood pressure), and was in respiratory distress.

There was also bleeding from the central venous catheter site. emergency room (ER) physician was called in and the patient was intubated and a new central line was placed. The bleeding was controlled.

Review of policy

Policy #900-338 titled Transfer of patients from GCMC to another facility dated 5/2008 documented the following information:

"The transferring physician must personally examine and evaluate the patient before an attempt to transfer is made.

The transferring physician shall determine and order life support measures which are medically appropriate to stabilize the patient prior to transfer and to sustain the patient during the transfer.

The transferring physician shall determine and order the utilization of appropriate personnel and aguirment for transfer.

The transferring physician shall determine and order the utilization of appropriate personnel and equipment for transfer.

In determining the use of medically appropriate life support measures, personnel, and equipment, the transferring physician shall exercise that degree of care which a reasonable and prudent physician exercising ordinary care in the same or similar locality would use for the transfer.

If a patient at a hospital has an emergency medical condition which has not been stabilized or when stabilization of the patient 's vital sign is not possible because the hospital or emergency department does not have the appropriate equipment or personnel to correct the underlying process, evaluation and treatment should be performed and transfer should be carried out as quickly as possible."

During an interview on 3/1/12 at 10:15 am with Staff # 52 RN that transferred the patient, she stated she could not re call if the patient was transferred on ventilator. She reviewed the record but was not able to tell whether or not the patient left the unit on a ventilator.

During an interview on 3/1/11 at 9:30 am with Physician # 53(Hospitalist) he stated the patient was initially in his care and was taken over

by physicians from his group. The physician stated a transfer order should have been written. He further stated the patient was not stable enough to be transferred prior to the time she was transferred. (The patient's stability was never evaluated prior to transfer).

During an interview on 2/29/12 at 3:00 pm with Physician # (50) Obstetrician she stated there was a breakdown in communication, she was not informed when the patient was being transferred from the facility. The physician stated she would have ensured the patient was appropriately transferred.

Physician (# 50) stated the patient should have been transferred by air ambulance instead of ground transport especially after the patient desaturated and had to be returned to the unit.

During an interview on 2/29/12 at 1:35 pm with the Chief Nursing Officer she stated she wanted the patient to be transferred by air ambulance but the order was for ground ambulance. The Chief Nursing officer also stated "Administrative personnel were not aware until after the fact that the patient was transferred out without the vent. She further stated patients like those did not do well with bagging ".

During an interview on 3/1/12 at 11:35 am with the Director of the ambulance service, he gave the following information:

The Ambulance Service did not have PEEP (Positive End Expiratory Pressure) capability on their ventilators. The request was made for a vent, PEEP capability was not ordered.

During the interview on 3/1/12 at 11:25 am with the Director of the Ambulance Service he stated the EMT personnel initially took the patient from the unit on a portable vent. When EMT personnel arrived downstairs to the ambulance the patient began to desaturate, her oxygen saturation dropped and they had to get the ER personnel to assist. After two hours had elapsed the EMT personnel were called to transport the patient. There was a discussion with Nurses on the floor and the EMT and nurses decided that since the patient did well on the BVM with PEEP the patient would be transported with the BVM instead of the ventilator.

(There was no assessment by the physician to determine the patient's respiratory status and the type of respiratory support that was needed for the transfer).



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Report date Number of violations

March 1, 20124 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. Incomplete reports

No incomplete reports available.



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BROWNWOOD REGIONAL MEDICAL CENTER ->

Report No. 1530

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

BROWNWOOD REGIONAL MEDICAL CENTER

1501 BURNET DR BROWNWOOD, TX 76801

Feb. 28, 2012

VIOLATION: PATIENT RIGHTS: CONFIDENTIALITY OF RECORDS

Tag No: A0147

Based on review of documentation and interview with staff, it was determined the facility failed to maintain the privacy and confidentiality of patient information as departmental reports with patient identifiers were taken out of the facility. The facility also failed to follow its own policies and procedures.

Findings included:

A review of facility policy #900-RI-06 entitled, "Patient Rights" stated "Brownwood Regional Medical Center respects the rights of patients..." Further review of the policy revealed, "Rules: 3. Patient rights are summarized below E. To security, personal privacy and confidentiality of information."

A review of facility policy #909-MI-19 entitled, "HIPAA Security" stated "Disciplinary action for breaches of confidentiality will be addressed through Information Security Violations standards established by the Multi-Facility and Facility Security Committees. Minimally, standards should reflect the violation guidelines outlined in the procedure below..." Further review of the policy revealed, "Rules: 1. Employees: Employees found in violation of Appropriate Access policies will be confronted with the violation by their manager and the HIPAA Security Official or designee."

In an interview with staff member #2 on 2/28/2012 at 11:30am, it was confirmed that a departmental report was taken home which had patient labels on the documents. Staff member #2 mentioned the report was "how many billable treatments per man hours."



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Report date Number of violations

Feb. 28, 20121 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. Incomplete reports

No incomplete reports available.



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DOCTORS HOSPITAL AT RENAISSANCE ->

Report No. 1580

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

DOCTORS HOSPITAL AT RENAISSANCE

5501 SOUTH MCCOLL EDINBURG, TX 78539

Feb. 28, 2012

Tag No: A0115

VIOLATION: PATIENT RIGHTS

Based on staff interviews, review of video surveillance and record reviews, the facility failed to protect and promote the rights of patient #1 because staff did not follow facility policy and procedure on the use of restraints and seclusion during the 02/19/12 restraint of patient #1.

Although the facility terminated RN #1 due to her inappropriate restraint and failiure to appropriately document the restraint of patient #1, as of 02/28/12, patient #1 remained in the facility and all staff who participated in the restraint have not been retrained on following facility policy and procedures on the use of restraints and seclusion. Patient #1 continued to display verbal and physical aggression that could require restraint and/or seclusion after the 02/19/12 restraint.

Cross Reference CFR 482.13 (e).

VIOLATION: USE OF RESTRAINT OR SECLUSION

Tag No: A0154

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on staff interviews, review of video surveillance, and record reviews, the facility failed to follow their own policy and procedure on Restraint and Seclusion of Patients. The facility failed to obtain a physician's order after the use of behavioral restraints on 02/19/12 for one of one restrained patients (patient #1). After terminating the employment of one registered nurse (RN#1) due to not following the facility policy and procedure on the use of restraints, the facility failed to retrain all staff who were involved in the application of the restraint to patient #1. Patient #1 remained in the facility as of 02/28/12 and continued to display verbal and physical aggression that had required a restraint on 02/27/12.

Findings included:

Interview in the administrative conference room on 02/28/12 at 10:30 AM with Director of Clinical Services revealed that she and other administrative staff were familiar with the complaint regarding the 02/19/12 restraint of patient #1 and the facility was still in the process of completing their investigation. She stated the facility terminated the employment of RN #1 on 02/27/12. She stated they have not completed other personnel actions or retrained all staff on the use of restraints. She confirmed that other staff involved in the restraint of patient #1 continue to work at the facility.

Interview in the nursing supervisor's office on 02/28/12 at 10:45 AM with the Program Manager for the Adult/Geriatric Unit revealed that patient #1 asked to speak with her on Monday 02/21/12. She stated patient #1 reported a nurse (RN #1) "restrained her and in the process choked her and threatened to medicate her if she did not start behaving." The Program Manager questioned staff that was on duty at the time of the restraint and was able to get written statements from all staff involved; she had submitted them to Risk

Management to help with the facility investigation. She's stated that RN #1's employment had been terminated. The Program Manager stated that she had been conducting re-training of staff on proper documentation and the application of restraints but has not documented the training. She confirmed that all staff who may provide care for patient #1 have not been re-trained on the use of restraints.

Interview in the nursing supervisor's office of Mental Health Technician (MHT) # 1 on 02/28/12 at 11:00 revealed that on 02/19/12 in the morning time, he was trying to get one of the patients to get out of the quiet room because the facility does not allow female and male patients to be in the same room together. The female and male patient were not receptive to one of them leaving the quiet room, and the female was very vocal about it. She requested to go talk to registered nurse (RN) #2 and walked out of the room only to return and try to force herself back into the quiet room. Mental Health Technician #1 stated he was blocking the door as to not to allow her back in the room, but patient forced herself into the room and tried to hit him. During the scuffle a registered nurse #1 walked into the room and grabbed the female patient and somehow fell to the ground. Mental Health Technician #1 stated he assisted the male patient out of the room. RN #1 and another female staff member restrained the Patient #1 on the ground. He stated he walked out of the room to help guide other patients out of the area. He stated that he is usually able to talk to the Patient #1 and de-escalate the situation by talking to her and that is what he was trying to do, but RN #1 walked in and took immediate action without trying to speak to the patient. He stated that he has only had to physically restrain a patient once or twice during the four years he has worked here and that was only to protect the patient from causing harm to themselves or staff. He stated that the RN #1 did not try to speak to the patient to de-escalate her aggressive behavior before initiating the restraint. He stated he did not know who to report the incident to since RN #1 was the charge nurse for the unit. He stated that after the 02/19/12 restraint, supervising staff reminded staff of the proper use of restraints and proper documentation.

Interview in the nursing supervisor's office on 02/28/12 at 11:15 AM with MHT #2 revealed the following: MHT #2 was in the day room where the patient had been wrestled to the floor and she assisted with the restraint of patient #1 by holding down her feet. She stated RN #1 was speaking to the patient in a rough manner during the time patient #1 was restrained on the floor. MHT #2 described RN #1 as unprofessional and she had never seen a nurse behave like RN #1. When asked about prior use of restraints at the facility, MHT #2 stated that she had not restrained a patient in the three years that she had worked at the facility. MHT #2 stated that she verbally descalates and calm patients down, and the facility trains all staff to use verbal de-escalation when dealing with aggressive patients. MHT #2 was asked why she did not report this incident to anyone until asked about it by the Program Manager, she was unable to give a reason. She confirmed that she has not been retrained on appropriate restraining of patients since the 02/19/12 restraint of patient #1.

Interview in nursing supervisor's office on 02/28/12 at 2:20 PM with RN #2 revealed that when he entered the quiet room, he saw RN #1 on the floor restraining patient #1. RN #1 instructed him to get an as needed (PRN) medication for patient #1 and he complied. He stated that during the time of the restraint, he overheard RN #1 tell patient #1 that "I am going to give you a shot. Are you going to give me a hard time?" He indicated that he assumed RN #1 who was the charge nurse would document the restraint.

Review in the Adult/Geriatric Manager's Office on 02/28/12 of video surveillance for 02/19/12 restraint of patient #1 revealed the following: In the quiet room otherwise known as the "fish bowl", two patients, one male and one female (Patient #1) were sitting on opposite ends of a couch. MHT #1 entered the room and started speaking to the patients. This went on for a couple of minutes and then the Patient #1 walked out of the room. Patient #1 returns and tried to get back into the room, but MHT #1 was blocking the door. There was a struggle and eventually Patient #1 got into the room, the struggle continued towards the back corner of room, and the struggle was almost out of sight. A female staff member (identified as RN #1) rushed in the room and grabbed patient #1. Patient #1 and RN #1 struggled and ended up on the floor with the RN #1 laying on top of patient #1. MHT #2 arrived and held the legs and feet of patient #1. A male staff (identified as RN #2) walked into the room and walked out. RN #2 returned with an injectable medication and administered the medication to patient #1. Staff members relaxed the hold on the patient and eventually the patient was released.

Continued review of the video surveillance from 02/19/12 revealed a second scene whereby patient #1 was escorted into a quiet room by MHT #1 and then RN #1 entered the room in a very threatening manner, stood in front of patient #1 with her arms crossed and legs slightly spread apart. Patient #1 started to become agitated and MHT #1 stood between RN #1 and patient #1. RN #1 was seen pointing at patient #1 and appeared to be talking to her. This continued for several minutes and patient #1 seemed to be getting more and more agitated. RN #1 walked out of room and MHT #1 was seen talking to patient #1 who sat on a mat in the room. MHT #1 sat next to patient #1 and they appeared to be talking.

Record review on 02/28/12 of patient #1's medical record revealed she was admitted to the facility on [DATE] and remains in-patient at the facility. The patient's admitting diagnoses included [DIAGNOSES REDACTED]

Record review of patient #1's medical record on 2/28/2012 revealed the medical record did not contain a physician's order for the 02/19/12 restraint, any licensed independent practitioner or medical doctor evaluation after the use of a restraint. Review of patient #1's nursing notes for 02/19/12 did not reveal documentation for the use of the restraint of patient #1 or documentation regarding the events leading to the use of the restraint. Patient #1's nursing notes for 02/27/12 revealed that on 02/27/12 and documented on 02/27/12 at 1531, "patient #1 became combative to her assigned one to one staff (MHT #1) punching and tearing around door area. Patient was not listening to verbal redirection and eventually needed to be physically restrained as explained by staff. During the restraint, patient #1 bit MHT #1 to his left bicep. RN #2 gave patient #1 a PRN injection during the time of this restraint."

Record review on 02/28/12 of Restraints and Seclusion, Policy#RBC-LD-1015, effective 09/06, last revised 04/11 revealed the following: The facility " is committed to preventing, reducing, and striving to eliminate the use of restraints. The hospital attempts to prevent emergency situations that have the potential to lead to the use of restraints and employs the use of nonphysical interventions when possible as the preferred alternative to restraint use.

Summary: (1) Restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. General provisions for restraint and seclusion: Indications: (a) Restraint or seclusion may only be used when less restrictive means are not sufficient to protect the physical safety of patients, staff members or others. Initiation: each episode of restraint or seclusion shall be initiated(a) upon the order of a licensed independent practitioner who is responsible for the patient, or (b) by a trained registered nurse when she determines it is necessary to protect the patient. An order from a licensed independent practitioner who is responsible for the patient shall be obtained immediately after such situation (in this instance " immediate " means as soon as it is clinically appropriate to pause in the process of providing care)"

Record review on 02/28/12 of Registered Nurse (RN) #1's Employee Discipline Form, dated 02/27/12, revealed that RN #1 was terminated due to not documenting the 02/19/12 restraint of patient #1 and "not following the Crisis Prevention Intervention (CPI) technique used by the facility to de-escalate agitated patients. CPI requires the use of therapeutic communication, identifying early signs of physical restraint as a last resort only when other interventions have been unsuccessful. It does not teach staff members to restrain patients on the floor. Staff members are taught to release a patient immediately in the event that a physical restraint ends on the floor. RN #1 violated facility policy and procedures. She used a technique which is not taught in CPI. She violated patient's rights by threatening and

intimidating a patient. She provoked a patient in the quiet room with her gesture, stance, and presence. She failed to follow LD policy 1015 "Seclusion and Restraints" by not documenting the restraint episode, and not notifying the Program Manager of the use of the restraint. She failed to get a restraint order from the physician. She failed to conduct a debriefing after the restraint incident. She failed to assess the patient and staff members for injury. She failed to provide and maintain a therapeutic and safe environment for the patients and the staff members."



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Report date Number of violations

Feb. 28, 20122 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

Report date Number of incomplete reportsNumber of violations Feb. 22, 20121



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TEXAS HEALTH HEART & VASCULAR HOSPITAL ARLINGTON TEXAS HEALTH HEART & VASCULAR HOSPITAL ARLINGTON

811 WRIGHT STREET ARLINGTON, TX 76012 | Proprietary

View hospital's federal Hospital Compare record

Report date Number of violations

Feb. 28, 20121 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. **Incomplete reports**

No incomplete reports available.



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TEXAS HEALTH HEART & VASCULAR HOSPITAL ARLINGTON ->

Report No. 1776

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

TEXAS HEALTH HEART & VASCULAR HOSPITAL 811 WRIGHT STREET ARLINGTON, Feb. 28, ARLINGTON TX 76012 2012

VIOLATION: DISCHARGE PLAN

Tag No: A0817

Based on observation, review of documentation, and interviews with facility staff, the facility failed to ensure that specific discharge plan requirements are met as there was no physician's order for discharge of the patient in the medical record of 1 of 1 patient records reviewed.

The findings were:

The Rules and Regulations of the Medical Staff of Texas Health Heart & Vascular Hospital dated 9/10 were reviewed on the afternoon of 2/27/12 and reflected "10. Patient Discharge: a. Patients shall be discharged on ly on written order from the physician or another individual with privileges to write orders."

The medical record of patient #1 was reviewed on 2/27/12, and revealed that there was no physician order in the record for the patient's discharge. In an interview with staff #2 on 2/27/12 at 4:50 pm, the physician orders in the record of patient #1 were reviewed with her and she stated that there was no physician order in the record for the patient's discharge. She further stated that the usual procedure would be for the physician or physician's assistant to enter the discharge order into the electronic record system, or a nurse could enter a verbal order into the system.

The facility "Safety Action Learning Tool Form" dated 8/1/11 was reviewed on the afternoon of 2/27/12. The form was regarding patient #1; the date and time of the incident was 4/20/11 at 7:49 pm; the general location was the Telemetry Unit; and the reporting department was Cardiac Telemetry. The incident description reflected "Discharge planning was done by social worker, case manager, and physician's assistant. DC (discharge) summary written by PA (physician's assistant) and cosigned by physician. No discharge orders written. Husband called and wanted to know how we can discharge a patient without an order or notifying him. He feels we did something illegal. All paperwork is in order, third party transfer and MOT (Memorandum of Transfer) done, report called to rehab center. Discussion of transfer to rehab center held by CM (case manager)/SW (social worker)/PA/NP (nurse practitioner) and all documentation showed patient was to be transferred. Order for discharge never written."



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MEDICAL CENTER OF PLANO ->

Report No. 1543

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MEDICAL CENTER OF PLANO

3901 W 15TH ST PLANO, TX 75075

Feb. 27, 2012

VIOLATION: COMPLIANCE WITH 489.24

Tag No: A2400

Tag No: A2404

Based on record reviews and interviews, Hospital B failed to comply with 489.24 as follows:

1) Hospital B did not ensure the availability of on-call trauma specialty physicians on it's medical staff to meet the needs of the hospital's patients, in that, the hospital could not provide for a neurosurgical evaluation for 1 of 1 patient (Patient # 1), who had an emergency medical condition during the month of December 2011.

Patient #1 was accepted at Hospital B as a transfer from Hospital A on 12/27/11 to be evaluated and treated by an on-call neurosurgeon for identified spinal fractures received in a fall down 2 flights of stairs, 2 days prior.

The Trauma Physician Progress Notes from the medical record described the efforts to have either one of two neurosurgeons, who were on-call, to come to the ED to evaluate and treat Patient #1, without success.

Cross Refer to A-2404.

2) Hospital B did not ensure that necessary stabilizing treatment for an emergency condition was available, as they failed to provide the medical treatment that was needed for 1 of 1 patient (Patient # 1), and which was within their capacity as a Trauma Center, in that, the 2 neurosurgeons on-call refused to come to the hospital when called.

The ED Physician On-Call Schedule for 12/27/11 and 12/28/11 noted the following: 12/27/11: Primary on-call physician, Personnel #10; Backup physician, Personnel #9. 12/28/11: Primary on-call physician, Personnel #10; Backup physician, Personnel #9.

The Trauma Physician Progress Notes from the medical record described the efforts to have either one of two neurosurgeons, who were on-call, to come to the ED to evaluate and treat Patient #1, without success. Without neurosurgery support, the hospital was unable to provide the medical treatment that was within their capacity as a Trauma center.

Cross Refer to A-2407

VIOLATION: ON CALL PHYSICIANS

Based on record reviews and interviews, Hospital B did not meet the requirements of 489.24(j)(1) to ensure the availability of on-call trauma specialty physicians on it's medical staff to meet the needs of the hospital's patients, in that, the hospital could not provide a neurosurgical evaluation for 1 (Patient # 1) of 3 patients, who had an emergency medical condition during the month of December 2011.

Findings Included:

Review of the medical record for Patient # 1, revealed he had been transferred from Hospital A to Hospital B on 12/27/11, to be evaluated and treated by a neurosurgeon for identified spinal fractures received in a fall down 2 flights of stairs, 2 days prior. An evaluation by Hospital B's Emergency Department (ED) physician (Personnel # 12), at 9:28 PM described specific neck and back pain, and a sensory deficit present (numbness and tingling to the left arm and slightly weaker grip in left hand).

The ED physician documented the following sequence of events related to obtaining a neurosurgery consult the evening of 12/27/11: 9:50 PM: Discussed with Personnel # 9 (backup neurosurgeon on-call), neurosurgery declining to see patient.

10:00 PM: Trauma surgeon (Personnel # 13), is in the ED to evaluate patient.
11:01 PM: Discussed with Personnel # 9 (backup neurosurgeon), still declines to see patient.

11:40 PM: Trauma surgeon is currently trying to coordinate with neurosurgery to have patient evaluated.

01:45 AM: It does not appear that we will be able to obtain a spine/neuro surgery consult. Trauma surgeon has been attempting to coordinate care of Patient #1 for the last few hours and has agreed to coordinate transfer to Hospital C if necessary.

The Trauma surgeon noted: "plan was to have neurosurgery consultation on the patient ...upon consultation with the neurosurgeon, the neurosurgeon on-call refused to see the consult ...I referred this to the chief of surgery, who had asked if I would consult the neurosurgeon on-call for spine, Personnel #9 ...I called his partner, Personnel #10....subsequently, Personnel #9 called back and reported that neither he or Personnel #10 would see the patient in the emergency room and they were not going to see him in the future ...'

Hospital B's ED Physician Call Schedule for Neurosurgery for the Month of December 2011, included the following on-call physicians: 12/27/11: Primary on-call physician, Personnel #10; Backup physician, Personnel #9. 12/28/11: Primary on-call physician, Personnel #10; Backup physician, Personnel #9.

Professional Services Agreement:

The written contract between Hospital B and the neurosurgeon (Personnel #10) included the following requirements to be fulfilled by the contractor (Personnel #10):

- "Contractor will provide Émergency Department call coverage in accordance with Facility's Bylaws, Rules and Regulations and Policies and Procedures and in accordance with the call schedule maintained by the Facility."
- "Contractor must provide timely and complete coverage services 24 hours per day, 7 days per week as assigned by ED call schedule as set forth by Medical Staff Bylaws and Rules and Regulations."

- "Contractor must respond to Facility Emergency Department in accordance with Trauma Team Activation Guidelines ..."

- "Contractor must be dedicated to the facility when on call. Contractor will have posted backup coverage in the event dedicated call surgeon is engaged in patient care and unavailable...
- "Contractor will accept patient transfers requiring neurosurgical services within physician capabilities from all facilities which have been approved by Facility...

"...Üontractor will personally evaluate all ED patients requiring neurosurgical consultation

Hospital B's "Medical Staff By-Laws," which also included a section of "Medical Staff Rules & Regulations," last revised 09/04/08, required that physicians: "when on call to the Emergency department for the respective department/specialty, members of the staff shall accept responsibility for emergency service care of their own patients as well as those patients determined to be unassigned to any physician ...the on-call physician must respond to the Emergency Department within 30 minutes of being paged; and arrive at the hospital within one hour if the clinical situation warrants the presence of the on-call physician as determined by the Emergency Department physician."

The Physician Re-credentialing File of both Personnel #9 and Personnel #10's revealed each of these neurosurgeons signed a statement that they "agreed to abide by the Medical Staff Bylaws, Rules & Regulations and Policies & Procedures of (Hospital B), if reappointed to the Medical Staff."

In an interview at 3:45 PM on 02/27/12 with the Director of Medical Staff Services(Personnel #8), she stated that Hospital B had addressed this lack of response from the neurosurgeon (Personnel #9), by following the Medical Staff By-Laws, and it's process as documented in the Medical Executive Committee (MEC) minutes on 01/18/12. Personnel #8 verified that the lack of response from Personnel #10, was being addressed according to his contract with the facility, and the issue had been referred to administration for contractual enforcement.

In a telephone interview at 4:00 PM on 02/28/12 with the Chief of Medical Staff (Personnel #11), he confirmed that Hospital B had proceeded according to the Medical Staff By-Laws, and that he had been personally involved in this process.

Hospital B's "Trauma Patient Evaluation, Admission, transfer in the Emergency Department" policy, last revised 09/2011, noted: "Trauma patients with a High Risk of serious injury who, during or after evaluation by the ED, have been determined to require hospitalization and immediate surgical evaluation will receive a surgical evaluation in the Emergency Department (ED) by the appropriate surgical service prior to admission to the hospital...physicians, Admitting and/or Consulting, shall arrive within 30 minutes of notification as requested by the ED physician ...the ED physician will determine if a patient is considered to be at High Risk for serious injury ...and may use this list as part of their evaluation in determining if a patient is at high risk...and, includes...Falls over 10 feet."

Tag No: A2407

VIOLATION: STABILIZING TREATMENT

Based on record review and interviews, the facility (Hospital B), under 489.24(d)(1), failed to provide the necessary stabilizing medical treatment that was needed for 1 of 1 patient (Patient # 1), and which was within their capacity as a Trauma Center, in that, the 2 neurosurgeons on-call refused to come to the hospital when called.

Findings Included:

Review of the medical record for Patient #1, revealed he had been transferred from Hospital A to Hospital B on 12/27/11, to be evaluated and treated by a neurosurgeon for identified spinal fractures received in a fall down 2 flights of stairs, 2 days prior. An evaluation by Hospital B's Emergency Department (ED) physician (Personnel # 12), at 9:28 PM described specific neck and back pain, and a sensory deficit present (numbness and tingling to the left arm and slightly weaker grip in left hand).

Hospital B's ED Physician Call Schedule for Neurosurgery for the Month of December 2011, included the following on-call physicians: 12/27/11: Primary on-call physician, Personnel #10; Backup physician, Personnel #9. 12/28/11: Primary on-call physician, Personnel #10; Backup physician, Personnel #9.

The Trauma surgeon noted: "plan was to have neurosurgery consultation on the patient ...upon consultation with the neurosurgeon, the neurosurgeon on-call refused to see the consult ...I referred this to the chief of surgery, who had asked if I would consult the neurosurgeon on-call for spine, Personnel #9 ...I called his partner, Personnel #10....subsequently, Personnel #9 called back and reported that neither he or Personnel #10 would see the patient in the emergency room and they were not going to see him in the future ..."

The ED physician documented the following in the medical record, regarding the lack of response from the 2 neurosurgeons on-call the early morning of 12/28/11:

01:45 AM: It does not appear that we will be able to obtain a spine/neuro surgery consult. Trauma surgeon has been attempting to coordinate care of Patient #1 for the last few hours and has agreed to coordinate transfer to Hospital C if necessary.

In a telephone interview at 4:00 PM on 02/28/12 with the Chief of Medical Staff (Personnel #11), he confirmed that Hospital B had not been able to provide the medical treatment necessary to stabilize Patient #1, and which was within the hospital's capacity, as neither of the 2 on-call neurosurgeons had responded when called.

Evaluation, Admission, transfer in the Emergency Department" policy, last revised 09/2011, noted: "Trauma patients with a High Risk of serious injury who, during or after evaluation by the ED, have been determined to require hospitalization and immediate surgical evaluation will receive a surgical evaluation in the Emergency Department (ED) by the appropriate surgical service prior to admission to the hospital...physicians, Admitting and/or Consulting, shall arrive within 30 minutes of notification as requested by the ED physician ...the ED physician will determine if a patient is considered to be at High Risk for serious injury ...and may use this list as part of their evaluation in determining if a patient is at high risk...and, includes...Falls over 10 feet."

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EMERUS HOSPITAL ->

Report No. 1770

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EMERUS HOSPITAL 16000 SOUTHWEST FREEWAY SUGAR LAND, TX 77479

Feb. 27, 2012

VIOLATION: MEDICAL STAFF ACCOUNTABILITY

Tag No: A0347

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview, and record review, Physician (ID # 59) admitted a patient (ID # 21) with care requirements listed as " exclusion to admission."

Physician (ID # 5) admitted Patient (ID # 21) who required continuous telemetry monitoring on 02-26-12. The facility 's admission criteria, approved by the Governing Body, excluded from admission those patients who required continuous telemetry.

Findings include:

Intake # TX 108

Observation on 02-27-12 at 9:40 a.m., during initial tour of the facility, revealed an in-patient census of one (1) patient (ID # 21).

Interview with Registered Nurse (RN / ID # 58) at the time of observation she stated Patient # 21 had been admitted the day before for observation with " chest pain and was on telemetry. "

Record review of Patient #21 's clinical record revealed she was [AGE] years old and admitted to the facility on on [DATE] for observation status for chest pain.

Further review of Patient (ID # 21) 's record revealed orders written by Physician (ID # 59), dated 02-26-12 that read: Chest pain/telemetry ...EKG every 8 hours with cardiac enzymes x 2. "

Review of hospital policy titled " Admission Exclusion, " revised date 02-06-12, revealed " ...The hospital (s) is designed to provide inpatient medical care for all medical conditions excluding the following: Patients Requiring Continuous Telemetry ... " Further review of the policy revealed it had been approved by the Governing Body.

Interview on 02-27-12 at 10:30 a.m. with the Chief Nursing Officer (CNO/ ID # 53) he stated Patient ID # 21 was admitted for continuous telemetry and acknowledged the admission criteria excluded the acceptance of patients requiring telemetry. He went on to say the facility currently had a telemetry monitor on the "emergency room side and had ordered an additional telemetry monitor for the in-patient nurse station." The CNO (ID # 53) said it was his understanding the facility would not accept patients requiring telemetry until the in-patient nurse station monitor was obtained. The CNO (ID # 53) said there must have been a miscommunication with Physician # 59



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Report No. 1500

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MEMORIAL HERMANN HOSPITAL SYSTEM

1635 NORTH LOOP WEST HOUSTON, TX 77008

Feb. 22, 2012

VIOLATION: RN SUPERVISION OF NURSING CARE

Tag No: A0395

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the facility failed to ensure adequate RN supervision and assessment of patient needs for 1 of 10 Emergency Department patients (Patient ID # 1).

Emergency Department (ED) nursing staff failed to appropriately monitor and assess Patient ID #1's blood pressure based on the severity of his condition.

Findings include:

Intake # TX 754

Record review of Patient ID #1 's clinical record revealed he was [AGE] years old and admitted to the facility ED via ambulance at on 12-14-2011 at 2:27 p.m. He was triaged at 2:28 p.m with a chief complaint documented as "Headache, Abdominal Pain, and ETOH Abuse."

Review of the ED physician assessment dated [DATE] revealed Patient ID # 1 was alert and oriented and his chief complaint was "fall." In addition, it was documented the patient was complaining of nausea and vomiting. The "Clinical Impression" documented by the ED physician read: "1. Hypertensive Emergency 2. Fall. 3. Intraventricular Hemorrhage."

A CT Scan of the head was done on 12-14-11 at 4:30 p.m. that showed evidence of a stroke: "hemorrhage within the right basal ganglia with extension into the ventricular system ... "An additional CT of the head was done on 12-14-11 at 10: 42 p.m. that showed "small amount subarachnoid hemorrhage...stable CT as compared to earlier CT..."

Further review of Patient ID # 1 's clinical record for 12-14-11 revealed the following:

Traiage assessment at 2: 28 p.m.; blood pressure was 177/117.

An additional blood pressure measurement was not obtained until 2 hours and 33 minutes later at 5:01 p.m. At this time, Patient ID # 1 's blood pressure was documented as 196/117; he was medicated with Enalipril 1.25 milligrams (mg) Intravenous (IV) Push.

5:11 p.m. blood pressure documented as 179/106

6:00 p.m: blood pressure documented as 170/107

7:17 p.m.:blood pressure was 206/143. Patient ID # 1 was medicated with Labetalol 20 mg IV push; shortly thereafter, Patient ID # 1 's

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blood pressure was 157/101.

9:15~p.m: blood pressure was 187/~114; Patient ID # 1 was medicated with Hydralizine 20 mg IV Push. Blood pressure was not reassessed until 1 hour and 15 minutes later at 10:30~p.m., when it was 116/72.

Interview on 02-22-12 at 1:45 p.m. with the ED Director (ID # 59) she stated that Patient ID # 1 's admission blood pressure was "very high and it should have been monitored more frequently while he was in the ED."

Review of policy titled " Assessment Reassessment (Emergency Services), " review date 02-20-2011, revealed " " ...3.3 the frequency of reassessment is based on the patient 's acuity, condition, history and complaint, or as directed by the physician; minimally every four (4) hours.



Training

Resources

Tag No: A0395

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EAST TEXAS MEDICAL CENTER ->

Report No. 1487

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

EAST TEXAS MEDICAL CENTER 1000 SOUTH BECKHAM STREET TYLER, TX 75701 Feb. 21, 2012

VIOLATION: RN SUPERVISION OF NURSING CARE

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on document review and interview the facility failed to insure nursing staff accurately assessed the needs and provide nursing interventions for 1 of 1 patents reviewed.

On 2/23/2012 at 9:30 am in the conference room the patient 's medical record was reviewed. The medical record revealed the following

physician documentation:
Patient (pt) #1 was an [AGE] year old female who was admitted on [DATE] following a motor vehicle collision (MVC) for stabilization of her injuries.

Pt #1 diagnosis upon admission to the specialty hospital included the following:

- -Acute respiratory failure
- -Chronic respiratory failure
- -Dysphasia
- -Protein Energy Malnutrition (albumin 2.3 normal 3.5 or greater)
- -Debilitation
- -Multiple Fractures (Fx)
- -Chest wall contusions
- -Abdominal wall contusions
- -On 2/25/2012 the pt was evaluated in the emergency department by Emergency -Department (ED) physician.
- -ED physician notified the trauma the on call trauma surgeon.
- -ED physician noted the pt might require resuscitation and even ventilatory support over night.
- -The trauma surgeon took the pt to surgery on 2/25/2012.
 -The attending physician documented the pt returned from surgery 2/25/2012intubated.
- -The pt was still intubated when she returned to surgery on 2/26/2012 -The attending documented pt #1 failed multiple attempts to extubate.
- -The pt received two (2) units packed red blood cells on the 2/27/2012
- -Documentation recorded the pt developed thick secretions over the next two (2) days from her airway.
- -Documentation records the pt underwent a bronchoscopy and bronchoaveolar lavage on 2/28/2012
- -Physician recorded the pt underwent a tracheostomy on 3/5/2012
- -Documentation records the pt underwent a swallowing evaluation 3/9/2012
- The pt underwent percutaneous endoscopic gastrostomy (PEG) placement on 3/11/2012.
- -Documentation records attempts to downs size her tracheostomy resulted in difficulty ventilating
- -Nursing documentation recorded the pt developed a reddened area with drainage to the back of her head on 3/11/2012 wound care orders were noted 3/12/2012
- -The patient tracheostomy was down sized on 3/17/2012
- -The pt was seen for consult by an otolaryngologist on 3/22/2012 and diagnosed with subglottic edema

Pt was transferred to the specialty hospital on [DATE]

- Review of the pt 's nursing assessment revealed:
 -The pt mobility was recorded as very limited when in fact she was in a drug induced coma secondary to mechanical ventilation 2/25/2012
 -The nursing assessments documented the pt 's nutritional status as adequate when the pt 's was admitted with a PEM 2/25/2012
 -The pt later required a peg tube 3/11/2012
 -There was no documentation the nursing staff recognized the risk to skin break down or the difficulty healing the patient faced with PEM, immobility, multiple fx and multiple underlying etiologies.
 -There was no documentation a special low air loss bed or any other off loading intervention was in use for this immobile patient until after the wound had occurred on the pt 's head.

The nursing staff failed to accurately assess the needs and provide intervention for this debilitated pt even though physician documentation was available.



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HILLCREST BAPTIST MEDICAL CENTER ->

Report No. 1490

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HILLCREST BAPTIST MEDICAL CENTER

100 HILLCREST MEDICAL BLVD WACO, TX 76712

Feb. 21, 2012

Tag No: A0395

VIOLATION: RN SUPERVISION OF NURSING CARE

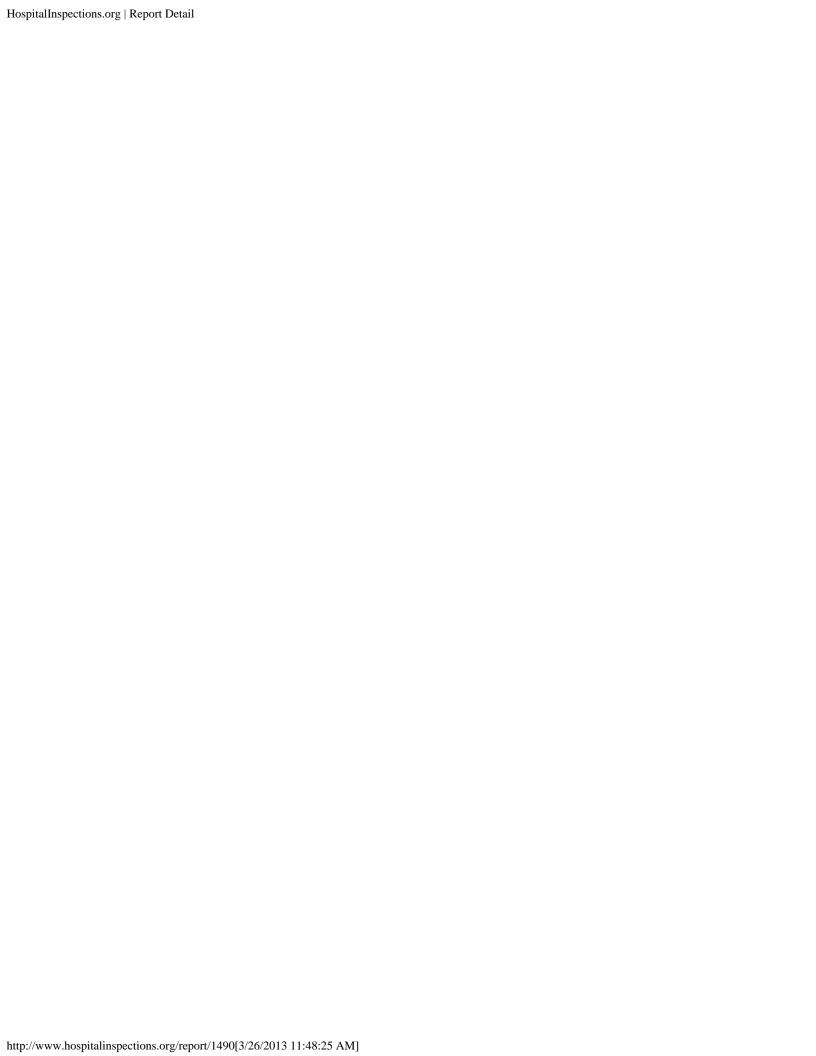
Based on review of documentation and interview with staff, the facility failed to document that a registered nurse supervised and evaluated the nursing care for 1 of 1 patient whose record was reviewed. Patient #1 was determined to be at a high risk for falls; however, the nursing staff did not ensure there was documentation of hourly rounds for fall prevention in the patient's medical record per facility policy.

Findings were:

Facility policy 1.4, entitled Fall Risk Assessment, last approved in April 2011, was reviewed. According to the policy, all patients are assessed for risk of falling when they are admitted and once per shift, or change in the patient's condition. The policy designates three levels of fall risk, and lists interventions appropriate for each level. The highest risk level is Level III. If a patient's risk score is 9 or above, he or she falls into this level. Included in the fall prevention interventions for Level III is the requirement, "All patients with a Fall Risk level of III should have a minimum of every one hour rounding checks assigned and documented."

The RN admission procedure includes the determination of a fall risk score. On 6/17/11, Patient #1 was evaluated and had a fall risk score of 11 (on a scale of 0.0 - 30.0). According to the fall prevention policy, the patient was considered a Level III, and the requirement was that the patient's status should be checked hourly and documented. The facility's electronic medical record allows a section to be utilized, entitled Safety/Quick Rounds. This section allows documentation regarding the evaluation of the safety precautions for patients, including those with risk of falls. These evaluations were not documented hourly for Patient #1. For example, rounds were documented on 6/17/11 at 00:24 am. The next safety rounds were documented at 2:55 am. Nursing staff documented in narrative notes Patient #1's non-compliance with safety instructions between 4:30 am and 5:47 am, along with an unwitnessed fall. No injuries were noted as a result of the fall. At 6:14 am, the Safety/Quick Rounds documentation indicated that Patient #1 was in bed and all safety precautions were in place. Safety/Quick Rounds were not documented again until 8 am and 10 am on 6/17/2012. The patient was discharged that day.

An in-person interview was conducted 2/21/12 at 5 pm in a facility conference room with the facility's Chief Nursing Officer (CNO). The CNO indicated that each patient is seen hourly by nursing staff, and this is documented on an hourly rounding sheet that is on the patient's door. It includes aspects of care such as toileting needs, pain, and safety. According to the CNO, these forms are kept by a nursing supervisor for a month then thrown away. No hourly rounding sheet was available to determine if Patient #1 was monitored according to the fall prevention policy.





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HILLCREST BAPTIST MEDICAL CENTER HILLCREST BAPTIST MEDICAL CENTER

100 HILLCREST MEDICAL BLVD WACO, TX 76712 | Voluntary non-profit - Private

View hospital's federal Hospital Compare record

Report date Number of violations

Feb. 21, 20121 (click for details) Read full report Dec. 20, 20111 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

No incomplete reports available.

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ST MARKS MEDICAL CENTER ->

Report No. 1758

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ST MARKS MEDICAL CENTER ONE ST MARK'S PLACE LA GRANGE, TX 78945 Feb. 21, 2012

VIOLATION: CONTRACTED SERVICES

Tag No: A0083

Based on interview with staff and a review of documentation, the governing body failed to be responsible for services furnished in the hospital.

Findings were:

A review of facility policy HRS-9010 titled "Employee Counseling" states, in part, STANDARDS OF CONDUCT 1.) Employees are expected at all times to conduct themselves in a positive manner in order to promote the best interests of St Mark's Medical Center. Appropriate employee conduct includes: a.) Treating all customers, visitors and coworkers in a courteous manner ...2.) ...The following examples of impermissible behavior described below are not intended to be an all-inclusive list ...l.) Unsatisfactory performance or conduct (for example: Gambling on SMMC property, playing pranks or engaging in horseplay, using profanity or abusive language; "

A review of facility policy ADM-212 titled " Code of Conduct " states, in part, " III. Guiding Principles A.) Quality of Care 1.) e.) I will communicate to patients in a clear, professional, informed and understandable manner ...f.) I will treat all customers, including patients, families, physicians, co-workers and all outside contacts, with courtesy, dignity, respect and professionalism. "

In a (telephonic) interview with Dale Butts RN on 2-21-12 at 1005, he confirmed that he said to the patient on 1-14-12 (in part) "you just shit all over me."

The above was confirmed in an exit conference with the Chief Operating Officer, the Chief Nursing Officer, The Chief Executive Officer and the emergency room Director on the afternoon of 2-21-12 in the facility conference room.



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BRINGING TRANSPARENCY TO FEDERAL INSPECTIONS

Home -> Texas -> ST MARKS MEDICAL CENTER ST MARKS MEDICAL CENTER

ONE ST MARK'S PLACE LA GRANGE, TX 78945 | Voluntary non-profit - Other

View hospital's federal Hospital Compare record

Report date Number of violations

Feb. 21, 20121 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. Incomplete reports

No incomplete reports available.



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BAPTIST MEDICAL CENTER ->

Report No. 1479

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BAPTIST MEDICAL CENTER 111 DALLAS STREET SAN ANTONIO, TX 78205

Feb. 8, 2012

Tag No: A0168

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on record review and interview, the facility failed to follow their own policy and procedure on Restraint and Seclusion of Patients. The facility failed to obtain a physician 's order after the use of behavioral restraints of one of one restrained patients (Patient #1)

Findings included:

- a. In review on 02/08/12 of facility policy on "Restraint and Seclusion", effective 07/11, revealed the following: "Restraint shall be ordered by a physician member of the medical staff. Restraint shall only be used for the protection of the patient, staff members or others. Such indications will be present and documented at the initiation of and throughout the episode of restraint. Initiation of Restraint: A registered nurse (RN) may initiate restraint or seclusion in advance of the physician's order. As soon as possible, but no later than one hour after the initiation of restraint or seclusion, the RN shall consult with a responsible physician about the patient's physical and psychological status and obtain an order (written or verbal)."
- b. Reviewed event report on 02/08/12 of the incident, dated 01/26/12 to 01/29/12 revealed the following information: Staff #6 RN made the following statement that was placed on the events list: "At 01/26/12 at 5:10 AM, Patient #1 attempted to elope. She was admitted for psychiatric evaluation; she attempted to leave the floor and got on the elevator. Two staff including the unit secretary was behind her telling her she needed to go back to her room and she started elbowing the unit secretary. I did grab her wrists for her safety as well as ours. She started hitting, biting, scratching and kicking. During this, she lost her balance and went to the floor taking me down with her. Security showed up as we were trying to get her back to her feet. The second time she got on the elevator we again called security. I put my foot in the elevator door to prevent it from closing. She started kicking my leg and stomping my foot. Security escorted her to her room and stayed outside her door until shift change. The House Supervisor was notified twice as well "The House Supervisor #12 wrote the following on 01/29/12 at 1102 regarding the event: "In following up with staff #6, RN had read the patient had a past history of psychiatric problems and that although the emergency department physician had written being admitted for psychiatric evaluation, she was being admitted for a medical condition. I also educated staff #6, RN that although patients should not leave the floor, to never stop a patient even though concern for patient" 's safety is foremost. To allow patient to leave floor, not to stop her, call a code green, notify House Officer and to send an aide with her if possible "The following statement was documented by the unit secretary regarding this incident: "Wednesday night through Thursday morning, the patient was agitated about a number of things and wanted to leave the unit. She made several attempts to leave. First, she walkled to the elevator with her oxygen tank and the nurse and I were holding the door to preven
- c. Reviewed on 02/08/12 of a facility Security Report, dated 01/25/12 but referring to 01/26/12 at 0510 AM revealed the following: " Duress

Alarm on 4D (where patient #1 was residing). When officers arrived patient was in the hallway floor, two registered nurses were holding her down. Patient is upset and wants specific medications of which her doctor will not prescribe. Patient was lifted off the floor by techs and was taken back to her room 418. Patient is now calm enough to converse with staff ".

- d. Record review on 02/08/12 of patient #1 's physician 's orders, dated 01/26/12 (date of admission) to 01/29/12 (date of discharge) did not reveal a physician 's order for restraint. Review of nursing notes for this same time period did not reveal a description of the above described altercation.
- e. Interviewed staff #12 admitting physician via telephone on 02/08/12 at 2:55 PM revealed that she was not aware that patient #1 had been restrained and she did not give an order for restraint nor did she give an order for her to remain on the fourth floor.
- f. Interview on 02/07/12 at 3:10 PM via telephone with RN #6, who was the charge nurse on the 4th floor at the time of the altercation with patient #1, revealed the following: "He confirmed that patient #1 wanted to leave the floor to go to the emergency room via the elevator. He stated the unit secretary got on the elevator with her asking patient #1 to return to her room. He stated he grabbed her wrists and pulled her off the elevator. He stated she then began hitting; kicking and they were pulled to the floor due to her behavior. He stated that he did not have any current training in how to prevent physical aggression in patients. He confirmed the next day he was told by an administrative nurse that if patients want to leave the floor, we need to let them leave and call a code purple (elopement) ".
- g. Interviewed staff #8, unit secretary on 4D at 3:30pm on February 7, 2012 via telephone revealed the following: " She stated that she remembered the charge nurse (RN #6) standing in doorway of stairs to keep patient #1 from leaving by the stairwell. She stated he was holding her in a " bear hug " from behind and told her to go and get security. She stated she called a code strong and returned to find the charge nurse and patient #1 on the floor. She stated she also remembered the charge nurse grabbing the patient 's arms during some of this altercation ".
- h. Interviewed staff #2, Baptist Health System Regional Director for Risk Management at 3:20pm on February 8, 2012 in the administration conference room confirmed that it appeared she was restrained during this altercation and a physician 's order should have been obtained as well as the event being documented in the nursing notes.



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METHODIST DALLAS MEDICAL CENTER ->

Report No. 1473

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METHODIST DALLAS MEDICAL CENTER

1441 NORTH BECKLEY AVENUE DALLAS, TX F 75203

Feb. 7, 2012

VIOLATION: PATIENT RIGHTS: INFORMED CONSENT

Tag No: A0131

Based on review of records and interview with staff, the facility failed to ensure that 1 of 1 patient whose record was reviewed was informed of his or her health status, including participation in the plan of care. Patient #1's spouse (next of kin) was not aware of a pressure ulcer that developed during the patient's stay at the facility.

Findings were:

Review of Patient #1's medical record revealed that the patient had an altered mental status and a diagnosis of dementia. The patient did receive a copy of the patient rights information supplied to each patient at the time of admission. Included in the packet is a pamphlet entitled, Speak Up ...Know Your Rights. The brochure states that "knowing your rights and role can help you make better decisions about your care." The first patient right listed in the pamphlet is "You have the right to be informed about the care you will receive."

An in-person interview was conducted with the Manager of Guest Services, Staff #5, on 2/6/12 at 2:10 pm in a facility conference room. According to Staff #5, Patient #1's spouse called and filed a grievance with the hospital about not being informed of the patient's skin ulcer, and didn't recall seeing any treatment. Staff #5 stated that a review of the grievance was performed, and the main finding of the internal investigation was that Patient #1's rights were violated, as the staff didn't communicate with the patient's spouse about the status and treatment of the pressure ulcer. Staff #5 also found during the investigation of the grievance that during care of the wound to the buttock area, the family was asked to leave the room, and no one communicated with them about the ulcer.

VIOLATION: RN SUPERVISION OF NURSING CARE

Tag No: A0395

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of records and interviews with staff, the facility failed to ensure that a registered nurse supervised and evaluated the nursing care for 1 of 1 patient whose record was reviewed. Patient #1 developed a pressure ulcer during an inpatient stay, and the staff did not address the ulcer per facility policy.

Findings were:

An in-person interview was conducted at 2:30 pm on 2/6/12 with Staff #6, the Clinical Nurse Supervisor of MICU/CCU. Staff #6 explained that Patient #1 came to the hospital in cardiogenic shock (a state in which the heart has been damaged so much that it is unable to supply enough blood to the organs of the body). The patient was admitted to the unit from the cardiac catheterization lab on a balloon pump (mechanical device that increases oxygen perfusion to the heart muscle while at the same time increases cardiac output). Patient #1 also came to the unit with a temporary pacemaker in his groin area, and with the balloon pump, ventilator, and pacemaker, it was difficult to

turn except by log roll. Staff #6 stated that the patient stayed on the unit for 19 days. According to the Clinical Nurse Supervisor, Patient #1 received blue protective ointment over the skin in order to protect the skin from breakdown, and was repositioned every 2 hours. Because of tube feedings, the patient started having diarrhea, and a flexi-seal was placed. (This device is a temporary containment device, indicated for bedridden or immobilized incontinent patients with liquid or semi-liquid stool). According to Staff #6, on 10/24/11, because of the fecal incontinence, the ointment was changed to zinc oxide. Staff #6 assessed Patient #1's skin on 11/3/11 for the first time. By this time it was darker in color, so they switched to Xeniderm ointment, which required a physician order. November 3, 2011 was a Thursday; Staff #6 stated that the weekend nurse left a note requesting reevaluation of the patient's skin, because it had gotten worse, becoming darker and sloughing. A wound care physician was consulted on 11/7/11, 4 days after the worsening of the pressure ulcer was noted. The physician identified the ulcer as stage II (out of Stages I-IV). The physician ordered MIST therapy-which is a device used to help improve circulation. The patient was then transferred the next day to a long term acute care hospital for further treatment.

Review of the medical record of Patient #1 revealed that at the time of admission 10/20/11, the nursing assessment reported that skin was intact. The nursing notes state "no wounds." On 10/22/11, nursing notes also state "no wounds." On 10/23/11, nursing notes identify "multiple bruises with blanchable redness to bilateral buttocks/coccyx area." The nurses have documented turning the patient every 2 hours and applying protective cream to the patient's back. Nursing staff performs the Braden Scale evaluation of patients, which is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers. A score of 15-16 = low risk, 13-14 = moderate risk, 12 or less = high risk. Nursing notes for the day of admission indicate Patient #1's score as 14, moderate risk. The facility policy which is printed in the electronic medical record states "A Braden score of 18 or less will trigger a notification to Wound care." On 10/21/11, the day after the patient was admitted , the Braden score was 14; by 10/26/11, the score was 11, considered high risk. Nursing staff also evaluates for skin breakdown if the patient has a urinary catheter. Patient #1 had a catheter each day during the stay to protect against skin breakdown due to incontinence. Each evaluation throughout the stay indicated that there was no skin breakdown on the patient's back. On 11/7/11, Patient #1's 18th day on the unit, a wound care physician was consulted and a stage II pressure ulcer was diagnosed . Patient #1 was discharged on [DATE] to a long term acute care hospital.

In an in-person interview conducted the afternoon of 2/6/12, the facility CNO stated that there is usually a nurse who is trained in wound care and oversees the care of patient wounds for the hospital. According to the CNO, this nurse would evaluate the patient with a low Braden Scale score. At the time of Patient #1 's stay, the wound-care nurse position was vacant. The CNO acknowledged the above findings during the interview.



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STEPHENS MEMORIAL HOSPITAL ->

Report No. 1529

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STEPHENS MEMORIAL HOSPITAL 200 SOUTH GENEVA BRECKENRIDGE, TX 76424 Feb. 1, 2012

VIOLATION: PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT

Tag No: A0145

Based on review of documentation and interviews with facility staff, the facility failed to ensure that the patient has the right to be free from all forms of abuse or harassment as the facility policy entitled "Abuse Identification and Care of Suspected Child, Domestic or Elderly" was not completely followed in the case of patient #1.

The findings were:

The medical record of patient #1 was reviewed on the afternoon of 1/30/12 which reflected that on 12/31/11 at 0015, an entry was made to the nurses notes by the licensed vocational nurse, staff #3, "Pt (patient) started screaming while being changed and repositioned. Staff observed daughter placing her hand over her mother's mouth, telling her to hush. Staff moved daughter's hand and requested that she stop. Will continue to monitor. Reported to RN Charge Nurse."

An entry to the nurses notes was also made at 12/31/11 at 0015 by the licensed vocational nurse, staff #4, which reflected "While assisting to change pt with other nurse, this nurse witnessed pt daughter popping pt in mouth while covering pt mouth to silence patient who was confused and yelling. Staff asked family member to remove hand. Four more times daughter placed hand over pt mouth. Staff witnessed daughter to use elbow to dig into pt mouth to make pt stop yelling out in confusion. Staff gently intervened by stepping in between pt and family member when this nurse went to opposite side of bed to assist in turning patient to cleanse buttocks. The daughter roughly grabbed patient's arms and aggressively held patient arms down while harshly saying 'shush mother, think of the other pts, you are so loud.' Staff intervened by gently taking pts arms and gently turning her. Daughter was witnessed talking harshly multiple times as well as smacking at pts mouth or firmly placing her hand over pts mouth. Staff intervened whenever possible. Continue to monitor."

On 12/31/11 at 0500, an entry to the nurses notes was made by the licensed vocational nurse, staff #2 which reflected "In bed with eyes closed, no distress noted. Moans out in sleep. Daughter at bedside. Will continue to monitor."

On 12/31/11 at 1030, an entry to the nurses notes was made by the registered nurse, staff #6, which reflected "the physician, staff #5, notified of staff concern re: daughter's tx (treatment) of patient. He requested APS (Adult Protective Services) be notified. At 1430, the registered nurse, staff #6, charted "Report made by phone to APS hotline, case # 620 to staff ID# 1175. Daughter has not been observed with any with any abusive activity today, but report filed based on charted behavior of previous shift."

The facility policy entitled "Abuse, Identification and Care of Suspected Child, Domestic or Elderly" with a revision date of 11/11 was reviewed on the afternoon of 1/30/12 and reflected that "3.2.20.3 Notify Utilization Review nurse if need for information and/or referrals to community agencies during hospitalization or in the implementation of a discharge plan. 3.3.21 Whenever a report is made to Adult Protective Services, refer patient to Social Services and/or the Nurse Manager/Relief Charge Nurse to function as a liaison with Adult Protective Services regarding safe disposition of the patient. 3.2.22 Nurse Manager/Relief Charge nurse will collaborate with physician, nursing staff and Adult Protective Services regarding safe disposition of the patient. 3.3.23 CNO/ACNO, in collaboration with the Legal Department, will coordinate guardianship process if indicated."

In an interview with the facility utilization review nurse, personnel #2, on 1/30/12 at 2:30 pm, she stated that it was not reported to her that the nursing staff had made a report to adult protective services.

In an interview with the facility chief nursing officer, personnel #1, on 1/30/12 at 4:30 pm she stated that the nurses did not report the incident to the nurse manager or to the chief nursing officer. She stated that she would have expected the nursing staff to report to the nurse manager in a timely manner and complete an unusual event report.

In an interview with the facility medical-surgical nursing supervisor, staff #7, on 1/31/12 at 10:25 am she stated that she did not hear about the incident until 1/2/12 or 1/3/12. She stated did not receive a written report regarding the incident, nor did she initiate one. She stated she told the nursing staff to continue to watch the patient closely. She stated she did not report it to the utilization review nurse or chief nursing officer because she felt the patient was in no further danger.

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STEPHENS MEMORIAL HOSPITAL STEPHENS MEMORIAL HOSPITAL

200 SOUTH GENEVA BRECKENRIDGE, TX 76424 | Government - Local

View hospital's federal Hospital Compare record

Report date Number of violations

Feb. 1, 20121 (click for details) Read full report

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No incomplete reports available.



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PARKLAND HEALTH AND HOSPITAL SYSTEM ->

Report No. 1461

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PARKLAND HEALTH AND HOSPITAL SYSTEM

5201 HARRY HINES BLVD DALLAS, TX J 75235 20

Jan. 24, 2012

Tag No: A0144

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on interviews and records review, the hospital failed to ensure 1 of 1 patient (Patient #1) was provided a safe environment. (Patient #1) was found on the floor in the ED (Emergency Department) after being physically restrained with soft wrist restraints. (Patient #1) had removed the tracheostomy tube while residing in the nursing home and was at the hospital for for re-insertion of the tracheostomy tube. (Patient #1) had a known history of TBI (Traumatic Brain Injury) and was not identified as a fall risk. The assigned nurse, Personnel #13, failed to initiate the ED Fall Protocol. This failure contributed to (Patient #1) falling out of bed and sustaining injuries.

Findings included:

Patient #1's hospital medical record reflected, "Admit 12/27/11 at 04:26 AM to the ED (Emergency Department)...per EMS (emergency medical system) report, pt (Patient) pulled out his trach (tracheotomy)...TBI (traumatic brain injury)...discharged at 2:52 PM..."

The nursing note dated 12/27/11 timed at 10:07 AM reflected, "Pt (patient) is awaiting social worker to help decide where pt will go and where they will receive further ongoing treatment. 1:1 sitter present at bedside....at 14:11...pt instructed not to pull out trach tube...soft restraints removed, 1:1 sitter at bedside..." The above medical record was Patient #1's first admission to the ED (Emergency Department) for tracheostomy tube replacement.

The physician provider note dated 12/28/11 timed at 11:00 AM on Patient #1's second admit medical record reflected, "24M (Male)...TBI (Traumatic Brain Injury) with trach (Tracheotomy)...returns to ED (Emergency Department) after pulling out trach...patient not vent dependent...past medical diagnosis...traumatic brain injury and unspecified mental or behavioral problem schizophrenia...responds yes to any questioning...well healed scars to head..."

The physician orders dated 12/28/11 timed at 11:54 AM and acknowledged by the nurse at 12:52 PM reflected, "Soft wrist restraints...reason...pulling/dislodging essential medical devices."

The nursing note dated 12/28/11 timed at 13:32 PM reflected, "Upon entering room, found pt (patient) on floor. When asked if pt climbed out of bed, pt responds "yes." Pt in no obvious distress. Pt returned to stretcher by staff...pt removed restraints, is refusing to have them put back on, states "I do not like them." 1:1 sitter now present. Pt smiling says "I know what I like; I know what I don't like." Awaiting scan, will continue to monitor..."

The physician consult note dated 12/28/11 timed at 19:51 PM reflected, "CT of the head shows left sided squamous temporal bone fx (fracture)...CT cervical-spine shows C6 (Cervical) lamina fx (fracture) and C7 lateral mass fx (fracture)...neurosurgery consulted for evaluation of temporal bone fracture...encephalomalacia of the left temporal lobe and left occipital lobe, compatible with this patient's history of traumatic brain injury...no neurological intervention or follow-up needed...continue c-collar. Cervical fracture mgmt (management) per ortho (orthopaedic) spine..."

The physician note dated 12/28/11 timed at 18:50 PM, reflected, "Pt (patient) was found down in his room despite being in soft wrist restraints. He is unable to provide any history given his TBI (traumatic brain injury). He has no signs of external trauma, but was clutching

at his left hip repeatedly. No palpable spine deformity or tenderness with palpation. Given his mental status, CT head and CT spine as well as XR (X-Ray) hip were ordered. A sitter was assigned ...CT head revealed L (left) temporal bone fx (fracture) read as acute, as well as C5-C6 fx (fracture)..."

The nursing note dated 12/29/11 timed at 02:09 AM reflected, "Patient continues to be combative/aggressive pulling at cervical-collar/trach (tracheotomy), patient not maintaining cervical-spine precautions despite repeated verbal reminders...1:1 sitter at bedside....will continue to monitor..."

No documentation was found indicating fall protocol precautions were initiated for Patient #1 upon his arrival and during his stay in the Emergency Department 12/28/11.

On 01/17/12 at 1:00 PM Personnel #12 was interviewed. Personnel #12 stated the nurse should have initiated the ED (emergency department) fall protocol, especially due to the patient's history of traumatic brain injury. Personnel #12 reviewed the medical record for documentation from the nurse indicating the ED (emergency department) fall protocol was not initiated and/or followed. He stated the patient was placed in a private room instead of a bed in view of the nursing station. Personnel #12 said with the patient's history of pulling his tracheotomy out he should have had a sitter.

On 01/17/12 at 2:00 PM Personnel #13 was interviewed. Personnel #13 was asked to review Patient #1's medical record. She stated she was informed by one of the nurses the patient was on the floor. Personnel #13 was asked if she initiated the ED fall protocol for Patient #1. Personnel #13 did not offer a response to the surveyor's guestion.

The Emergency Services Department Modified Fall Protocol for Emergency Services with a revision date of 06/11 reflected, "All patients in the emergency room are considered a fall risk due to the nature of the environment. However, patients with the following should be identified as a fall risk and placed on fall protocol...patient who presents to Emergency Services with the following are considered as High Risk for fall: altered mental status...post-ictal, intoxicated, dementia or any other reason patient is unable to comply with instructions...inability to perform activities of daily living...unsteady gait, motor/sensory deficits, or history of previous fall...if a patient has any of the identified risk factors, that patient will be placed on the modified fall protocol, and documentation will be placed in the medical record...patients on fall protocol will have rounds every hour to confirm: bed is in low position...call light/Bell are in reach, toileting offered if awake and allowed by treatment plan/condition...fluids offered if awake and allowed by treatment plan/condition ...rounds will be documented...patient on Fall Protocol should be placed in close proximity to the nurse's station..."

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on interviews and records review, the hospital failed to ensure that a POC (Plan of Care) was initiated for 1 of 1 patient (Patient #1) who was physically restrained with soft wrist restraints on 12/28/11 in the hospital's Emergency Department in order to stop Patient #1 from pulling out or dislodging his tracheotomy tube.

Tag No: A0166

Findings included:

The physician provider note dated 12/28/11 timed at 11:00 AM reflected, "24M (Male)...TBI (Traumatic Brain Injury) with trach (Tracheotomy)...returns to ED (Emergency Department) after pulling out trach...patient not vent dependent...past medical diagnosis...traumatic brain injury and unspecified mental or behavioral problem schizophrenia...responds yes to any questioning...well healed scars to head..."

The physician orders dated 12/28/11 timed at 11:54 AM and acknowledged by the nurse at 12:52 PM reflected, "Soft wrist restraints...reason...pulling/dislodging essential medical devices."

The nursing note dated 12/28/11 timed at 13:32 PM reflected, "Upon entering room, found pt (patient) on floor. When asked if pt climbed out of bed, pt responds "yes." Pt in no obvious distress. Pt returned to stretcher by staff...pt removed restraints, is refusing to have them put back on, states "I do not like them." 1:1 sitter now present. Pt smiling says "I know what I like; I know what I don't like." Awaiting scan, will continue to monitor..."

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The physician note dated 12/28/11 timed at 18:50 PM, reflected, "Pt (patient) was found down in his room despite being in soft wrist restraints. He is unable to provide any history given his TBI (traumatic brain injury). He has no signs of external trauma, but was clutching at his left hip repeatedly. No palpable spine deformity or tenderness with palpation. Given his mental status, CT head and CT spine as well as XR (X-Ray) hip were ordered. A sitter was assigned ...CT head revealed L (left) temporal bone fx (fracture) read as acute, as well as C5-C6 fx (fracture)..."

The nursing note dated 12/29/11 timed at 02:09 AM reflected, "Patient continues to be combative/aggressive pulling at cervical-collar/trach (tracheotomy), patient not maintaining cervical-spine precautions despite repeated verbal reminders...1:1 sitter at bedside....will continue to monitor..."

No documentation was found indicating that a plan of care was initiated for Patient #1 which addressed patient safety and the use of soft wrist restraints.

On 01/17/12 at 1:00 PM Personnel #12 was interviewed. Personnel #12 was asked to review (Patient #1's) medical record for documentation indicating that a plan of care was initiated for (Patient #1) after being placed in wrist restraints. Personnel #12 said he did not find any documentation with a plan of care that addressed patient safety and wrist restraints.

The policy entitled, "Non-Violent/Non-Self Destructive and Violent/Self Destructive Restraints" with a revision date of 07/11 reflected, "Modification of the plan of care and achievement of goal...results of all monitoring, reassessments and related interventions related to restraint use..."



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VHS BROWNSVILLE HOSPITAL COMPANY, LLC ->

Report No. 1465

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VHS BROWNSVILLE HOSPITAL COMPANY, LLC

1040 W JEFFERSON ST BROWNSVILLE, TX 78520

Jan. 24, 2012

VIOLATION: STAFF TREATMENT OF RESIDENTS (483.13(C))

Tag No: A1534

Based on a review of documentation and clinical record review, the facility failed to report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property immediately to the administrator of the facility and to other officials in accordance with State law through established procedures.

Findings were:

? Facility policy & procedure titled Mandatory Abuse and/or neglect reporting requirement of an allegation of abuse and/or neglect of a patient by a medical staff member, independent contractor, volunteer, consultant, visitor, other patient, employee or other patient states, in part, "1) All allegations or suspicion of the abuse/and or neglect of a patient by a medical staff member, independent contractor, consultant, family member or employee will be reported within one hour of discovery to Adult Protective Services, Texas Department of Protective and Regulatory Services and within twenty-four (24) hours to the Texas Department of State Health Services."

? Based on a review of a clinical record for Patient # 1 and related facility based investigation, an alleged incident of abuse involving this patient and a facility staff member was not reported to the Adult Protective Services, Texas Department of Protective and Regulatory Services per policy and regulation.

In an interview on 1/24/12, the facility Administrator and the interim Director of Nursing confirmed that the facility failed to report this allegation of abuse to all appropriate state agencies.

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Incomplete reports

No incomplete reports available.

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Tag No: A0450

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WADLEY REGIONAL MEDICAL CENTER ->

Report No. 1504

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WADLEY REGIONAL MEDICAL CENTER 1000 PINE STREET TEXARKANA, TX 75501 Jan. 17, 2012

VIOLATION: MEDICAL RECORD SERVICES

Based on record review and interview, the facility failed to assure hemodialysis orders contained all necessary components. 7 of 16 hemodialysis orders lacked an order for blood flow rate and dialysate flow rate. There was also no target weight (or dry weight) ordered/documented for 1 of 1 patient.

Findings include:

Further review of patient #1's chart revealed no order for blood flow rate or dialysate flow rate for 7 of 16 hemodialysis treatments on the following dates: 9/14/11, 9/16/11, 9/18/11, 9/20/11, 10/03/11, 10/10/11, and 10/12/11.

Review of patient #1's medical record revealed no documented target weight (or dry weight).

During an interview on 1/18/12 at 1:25pm in the administrative offices, staff #2 reported the following:

- -The patient 's weight gain since the last dialysis treatment (interval weight gain) is the amount of weight that should be removed during the dialysis treatment
- -If the interval weight gain is not the target, the physician should write an order for the target weight
- -Staff #2 was not aware of a policy or standing order that specified the amount of weight that should be removed during a dialysis treatment

Review of the hemodialysis policy and procedures revealed no policy guidance for weight to be removed during a dialysis treatment.



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Incomplete reports

No incomplete reports available.



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ODESSA REGIONAL HOSPITAL ->

Report No. 1549

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ODESSA REGIONAL HOSPITAL

520 E 6TH STREET ODESSA, TX 79761

Jan. 16, 2012

VIOLATION: CONTRACTED SERVICES

Tag No: A0083

Based on a review of documentation, the governing body was not responsible for services furnished in the hospital.

Findings were:

Facility policy & procedure IM1.22 titled "Imaging Procedure - Resuscitation" states, in part, " A crash cart is kept in the CT and X-ray department ...The cart will be checked each morning by a Tech. The tech visually checking the cart must initial the calendar (on side of cart) after ensuring the defibrillators and suction are in working condition and all drawers are locked. If for any reason the cart has been opened, the tech will call respiratory to stock and replenish immediately. A pharmaceutical technician will then verify medication contents and replace the lock ...The x-ray technologist assigned to check the drug tray will visually check the drug tray daily to assure the lock is intact and to assure contents are in good condition."

A review of the radiology crash cart daily checklist revealed that for the time period of 11-1-10 through 11-8-10, the " Pharm Lock# " column states, " unlocked " , indicating that the medication drawers of the imaging crash cart were unlocked.

The above was confirmed in a meeting with the Chief Financial Officer and the Director of Risk Management on the evening of 1-16-12 in the facility conference room.

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Incomplete reports

No incomplete reports available.

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NIX HEALTH CARE SYSTEM ->

Report No. 1497

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

NIX HEALTH CARE SYSTEM 414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205 Jan. 10, 2012

VIOLATION: CONTRACTED SERVICES

Tag No: A0083

Based on a review of documentation, the governing body was not responsible for services furnished in the hospital.

Findings were:

A review of the census for 9-21-11 and 9-22-11 revealed a total of 21 patients in the child/adolescent unit for each date.

Per the facility staffing grid, minimum staffing requirements for 21 child/adolescent patients on the 11p-7a shift are as follows:

- ? 1 Registered Nurse
- ? 1 Licensed Vocational Nurse
- ? 2 Mental Health Technicians

A review of the staffing sheet for the child/adolescent unit for the 11p-7a shift on 9-21-11 revealed only one mental health technician (as opposed to two).

Per the facility staffing grid, minimum staffing requirements for 21 child/adolescent patients on the 7a-3p shift are as follows:

- ? 2 Registered Nurses
- ? 1 Licensed Vocational Nurse
- ? 2 Mental Health Technicians

A review of the staffing sheet for the child/adolescent unit for the 7a-3p shift on 9-22-11 revealed only one registered nurse (as opposed to two).

The above was discussed in an interview with the Vice-President of Intake as well as the Vice-President of Behavioral Health on the afternoon of 1-10-12 in the facility conference room.

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Incomplete reports

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ALLEGIANCE SPECIALTY HOSPITAL OF KILGORE ->

Report No. 1528

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ALLEGIANCE SPECIALTY HOSPITAL OF 1612 SOUTH HENDERSON BLVD KILGORE, Dec. 29, KILGORE TX 75662 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on record review and interview the client failed to receive care in a safe setting from the facility.

Review of patient's record revealed patient had a weight gain from 130 pounds on 12/6/2011 to 146.5 pounds on 12/15/2011. Last weight recorded before discharge was 131 pounds on 12/20/2011. The nurse 's note of the patient's record did not reflect any type of notation about the weight grain of 16.5 pounds or the weight loss of 15.5 pounds on time of discharge.

An interview with staff #10 on 12/29/2011 at 1:30 PM reported after reviewing the patient's record, staff #10 had not picked up on the patient's weight gain or loss during the hospital stay between 12/6/2011 thru 12/23/2011.

Review of patient's record at the hospital facility revealed the patient had fallen on 12/14/2011 at 10:20 PM, It was documented in the client record " no signs of redness or edema Moves all extremities without difficulty No evidence of injury Denies any pain or discomfort."

Review of patient's record from the nursing home where patient was admitted after leaving the hospital setting revealed patient had abrasion below the right knee with a knot the size of a golf ball. X-ray obtained on 12/30/2011 and the results are "Bones: There appears to be old avulsion fracture fragment off the anterior/superior tibial tuberosity. The fracture may not be completely healed. Conclusions: There is either fractured spur or simple fragment off the anterior /superior tibial tuberosity at the proximal right tibia. This appears to be nonunited fracture."

VIOLATION: STAFFING AND DELIVERY OF CARE

Tag No: A0392

Based on document review and interview the facility failed to orientate 1 of 1 agency staff employed.

On 12/28/2011 at 3:00 PM nursing department staff folders were reviewed and 1 agency Mental Health Technician (MHT) was found to have no competencies and no general orientation to the Geri psychiatric, unit where the agency staff worked.

On 12/29/2011 at 10:00 AM an interview with the Chief Nursing Officer (CNO) revealed that agency staff was not used often. The CNO revealed that only on occasion was a nurse scheduled through an agency, usually agency staff was MHT and because they were agency they did not attend general orientation. The Agency supplied the background check, drug screening, identifying information, CPR verification, health information and verification of Texas registry or license. Then the agency staff was assigned 1:1 with another experienced staff for the shift.

A reviewed of 5 of 5 hospital MHT employees revealed all employees had signed confidentiality forms, communication forms, how to diffuse an agitated patient, acknowledgement of video surveillance, patient rights forms and Occupational Safety Health Administration (OSHA) forms.

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ALLEGIANCE SPECIALTY HOSPITAL OF KILGORE ALLEGIANCE SPECIALTY HOSPITAL OF KILGORE

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ALLEGIANCE HOSPITAL OF MIDLAND-PERMIAN BASIN ->

Report No. 1774

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ALLEGIANCE HOSPITAL OF MIDLAND-PERMIAN BASIN

207 TRADEWINDS BLVD MIDLAND, TX 79706

Dec. 22, 2011

VIOLATION: MEDICAL STAFF - ACCOUNTABILITY

Tag No: A0049

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview it was determined that the facility failed to ensure that quality patient care was provided; a psychiatrist ordered a "medical consult" for Patient #1, the "medical consult" was not carried out until 5 days after it was ordered.

Findings were:

Review of Patient #1's medical record on 12/22/11 revealed the following:

A psychiatrist ordered a "medical consult" for Patient #1 on 11/2/11.

No evidence could be found indicating that the medical consult was carried out until the afternoon of 11/7/11.

A nurse's note dated 11/7/11 and timed 1600 (4:00PM) indicated that a physician assistant saw Patient #1. The nurses note stated "Physician assistant assess pt. Advises staff to encourage & offer pt to drink fluid Q hr."

During an interview with the Chief Nursing Officer on 12/22/11 she stated that the above documentation was evidence of the "medical consult" ordered on [DATE] being carried out. She stated that there was no evidence that the first medical consult on 11/2/11 was carried out for 5 days, from 11/2/11 to 11/7/11 at 4 PM.

A psychiatrist ordered a second "medical consult" for Patient #1 on 11/7/11.

A progress note from a psychiatrist on 11/7/11 at 1900 (7:00PM) stated the following "I evaluated the pt, he was lying on the bed mumbling a few intelligible words. Per staff reports, the patients nutritional intake, fluid intake, and out put has been minimal in the past 4 days. Internal medicine services was consulted by myself on 11/2/11. Per records they have not ordered any labs or imaging. At this time I feel that the patient's current condition is not entirely due to his mental health condition, but more so due to his nutritional and general medical status, which has severely deteriorated since admission."

After being seen by an internal medicine physician on 11/9/11 Patient #1 was transferred to a hospital for treatment of dehydration.

During an interview with the Chief Nursing Officer on 12/22/11 she confirmed the above findings.



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207 TRADEWINDS BLVD MIDLAND, TX 79706 | Proprietary

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Incomplete reports

No incomplete reports available.



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HILLCREST BAPTIST MEDICAL CENTER ->

Report No. 1489

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HILLCREST BAPTIST MEDICAL CENTER

100 HILLCREST MEDICAL BLVD WACO, TX 76712

Dec. 20, 2011

VIOLATION: PATIENT RIGHTS: PERSONAL PRIVACY

Tag No: A0143

Based on observation and interview with staff, the hospital failed to ensure patients' personal privacy, as the monitors for cameras over patient beds could be seen by anyone walking down the hallway of a rehabilitation facility unit.

Findings were:

A tour of the rehabilitation unit was conducted the morning of 12/20/11 in the company of the Director of Nursing (DON) of the facility. The hospital utilizes cameras inside patient's rooms in an area of the facility for the purposes of staff monitoring to ensure patient safety. The camera monitors are situated overhead in the nursing station, and anyone walking down the hallway past the station can view the patients in their beds, not just the staff responsible for the patients. This was confirmed by the DON during the tour.



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VHS BROWNSVILLE HOSPITAL COMPANY, LLC ->

Report No. 1464

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VHS BROWNSVILLE HOSPITAL COMPANY, LLC

1040 W JEFFERSON ST BROWNSVILLE, TX Dec. 6, 78520 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on review of available records and staff interviews, the hospital failed to ensure that Patient #1 received care in a safe setting as he was not monitored according to physician order.

Findings were:

Patient #1 was not monitored every 15 minutes as ordered between 2:50 pm and 3:20 pm on 9/4/2011. The patient was found with a sheet around his neck in his bedroom wardrobe at approximately 3:20 pm. The patient sustained no harm. This was confirmed in interview on 12/6/11 with Staff #2, Staff #3, and Staff #4.

VIOLATION: RN SUPERVISION OF NURSING CARE

Tag No: A0395

Based on review of the patient record and staff interviews, the hospital failed to ensure that a registered nurse supervised and evaluated the care for each patient as a patient was not monitored according to orders and documentation was not complete.

Findings were:

Review of the medical record for Patient #1 revealed that Staff #6, an MHT who was responsible for monitoring Patient #1 every 15 minutes documented that she observed the patient on 9/4/11 at 3:00 pm, but per review of video monitoring of the unit, facility reports, the personnel record for Staff #6, and staff interviews, Staff #6 did not observe the patient for the 3:00 pm monitoring.

Review of hospital policy 15 Fifteen Minute Rounds revealed "The charge nurse will be responsible for assigning, ensuring the rounds are performed and documented by the assigned staff ...the staff member will converse with each patient during each round while awake ...the staff member will ensure the patient is not experiencing any difficulties or performing self injurious behavior."

Review of the medical record for Patient #1 revealed that there was no nursing assessment or progress note for 9/6/2011 between 7 am and 7 pm. Patient #1 had a physician 's order for 1:1 monitoring on 9/6/2011 between the hours of 7 am and 7 pm and there was no nursing documentation to reflect 1:1 monitoring between those hours. Staff #1 and Staff #3 stated in an interview on 12/6/11 that a nursing assessment/nursing progress note is required for each patient every 12 hour shift. In an interview on 12/6/11, Staff #1, Staff #2 and Staff #3 confirmed that there was no nursing assessment or progress note for Patient #1 on 9/6/2011 during the day shift between 7 am and 7 pm.

The above was confirmed in interview with Staff #1, Staff #2, and Staff #3 on 12/6/2011.

VIOLATION: FORM AND RETENTION OF RECORDS

Tag No: A0438

Based on review of the patient record and staff interviews, the hospital failed to ensure that the medical record for Patient #1 was complete.

Findings were:

Review of the medical record for Patient #1 revealed that there was no nursing assessment or progress note for 9/6/2011 between 7 am and 7 pm. Patient #1 had a physician 's order for 1:1 monitoring on 9/6/2011 between the hours of 7 am and 7 pm and there was no nursing documentation to reflect 1:1 monitoring between those hours. Staff #1 and Staff #3 stated in an interview on 12/6/11 that a nursing assessment/nursing progress note is required for each patient every 12 hour shift. In an interview on 12/6/11, Staff #1, Staff #2 and Staff #3 confirmed that there was no nursing assessment or progress note for Patient #1 on 9/6/2011 during the day shift between 7 am and 7 pm.



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ATLANTA MEMORIAL HOSPITAL ->

Report No. 1534

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

ATLANTA MEMORIAL HOSPITAL

1007 SOUTH WILLIAMS STREET ATLANTA, TX

Dec. 1, 2011

Tag No: A0115

Tag No: A0154

75551

VIOLATION: PATIENT RIGHTS

Based on document review and interview the facility failed to insure the right of 1 of 1 psychiatric patient identified.

A. A-154 482.13 (e)

Based on interview and documentation the facility failed to insure the use of restraint (chemical, and mechanical) were not used for convenience as evidenced by 1 of 1 patient reviewed.

Refer to tag

B. A 159 482.13.(e) (1) (i) (A) Based on document review and interview the facility failed to develop and implement policies and procedures for the use of restraint Refer to tag

C. A 0160 482.13 (e)(1)(i)(A)

Based on document review and interview the facility failed to insure the rights of 1 of 1 psychiatric patient identified.

Refer to tag

D. A 166 482.13 (e) (4) (i)

Based on document review and interview the facility failed to modify the patients treatment plan to reflect the use of seclusion in 1 of 1 patient identified.

Refer to tag

VIOLATION: USE OF RESTRAINT OR SECLUSION

Based on interview and documentation the facility failed to insure the use of restraint (chemical, and mechanical) were not used for convenience as evidenced by 1 of 1 patient reviewed.

On 12/1/2011 at 10:30 AM in the Senior Care unit Staff #3 was interviewed and confirmed there were no specific policies and procedure for restraint and seclusion for the Senior Care unit. When asked how long would a patient stay in seclusion she stated, "a couple of hours or until they calmed down or the physician said let them out"

On 12/1/2011 at 11:00 AM in the conference room patient #1 medical record was reviewed and revealed the following nurses narrative: 1.) 5/18/2011 1714 hours (hrs). Patient #1 was involuntarily admitted to the Senior Care unit. Documentation reveals patient #1 was pleasant and cooperative neat clean and ambulatory.
2.) 5/19/2011 at 0441 hrs the following: "Pt awake, denies pain or discomfort, assisted in to Geri--chair and moved closer to nurses

3.) 5/19/2011 1916 hrs. "Pt sitting near nurses station in Geri-chair...." 5/19/2011 0042 hrs...Assisted to bed from Geri-chair..." 4.) 5/21/2011 1035 hrs "Pt sitting (in Geri-chair) in front of the nurses station..." 5/21/2011 1058 hrs. "Pt agitated, raising voice beating on the tray on his chair. Pt stated "I don't know who I am or what I am doing" Geodon 10 mg. IM (intramuscularly) given without resistance. Assisted to the bathroom and was not combative or aggressive. 1:1 monitoring cont".

- 5.) 5/22/2011 1200 hrs. "Frequent contact with patient, camera monitored room..."
 6.) 5/23/2011 2001 hrs. "Pt sleeping quietly at present....Pt is level 3 f/p (fall/precaution) resting in Geri-Chair at this time".
 7.) 5/24/2011 0614 hrs. "Pt sleeping quietly....resting in Geri-Chair near nurses station..."
 8.) 5/25/2011 0528 hrs. "Pt finally sleeping to the purpose at this pipe of the present sleeping in Geri-chair near nurses station".

5/25/2011 1425 hrs. "has been sleeping at nurses station in reclining Geri-chair since this AM". 5/25/2011 1540 hrs. "is becoming agitated, redirect ineffective. All interventions ineffective. Assaulted 3 staff called staff #4 orders received for locked door seclusion". Late entry 1830 hrs

5/25/2011 1800 hrs "Earlier attempt at locked door seclusion ineffective. Pt breaking door down. Security and police called. Placed in handcuff by police and was effective in subduing pt, allowing staff to administer medications to pt for sedation..." Late entry 1845 hrs. 5/25/2011 2024 hrs. "Staff #4 notified of patient condition with new order for Geodon 10 mg IM administered at 1715 pt remains in police handcuffs at this time pt calmer at 1815 police remove handcuffs and new order for wrist restraints obtained per staff #4 Bilateral soft wrist restraints applied pt in room in bed"

5/25/2011 2359 hrs. "Pt is in bed with wrist restraint...."

9.) 5/26/2011 0100 hrs "Unable to remove wrist restraints patient continues to be hostile toward caregiver".

- 5/26/2011 0353 hrs. "still unable to remove restraints, patient still aggressive, hostile, danger toward others".
 5/26/2011 0432 hrs. "Pt is still in wrist restraints but agitation is increasing, cursing, bawling like an animal, banging his heels on the foot of the bed kicking as staff approach him..."

5/26/2011 0500 hrs. "Geodon 5mg IM ineffective. patient continues sitting up in bed with wrist restraints on. sliding down to the foot of the bed shaking the bed so hard the top of the bed is rising off the floor patient is about to turn bed over on himself. staff #4 contacted new order received Geodon 10 mg IM left thigh at 0500, ankle restraints applied".

5/26/2011 0546 hrs. "Pt is more calm, has stopped yelling but is still sitting up in bed with all restraints on"
5/26/2011 0835 hrs. "Pt continues to be calm at present wrist restraint on, ankle restraints removed pt tolerated removal no kicking or moving about in bed at this time...."

5/26/2011 1855 hrs. "wrist restraints removed per staff #4 at 0945 hrs...."

On 12/1/2011 at 11:30 AM a review of patient #1 medical record revealed there were no physician's orders for the placement of patient #1 in a Geri-chair with a tray. Restraint records which begin on 5/25/2011 do not include a Geri-chair with a tray as a restraint.

Although the Patient #1 demonstrated aggressive combative behavior the facility had no policy or procedure to guide staff in what was considered a restraint. How and when to apply the restraint. How frequently restraints had to be released or how to monitor a patient in restraints. The patient was restraint out of staff fear of his aggressive history.

Further review of medical record for Patient #1 revealed the following:

- 1.) Physician's order 5/18/2011 1630 hrs. Geodon 10 mg IM (intramuscularly) Q (every) 6 hours, PRN (as needed) combativeness was ordered.
- 2.) Physician's orders sheet 5/19/2011 1100 hrs. decrease Geodon 5mg IM Q6 hrs PRN combativeness.
- 3.) Further review of medical record revealed nurses narrative dated 5/20/2011 1844 hrs. "Pt became very restless...given Seroquel 50 mg. Pt continues to escalate and constantly walking around the unit without his walker. Geodon 10 mg IM given without difficulty or resistance. Pt has not been combative but body language indicates he could..." The order is written for Geodon as needed for combativeness. The patient was not combative or even resistive.
- 4.) Nurses narrative dated 5/21/2011 1058 hrs. "Pt agitated. raising voice beating on the tray on his chair ...Pt given Geodon 10 mg IM without resistance. Assisted to bathroom was not combative or aggressive".

 The order is written for Geodon 5mg as needed for combativeness. The nurse administered 10 mg Geodon IM without an order. (The patient is already restrained in a Geri-chair)The patient was not combative or even resistive.
- 5.) Nurses narrative dated 5/22/2011 0000 hrs. "Seroquel ineffective, patient still restless, swinging arms, behavior unpredictable, Geodon 5mg IM left arm..."

The Geodon was administered without combativeness observed or documented.

- 6.) Nurses narrative dated 5/23/2011 1544 hrs. "Pt became restless, yelling at nurse and shaking fist at nurse....Pt cont to escalate and walk into other rooms difficult to redirect. Geodon 5mg IM given without difficulty or resistance... The order for Geodon is for combative behavior. The patient was either combative no resistant. He was difficult to redirect.
- 7.) Nurses narrative dated 5/24/2011 0151 hrs. "Pt continues to be awake restless and agitated. Seroquel 50 mg PO (by mouth) given x 2 PRN not effective. Geodon 5 mg given IM in right thigh for restlessness and agitation." The order is Geodon as needed for combative behavior not restless agitation.
- 8.) Nurses narrative dated 5/25/2011 1425 hrs. "(Pt) has been asleep at nurses station in reclining Geri-chair since this AM". Nurses narrative dated 5/25/2011 1640 hrs. "is becoming agitated redirect ineffective. All interventions ineffective assaulted 3 staff. Called staff #4 orders received for locked door seclusion."

There is no documentation for the time between 1425 hrs and 1640 hrs. The narrative reads as if the patient went to sleep and woke up assaulting 3 staff. Although the narrative reads that no interventions altered the behavior no actual intervention are listed.

Geodon IM was given five (5) times for the staffs convenience as no combative behavior was observed or documented until 5/25/2011.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on document review and interview the facility failed to develop and implement policies and procedures defining a restraint or the need for and the use of restraint (chemical and mechanical) and seclusion as evidenced by 1 of 1 patient reviewed.

Tag No: A0159

On 12/1/2011 at 10:30 AM in the Senior Care unit Staff #3 was interviewed and confirmed there were no specific policies and procedure for restraint and seclusion for the Senior Care unit. When asked how long would a patient stay in seclusion she stated, "a couple of hours or until they calmed down or the physician said let them out"

On 12/1/2011 at 1:00 PM in the conference room the policies and procedures for the Sr Care unit were reviewed and revealed the

following:

Senior Care Unit Policy and Procedure manual table of contents.

Section V: Special Treatment Procedures which include; Mechanical restraint, protective & supportive devices, seclusion clinical time out and quiet time, Transferring patients from / to Medical services and Prohibited practices has a line drawn across the page and a hand written note which reads...Šee SrCare policy & Procedure manual for 500-501 & 501. It is signed by a staff member and dated 4/10/09. These policies were not found in the SrCare policy manual.

2. There was no policy for chemical restraint.

3. There was no policy for outside assistance in restraint (Police intervention)

On 12/1/2011 at 11:00 AM in the conference room patient #1 medical record was reviewed and revealed the following:

- 1.) Nursing documentation reflects 5/18/2011 1714 hours (hrs). Patient #1 was involuntarily admitted to the Senior Care unit. Documentation reveals patient #1 was "pleasant and cooperative neat clean and ambulatory".
- 2.) Nursing assessment 5/19/2011 at 0441 hrs the following: "Pt awake, denies pain or discomfort, assisted in to Geri--chair and moved closer to nurses station...
- 3.) Nurses narrative 5/19/2011 1916 hrs. "Pt sitting near nurses station in Geri-chair.... 5/19/2011 0042 hrs... Assisted to bed from Gerichair..."
- 4.) Nurses narrative 5/21/2011 1035 hrs "Pt sitting (in Geri-chair) in front of the nurses station..."5/21/2011 1058 hrs. "Pt agitated, raising voice beating on the tray on his chair. Pt stated "I don't know who I am or what I am doing" Geodon 10 mg. IM (intramuscularly) given without resistance. Assisted to the bathroom and was not combative or aggressive. 1:1 monitoring cont".

5.) Nurses narrative 5/22/2011 1200 hrs. "Frequent contact with patient, camera monitored room..."
6.) Nurses narrative 5/23/2011 2001 hrs. "Pt sleeping quietly at present....Pt is level 3 f/p (fall/precaution) resting in Geri-Chair at this time".
7.) Nurses narrative 5/24/2011 0614 hrs. "Pt sleeping quietly...resting in Geri-Chair near nurses station..."
8.) Nurses narrative 5/25/2011 0528 hrs. "Pt finally sleeping quietly since 2:00 AM...at present sleeping in Geri-chair near nurses station".
5/25/2011 1425 hrs. "has been sleeping in Geri-chair since this AM". 5/25/2011 1540 hrs. "is becoming agitated, addition in religion of the faction of redirect ineffective. All interventions ineffective. Assaulted 3 staff called staff #4 orders received for locked door seclusion". Late entry 1830

5/25/2011 1800 hrs "Earlier attempt at locked door seclusion ineffective. Pt breaking door down. Security and police called. Placed in handcuff by police and was effective in subduing pt, allowing staff to administer medications to pt for sedation..." Late entry 1845 hrs. 5/25/2011 2024 hrs. Staff #4 "notified of patient condition with new order for Geodon 10 mg IM administered at 1715 pt remains in police handcuffs at this time pt calmer at 1815 police remove handcuffs and new order for wrist restraints obtained per staff #4 Bilateral soft wrist restraints applied pt in room in bed".
5/25/2011 2359 hrs. "Pt is in bed with wrist restraint...."
9.) Nurses narrative 5/26/2011 0100 hrs "Unable to remove wrist restraints patient continues to be hostile toward caregiver".

5/26/2011 0353 hrs. "still unable to remove restraints, patient still aggressive, hostile, danger toward others". 5/26/2011 0432 hrs. "Pt is still in wrist restraints but agitation is increasing, cursing, bawling like an animal, banging his heels on the foot of the bed kicking as staff approach him..."
5/26/2011 0500 hrs. "Geodon 5mg IM ineffective. patient continues sitting up in bed with wrist restraints on. sliding down to the foot of the

bed shaking the bed so hard the top of the bed is rising off the floor patient is about to turn bed over on himself. staff #4 contacted new order received Geodon 10 mg IM left thigh at 0500, ankle restraints applied".

5/26/2011 0546 hrs. "Pt is more calm, has stopped yelling but is still sitting up in bed with all restraints on"
5/26/2011 0835 hrs. "Pt continues to be calm at present wrist restraint on, ankle restraints removed pt tolerated removal no kicking or moving about in bed at this time....

5/26/2011 1855 hrs. "wrist restraints removed per staff #4 at 0945 hrs...."

On 12/1/2011 at 11:30 AM a review of patient #1 medical record revealed there were no signed physician's orders for the placement of patient #1 in a Geri-chair with tray. Restraint records which begin on 5/25/2011 do not include a Geri-chair with a tray as a restraint. Geodon which is given five (5) times to control Patient #1 out burst and is not identified as a restraint on any monitoring document. There was no policy or procedure to guide staff in what was considered a restraint, how to use the restraints, or when a restraint might be needed.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on record review the facility failed to insure that As Needed (PRN) medications were not used to manage patients behavior and restrict the patients movement in 1 of 1 patients identified.

Tag No: A0160

On 12/1/2011 at 11:00 AM in the conference room the medical record for patient #1 was reviewed and revealed the following: 1.) Physician's order reflects 5/18/2011 1630 hrs. Geodon 10 mg IM (intramuscularly) Q (every) 6 hours, PRN (as needed) combativeness was ordered.

- 2.) Physician's orders sheet 5/19/2011 1100 hrs. reflects decrease Geodon 5mg IM Q6 hrs PRN combativeness.
- 3.) Further review of medical record revealed nurses narrative dated 5/20/2011 1844 hrs. "Pt became very restless...given Seroquel 50 mg. Pt continues to escalate and constantly walking around the unit without his walker. Geodon 10 mg IM given without difficulty or resistance. Pt has not been combative but body language indicates he could...'

The physician's order is written for Geodon as needed for combativeness. Nursing documentation reflects the patient was not combative or even resistive. Geodon 10 mg IM was not ordered by the physician but was given by the nurse.

- 4.) Nurses narrative dated 5/21/2011 1058 hrs. "Pt agitated. raising voice beating on the tray on his chair ...Pt given Geodon 10 mg IM without resistance. Assisted to bathroom was not combative or aggressive".
- The physician's order is written for Geodon 5mg as needed for combativeness. The nurse administered 10 mg Geodon IM without an order. Nurses narrative reflects the patient is already restrained in a Geri-chair. The nurses reflects the patient was not combative or even resistive. Geodon 5mg IM was ordered by the physician but Geodon 10 mg IM was given by the nurse.
- 5.) Nurses narrative dated 5/22/2011 0000 hrs. "Seroquel ineffective, patient still restless, swinging arms, behavior unpredictable, Geodon 5mg IM left arm...

Nurses narrative does not document combative behavior from the patient yet Geodon was administered IM

6.) Nurses narrative dated 5/23/2011 1544 hrs. "Pt became restless, yelling at nurse and shaking fist at nurse....Pt cont to escalate and walk into other rooms difficult to redirect. Geodon 5mg IM given without difficulty or resistance...'

The physician's order if for Geodon for combative behavior. Nurses narrative does not reflect the patient was combative. Nurses documentation reflects he was difficult to redirect.

7.) Nurses narrative dated 5/24/2011 0151 hrs. "Pt continues to be awake restless and agitated. Seroquel 50 mg PO (by mouth) given x 2 PŔN not effective. Geodon 5 mg given IM in right thigh for restlessness and agitation." The physician's order is for Geodon as needed for combative behavior not restless agitation. Nurses narrative does not reflect combative

behavior.

8.) Nurses narrative dated 5/25/2011 1425 hrs. "(Pt) has been asleep at nurses station in reclining Geri-chair since this AM". Nurses narrative dated 5/25/2011 1640 hrs. "is becoming agitated redirect ineffective. All interventions ineffective assaulted 3 staff. Called staff #4 orders received for locked door seclusion."

There is no documentation for the time between 1425 hrs and 1640 hrs. The nurses narrative reads as if the patient went to sleep and woke up assaulting 3 staff. Although nurses narrative reads that no interventions altered the behavior, no actual intervention are listed.

Geodon IM was given five (5) times for the staffs convenience to manage the patient's behavior. No combative behavior was observed or documented until 5/25/2011.

Tag No: A0166

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on document review the facility failed to modify the patients treatment plan to reflect the use of restraints and seclusion in 1 of 1 patient identified.

On 12/1/2011 at 11:00 AM in the conference room the medical record for patient #1 was reviewed and revealed the following:

1. The treatment plan did not address the use of chemical, mechanical, physical restraint or seclusion at any point during patient #1 stay in the facility. Patient #1 was admitted on [DATE] and discharged on [DATE], 10 days.

 Nurses narrative reveals the patient spent a portion of each day in a Geri-chair with a lap tray without physician's order.
 Nursing documentation reflects patient #1 was given five (5) IM injections without combativeness documented. The "As Needed" order from the physician was for combative behavior.

4. The nurses narrative dated 5/25/2011 1540 hours, reflect a physician's order was obtained for locked door seclusion.

5. Nurses narrative dated 5/25/2011 1800 hours, reflect staff were unable to get the patient safely into the seclusion room and opted for police intervention and as needed medication for combativeness instead.

The treatment plan did not reflect interventions for any behavioral outburst or any restraints during the 10 day stay in the facility.

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ATLANTA MEMORIAL HOSPITAL ATLANTA MEMORIAL HOSPITAL

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Dec. 1, 20115 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. Incomplete reports

No incomplete reports available.

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DOCTORS HOSPITAL ->

Report No. 1553

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

DOCTORS HOSPITAL

9440 POPPY DR DALLAS, TX 75218

Dec. 1, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on record review and interviews, the facility failed to provide a safe setting for one of one patient (patient #1) in that the patient was approached and touched by a visitor that was unknown to the patient.

Findings included:

- 1) The medical record for patient #1 included that on 11/07/11 at about 1730 she had a visitor in her room that touched her chest and asked if the facility had taken her bone marrow. Patient #1 had surgery that morning and was still receiving morphine. She told the nurse that she did not know the visitor and the nurse told the visitor he had to leave the unit.
- 2) The investigation report included that security was called and escorted the visitor out of the facility. The local police department was called. The events as recorded in the medical record were confirmed.
- 3) Facility Policy "Patients Rights and Responsibilities, Every Patient shall have the right to:...A safe environment..."
 3) During interviews with the surveyor, the Risk Manager (at 0904 on 12/01/11), the RN (Personnel #3)who noted the events (at 1426 on 12/01/11) and the Facility Manager (at 0955 on 12/01/11) were asked if Patient #1 was approached and touched by an unknown visitor. They confirmed that the incident occurred.



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BRINGING TRANSPARENCY TO FEDERAL INSPECTIONS

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WESTBURY COMMUNITY HOSPITAL, LLC ->

Report No. 1780

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

WESTBURY COMMUNITY HOSPITAL, LLC 5556 GASMER HOUSTON, TX 77035 Dec. 1, 2011

VIOLATION: PATIENT RIGHTS Tag No: A0115

Based upon record review and interview, the facility failed to ensure the safety of 3 of 3 (#2, #8, #6) adolescent patients while receiving care. 1. Patient #2 was allegedly physically abused by Staff #57. 2. Patient #8 was allegedly physically abused by Staff #57 and reported by patient #7 who was a witness. 3. Patient #6 was physically abused by Staff #57. The physical abuse of Patient #6 was witnessed by a contracted electrical worker. The facility failed to have a process in place for investigating allegations of abuse. The facility also failed to thoroughly investigate allegations of abuse made by Patient #2 against Staff #57. As a result of the lack of investigation to allegations of abuse of patient #2, there were witnessed incidents of abuse of patient #6 and #8 by Staff #57.

REFER TO TAG A-144

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based upon record review and interview, the facility failed to ensure the safety of 3of 3(#2, #8, #6) adolescent patients while receiving care. 1. Patient #2 was allegedly physically abused by Staff #57. 2. Patient #8 was allegedly physically abused by Staff #57 and reported by patient #7 who was a witness. 3. Patient #6 was physically abused by Staff #57. The physical abuse of Patient #6 was witnessed by a contracted electrical worker.

1. Review of medical record of patient # 2 revealed patient was a[AGE] year old male admitted on [DATE] from a residential treatment program with diagnoses of Mood Disorder, Psychosis, ADHD (Attention Deficit Disorder), and ODD (Oppositional Defiant Disorder). Patient was admitted due to reports of hearing voices telling him to harm others, impulsive, and angry after he assaulted a peer. History reported patient witnessed his father kill his mother.

Review of the complaint information called to the agency 's hotline revealed, "Patient #2 reported on 11/7/11, his first day at the facility, Staff #57 banged patient 's head on a table several times for no reason. Patient has a small bruise underneath his left eye. Patient reported he does not feel safe at the facility.

Review of the occurrence report dated 11/8/11 at 8:00 am revealed the following: " On the above date and time, staff asked patient if he would like breakfast. The patient cursed at the staff and attempted to assault staff. " The occurrence report did not indicate who the staff member was involved in the verbal exchange with the patient. The occurrence report did contain a notation that the Nursing Supervisor was notified.

An interview was conducted with Staff #60 (Nursing Supervisor) on 12/1/11 at 2:00 pm.

Staff #60 reported she went to the unit to investigate the occurrence on 12/8/11. Staff #60 reported she interviewed patient #2 and he reported to her that Staff #57 (Mental Health Technician) came into patient 's room and threatened patient #2 and patient #2 told staff that he couldn 't do anything to him because he did nothing wrong. Patient #2 reported to Staff #60 that Staff #57 pushed him to the ground and he started to pound his head on the ground and put his knee to his back to hold him down. Staff #60 asked patient #2 to write a statement describing the incident.

Review of patient #2 's written statement dated 11/9/11 revealed the following: Staff #57 " came in my room and said, 'Do you want me to put my hands on you now or later. 'I told him no and he repeated it. I told him you can 't put your hands on me unless I am doing wrong. He asked me to stand and I refused to stand up and he pushed me to the ground and he started to beat my head to the ground and putting his knee in my back. I am scared to be here because what happened could happen again and staff try to tell me I came in with this bump but I did not and they took pictures of me after the incident. They told me I already did this, but I beg to differ. It was not. "

Review of pictures of patient #2 dated 11/8/11 revealed patient had a darkened area and swelling noted to his left eye and temple area. Review of the documentation of physical/medical issues during the admission process, did not indicate that the discoloration or swelling was present on admission.

Review of written statements related to this occurrence report revealed the following:

Staff #68 reported patient #2 " was admitted on [DATE] at 8:00 pm. Upon admission, I noted swelling to the left lateral eye. His lips were swollen and sore. Some bruises noted to face and upper body. "

Staff #69 written statement - " On 11/8/11 at 6:45 am, upon entering the unit, I observed patient #2 in the hallway. My initial observation of the patient was his left eye was black and swollen. I also observed the patient 's bottom lip was swollen and scabbed. As I was redirecting the patient to go into his room, I asked the patient how he got his injuries. The patient states that he bites his lip. The patient also stated that he had his eye injury previous to coming to the hospital. Throughout the shift patient was observed intentionally irritating his left eye by pressing on it. I personally redirected the patient numerous times about not touching his left eye. The patient also stated to me that he got into a physical altercation with a peer from his placement prior to coming to the hospital. The patient stated that his peer at his placement gave him his black eye. The patient also stated that he was restrained several times before coming to the hospital by his placement staff for aggressive behavior and attempts to leave. "

Review of the nurse 's admission assessment for patient #2 revealed no documentation that there was any problem with the patient 's eye on admission. The diagram of the body on the assessment form did not have any markings on or around the patient 's left eye.

An interview was conducted with Staff #60 on 12/1/11 at 2:00 pm. Staff #60 reported that when patient #2 made the allegations of abuse against staff #57, Staff #60 reassigned staff #57 to work on the general adult psychiatric unit until the investigation was completed. Staff #60 reported that patient #2 continued to make the allegations throughout his hospitalization and his story was consistent and never changed.

Staff #60 further reported there was no policy regarding investigating patient allegations of abuse, neglect, or exploitation. Staff #60 reported patient #2 was discharged from the facility on 11/18/11 and Staff #57 was then allowed to return to work on the adolescent unit and there was never any determination if the allegations of abuse were substantiated.

2. Interviews were conducted on 12/1/11 with Staff #50 and Staff #55 at approximately 2:30 pm. Both Staff #50 and Staff #55 reported there was no policy regarding the investigation of patient allegations of abuse, neglect, and exploitation. Staffs #50 and #55 were asked to bring all Occurrence Reports alleging abuse to surveyor for review.

The occurrence documents provided by Staff #50 and Staff #55 were as follows: A form titled " Patient/Employee Complaint Form " dated 11/17/11 was completed by patient #7 regarding patient #8. " Patient #8 was in the day room doing nothing and a tech (Staff #57) chased him around pushing him a number of times and hit him in the jaw eight times. Please do something about it. " Another written statement dated 11/18/11 at 11:34 am from staff #66 revealed " I was escorting a patient out after discharge. He informed me that a tall, bald tech (Staff #57) punched patient #8 in the face and punched him eight more times. He stated that this took place in the activity room and that 's how the television was broken. The patient also stated that another dark, older tech (Staff #67) was present. There was no documentation that this patient complaint and employees written statement was ever reported to Nursing Supervisor, Patient Advocate, or Risk Manager. There also was no evidence of any investigation of the alleged abuse of patient #8 by staff #57.

An interview was conducted with Staff #60 on 12/1/11 at 2:00pm. Staff #60 reported she was not informed of the incident between patient #8 and staff #57 which allegedly occurred on 11/17/11. Staff #60 reported she found out about that alleged incident after receiving the report of physical abuse of patient #6 by staff #57 and to her knowledge the incident involving patient #8 was never investigated. Staff #60 also reported that the alleged incident involving patient #8 occurred 2 hours after Staff #57 returned to work on the adolescent unit.

3. Review of occurrence report dated 11/21/11 at 10:50 am revealed the incident occurred in the hallway in the adolescent unit. Patient #6 reported he was grabbed by neck and held in a choke hold then thrown to the ground by Staff #57. Patient complained of soreness around the neck. Further review of the occurrence report revealed patient #6 was agitated and using profanity and refusing redirection. Staff #57 placed patient in a choke hold and held him down on the floor. Staff #57 was immediately asked to leave the adolescent unit.

Review of written statement by Patient #6 revealed the following: "I feel like I was being abused in this situation. Because he (staff #57) had asked if I ' m a prostitute and I said ' Hell no ' then he got in my face. I told him to ' get the fuck out of my face. ' That ' s when he started to put his arm around my neck and took me down to the ground and slammed my head against the floor. I said ' You going to hit me again?' He had his knee in my back the whole time and everyone in that hallway can tell you I never laid a hand on him."

Review of the written statement by contracted electrical worker (#64) revealed the following: " I seen Tech (Staff #57) tell patient #6 to get into room. That caught my eye. Staff #57 did not see me. I was in doorway across the hall from the room. Staff #57 told patient #6 he needs to respect him and patient asked why two times. Patient said ' I didn ' t say a fucking thing ' . Patient did not put a hand or finger on staff #57. Staff #57 grabbed patient #6, threw him against the wall to the right hard, then spun him around to left, threw him to the ground. Staff #57 climbed on top and shoved patient ' s head onto the floor 2-3 times then was on top with knees into patient ' s side and back, all the time the tech saying you are going to respect me and I am not your friend. He stayed on top of him for at least 5 minutes. He gets up and must have seen me. I was going to get his name off his name badge but his badge disappeared. It was there when he got up off of patient but then disappeared when he realized I saw the incident. I went and told nurses at nurse ' s station. No one was there to witness what I seen until the very end just before he got up and off of patient. The other techs were at each end of hall, so they did not see the patient being abused. "

A written statement by Staff #65 on 11/21/11 revealed, "Patient #6 came onto the hall while the other patients were exercising. Staff #57 asked the patient was he going to participate. The patient began cursing the staff and pushed pass the staff bumping the staff. Staff #57 took the patient to the floor."

A written statement by Staff #57 (alleged perpetrator) revealed, "On 11/21/11, in the hallway while all the patients were working out in the hallway, staff asked patient if he was going to participate. He replied by cursing saying 'Hell no, get the fuck out of my face and shut the fuck up' then pushed by me in an aggressive manner bumping me. I then used the proper technique to keep the patient and myself safe, gave him verbal directives, then he stood up and was fine. Patient #6 then apologized and his behavior on the unit was fine. "

An interview was conducted on 12/1/11 at 2:00 pm with Staff #60. Staff #60 reported she instructed staff #57 to leave the unit immediately and proceeded to interview patient and witnesses. Staff #60 reported that 11/21/11 was the last day staff #57 worked at the facility.

An interview was conducted with Staff #54, Vice President of the Corporation and functioning in the capacity of Risk Manager, and Staff #55, Patient Advocate, on 12/1/11 at 2:30 pm. When survey findings were discussed with staff, they both acknowledged the discussion was the first of their hearing about these occurrences. Staff #54 reported there was no formal process for conducting investigations for abuse, neglect, and exploitation. He further reported they have a process for reporting abuse and neglect of patients when the abuse has occurred outside of the facility but there was nothing in place for abuse within the facility.

Review of Staff #57 personnel records revealed a form titled "Personnel Action Form". The form contained the following information: Involuntary Separation due to Violation of Company Policy. Last Day Worked - 11/21/11. Not eligible for rehire. Review of section titled Miscellaneous Comments revealed "Patient Abuse-Confirmed.

VIOLATION: PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT

Based upon record review and interview, the facility failed to have a process in place for investigating allegations of abuse. The facility also failed to thoroughly investigate allegations of abuse made by Patient #2 against Staff #57. As a result of the lack of investigation to allegations of abuse of patient #2, there were witnessed incidents of abuse of patient #6 and #8 by Staff #57.

Tag No: A0145

REFER TO TAG - A-144

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LUBBOCK HEART HOSPITAL LP ->

Report No. 1581

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LUBBOCK HEART HOSPITAL LP 4810 NORTH LOOP 289 LUBBOCK, TX 79416 Nov. 30, 2011

VIOLATION: MEDICAL STAFF CREDENTIALING Tag No: A0341

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview, it was determined that the facility failed to follow their policy and procedure related to physician credentials for moderate sedation and physician privileges for Propofol administration.

Findings Were:

Facility policy entitled "Moderate Sedation ... Effective Date: [DATE]," reviewed on 11/30/11, stated the following:

- On page 2 of 11: "4. Qualified Personnel ...Physicians must be credentialed for moderate sedation to order and/or administer moderate sedation as they must demonstrate a working knowledge of resuscitation equipment, monitoring equipment, commonly utilized medications and their dosages and risks, be able to interpret the clinical findings, and be able to rescue a patient from the next level of sedation. Physicians will maintain credentials to order/administer moderate sedation and will be encouraged to maintain ACLS provider status."
- On page 7 of 11: "Agents Used for Moderate Sedation...Physicians and nurses who do not have privileges in anesthesiology should not administer drugs classified as anesthetic agents, including but not limited to Propofol ..."

The facility's Medical Bylaws were reviewed on 11/30/11. The Medical Bylaws entitled "Lubbock Heart Hospital, L.L.C. Bylaws of the Medical Staff" stated under "Article V Determination of Clinical Privileges" section "5.1 Exercise of Privileges" stated "Every Medical Staff member of Affiliate providing direct Clinical services at the Hospital shall, in connection with such practice and except as otherwise provided in Sections 5.6 and 5.7 be entitled to exercise only those clinical privileges or specified services specifically granted to him/her by the Governing Body."

Provider #2's (physician) credential file was reviewed on 11/30/11. No evidence could be found by the surveyor, or provided to the surveyor by the facility's staff, regarding Provider #2's credentials for moderate sedation, or privileges for anesthesia.

The following patient medical records, reviewed on 11/29/11 and 11/30/11, had an invasive cardiac procedure performed by Provider #2:

- Patient #1: An intra-operative note by Provider #2 stated that during a procedure on 2/11/11 the patient received "conscious sedation." A medication record from this procedure indicated that a total of 5 mg of Versed were ordered by Provider #2 and administered to the patient by a nurse between 2:39PM and 3:44PM. Additionally, this record indicated that 30 mg of Propofol (as a drip at the rate of 20 mcg/kg/min) was ordered by Provider #2 and administered by Provider #2 between 2:35PM and 3:35PM.
- Patient #2: An intra-operative note by Provider #2 stated that during a procedure on 1/23/11 the patient received "conscious sedation." A medication record from this procedure indicated that a total of 4 mg of Versed were ordered by Provider #2 and administered to the

patient by a nurse between 9:06AM and 9:36AM.

- Patient #3: An intra-operative note by Provider #2 stated that during a procedure on 9/19/11 the patient received "conscious sedation." A medication record from this procedure indicated that a total of 24 mg of Versed were ordered by Provider #2 and administered to the patient by a nurse between 1:46PM and 3:10PM.
- Patient #4: An intra-operative note by Provider #2 stated that during a procedure on 10/13/11 the patient received "conscious sedation." A medication record from this procedure indicated that a total of 20 mg of Versed were ordered by Provider #2 and administered to the patient by a nurse between 3:14PM and 4:13PM.
- Patient #5: An intra-operative note by Provider #2 stated that during a procedure on 9/711 the patient received "conscious sedation " A medication record from this procedure indicated that a total of 17 mg of Versed were ordered by Provider #2 and administered to the patient by a nurse between 7:26AM and 8:13AM.
- Patient #6: An intra-operative note by Provider #2 stated that during a procedure on 6/1/11 the patient received "conscious sedation." A medication record from this procedure indicated that a total of 10 mg of Versed were ordered by Provider #2 and administered to the patient by a nurse between 8:52AM and 8:58AM.
- Patient #7: An intra-operative note by Provider #2 stated that during a procedure on 6/1/11 the patient received "conscious sedation." A medication record from this procedure indicated that a total of 5 mg of Versed were ordered by Provider #2 and administered to the patient by a nurse between 11:35AM and 11:44AM.

The above findings were confirmed by the Staff #4 (Chief Nursing Officer) during an interview on 11/30/11.



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4810 NORTH LOOP 289 LUBBOCK, TX 79416 | Government - Local

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Nov. 30, 20111 (click for details) Read full report

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No incomplete reports available.

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CARE REGIONAL MEDICAL CENTER ->

Report No. 1533

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CARE REGIONAL MEDICAL CENTER

1711 W WHEELER AVENUE ARANSAS PASS, TX Nov. 22, 78336 2011

VIOLATION: *DELIVERY OF DRUGS*

Tag No: A0500

Tag No: A0144

Upon facility tour, interview with staff and review of policies and procedures, the facility failed to ensure that controlled substances are secured and locked as required.

Findigns:

- a. Upon facility tour of the emergency room , found that controlled substances are being stored in small metal cabinet with two drawers. The cabinet key was found in an unattended desk drawer by the nurses station.
- b. Interviewed staff nurse who stated that key is supposed to be with staff nurse but sometimes they just put it in the drawer so that all staff can find it easily. She confirmed that the key was not secured and that desk where key is kept is sometimes unattended.
- c. Reviewed facility policy titled "Distribution and administration of controlled subtances" Procedure 2.4.12 states that Keys to the narcotic drawer are kept by each nurse dispensing medication." Staff nurse agreed that the key is not being kept by each nurse and that sometimes they put it in the drawer. She was unable to provide evidence with compliance to this policy.

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based upon review of personnel files, and interviews with staff the facility failed to provide services in a safe setting.

Findings:

- a. Reviewed 17 Staff personnel files, found 4 staff members who had positive urine drug screen results since being employed at the facility, 3 of those files contained documentation required per facility policy for staff member to return to work, 1 file did not contain the proof required per facility policy for staff member to return to work.
- b. Interviewed Director of Human Resources on 21 November, 2011 in the administration conference room, she stated that by facility policy all staff members that have positive urnie drug screen results are required to bring in proof of any medication that is prescribed or over the counter that they took, but she agreed that one (1) staff member file did not contain proof required and three (3) other staff member files did contain the required documentation. The Director of Human resources confirmed that staff member was allowed to return to work but could not provide evidence that staff complied with requirement.

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CARE REGIONAL MEDICAL CENTER CARE REGIONAL MEDICAL CENTER

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Incomplete reports

No incomplete reports available.



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Report No. 1773

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ALLEGIANCE HOSPITAL OF MIDLAND-PERMIAN BASIN

207 TRADEWINDS BLVD MIDLAND, Nov. 17, TX 79706 Nov. 17

VIOLATION: ADEQUACY OF LABORATORY SERVICES

Tag No: A0582

Tag No: A0392

Based on record review and interview it was determined that the facility failed to provide laboratory services ordered by a physician in 2 of 7 patient records reviewed.

Findings were:

The following patient records were reviewed on 11/17/11:

- Patient #1 had a laboratory test ordered by a physician for a "stool occult blood x3" on 10/14/11: however there was no indication of a completed stool occult blood lab found in her medical record.
- Patient #7 had a laboratory test ordered by a physician for a CBC (complete blood count) on 10/12/11; however there was no indication of a completed CBC lab found in her medical record.

During and interview with the Facility's Chief Nursing Officer (Personnel #7) on 11/17/11 she confirmed the above findings, and stated that when labs are ordered by a physician they should completed as ordered within a timely manner.

VIOLATION: STAFFING AND DELIVERY OF CARE

Based on record review and interview it was determined that the facility failed to provide an adequate number of licensed practical (vocational) nurses, and unlicensed patient care staff for two shifts; on 10/23/11 (Sunday) the facility failed to meet the staff-to-patient ratio identified in their staffing plan for the 7am-3pm and 3pm-11pm shifts.

Findings were:

The following documents were reviewed on 11/17/11:

A facility document entitled "Allegiance Specialty Hospital of the Permian Basin Staffing Matrix," indicated the following:
- For the 7am-3pm and 3pm-11pm shifts with a census of 15 patients on one unit and a census of 12 patients on the second unit, there must be a total of 3 registered nurses (RN), 3 licensed vocational nurses (LVN), and 4 mental health technicians (MHT) working.

On 10/23/11 the facility's daily census included 15 patients on one unit, and 12 patients on the second unit.

The facility 's staffing schedule on 10/23/11 identified that during the 7am-3pm shift there were 3 RNs, 2 LVNs, and 2 MHTs working. According to the facility's staffing plan, during this shift the facility was short 1 LVN and 2 MHTs.

The facility 's staffing schedule on 10/23/11 identified that during the 3pm-11pm shift there were 3 RNs, 3 LVNs, and 2 MHTs working. According to the facility's staffing plan, during this shift the facility was short 2 MHTs.

During an interview with the Chief Nursing Officer (Personnel #7), on 11/17/11, she confirmed that the facility was short staffed on 10/23/11 for the 7am-3pm and 3pm-11pm shifts.

VIOLATION: TIMELY DISCHARGE PLANNING EVALUATIONS

Tag No: A0810

Based on record review and interview it was determined that the facility failed to make appropriate arrangements to avoid unnecessary delays in discharge for 1 of 7 patient records reviewed.

Findings were:

Patient #4's medical record was reviewed on 11/17/11. The patient had an order written on 10/17/11 stating that he was to be discharged home on 10/18/11; a document entitled "Billing Form" indicated that he was not discharged until 10/19/11. The record indicated that the patient was discharged to an area outside of the town in which the facility was located.

During an interview with the facility's CEO on 11/17/11 she stated that the patient's discharge was delayed due to transportation issues, however an order to delay the discharge was never documented in the patient's medical record.



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VHS HARLINGEN HOSPITAL COMPANY LLC VHS HARLINGEN HOSPITAL COMPANY LLC

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Report date Number of violations

Nov. 16, 2011 3 (click for details) Read full report Sept. 21, 20111 (<u>click for details</u>) Read full report

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Incomplete reports

No incomplete reports available.



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Tag No: A0467

Tag No: A0469

Tag No: A0959

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Report No. 1467

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VHS HARLINGEN HOSPITAL COMPANY 2101 PEASE ST HARLINGEN, TX 78550 Nov. 16, 2011 LLC

VIOLATION: CONTENT OF RECORD - OTHER INFORMATION

Based upon reviews of medical record and reports, and interview with the facility's staff, the facility did not maintain a medical record for this patient admission that contained all reports.

Findings include:

- a. Review of the medical record and reports at 10:00 a.m., November 16, 2011, in the facility's conference room revealed that the medical record did not contain the operative report for a surgical procedure performed on 21 November, 2008.
- b. During interviews with the facility's Director of Health Information Management at 12:45 p.m., November 16, 2011, in the facility's conference room, following her own reviews of the medical record and reports, she verified that the facility's failed to complete the maintain a complete medical record for the patient, she could not find the operative report for procedure done on 21 November, 2008. She also verified that she could provide no evidence of the facility's compliance with this requirement.

VIOLATION: CONTENT OF RECORD - DISCHARGE DIAGNOSIS

Based upon reviews of medical record and reports, and interview with the facility's staff, the facility did not have a complete medical record for this patient admission within the required time.

Findings include:

- a. Review of the medical record and reports at 10:00 a.m., November 16, 2011, in the facility's conference room revealed that the medical record was not complete within 30 calendar days following discharge. Investigator could not find the operative report for a surgical procedure performed on 21 November, 2008.
- b. During interviews with the facility's Director of Risk Management at 12:10 p.m., November 16, 2011, in the facility's conference room, following her own reviews of the medical record and reports, she verified that the facility's failed to complete the medical record, she could not find the operative report for procedure done on 21 November, 2008. She also verified that she could provide no evidence of the facility's compliance with this requirement.

VIOLATION: OPERATIVE REPORT

Based upon reviews of medical record and reports, and interview with the facility's staff, the facility did not have an operative report for procedure performed on patient.

Review of the medical record and reports at 10:00 a.m., November 16, 2011, in the facility's conference room revealed that the medical record did not contain an operative report for a surgical procedure performed on 21 November, 2008.

During interviews with the Surgeon that performed the surgical procedure at 11:40 a.m., November 16, 2011, in the facility's conference room, following his own review of the medical record and reports, he verified that the medical record did not contain an operative report for procedure performed on 21 November, 2008. He also verified that he could provide no evidence of the facility's compliance with this requirement.



Training

Resources

Tag No: A0083

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BAPTIST MEDICAL CENTER ->

Report No. 1478

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BAPTIST MEDICAL CENTER 111 DALLAS STREET SAN ANTONIO, TX 78205 Nov. 10, 2011

VIOLATION: CONTRACTED SERVICES

Based on a review of records, hospital policies and procedures, and staff interviews, the governing body failed to ensure that the hospital protected each patient 's rights; that treatment plans were updated; that nursing care, assessments and documentation were properly supervised, conducted, and completed; that medications were administered as ordered; and that consents were properly obtained and documented.

Findings were:

Patient treatment plans were not reviewed, revised or updated following a significant change in the patient 's condition.

Cross refer: CFR 482.13(c)(2)

Nursing care for each patient was not properly supervised and evaluated, including not following chain of command or fall incident reporting policies, not completing and/or documenting patient assessments, and not updating nursing care plans for patient treatment following a significant change in a patient 's condition.

Cross refer: CFR 482.23(b)(3)

Patient teaching was not provided and informed medication consent was not obtained and documented in the medical record for the administration of psychoactive medications.

Cross refer: CFR 482.24(c)(1)

In 9 out of 13 patient records reviewed, 237 medications were administered outside the 30 minute time frame and not in accordance with physician orders and hospital policy.

Cross refer: CFR 482.23(c)

Review of Governing Body Minutes and Quality & Patient Safety Steering Committee Minutes for 2011 revealed no mention of the above findings. In an interview with the regional compliance officer the afternoon of 11/8/2011, she stated a call was received on the corporate compliance staff hotline on July 28, 2011 regarding the geropsych unit identifying clinical issues, the function of the unit, documentation, and patient care; an audit conducted revealed that 72% of geropsych records that had negative issues that should be corrected. In an interview with the regional risk manager on 11/10/2011, she stated the information from the hotline call and the audits were reported to the hospital president but were not reported to the Governing Body or included in the Quality Assessment and Performance Improvement Program.

Review of hospital policy Quality and Patient Safety Plan Document number PLAN-PI states " The leadership at each facility will ...establish and maintain operational linkage between Risk Management, Case Management, Patient Safety and Performance Improvement. "

VIOLATION: PATIENT RIGHTS

Based on review of medical records, hospital policies and procedures, and the hospital failed to protect and promote each patient 's rights related to medication education, informed consent, and treatment planning.

Tag No: A0115

Tag No: A0385

Findings were:

Patient teaching was not provided and informed medication consent was not obtained and documented in the medical record for the administration of psychoactive medications.

Cross refer: CFR 482.24(c)(1)

Nursing care for each patient was not properly supervised and evaluated, including not completing and/or documenting patient assessments related to falls and deteriorating medical condition, and not updating nursing care plans for patient treatment following a significant change in the patient 's condition.

Cross refer: CFR 482.23(b)(3)

Patient treatment plans were not reviewed, revised or updated following a significant change in the patient 's condition.

Cross refer: CFR 482.13(c)(2)

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of medical records and staff interviews, the hospital failed to ensure that each patient had an updated treatment plan to provide for care in a safe setting after a fall and significant change in condition.

Findings were:

Review of 2 out of 14 records revealed that the treatment plan was not reviewed, revised or updated following a fall in the hospital and a significant change in the patient 's condition:

- 1. Patient #9, an [AGE] year old female, admitted on [DATE], experienced a fall and landed on her buttocks on 6/6/11. Physician progress note on 6/7/11 stated " sacral x-ray possible fx at s3 ...fx likely fall related. " The patient ' s treatment plan was not revised or updated after the patient ' s fall to reflect the possible fracture.
- 2. Patient #11, a [AGE] year old female admitted on [DATE], experienced a fall and hit the back of her head, with a 1? inch laceration to the occipital region of the head on 6/11/11. The patient 's treatment plan was not revised or updated after the patient 's fall to reflect the head injury.

VIOLATION: NURSING SERVICES

Based on review of hospital documentation, patient records, and interview with staff, the hospital failed to ensure that nursing care was properly supervised and evaluated and chain of command was followed in reporting needed medical attention, that patient assessments were completed, accurate, and documented, that care plans were updated following a significant change in a patient 's conditions, that medication teaching and informed consent were completed, and that medications were administered as ordered and per policy.

Findings were:

Nursing care for each patient was not properly supervised and evaluated, including not following chain of command or fall incident reporting policies, not completing and/or documenting patient assessments, and not updating nursing care plans for patient treatment following a significant change in a patient 's condition.

Cross refer: CFR 482.23(b)(3)

Patient treatment plans were not reviewed, revised or updated following a significant change in the patient 's condition.

Cross refer: CFR 482.13(c)(2)

The hospital failed to ensure that patient teaching was provided and informed medication consent was obtained and documented in the medical record for the administration of psychoactive medications.

Cross refer: CFR 482.24(c)(1)

In 9 out of 13 patient records, 237 medications were administered outside the 30 minute time frame in accordance with physician orders and hospital policy.

Cross refer: CFR 482.23(c)

VIOLATION: RN SUPERVISION OF NURSING CARE Tag No: A0395

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of records, hospital policies and procedures, and staff interviews, the hospital failed to ensure that a registered nurse properly supervised and evaluated the nursing care for each patient, including not following chain of command or fall incident reporting policies, not completing and/or documenting assessments, and not updating nursing care plans.

Findings were:

Patient #5, a [AGE] year old female was admitted on [DATE] at 2100 from the telemetry/medical unit to the geropsych unit in a catatonic state. Nursing notes document that patient had no oral intake or no urinary output, was rigid, unresponsive, clammy, sweaty skin, jaw clenched, eyes fixated and drooling; the physician was notified four times. The patient remained on the geropsych unit in this state for 17 hours until transferred to the telemetry/medical unit on 5/17/11 at 1400. The nurse continued to document contact with the physician, but did not follow nursing policy regarding chain of command notification of the patient 's lack of intake or output and deteriorating medical condition and need for medical assessment for 17 hours. The nursing care plan was not updated to reflect this significant change in condition and the patient was not transferred when it was determined that the patient had more serious physical problems than the staff on the geropsych unit could handle.

Patient #9, an [AGE] year old female sustained a fall on her buttocks in the geropsych unit on 6/6/11. An x-ray of sacral and coccyx region was completed on 6/6/11. Physician progress note on 6/7/11 stated " sacral x-ray - possible fx at s3 ...fx - likely fall related. " There was no nursing documentation in the record to reflect assessment of the patient 's injury after the initial documentation of the fall. A fall incident report was not completed for the patient 's fall, and the nursing care plan was not updated to reflect the patient 's injury. The nursing care plan was not updated to reflect this significant change in condition.

Patient #10 a [AGE] year old male was admitted to the geropsych unit on 5-10-11 with the diagnosis, " decubitus of heels, status post fracture of ankle. " Order on 5/10/11 at 2030, " waffle boots for decubitus heels on admission. " Nursing patient care records shift documentation revealed the following inconsistencies and inaccurate or incomplete assessments:
5/10/11 7 pm - 7 am Wound/lesion " decubitus both heels "
5/11/11 7am - 7pm Checked " N " [No] for Decubitus ulcer and wrote " none " in the space provided; circled " N/A " for Wound/Lesion,

5/11/11 7am - 7pm Checked " N " [No] for Decubitus ulcer and wrote " none in the space provided wrote " n/a " for risk for pressure ulcer development.
5/11/11 7pm - 7am Checked " N " [No] for Decubitus ulcer, circled " N/A " for Wound Lesion.
5/12/11 7 am - 7 pm Pressure ulcer assessment left blank/not completed.
5/12/11 7 pm - 7 am Wound/lesion circled " N/A " ; Decubitus Ulcer space left blank.
5/13/11 7 am - 7 pm Wound/lesion left blank; decubitus ulcer space left blank.
5/13/11 7 pm - 7 am Wound/lesion left blank; decubitus ulcer space " bilat II heels. "

5/13/11 7 pm - 7 am Wound/lesion left blank; decubitus ulcer space " bilat II heels. "

5/14/11 7 am - 7 pm Pressure ulcer assessment wrote " n/a "

5/14/11 7 am - 7 pm Wound/lesion left blank; decubitus ulcer checked "N" [No] and wrote "none".
5/14/11 7 pm - 7 am Wound/lesion circled "N/A"; Decubitus Ulcer space wrote "Stage III bilat heels. "
5/15/11 7 am - 7 pm Pressure ulcer assessment stated "Site A Stage III resolving; Site B Stage III resolving. "
5/15/11 7 am - 7 pm Wound/lesion left blank; decubitus ulcer checked "N" [No] and wrote "none".
5/15/11 7 pm - 7 am Wound/lesion space wrote "dry flaky"; decubitus ulcer checked "Y" [Yes] and wrote "bilateral heels III".

Patient #11, a [AGE] year old female admitted on [DATE] fell to the floor on 6/11/11 at 2230, hitting the back of her head on the floor and had a 1? inch laceration to the occipital region of the head, which was oozing blood. The nurse notified the physician and the emergency department physician was to evaluate the patient for the head injury. The patient was not medically evaluated until the following morning, 6/12/11 at 0830. During the night, the nurse notified the physician twice and the house officer that the patient had not been evaluated, documenting that, "pt continues to have small amt of oozing, fresh blood, "but the notification chain of command policy was not followed and the patient was not medically evaluated for her laceration and head injury for 12 hours.

Review of 3 of 12 records revealed that fall interventions or assessments were not completed as ordered on the geropsych unit.

- 1. Patient #4 had a physician 's order for fall precautions. On 6/17/11 between 7 am and 7 pm, there was no documentation of nursing fall interventions.
- 2. Patient #10 had a physician 's order for fall precautions. On 5/13/ between 7 am and 7 pm, there was no documentation of nursing fall
- 3. Patient #11, a [AGE] year old female had a physician 's order for fall precautions. On 6/11/11, the falls prevention risk assessment (completed every shift and prn) was not completed for the 7 am - 7 pm shift.

Review of hospital policy Physician Notification Protocol/Chain of Command Document number LD-MS-06 stated " A. When a staff member has a concern regarding a medical staff issue, the staff member will speak with the medical staff member regarding the concern. B. If the staff member believes the issue is not resolved or requires more review, the staff member will contact the ...house officer ...depending on the severity of the situation or issue, or inappropriate response from attending physician, the department director/house officer in consultation with the administrator on call, may elect to notify the chief of staff at the facility.

Review of hospital policy Medical Readmission and/or Transfer to Behavioral Health Units Document number BH-23 states, "Periodically, behavioral health patients develop more serious physical problems than staff on the Unit can handle. When this occurs, it is important to assess what level of care the patient needs and transfer the patient to a medical/surgical floor. '

Review of hospital policy Adult Patient Fall Prevention Document number RM-PS-07 stated "E. Follow-up after a fall ...4. The fall episode is to be documented in Midas Risk at the time of the event by the nurse caring for the patient. "The policy also states that "At a minimum, upon admission and twice daily completed the Hendrich II-Patient Fall Risk Assessment ... to determine fall interventions to be initiated."

In an interview with the hospital risk manager on 11-10-11 at 12:20 pm, she stated there was no falls incident report completed by the nurse for the fall episode for Patient #9.

VIOLATION: UNSPECIFIED CATEGORY Tag No: Based on a review of hospital policies and a review of patient records, in 9 out of 13 patient records on the geropsych unit, 237 medications were administered outside the 30 minute time frame in accordance with physician orders and hospital policy.

Findings were:

Patient #1 received 49 total medications which not given within 30 minutes as ordered or scheduled, including the following:

Buspirone ordered to be given at 2000, given at 2135. Trazadone ordered to be given at 2200, given at 2135.

Prilosec ordered to be given at 0730, given at 0900.

Carafate ordered to be given at 0800, given at 0900; ordered to be given at 1800, given at 1900.

6/20/11

Reglan, ordered to be given at 1400, given at 1320; ordered to be given at 1900, given at 2100.

Buspar ordered to be given at 0800, given at 0850.

Robaxin ordered to be given at 1400, given at 1320; ordered to be given at 1900, given at 2100.

Prilosec ordered to be given at 1630, given at 1750.

Xanax ordered to be given at 1900, given at 2100.

Carafate ordered to be given at 0800, given at 0850.

Reglan, ordered to be given at 0900, given at 0825; ordered to be given at 1900, given at 1800.

Buspar ordered to be given at 2000, given at 2110. Trazadone ordered to be given at 2200, given at 2110.

Robaxin ordered to be given at 0900, given at 0825; ordered to be given at 1400, given at 1325, ordered to be given at 1900, given at 1800.

Vitamin D ordered to be given at 0000, given at 2306.

Prilosec ordered to be given at 0730, given at 0825.

Xanax ordered to be given at 0900 given at 0825; ordered to be given at 1400, given at 1325; ordered to be given at 1900, given at 1800.

Cymbalta ordered to be given at 2000, given at 2110.

Norvasc ordered to be given at 0900, given at 0825.

6/22/11

Buspar ordered to be given at 2000, given at 2120. Trazadone ordered to be given at 2200, given at 2120. Prilosec ordered to be given at 1830, given at 2120.

Carafate ordered to be given at 2300, given at 2200.

Cymbalta ordered to be given at 2000, given at 2120.

6/25/11

Reglan ordered to be given at 1900, given at 2217.

Buspar ordered to be given at 0800, given at 0835; ordered to be given at 2000, given at 2217.

Robaxin, ordered to be given at 1900, given at 2217.

Prilosec ordered to be given at 0730, given at 0835; ordered to be given at 1630, given at 1800. Carafate ordered to be given at 1300, given at 1355; ordered to be given at 2300, given at 2217.

Cymbalta ordered to be given at 0800, given at 0835; ordered to be given at 2000, given at 2217.

Remeron, ordered to be given at 2100, given at 2217.

Reglan ordered to be given at 1900, given at 2140.

Buspar ordered to be given at 2000, given at 2140.

Robaxin ordered to be given at 1900, given at 2140.

Prilosec ordered to be given at 0730, given at 0830.

Carafate ordered to be given at 2300, given at 2200.

Cymbalta ordered to be given at 2000, given at 2140.

Patient #2 received 20 total medications which not given within 30 minutes as ordered to be given at or scheduled, including the following:

Colace ordered to be given at 0900, given at 0825.

Prilosec ordered to be given at 0900, given at 0645.

Lumigan ordered to be given at 2100, given at 2000. Flonase ordered to be given at 0900, given at 0825.

Zocor ordered to be given at 2100, given at 2000.

Micardis ordered to be given at 0900, given at 0825.

Seroquel ordered to be given at 0900, given at 0825.

9/24/11

Prilosec ordered to be given at 0900, given at 0615. Lumigan ordered to be given at 2100, given at 2000.

Lumigan ordered to be given at 2100, given at 2020. Zocor ordered to be given at 2100, given at 2020. Protonix ordered to be given at 0900, given at 0700. Zoloft ordered to be given at 0900, given at 1315.

9/27/11 Lumigan ordered to be given at 2100, given at 2005.

Flonase ordered to be given at 0900, given at 0820.

Zocor ordered to be given at 2100, given at 2005. Micardis ordered to be given at 0900, given at 0820. Seroquel ordered to be given at 0900, given at 0820. Protonix ordered to be given at 0900, given at 0630.

9/28/11

Protonix ordered to be given at 0900, given at 0650.

Patient #3 received 7 total medications which not given within 30 minutes as ordered to be given at or scheduled, including the following: 5/10/11

Colace ordered to be given at 2000, given at 2122. Prilosec ordered to be given at 0730, given at 0650.

Aricept ordered to be given at 0900, given at 1255.

Norvasc ordered to be given at 0900, given at 1255.

Fragmin ordered to be given at 0800, given at 1255.

5/13/11

Colace ordered to be given at 2000, given at 1200. 5/15/11

Prilosec ordered to be given at 0730, given at 0630.

In addition, Patient #4 received 19 medications which were not given within 30 minutes as ordered or scheduled; Patient #8 received 7 medications which were not given within 30 minutes as ordered or scheduled; Patient #9 received 81 medications which were not given within 30 minutes as ordered or scheduled; Patient #10 received 9 medications which were not given within 30 minutes as ordered or scheduled; Patient #11 received 37 medications which were not given within 30 minutes as ordered or scheduled; and Patient #12 received 8 medications which were not given within 30 minutes as ordered or scheduled.

In addition, review of the record for Patient #10 revealed an order on 5/12/11 at 2100 for " Haldol 10 mgm po QHS 1st dose now. " There was no documentation in the medication administration record or progress notes to indicate the patient received the now dose of Haldol ordered at 2100 on 5/12/11.

Review of hospital policy Medication Administration and Monitoring Document number MEDMGT-22 states " 3. Doses are considered " on time " for quality review purposes if administered within 30 minutes before or after the scheduled time. "

VIOLATION: MEDICAL RECORD SERVICES

Based on review of patient records, hospital policies, and staff interviews, the hospital failed to ensure that patient teaching was provided and informed medication consent was obtained and documented in the medical record for the administration of psychoactive medications.

Tag No: A0450

Tag No: A0464

Findings were:

Review of 4 of 12 medical records revealed that patients received psychotropic medications without correct or completed medication consent documented or patient teaching documented in the medical record.

- 1. Patient #1 received the following psychotropic medications without medication consents or patient teaching documented in the record: Buspar, Cymbalta Xanax, Trazadone, or Remeron.
- 2. Patient #2 received the following psychotropic medications without medication consents or patient teaching documented in the record: Seroquel, and Zoloft.
- 3. Patient #12 received the following psychotropic medications without medication consents or patient teaching documented in the record: Ambien, Thorazine, and Saphris.
- 4. Patient #9 had no documentation in the medical record to indicate that the patient had a medical power of attorney or guardian. The patient gave verbal consent for the medication Depakote on 6/11/11, but on 6/2/11, her granddaughter signed the medication consents for Risperdal, Ativan, and Ambien. There was no documentation in the record that the patient gave informed consent or received patient teaching for the medications Risperdal, Ativan, and Ambien.

Review of hospital policy Informed Consent for Psychoactive Medications Document number BH-40 states " Prior to initiation of Psychoactive Agents, the person being treated shall be informed of the potential benefits and risks of the prescribed medication, and that information is documented in the medical record ...For each individual medication, a separate form (MHRS 9-7) will need to be completed ...All patient teaching done needs to be documented on the form MHRS 9-7, and in addition needs to be recorded in the progress notes of the medical record. " The above was confirmed in interview with staff #2.

VIOLATION: CONTENT OF RECORD - CONSULTS

Based on review of records and available documentation, the hospital failed to ensure that evaluations were conducted as ordered and included in the medical record.

Findings were:

Review of 5 of 12 records on the geropsych unit revealed that physical therapy evaluations and treatment were ordered on admission, but physical therapy evaluations and treatment results or findings were not included in the medical record. The records for patient #2, patient #4, patient #8, patient #9, and patient #12 contained orders for a physical therapy evaluation and treatment. There was no evidence in the record indicating that these patients received a physical therapy evaluation or physical therapy treatment.





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TRUSTPOINT HOSPITAL ->

Report No. 1766

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TRUSTPOINT HOSPITAL

4302 PRINCETON LUBBOCK, TX 79415

Nov. 9, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on review of the patient record, incident reports and staff interview, the hospital failed to ensure that patient #1 received care in a safe setting as she was dropped by staff on two occasions.

Findings were:

Based on review of the record of patient #1 She was transferred by staff on two occasions without the use of a gait belt (A handling aide) and was dropped. These occurrences were documented in incident reports. The facility policy entitled Patient Handling and Movement stated in part:

"3. Approved mechanical lifting equipment or other approved handling aids will be used to prevent manual handling of patients except when absolutely necessary, such as in an emergency, life-threatening, or otherwise exceptional circumstances The staff failed to follow this policy on two separate occasions during the stay of patient #1.

This was confirmed in interview with the Nursing Director on 11/09/11 in the conference room.



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NORTHWEST HILLS SURGICAL HOSPITAL ->

Report No. 1572

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NORTHWEST HILLS SURGICAL HOSPITAL

6818 AUSTIN CTR BLVD SUITE 100 AUSTIN, TX 78731

Nov. 2011

VIOLATION: INFECTION CONTROL OFFICER(S)

Tag No

Based on interviews with staff and review of available records, it was determined that the facility through the infection control officer did not ensu policies were implemented to avoid sources of infection as approximately two-thirds or more of the surgical instruments sterilized in calendar ye to date were flash sterilized.

Findings were:

The facility sterilization log revealed that in January 2011, 199 total sterilizing loads were run and 144 of those were flash loads; in February 20 total loads were run and 107 were flash loads; in March 2011, 195 total loads were run and 174 were flash loads; in April 2011, 200 total loads and 151 were flash loads; in May 2011, 174 total loads were run and 162 were flash loads; in June 2011, 176 total loads were run and 164 we loads; in July, 180 total loads were run and 160 were flash loads; in August 2011, 181 total loads were run and 160 were flash loads; in Septem 2011, 176 total loads were run and 157 were flash loads; in October 2011, 190 total loads were run and 150 were flash loads.

The Infection Control Director stated in interviews on 11/7/11 that the flash sterilization should " only be used in an emergency, such as a dropp instrument. " The above was confirmed with the Infection Control Director.

Facility policy, OR PROTOCOL: FLASH STERILIZATION, policy #OR065 states that, " Flash sterilization will be only utilized as needed."

The Centers for Disease Control and Prevention (CDC) website article, GUIDELINE FOR DISINFECTION AND STERILIZATION IN HEALTHCA FACILITIES, 2008, by William A. Rutala, Ph.D., M.P.H., David J. Weber, M.D., M.P.H., and the Healthcare Infection Control Practices Advisory Committee (HICPAC), found at:

http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2 states on page 60 that "it [flash sterilization] is not recommended as a routine sterilization method because of the lack of timely biological indica monitor performance, absence of protective packaging following sterilization, possibility for contamination of processed items during transportati operating rooms, and the sterilization cycle parameters (i.e., time, temperature, pressure) are minimal. "

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NORTHWEST HILLS SURGICAL HOSPITAL NORTHWEST HILLS SURGICAL HOSPITAL

6818 AUSTIN CTR BLVD SUITE 100 AUSTIN, TX 78731 | Proprietary

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Report date Number of violations

Nov. 7, 20111 (click for details) Read full report

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No incomplete reports available.



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PARKLAND HEALTH AND HOSPITAL SYSTEM ->

Report No. 1460

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PARKLAND HEALTH AND HOSPITAL SYSTEM

5201 HARRY HINES BLVD DALLAS, TX 75235

Nov. 4, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on interview and record review, the Hospital failed to ensure 1 of 1 patient (Patient #1) was provided a safe environment while seeking psychiatric intervention. Hospital personnel did not secure and/or remove a hazardous object (cigarette lighter) from (Patient #1) upon admission to the Psychiatric ED (Emergency Department). (Patient #1) removed a cigarette lighter from her pants and lit her shirt on fire while in seclusion.

Findings included:

Patient #1 was admitted to the Psychiatric ED with mood disorder, suicidal ideation, unspecified psychosis and episodic mood disorder.

The physician note dated 10/08/11 timed at 15:32 PM, reflected, "While in the dayroom patient became increasingly agitated, despite this writer's efforts to calm her down...patient quickly escalated, yelling profanities at this writer and other staff, throwing her cup of ice water at the window and banging on the window with her hands...patient was escorted to the seclusion at 15:30 PM, a personal hold was not needed, emergency medication given at 15:31 PM. Will continue to monitor patient..."

The nursing note dated 10/08/11 timed at 14:12 PM reflected, "Patient admits to police officer that she is depressed and wants to hurt herself. Patient attempted to kill herself by jumping out of a moving vehicle. Noted patient has multiple bruises on her arms and legs. Dr...aware...patient stated she is going through a lot...told Dr...she has been drinking...everyday. Patient with rapid pressured speech, paranoid, hyper verbal...search and scanned by...tech (technician)."

The Flow sheet data record dated 10/08/11 timed at 14:14 PM reflected, "Belongings checked, body checked, clothing checked..."

The Social Worker note dated 10/08/11 timed at 16:27 PM reflected, "After being placed in seclusion, pt (Patient) started a fire. Her shirt was fully enflamed before seclusion room staff entered the room. From the rooms TV (television) it showed that pt was not near the fire, removed before the room filled with smoke. Pt was not hurt and did not show any signs of stress over the fire..."

The nurse note dated 10/08/11 timed at 16:10 PM reflected, "Reported by...while watching the camera that this patient has started a fire in seclusion room...writer went to seclusion room right away and patient was already removed by...psych tech from seclusion room, fire is already extinguished. Per tech patients shirt is not on her person but lighted the shirt with lighter. Patient was examined and assessed, no visible injury, burns or signs and symptoms of smoke inhalation observed on the patient...Dr. was made aware...patient seclusion was discontinued..."

On 11/04/11 at 10:20 AM Personnel #2 was interviewed. Personnel #2 stated the technician did not search and/or scan the patient when she arrived. Personnel #2 stated the technician who was asssigned to monitor the patient one to one while Patient #1 was in seclusion turned his back away from the patient and did not conduct one to one supervision.

On 11/04/11 at 2:05 PM, Personnel #13 was interviewed. Personnel #13 was asked to review her nursing note entry for Patient #1 where she documented the patient was searched and scanned. Personnel #13 stated she did not physically see the technician search the

patient. Personnel #13 said she assumed the technician did the search and scan as it was their job.

The Hospital Video Clip dated 10/08/11 timed at 14:31 PM to 16:05 PM reflected, "14:32...technician verifying patient, plastic bag for valuables nurse present...ended 14:36 PM...no search/scan completed...seclusion room 03:26 PM placed in seclusion...received a shot at 03:30 PM...at 16:02;46 patient took lighter out of left lower pajama bottom pocket...16:03;31 lit a white tee shirt she had removed from her upper...16:04;34 smoke started filling the seclusion room...16:05 door opened, patient removed...shirt on floor of seclusion room on fire. Technician put out fire with his hands and removed the shirt still burning out of the seclusion room...returned and cleaned up the room from the burned shirt..."

The Hospital Property and Valuables Record dated 10/08/11 reflected, "Technician signed and dated 10/08/11 at 14:00 PM patient's valuables were obtained and secured...shoes, medications...lap..." No documentation was found which indicated a lighter was found.

The Patient Search and Scan Policy with a revision date of June 2011 reflected, "To provide a safe environment for patients in the Psychiatric Emergency Services Department (PESD), patients are searched and scanned to assure they are free of harmful items...Scan: a systematic search by the Psychiatric Technician utilizing a hand-held metal detector (wand). The patient is searched for items posing a danger to themselves or other...potentially dangerous items...removed from patients, including, but not limited to...shoes or shoelaces, jewelry, cigarettes and lighters/matches...the search and scan is documented in the Registered Nurse admission note including the identification of the staff member conducting the search and gathering/securing patient belongings..."

The Psychiatric Services Contraband policy with a revision date of June 2011 reflected, "A pat search and hand held metal detector sweep are done on all patients prior to being escorted to a secured patient area and all contraband is removed from the patient..."

The Patients Rights and Responsibilities policy Admin. 6-09 with a revision date of June 2011 reflected, "Patients have the right to...receive considerate and respectful care in a safe setting..."



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Tag No: A0144

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LAKE GRANBURY MEDICAL CENTER ->

Report No. 1531

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

LAKE GRANBURY MEDICAL CENTER 1310 PALUXY RD GRANBURY, TX 76048 Nov. 2, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on review of records, facility policies and procedures and interviews with facility staff, the facility failed to assure that the patient received care in a safe setting as 1 of 1 patients sustained injury to her left arm from an intravenous line infiltrating during a visit to the emergency department in violation of facility policies.

The findings were:

Review of the medical record of patient #1 reflected an entry by personnel #1that on 5/19/11 22:41 "Integumentary: IV (intravenous) to L (left) arm infiltrated. Pt (patient) has water blisters around elbow & on top of arm midway between shoulder and wrist. IV dc'ed (discontinued), arm wrapped with non-adhesive telfa & blankets from warmer applied to reduce swelling." The record also reflected that the patient had been administered "IV morphine 4 mg initiated at 5/19/11 22:10 ...Zofran 4mg initiated at 5/19/11 22:10." A complaint submitted to the facility by patient #1 reflected that she had complained to the nurse several times about the IV burning prior to when the medications were administered. There was no indication in the medical record of patient #1 that the nurse (personnel #1) notified the physician of the IV infiltration or the water blisters around the patients left elbow and on top of her arm. There were no physician orders in the medical record of patient #1 for dressings or warm blankets to be applied to the left arm.

The facility policy entitled "Intravenous Push Medications", policy #N37 with a revision date of 4/98, reflected that "Procedure F. Ensure IV is infusing properly." The facility policy entitled "Guidelines for Infection Control in Intravenous Therapy", policy #2.103 with an effective date of 8/03 reflected that "Peripheral venous catheter sites that are phlebitic, or infiltrated should be discontinued and/or changed immediately."

The facility policy entitled "Notifying Physician of Changes in Patient Condition", policy H5 with an effective date of 11/98 reflected that "The nurse responsible for care of the patient will notify the physician whenever the assessment of a patient's condition shows a significant deterioration or change ..." The facility policy entitled "Incident Reporting", policy #10.004 with an effective date of 4/99 reflected that "M. Incident Report forms should be utilized in the following circumstances/incidents: 1. physical injury of patients" The facility policy entitled "Patient Rights and Responsibilities", policy #4.005 with an effective date of 1/97 reflected that "The patient has a right to considerate and respectful care

In an interview with personnel #5 on 11/1/11 at 3:20 PM, she stated that the physician was not notified and there was no incident report completed by the nurse which is normal procedure when a patient sustains an injury in the facility.

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on review of records, facility policies and procedures and interviews with facility staff, the facility failed to assure that drugs are administered in accordance with accepted standards of practice as intravenous medications were given through an infiltrated intravenous line in 1 of 1 patients in violation of facility policy.

The findings were:

A complaint submitted to the facility by patient #1 reflected that she had complained to the nurse several times about the IV burning prior to when the medications were administered. The medical record of patient #1 reflected that the patient had been administered "IV morphine 4 mg initiated at 5/19/11 22:10 ...Zofran 4mg initiated at 5/19/11 22:10." The medical record of patient #1 reflected that on 5/19/11 22:41 "Integumentary: IV (intravenous) to L (left) arm infiltrated. Pt has water blisters around elbow & on top of arm midway between shoulder and wrist."

The facility policy entitled "Intravenous Push Medications", policy #N37 with a revision date of 4/98, reflected that "Procedure F. Ensure IV is infusing properly." The facility policy entitled "Guidelines for Infection Control in Intravenous Therapy", policy #2.103 with an effective date of 8/03 reflected that "Peripheral venous catheter sites that are phlebitic, or infiltrated should be discontinued and/or changed immediately."

In an interview with personnel #5 on 11/1/11 at 3:20 PM, in response to a question about the usual procedure for intravenous medications, she stated that the nurse should check the IV for patency, and if there was any indication that the IV was not patent, to stop the medication administration and notify the physician.



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LAKE GRANBURY MEDICAL CENTER

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Report date Number of violations

Nov. 2, 20112 (click for details) Read full report

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No incomplete reports available.

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MEMORIAL HERMANN BAPTIST BEAUMONT HOSPITAL ->

Report No. 1518

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MEMORIAL HERMANN BAPTIST BEAUMONT 3080 COLLEGE STREET BEAUMONT, HOSPITAL

TX 77701

Oct. 28, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on document review and interview the facility failed to provide care in a safe setting in 3 of 3 patients.

On 10/25/2011 at 1:45 PM patient (Pt) #1 medical record (MR) was reviewed and revealed 7/26/2011 9:57 medical screening: diagnosis of [DIAGNOSES REDACTED].

The MR revealed Pt #1 was admitted on [DATE] at 16:30 to the senior care unit. The record reflects an "[AGE] year old escorted by ambulance staff via stretcher. Pt is unable to sit in the admissions area for admission due to physical status. Pt is total care and non-verbal with staff. Pt yells "momma" frequently and screams out loudly. Pt has slight contracture of upper extremities, is disoriented, incoherent at times and incontinent. She was placed in bed and positioned by staff on to her left side for comfort."

Further review reveals 7/29/2011 13:33 Therapist/social services note: "Therapist attempted to meet individually with patient to obtain history, provide therapy, and to help develop treatment and aftercare plans. Pt unable to participate in interview. Pt appears disoriented, agitated, and uncooperative. Pt shows no insight and cannot acknowledge a need for inpatient or outpatient treatment. Pt has difficulty communicating. Pt has difficulty interacting appropriately with staff or peers."

Further review of MR revealed on 8/3/2011 at 15:16 nursing documentation reflects "Pt continues to be disruptive in groups due to audio visual hallucinations. Pt yells out "Mary" or "Momma" constantly. Pt is labile and easily distraught if not redirected." At 15:57 patient #1 was placed in a chair in the day room. Nursing documentation reflects "Pt sitting in day room, loud, disruptive, verbally aggressive with staff."

Further review of MR reveals at 17:47 Pt #1 who is 100 % dependent on staff is sitting in the day room. Nurses notes reflect the following:"...when he (patient #2) entered the dayroom he saw this peer (patient #1) sitting on a chair to his left of the door and grabbed her under the arms and threw her across the room 5-6 feet. This caused her injury to left of her forehead (hematoma the of 2 inches round) and left shoulder. The techs immediately went to her assistance. Once out of the room vital signs and neuro checks were done." This documentation indicates that Pt #1, who was thrown from her chair was not assessed for physical injury or head trauma prior to being removed from the day room for vital signs and neuro checks. No vital signs or neuro checks were found to be recorded for patient #1

Pt #2 who was subdued by staff as reflected in patient #1 chart "At the same time two RN's "assessed" him to the floor.... and code white was immediately called. ...patient was further subdued while Staff #4 (presently on unit) gave orders for emergency dose of medication." Pt #2 MR reveals on 8/3/2011 at 17:25 he was given Zyprexa 10 mg and Ativan 2 mg intramuscularly (IM) left buttock. 17:30 order was received to transfer to acute services. 8/3/2011 at 17 35 patient #2 MR reveals "pt continues to fight staff, is uncooperative, agitated, Dr remains on unit, orders given for medication, patient given Ativan 2 mg IM to the right buttock. 8/3/2011 17:38 report called to nurse on acute care unit. 8/3/2011 17:40 pt voluntarily walked with staff from senior care, drowsy from medication administration, left senior care

without incident pt escorted to acute care by the house supervisor and techs" There was no nursing documentation of assessment for this Pt after he was subdued by staff before he was transferred to acute care.

On 10/25/2011 at 2:30 PM Pt #3 MR record was reviewed and revealed the following. Pt #3 was admitted with a diagnosis of [DIAGNOSES REDACTED]"Pt was in the dayroom, was hit in the left eye by a peer (Pt #2) that was out of control. The peer (Pt #2) was throwing a chair, knocked over the vital signs machine, threw a peer (Pt #1) from her chair. This peer (Pt #3) was not specifically targeted,. This RN did not see this peer get hit. The peer reported it after the incident." There is no documented assessment of this Pt in the electronic medical record for injury. 8/3/2011 at 18:00 "reported to staff that he was hit in the left eye by a peer (Pt #2). assessed the pt, the pt has minimal swelling to the left eye with minor discoloration/bruising started. continue to monitor Dr present on the unit, had Dr. assess the pt, house supervisor notified." There was no nursing intervention documented in the electronic medical record. (No ice applied to the eye, no pain scale noted or pain medication offered)

On 10/25/2011 at 1:30 PM in the conference room staff #2 was interviewed and revealed on 8/3/2011 patient #1 was placed in the day room in a chair with other ambulatory patients. Staff #2 was questioned as to why an [AGE] year old depended geriatric patient who was agitated and yelling out was placed in the day room to be further stimulated and over stimulate other ambulatory psychiatric patient she answered "that's where patients sit. She was visible from the nurses station." When asked if she was comfortable placing a non ambulatory dependent patient in a day room with ambulatory patients she stated "I guess we could have placed her in her room"

Staff #2 was further questioned regarding the lack of nursing assessment for Pt #2 there was no comment. Staff #2 was also questioned about the lack of nursing intervention for Pt #3. Staff #2 indicated she had seen Pt #3 the next day and he had not said anything about needing pain medication.

The facility failed to provide care in a safe setting for Pt's #1, #2 and #3. Pt #1 was not protected from uncontrolled physical aggression directed toward her and was not safely assessed before being moved form the day room. Pt #2 aggressive outburst was not controlled safely within the environment. Neither Pt #2 or #3 were immediately assessed for injury.

VIOLATION: UNSPECIFIED CATEGORY

behaved in such a manner. Resolution "closed"

Tag No:

Based on record review and interview the facility failed to monitor the effectiveness and safety if service and quality of care based on 3 of 3 patients.

On 10/25/2011 at 4:00 PM in the conference room the incident reports were reviewed for Patients #1, #2 and #3 which were involved in the same incident on 8/3/2011. Pt #3 file ID was submitted 8/3/2011 and a "Brief factual description" is as follows: "pt attempting to go to the dayroom with only his underwear on, the pt redirected to go to this room if he did not want to get dressed, pt voluntarily walked to the end of the hallway, the pt then stopped and yelled "I'm not doing this", the pt ran to the dayroom pushed through the door, threw a peer on the floor, threw a chair, knocked over the vital sign machine breaking it, punched a peer in the left eye, the peer that he threw was sent to Baptist ER for treatment, the peer that he punched has a bruise to the left eye and mild swelling"

It is noted on the incident form "Suggestions for avoiding similar event: unknown, this event occurred quickly and spontaneously." The follow up is noted as "staff responded swiftly and appropriately. This patient has not history of aggressive behavior or reason to have

Pt #2 ID was submitted on 8/3/2011 a 'Brief factual description" is as follows. "pt was in the dayroom, a peer became agitated, hit the pt in the left eye causing a mild amt of swelling and bruising beginning." It is noted on the incident form "suggestions for avoiding similar event: unknown, the incident occurred quickly, staff attempting to get peers out of the dayroom." The follow up is noted as "patient attempting to block aggressive patient from entering further into the dayroom. He was struck by all account in the left eye. slight discoloration. NO swelling or pain reported." Resolution closed.

Pt #1 ID was submitted on 8/5/2011 a 'Brief factual description" is as follows. " Patient H.S. picked up victim and threw 5-6 feet. Victim landed on floor. Techs secured victim while nurses restrained H.S. Patient complained of dizziness and knee and shoulder pain. 911 was called, patient was transported to ER for further evaluation" Suggestions for avoiding similar events: Incident occurred rapidly with provocation. No history of past aggressive behavior." Follow up: waiting for all staff accounts. (1/5 staff statements were provided for review). Resolution: closed

On 10/26/2011 at 11:00 AM an interview with staff #2 revealed the family had notified the police. The police had given the facility a copy of the official report. The family had inquired if the facility had notified the police, they had not. Further interview with staff #3 revealed the facility had not conducted any Quality review for this event. Further interview with staff #2 revealed she felt the staff (nurses and techs) had functioned in an acceptable manner. No documentation was brought forward reviewing the appropriate placement for either the victim Pt #1 or the aggressor Pt #2. No problem was identified therefor no suggestions to avoid future patient injuries secondary to aggressive patient was formulated.



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Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

Report date Number of incomplete reportsNumber of violations Oct. 25, 20121

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Tag No: A0144

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Report No. 1535

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

DENTON REGIONAL MEDICAL CENTER 3535 SOUTH I35 EAST DENTON, TX 76210 Oct. 27, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on interview and record review, the hospital failed to provide a safe setting for 1 of 1 patients (Patient # 1). A) The nursing staff did not follow their "Post Falls Guidelines" policy, and/or B) Exercise good nursing judgement, to ensure safety interventions were initiated (providing a sitter) for an identified High Fall Risk patient.

Findings included:

- A) The "Post Falls Guidelines" policy dated 11/09, noted the following:
- -"Minor Injury defined as ...abrasion, bruise, minor laceration, skin tears and head trauma that is limited to soft tissue damage only."
- -For "Minor Injury ...#6. Consider placement of sitter with patient, if appropriate. "
 -"Major or High Risk Injury defined as ...fractures, head trauma that includes the cranial bones and the brain ...injuries which require medical or surgical intervention, increased hospital stay, or are disabling ...to a degree that the patient will have any degree of permanent lessened function ...patient on anticoagulants ...
- -For "Major or High Risk Injury (Suspected Head/Neck Injury or Use of anticoagulant)...#5 Place sitter with patient. "
- B) Patient #1's medical record reflected Patient #1 experienced 2 falls while hospitalized:

Minor Injury Fall:

The nursing note dated 03/27/10 timed at 6:45 AM reflected, "patient's bed alarm was activated at 06:45 AM, RN went to patient's room and found patient lying on the floor with a cut above his right eye. Patient was assessed for further injuries and helped back to bed with assist X 2 (2-person assist). A rapid response was called and doctor (Personnel # 9) was paged..."

The nursing note dated 03/27/10 timed at the 8:00 AM, Nursing Day Shift assessment reflected, "cut above right eye from fall 03/27/10 ...injured during fall when trying to go to the bathroom ...on bedrest ...short term memory loss - out of bed by self." The Fall Risk Assessment score prior to this fall was 22, and re-assessment after the fall was 28.

The day shift nursing "Fall Risk Assessment," dated 03/27/10 timed at 8:00 AM reflected, after this fall, recorded "fall history: + 11 (2) falls during this visit ...cognition: patient not aware of physical limitations ...total points: 28 ...high risk measures implemented: yes ...additional interventions may include: ...24 hours supervision/sitter, as needed ...High Fall risk comment: call light within reach, bed alarm on (comment did not include initiation of a sitter)."

Major or High Risk Injury Fall:

Patient # 1's Medication Administration Record reflected Patient # 1 received an anticoagulant, Plavix 75 mg. (milligrams) by mouth daily.

The nursing note dated 04/24/10 timed at 11:30 PM reflected, "alarms went off, when entered room nurse saw patient at foot of bed, who then slipped and fell. Patient landed on back and hit back of head. Laceration to left elbow. Occipital hematoma. Patient complained of headache. Rapid Response Team called immediately and doctor (Personnel # 10) paged. Patient placed on backboard and C-collar, and transported to CT for CT of Head and C-spine. Doctor (Personnel # 10) was notified of CT results which were negative." The nursing note dated 04/24/10 timed at 11:30 PM, reflected under the "Post Falls Summary," that before Patient # 1's fall - sitter present: none...

The nursing note for 04/25/10 at 8:00 AM reflected, "Received this AM but appears more confused for him, asking about moving something on the wall. Speech more garbled, non-coherent ...BP (blood pressure 133/79, P (pulse/heart rate)-94 which is higher for him. TC (telephone call) placed to doctor (Personnel # 10) to notify of change in patient. New orders received for repeat CT of Head." 8:45 AM, "Report of CT Scan called...to Personnel # 10 to notify him. Also notified supervisor of possible transfer. " 9:42 AM, TC from Personnel # 10 who stated he spoke with accepting physician at another hospital, and that Patient # 1 will be transferred to them. " 10:00 AM, "Wife at bedside and ambulance arrived, discharged per stretcher with EMT's (emergency medical technicians) to receiving hospital."

The Radiology "CT of Head/Brain without contrast" reported four (4) separate areas of hemorrhage in Patient # 1's brain.

The physician's (Personnel # 10's) "Discharge Summary," included "Acute cranial bleed associated with a fall."

On 10/26/11 at 9:05 AM Personnel # 1 was interviewed. Personnel # 1 stated, "sitters can be requested by nursing staff through the Nursing Supervisor, and are used based on patient condition." Personnel # 1 confirmed a physician order is not required for a sitter, but is based on nursing judgment. Personnel # 1 verified the nursing staff had knowledge of Patient # 1's condition after a stroke, and his increased high fall risk after a reported minor injury fall during his first week in the hospital (PCU), but never requested a sitter for this patient with indications that an additional safety intervention was needed. Personnel # 1 confirmed nursing had not requested a sitter prior to Patient # 1's fall while he was on the Inpatient Rehabilitation unit, which resulted in a major head injury, while on an anticoagulant, and required his transfer to a higher level of care facility for a neurosurgeon.

VIOLATION: PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES

Based on interview and record review, the hospital did not follow their grievance process. The hospital did not address a known grievance from a representative for 1 of 1 patients (Patient # 1). The hospital further failed to inform them of the time frames for review of the grievance, and/or provide them with a response.

Tag No: A0122

Findings included:

On 10/26/11 at 4:20 PM Personnel # 4 was interviewed. Personnel # 4 confirmed Patient # 1's representative (wife) had not filed a complaint or grievance with the hospital. She said the first time the hospital had heard of the complaint was from a follow-up call routinely made by a contracted company (Company # 1), who contacted patients approximately 3 months after being discharged from the Inpatient Rehabilitation Unit. Personnel # 4 stated Personnel # 5 had reported to her, she had received a "Rapid Response Report," from Company # 1 on 07/20/10, with a complaint from Patient # 1's wife regarding her dissatisfaction with her husband's care while at the hospital. Personnel # 4 said she had advised Personnel # 5 the hospital did not need to follow-up on a complaint received from a satisfaction survey, and that she was following their hospital's "Complaint & Grievance" policy.

On 10/26/11 at 3:10 PM Personnel # 5 was interviewed. Personnel # 5 said she had reported the complaint she had received from Company # 1, and reported it to Personnel # 4, who had advised her that no follow-up was needed for this complaint from a satisfaction survey. Personnel # 5 provided a copy of the following report from Company # 1 which noted the following:

-"Information source (wife) stated, My husband had 3 falls at (hospital). Two injured his head, and he ended up with a subdural hematoma. He was doing very well and ready to come home within two days when this happened. The nurses at (hospital) were negligent and I am going to sue for medical negligence."

Personnel # 5 was asked if she had received any Rapid Response Reports in the past, and if so, what did she do to address them. Personnel #5 said she had received 3 prior reports from the company, and she had reported them to Risk Management, and she had also initiated the grievance process by calling the complainant. Personnel #5 verified she had followed the advice from Risk Management, and had not initiated the grievance process for this serious complaint that met the definition of a "grievance."

In an interview at 4:20 PM on 10/26/11 with Personnel # 4, she agreed the complaint had been treated as a "complaint," not as a "grievance," and therefore, the hospital had not addressed the allegations made by the patient's representative (wife), according to the hospital's policy, including time frames for review and provision of a response to a "grievance."

The "Patient Complaint & Grievance Resolution Process," #9.115, dated 12/10, noted the following:

- Complaints that Would be considered a Grievance:
- -Any verbal or written complaints (including e-mails and faxes) from an inpatient, an outpatient, a released/discharged patient, or a patient's representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with CoPs (conditions of
- -Telephone calls received from a patient or patient's representative describing patient care issues.
- Complaints that Would Not be considered a Grievance:
- -Post hospital verbal communications, which would have been handled by staff present if staff was aware of the complaint. This includes patient satisfaction survey information.



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Report No. 1763

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

ST LUKE'S PATIENTS MEDICAL 4600 EAST SAM HOUSTON PARKWAY SOUTH CENTER PASADENA, TX 77505

Oct. 27, 2011

VIOLATION: DISCHARGE PLANNING

Tag No: A0799

Based on record review and interview, facility failed to operationalize it's policy and procedure to ensure 1/1 unstable patients from a sample of of 10 patients

was transferred from the facility to a hospital with appropriate specialized equipment and support measures which were medically appropriate to stabilize the patient and to sustain the patient during transfer.

Finding

Review of patient #'1's clinical record (Memorandum of Transfer) revealed the patient was transferred from hospital (A) to hospital (B) on 10/08/2011.

Review of the patient's clinical record revealed no evidence of an assessment of the patient's condition immediately prior to transfer by the registered nurse or a physician. Review of the patient's clinical record revealed, the Memorandum of Transfer was not signed by a physician at the transferring hospital. There was no order in the patient's clinical record as to specialized equipment and support measures which are medically appropriate to stabilize the patient and to sustain the patient during transfer.

Review of physician's progress (from receiving hospital B) notes dated 10/08/2011 at 8:20 p.m. revealed the following assessment of the patient: "When patient came to the unit, obtunded, not following the command, tachypnic, very cyanotic, no peripherals pulse (+) cyanosis, dilated pupils not reactive." The progress notes further indicated that the patient had fixed pupils, not able to follow commands and the patient was intubated immediately.

The patient was maintained on ventilator with vasopressors medications. Physician's progress notes at hospital (B) dated 10/10/2011 indicated that the patient had no spontaneous breathing, pupils were fixed and dilated and the patient was declared dead at 9:11 a.m.

Cross reference A-0837

VIOLATION: TRANSFER OR REFERRAL

Tag No: A0837

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on records review and interviews, the facility failed to operationalize it's policy and procedure to ensure that 1 of 1 unstable patient from a sample of 10 patients

was transferred from the facility to a hospital with appropriate specialized equipment and support measures which were medically appropriate to stabilize the patient and to sustain the patient during transfer. citing patient #1

Findings:

Review of facility's Current Policy and procedure on Patient transfer

Review of the facility's policy and procedure on patient transfer #115.09 directed staff as follows:

"The transferring physician will personally examine and evaluate the patient before an attempt to transfer is made. However, after receiving a report on the patient's condition from the hospital nursing staff by telephone or radio if the physician on call determines that an immediate transfer of the patient is medically appropriate and that the time required to conduct a personal evaluation of the patient will unnecessarily delay the transfer to the detriment of the patient, the physician on call may order the transfer by telephone or radio. If the physician on call issues orders for the transfer by telephone or radio, those orders shall be reduced to writing in the patient's medical record, signed by the hospital staff member receiving the order, and countersigned by the physician authorizing the transfer as soon as possible.

Physician 's duties:

- (1) The transferring physician shall determine and order life support measures which are medically appropriate to stabilize the patient prior to transfer and to sustain the patient during transfer
- (2) The transferring physician shall determine and order the utilization of appropriate personnel and equipment for transfer.
- (3) In determining the use of medically appropriate life support measures, personnel, and equipment, the transferring physician shall exercise that degree of care which a reasonable and prudent physician exercising ordinary care in the same or similar locally would use for the transfer
- (4) Except as modified above, when delay of transfer would appear to be a detriment to the patient, prior to each patient transfer, the physician who authorizes the transfer shall personally examine and evaluate the patient to determine the patient 's medical needs and to assure that the proper transfer procedures are used.
- (5) Prior to transfer the transferring physician shall secure a receiving physician at a receiving hospital that are appropriate to the medical needs of the patient and that will accept responsibility for the patient 's medical treatment and hospital care."

Patient #1

Review of the patient's clinical record (demographic data) revealed that she presented to the above facility's Emergency Department on 10/07/2011. The patient presented to the emergency room with chief complaint of pain from fall. The patient's history and physical indicated admitting diagnosis of [DIAGNOSES REDACTED].

Review of a progress notes by the Consulting pulmonologist (Dr B) dated 10/07/2011 revealed the following assessment of the patient: "Prognosis very very guarded."

Review of the patient's clinical record revealed a progress notes dated 10/08/2011 at 4:10 a.m. written by Dr A (a gastroenterologist) which stated: "Discussed care with Dr. B Pt to get trial of BiPAP." Review of the patient's clinical record revealed a physician's order dated 10/08/2011 at 4:20 a.m. written by Dr A to transfer patient to Hospital B.

Review of a follow up progress notes dated 10/08/2011 at 3:08 p.m. revealed the following documentation by Dr. B (pulmonologist): "Encephalopathic, Shock, on dialysis now. Multiorgan failure, Septic Shock. On full face mask decrease air entry bilaterally, CNS drowsy and confused. Plan: on BiPAP, Oxymetry ok. No need for intubation."

Review of the patient's clinical record (nurses notes) dated 10/08/2011 at 1:45 p.m. revealed the following entry by the registered nurse: "Pt. BP = 76/29. Levo increased to 15 mic from 10 mic. Pt remains on BiPAP 18/5 and tolerating well. RR=20's. O2 SAT= 94%. axillary temp 95. Warming blanket applied at 10:30 Dr--- notified."

Review of a subsequent nurse's progress notes dated 10/08/2011 at 14:45 revealed the following documentation: "Anesthesia MD at bedside to eval resp status for possible intubation. 14:30 ABG results given. No plans for orders for intubation at this time."

Review of the patient's clinical record revealed a final entry by the registered nurse assigned to the patient dated 10/08/2011 at 18:00: " --- EMS here to transfer pt to ---- Downtown. Breathing Tx given by RT. Pt. placed on NRM for transport. 02 sat 94%. RR =22, BP= 114/92. Hr + 81. Pt to leave shortly."

Review of the patient's clinical record revealed no further assessment by the registered nurse.

Review of the patient's clinical record revealed no evidence of an assessment of the patient's condition immediately prior to transfer by the registered nurse or a physician. Review of the patient's clinical record revealed the memorandum of transfer was not signed by a physician at the transferring hospital. There was no order in the patient's clinical record as to specialized equipment and support measures which are medically appropriate to stabilize the patient and to sustain the patient during transfer.

Memorandum of Transfer

Review of the patient's medical record from transferring /accepting hospital revealed a Memorandum of Transfer signed by the patient's mother on 10/08/2011 at 17:00. Medical record revealed the following entry: "Transfer of unstabilized patient: Reason for Transfer Higher level of care. Risk of transfer worsening." The Memorandum of Transfer indicated that the facility requested special equipment of BiPAP, monitors, and pumps. Personnel needed; Paramedic ACLS.

Review of physician's progress notes (from receiving hospital B) dated 10/08/2011 at 8:20 p.m. revealed the following assessment of the patient: "When patient came to the unit, obtunded, not following the command, tachypnic, very cyanotic, no peripherals pulse (+) cyanosis, dilated pupils not reactive." The progress notes further indicated that the patient had fixed pupils, not able to follow commands and the patient was intubated immediately.

The patient was maintained on ventilator with vasopressors medications. Physician's progress notes at hospital B dated 10/10/2011 showed that the patient had no spontaneous breathing, pulse were fixed and dilated, and the patient was declared dead at 9:11 a.m.

Paramedic statement

Review of a statement dated 10/08/2011, written by the licensed paramedic who transferred the patient from hospital (A) to hospital (B) revealed the following entry: "Hospital staff----- informed EMS personnel that pt family specifically requested that patient be transported with a service with BIPAP capabilities Mr-- and Ms-- were informed multiple times that -- ambulance did not have BIPAP capabilities.

At approximately 10 minutes into transport, O2 sat on portable pulse ox (attached to forehead) began to fluctuate and drop. O2 dropped into the 60's but continued up and down between the 60s and 80%. Pt remained conscious and was moving her arm, but not with the same vigor as previously noted. At that time the decision was made to to begin assisting PT, ventilations with BVM.at the rate of 12 - 15 breaths per minute."

Interview with intensive care Charge Nurse

In an interview with Intensive Care unit Charge Nurse (C) on 10/26/2011 at 11:15 a.m. in the chief nursing officer's office. She stated that she was the charge nurse in the intensive care unit during patient #1's transfer from the hospital. . She stated that she could recall details of the event although she was not directly assigned to her She stated that RN (D) was assigned to the patient. She said the accepting hospital called her and confirmed that it was OK to transfer the patient. She said she went to locate the Memorandum of Transportation (MOT) which she thought was filled out from the night before but there was none. She said she seek the help of a case manager to help her with completing the MOT.

Charge Nurse (C) said she did not directly conduct a need assessment on the patient but based on the information from the nurse who was assigned to the patient, she called the ambulance for transfer. She said she told the ambulance that the patient needed BiPAP and equipment to intubate along with a paramedic. Charge Nurse (C) said she did not notify the physician of the transfer since the nurse assigned to the patient told her that they were working on the transfer since earlier in the day. She said she spoke with the patient's mother and sister and told them that there were risks involved in transferring the patient. She said the patient was taken off the BiPAP machine and placed on a non re-breather mask for the transfer. The Surveyor asked the charge nurse if she had an order to change the BiPAP to a non rebreather mask. She stated no. She stated that she did not see the patient leave the unit and since she was not assigned to the patient she did not write a note on the event of the transfer.

Further interview with Charge Nurse (C) at 2:34 p.m. in the CNO office, she stated that she spoke with the patient's brother- in law via the telephone. She said he wanted to know the patient's vital signs, which she provided. She also assured him that the patient would be transferred in an ambulance which had BIPAP, the capability to intubate, ACLS personnel and pump. She said after providing him with the information on the transfer, he was ok with the transfer. She said she was not aware that the ambulance did not have BIPAP capability. Did not know who switched the patient from BIPAP to a non - re- breather mask.

The charge nurse said she did not know a lot about the patient, she only knew that the patient had liver problem and was been transferred to see a liver specialist. She said as the charge nurse she was assigned two patients of her own along with charge responsibility and precepting registered nurse (D) who was working in the facility less than 90 days.

Interview with Registered Nurse (D)

During an interview with Registered Nurse (D) on 10/26/2011 at 2:25 p.m. in the CNO's office, he stated that he was assigned to the patient during the transfer. Said he provided care to the patient from 7:00 a.m. He said he walked in the patient room in time to assist the EMS personnel with transferring the patient from the bed to the stretcher. He said there were two EMS personnel 's in the room but he did not know their names. He said the shorter of the two EMS personnel made a comment that he did not have BIPAP capability on the ambulance. He said he did not notify his charge nurse of the lack of BIPAP capability.

Registered nurse (D) said he spoke to the patient's covering attending physician approximately 7:30- to 8:00 a.m. on 10/08/2011. He said he cannot recall mention of transportation of the patient via life flight, neither can he recall the physician telling him that that he needed to revaluate the patient after hemodialysis. He said he did not think to stop and call the physician prior to the transfer.

Interview with Dr E

During an interview with Dr (E) on 10/26/2011 at 11:43 a.m. via the telephone, he stated that he was the covering physician for the patient's attending physician. He stated that he saw the patient at approximately 8:00 a.m. in the unit. He said at the time that the renal physician was present along with the gastroenterologist. He said that the renal physician was in the process of inserting a catheter to dialyze the patient. He said he and the gastroenterologist discussed arranging for transfer post hemodialysis. He said he spoke to the nurse assigned to the patient and informed him that he would revaluate the patient post hemodialysis treatment since the patient was critical and on vasopressors. He said he spoke with nurse assigned to the patient and told him that the patient may need life flight.

Dr (E) said that the nurse did not inform him about the patient's condition on transfer and that he had not seen or examine the patient after hemodialysis treatment. He said that he was of the opinion that at the time of transfer the attending physician needed to be called to discuss the patient's vital signs and the condition of the patient. He said the transfer order was written earlier in the morning by the consulting hematologist. He stated "To be frank with you, when I opened the patient's chart I did not know what time the patient left because I could not find any info. I spoke with the patient's attending physician the following Monday and informed him that the patient left the facility without been seen by me."

Interview with Dr (A)

During and interview with DR (A) (gastroenterologist) on 10//27/2011 at 10: 36 a.m. in the CNO's office, he stated that he ordered the transfer of patient #1 to a facility with liver transplantation capacity. He stated "I was worried about her that's why I came back I contemplated intubation."

Dr (A) stated "I don't order what equipment to be on board. They needed an ambulance specifically to deal with her condition. I am a consultant, I take care of her liver. Every one knew that the patient was to be transferred, and what specialized equipment she needed. She was on BiPAP all day."

Interview with Dr (B)

During an interview with Dr (B) (pulmonologist) on 10/27/2011 at 1:25 p.m., he said he assessed the patient on 10/08/2011 at approximately 3:08 p.m., and at that time after assessing the patient he made a determination that the patient did not need intubation but needed to continue on BiPAP. He said he spoke with the patient's mother and sister, and assured them that "we will reassess the patient when a bed becomes available in the intensive care unit of (hospital B)". Dr (B) said he had no direct or indirect contact with the patient or the family after that visit until approximately 9: 00 p.m., the patient's brother- in - law called him on his cell phone and told him that the patient was transferred from the hospital to the receiving hospital without BiPAP. Dr. B said that based on his assessment at 3:08 p.m. the patient should have been transferred on the BiPAP. He said his assessment at 3:08 p.m. revealed the patient was responsive but confused, but less confused than when he assessed her on 10/07/2011. He said when he saw the patient on 10/08/2011 at 3:08 p.m. the patient's pupils were reactive to light and the patient was not comatose. Dr (B) states "No one asked my opinion on the transfer. No doctor was called on the transfer, no one from the hospital or the EMS company." He said he called the administrator on call the same night and notified him that the patient was transferred without BIPAP capability.



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ST LUKE'S PATIENTS MEDICAL CENTER ST LUKE'S PATIENTS MEDICAL CENTER

4600 EAST SAM HOUSTON PARKWAY SOUTH PASADENA, TX 77505 | Proprietary

View hospital's federal Hospital Compare record

Report date Number of violations

Oct. 27, 20112 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. **Incomplete reports**

No incomplete reports available.



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BAYLOR MEDICAL CENTER AT WAXAHACHIE ->

Report No. 1519

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

BAYLOR MEDICAL CENTER AT WAXAHACHIE

1405 W JEFFERSON ST WAXAHACHIE, TX Oct. 13, 75165 2011

VIOLATION: CONTRACTED SERVICES

Tag No: A0084

Based on observation, interview and record review the Governing Body failed to ensure contracted services (Dietary and Housekeeping) were provided in a safe manner. The Dietary department was not maintained in a sanitary condition. The Housekeeping department failed to ensure equipment was clean. This practice placed patients at risk for developing and/or acquiring infections while residing in the hospital.

Findings Included:

On 10/11/11 at approximately 1:15 PM the 2 south nursing unit was observed. Three large metal housekeeping carts were observed. The three carts had a brown substance on the floor of the cart. Staff #9 stated housekeeping was to clean the entire cart everyday. Staff #9 stated the substance on the floor of the cart appeared as if it may be rust.

On 10/11/11 at approximately 2:00 PM the dining room was toured with Staff #1 and Staff #8. The following observations were made:

The dining room grill station had two soiled rags lying on the shelf where clean supplies were kept. The shelves were soiled with debris and buildup.

A mesh 10 compartment container which held paper products was rusted on the bottom of the surface. The surface was not sanitizable.

The internal swinging door to the kitchen was soiled with hand prints, grime and debris. The door surface had not been cleaned.

The rack which held pots, pans and trays was observed. Thirty eight pans used in food preparation were stacked wet on top of each other. The surveyor lifted the lip of multiple pans and water poured out onto the floor. Muffin tins (4) were rusted on the interior surface where food would have contact. Baked on debris and buildup was observed on the top and back of the tins. Staff #12 stated the dishes should not be stacked wet on top of each other and the rusted tins should be thrown away.

The walk in refrigerator unit and kitchen floors had debris, grime and buildup. Debris was observed under the equipment and work stations. Shelving throughout the kitchen was soiled and/or dusty.

The mop bucket color was yellow. The bucket was soiled with brown/black stains on the outside and inside of the bucket. The mop ringer had dirt and debris buildup and was rusted.

Two oven exterior surfaces had a collection of grease and debris. A white substance was observed on the exterior surface of the oven. Staff #8 stated he would clean the oven.

The grill station was observed. The space under the unit was observed with a large tray with a collection of grease. Lying in the grease was a stiff brush and a can of degreaser. The bottom part of the grill was soiled, dirty and greasy. Staff #8 acknowledged the space needed to be cleaned.

On 10/11/11 at 2:15 PM, Staff #8 verified the above findings. Staff #12 stated she could not provide evidence of a cleaning schedule.

The House Wide Council Minutes dated 09/07/11 reflected, "EVS (environmental services); more education may be needed on every other day linen changes...patient day rate has decreased with not using pads on the bed...Nutrition...there has been an increase in diet orders entered and changed at the tray line times...there are also trays being delivered to holdover..." No meeting discussion was documented for sanitation concerns in the dietary and housekeeping department.

The undated Hospital Plan of Care provided by Staff #1 on 10/13/11 reflected, "The hospital executive team...is responsible for developing operational objectives...reprioritizing strategic and performance improvement priorities in response to unexpected events and establishing policy. Additionally, hospital leadership is responsible to: Establish and implement policies and procedures, standards for patient care, and clinical practice guidelines; integrate processes through services...promote and provide an environment for patient safety...the hospital plans for the delivery of patient care through a systematic process of assessing, planning, implementing, and evaluating services it provides...periodically an environment assessment is conducted by the hospital....includes needs of hospital's major patient populations, and results of performance improvement activities..."

VIOLATION: INFECTION CONTROL OFFICER RESPONSIBILITIES

Tag No: A0749

Based on observation, interview and record review, the hospital Infection Control Officer failed to ensure, 1) The dietary department was maintained in a clean, sanitary condition. 2) 3 of 4 housekeeping carts were cleaned after each use. 3) The ED (Emergency Department) portable medical equipment was clean and ready for use. 4) 1 of 3 soiled linen rooms had linen stored appropriately and 5) The recovery room stored patient's belongings in a sanitary manner. These practices placed patients at risk for developing and/or acquiring infections while residing in the hospital.

Findings included:

On 10/11/11 at approximately 1:15 PM the 2 south nursing unit was observed. Three large metal housekeeping carts were observed. The three carts had a brown substance on the floor of the cart. Staff #9 stated housekeeping was to clean the entire cart everyday. Staff #9 stated the substance on the floor of the cart appeared as if it may be rust.

On 10/11/11 at 01:40 PM the 3 south nursing unit was observed. The soiled linen room had one large bag of soiled linen sitting on the floor of the room. A soiled microfiber pad was left on the counter.

On 10/11/11 at approximately 2:00 PM the dining room was toured with Staff #1 and Staff #8. The following observations were made:

The dining room grill station had two soiled rags lying on the shelf where clean supplies were kept. The shelves were soiled with debris.

A mesh 10 compartment container which held paper products was rusted on the bottom of the surface. The surface was not sanitizable.

The internal swinging door to the kitchen was soiled with hand prints, grime and debris. The door surface had not been cleaned.

The rack which held pots, pans and trays was observed. Thirty eight pans used in food preparation were stacked wet on top of each other. The surveyor lifted the lip of multiple pans and water poured out onto the floor. Muffin tins (4) were rusted on the interior surface where the food would have contact. Baked on debris and buildup was observed on the top and back of the tins. Staff #12 stated the dishes should not be stacked wet on top of each other and the rusted tins should be thrown away.

The walk in refrigerator unit and kitchen floors had debris, grime and buildup. Debris was observed under the equipment and work stations. Shelving throughout the kitchen was soiled and/or dusty.

The mop bucket color was yellow. The bucket was soiled with brown/black stains on the outside and inside of the bucket. The mop ringer had dirt and debris buildup and was rusted.

Two oven exterior surfaces had a collection of grease and debris. A white substance was observed on the exterior surface of the oven. Staff #8 stated he would clean the oven.

The grill station was observed. The space under the unit was observed with a large tray with a collection of grease. Lying in the grease was a stiff brush and a can of degreaser. The bottom part of the grill was soiled, dirty and greasy. Staff #8 acknowledged the space needed to be cleaned.

On 10/11/11 at 2:15 PM, Staff #8 verified the above findings. Staff #12 stated she could not provide evidence of a cleaning schedule.

On 10/11/11 at approximately 2:40 PM the ED was toured with Staff #1. The bladder scan machine and three vital sign machines on wheels had dust/dirt buildup on the base of the equipment. Staff #5 verified the equipment was to be cleaned every time it was used. This included the bottom of the equipment.

On 10/11/11 at approximately 2:45 PM the recovery room was toured with Staff #1. A soiled linen cart was observed in the corner. A bag of patient belongings was observed sitting on top of the soiled linen cart. Staff #1 verified the patient's belongings should not be stored on top of the soiled linen cart.

On 10/12/11 at approximately 10:20 AM Staff #7 was interviewed. Staff #7 stated the last health inspection in the dietary department was good. Staff #7 stated the non-clinical areas are looked at once a year. She stated this was done in the dietary department July 2011.

The environmental policy entitled, "Cleanup" with a date of September 2005 reflected, "Wipe down all equipment with ALPHA HP...clean equipment presents a professional image..."

The Food and Nutrition Services policy and procedures with a reviewed/revised date 04/20/11 entitled, "Storage of Perishable Food" reflected, "Maintain efficient refrigeration through proper cleaning and maintenance of the units."

The Food and Nutrition Services policy and procedures with a reviewed/revised date of 04/20/11 entitled, "Cleaning schedules" reflected,

"Schedules for cleaning are established for each piece of equipment as well as for the facility..." A second policy entitled, "Procedure for Washing Doors Daily" reflected, "Apply wash solution with clean cloth. Scrub all door surfaces. Include door knobs, hinges door stop..."

The Food and Nutrition Services policy and procedures with a revision date of May 2011 entitled, "Procedure for washing pots and pans" reflected, "Remove ware from sink and place on drain board, tipped in such a way that solution will drain completely. Allow to air dry...remove ware to proper storage until next use..."

The policy and procedure entitled, "General Infection Prevention Policy" with a revision date of February 24, 2011 reflected, "Work Practice Controls include but are not limited to...separation of clean and dirty items...maintenance of a clean and safe environment...cleaning, disinfection and sterilization is to be practiced according to local, State, and National Professional Standards...general cleanliness of all facilities will be maintained...new and/or rental equipment must be wiped down with a system approved disinfectant prior to use...portable blood pressure machines, monitors and other patient care equipment must be cleaned by the healthcare worker whenever visible contamination occurs. If portable units (some with attached cuffs) are taken into isolation rooms, single patient use blood pressure cuffs must be used and the unit must be cleaned with approved germicidal wipes or spray..."

VIOLATION: DIRECTOR OF DIETARY SERVICES

Based on observation, interview and record review the hospital failed to ensure the Dietary Director managed the dietary department in a responsible manner. The Dietary department was not maintained in a sanitary condition. This practice placed patients at risk for developing and/or acquiring infections while residing in the hospital.

Tag No: A0620

Findings Included:

On 10/11/11 at approximately 2:00 PM the dining room was toured with Staff #1 and Staff #8. The following observations were made:

The dining room grill station had two soiled rags lying on the shelf where clean supplies were kept. The shelves were soiled with debris.

A mesh 10 compartment container which held paper products was rusted on the bottom of the surface. The surface was not sanitizable.

The internal swinging door to the kitchen was soiled with hand prints, grime and debris. The door surface had not been cleaned.

The rack which held pots, pans and trays was observed. Thirty eight pans used in food preparation were stacked wet on top of each other. The surveyor lifted the lip of multiple pans and water poured out onto the floor. Muffin tins (4) were rusted on the interior surface where the food would have contact. Baked on debris and buildup was observed on the top and back of the tins. Staff #12 stated the dishes should not be stacked wet on top of each other and the rusted tins should be thrown away.

The walk in refrigerator unit and kitchen floors had debris, grime and buildup. Debris was observed under the equipment and work stations. Shelving throughout the kitchen was soiled and/or dusty.

The mop bucket color was yellow. The bucket was soiled with brown/black stains on the outside and inside of the bucket. The mop ringer had dirt and debris buildup and was rusted.

Two oven exterior surfaces had a collection of grease and debris. A white substance was observed on the exterior surface of the oven. Staff #8 stated he would clean the oven.

The grill station was observed. The space under the unit was observed with a large tray with a collection of grease. Lying in the grease was a stiff brush and a can of degreaser. The bottom part of the grill was soiled, dirty and greasy. Staff #8 acknowledged the space needed to be cleaned.

On 10/11/11 at 2:15 PM, Staff #8 verified the above findings and Staff #12 stated she could not provide evidence of a cleaning schedule.

On 10/12/11 at 10:20 AM Staff #7 was interviewed. Staff #7 stated non-clinical areas are rounded once a year. Staff #7 stated dietary was completed 07/21/11 and no major issues were found.

On 10/12/11 at approximately 11:30 AM Staff #8 provided the surveyor the 09/11 and 10/11 cleaning schedules for the dietary department. The cleaning schedules indicated the dietary department was being cleaned on a daily basis.

The Food Production assessment tool dated 10/04/11 reflected, under "#5 sanitation and safety standards are met" reflected a score of 10 critical flaw..."

The Director of Food Service Job Description dated and signed, 07/02/03 reflected, "Maintains product and service quality standards by conducting ongoing evaluations and investigating complaints...inspects food and food preparation to maintain quality standards and sanitation regulations..."



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ST LUKE'S THE WOODLANDS HOSPITAL ->

Report No. 1579

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ST LUKE'S THE WOODLANDS HOSPITAL

17200 ST LUKE'S WAY THE WOODLANDS, TX Oct. 3, 77384

2011

VIOLATION: NURSING CARE PLAN

Tag No: A0396

Based on interview and record review the nursing staff failed to keep a care plan current in 1 of 3 patients reviewed. (Patient ID# 1)

Findings include:

Interview 10/3/11 at 8:15 a.m. with Patient ID# 1's daughter revealed her [AGE] year-old father had back surgery at St. Luke's Hospital in June 2011. The daughter stated the family visited her father on the morning of June 12th, 2011 and noticed a strap had been placed across the patient's waist and connected to the sides of the bed. The nursing staff explained to the daughter that the strap was referred to as a "Gentle Reminder." The daughter was upset because her father was not confused and the device resembled a restraint limiting the patient's movement.

Record review of a nursing "patient care flow sheet "dated 6/12/11 at 7:30 a.m. stated "gentle reminder on." The nursing care plan identified the patient as a fall risk but the interventions did not include the use a "Gentle Reminder" strap across his waist. The nursing notes failed to document why it became necessary to use a "Gentle Reminder."

The Risk Manager (ID# 50) acknowledged 10/3/11 at 11:15 a.m. that a "Gentle Reminder" is a seatbelt with a guick release snap. The staff member further stated the "Gentle Reminder" is not classified as a restraint and that the hospital does not have a specific policy regarding the use of this device.

Record review of a policy titled "Restraint "dated June 2011 stated the Purpose:
"Promote a safe, consistent, patient-oriented approach to the use of restraints that preserves the patient's rights, dignity and well-being during restraint use;" The restraint policy also provided a list of exclusions for devices that were not classified as a restraint. A "Gentle Reminder" was not classified as an exclusion to a restraint.

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**



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ST LUKE'S THE WOODLANDS HOSPITAL ST LUKE'S THE WOODLANDS HOSPITAL

17200 ST LUKE'S WAY THE WOODLANDS, TX 77384 | Voluntary non-profit - Church

View hospital's federal Hospital Compare record

Report date Number of violations

Oct. 3, 20111 (click for details) Read full report

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No incomplete reports available.

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<u> SCOTT & WHITE MEMORIAL HOSPITAL</u> ->

Report No. 1475

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SCOTT & WHITE MEMORIAL HOSPITAL

2401 31ST ST TEMPLE, TX 76508

Sept. 22, 2011

VIOLATION: GOVERNING BODY

Tag No: A0043

Based on review of available documentation, observation and staff interviews, the governing body failed to be responsible for all areas of hospital operation; for example- the infection control program, physical plant, and patient rights within the hospital.

Findings were:

On 2-24-11, review of the meeting minutes from the Governing Body revealed that the Infection Control plan and evaluation including changes was presented and approved. There was no documentation of any areas of the hospital being inspected/viewed by Infection Control staff for Infection Control problems as there was no data available. Observation in the surgical suite, including operating rooms, pre- and post-operative areas, labor and delivery, nursery, radiology, and pediatric areas revealed there were multiple areas in need of monitoring for infection control practices.

Cross Refer: A747

The right of patients to personal privacy and to care in a safe setting was not met as patients were monitored via camera in their personal area and patient health information was being displayed; emergency call systems were not available or inaccessible, and restraint devices were unsecured.

During a tour of the psychiatric unit on 9/20/11, 12 of 18 patient bedrooms and partial bathrooms were being monitored with real time electronic surveillance monitoring cameras and the display was visible to those outside the nursing station, and during a tour of the 4 North inpatient unit on 9/21/11, patient health information was displayed outside of 2 of 2 patient rooms. During a tour of the emergency department on 9/20/11, as restraint devices were not secured and were available for patients in the " Safe Room ". Additionally, during a tour of the emergency department and labor and delivery area on 9/20/11 emergency call systems were not available or were inaccessible.

Cross Refer: A0115

Observation during a tour of the hospital and interviews with staff revealed the physical environment, including the kitchen, loading dock, inpatient units, surgical suite, and psychiatric unit, were not maintained to ensure the safety and well-being of the patients as there were holes in walls, broken floor tiles, water damaged ceilings, torn coverings on examination and operating room tables, rust in the operating rooms, disintegrated freezer door seals, rancid-smelling standing water, non-intact walls, and other safety issues, which prevented proper cleaning and made possible the entry of dirt particles, rodents, and insects.

Cross Refer: A0701





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VHS HARLINGEN HOSPITAL COMPANY LLC ->

Report No. 1466

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VHS HARLINGEN HOSPITAL COMPANY LLC

2101 PEASE ST HARLINGEN, TX 78550

Sept. 21, 2011

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Tag No: A0178

Based on staff interview and review of medical record, it was determined the hospital failed to ensure patient #1, who had behavioral restraints applied and whose record was reviewed, was seen face to face within 1 hour after initiation of the intervention by a person authorized to conduct restraint evaluations. This resulted in the inability of the hospital to adequately assess patient for causes of behaviors and treatment alternatives.

Findings include:

Patient 's medical record documented [AGE] year old female underwent posterior lumbar decompression and fusion. On 05/10/11 at 02:15 patient had pulled her IV out was yelling and screaming; would not let nursing staff assessed her and aggressive towards staff. Patient has a telephone order from her attending physician for 24 hour restraints, written at 02:31 on 05/11/11. After patient was placed in restraints, she was not seen face to face by a physician or LIP in order to assess the need for restraint and possible alternative interventions. The earliest documented physician visit is on 05/11/11 at 08:05.

The hospital 's Vice President Risk Management was interviewed on 09/21/11 at 2:30 PM. She had reviewed patient #1 record. She indicated a face to face reassessment of patient #1 was not completed within 1 hour of the use of restraints.

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**



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CARE REGIONAL MEDICAL CENTER ->

Report No. 1532

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CARE REGIONAL MEDICAL CENTER

1711 W WHEELER AVENUE ARANSAS PASS, TX Sept. 7, 78336 Sept. 7

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based upon review of medical records and an interview with facility staff, facility failed to provide a safe environment while patients were at the facility in that patients were put into an exam room and left for over two hours without follow up or care provided.

Findings include:

- 1. Per review of the medical record patient #4 and patient #8 were put into the same exam room at approximately 1600. No other documentation is noted in medical record until when nursing personnel documented that "patient angry and tired of waiting on the doctor. Patient and friend/ family left without being seen by the doctor.
- 2. Interview of staff #5 reveals that staff #5 was working on the day that patients were seen in the emergency room but does not remember any specific treatment provided. Staff #5 remembers patients being angry and does remember them leaving. She stated that facility personnel only put two different patients into the same room on patient's request or when patients are under age.

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Tag No: A0057

Tag No: A0466

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NIX HEALTH CARE SYSTEM ->

Report No. 1496

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NIX HEALTH CARE SYSTEM 414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205 Sept. 6, 2011

VIOLATION: CHIEF EXECUTIVE OFFICER

Based on a review of documents and interview with staff, the governing body failed to appoint a chief executive officer who was responsible for managing the hospital.

Findings were:

During a review of hospital policy entitled, "Nursing Staffing Policy and Plan "according to the staffing grid for the child and adolescent unit located in the Nursing Staffing Policy and Plan, the facility staffing did not meet the required staffing needs:

Date: 7-22-11, Shift: 3p-11p, Census: 16, Required: 2 nurses; 3 MHTs, Actual: 1 nurse, 3 MHTs Date: 7-25-11, Shift: 11p-7a, Census: 13, Required: 2 nurses; 1 MHT, Actual: 1 nurse, 2 MHTs Date: 7-26-11, Shift: 7a-3p, Census: 18, Required: 3 nurses; 3 MHTs, Actual: 2 nurses, 2 MHTs Date: 7-28-11, Shift: 7a-3p, Census: 18, Required: 3 nurses; 3 MHTs, Actual: 2 nurses, 3 MHTs

A review of hospital policy entitled, "Transfer of Patients to Other Facilities" states, in part, on page 5 of 6, "NHCS will provide a memorandum of transfer, as prescribed by the Texas Department of Health, to be completed for every patient who is transferred."

During a review of clinical record for Patient #1 and an interview with staff, no memorandum of transfer could be located within the clinical record or in another file for the transfer of Patient #1 to Methodist Hospital ER on 7-26-11.

The above was confirmed in an interview with the Chief Operating Officer and other administrative staff on the afternoon of 9/6/11 in the facility conference room.

VIOLATION: CONTENT OF RECORD - INFORMED CONSENT

Based on a review of facility documentation, the hospital's medical record service did not ensure that the patient's medical record contained properly executed consent forms.

Findings were:

Four of five consent forms for psychoactive medications did not contain properly executed consent from the minor patient's legal guardian.

The above was confirmed in an interview with the Chief Operating Officer and other administrative staff on the afternoon of 9/6/11 in the facility conference room.



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HOPKINS COUNTY MEMORIAL HOSPITAL ->

Report No. 1509

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HOPKINS COUNTY MEMORIAL HOSPITAL

115 AIRPORT RD SULPHUR SPRINGS, TX 75482

Sept. 6, 2011

VIOLATION: NURSING CARE PLAN

Tag No: A0396

Based on record review and observation the facility failed to develop and keep current a nursing plan of care for 1 of 1 patient record reviewed.

On 9/6/2011 at 9:30 AM the patient medical record was reviewed and revealed the following. The patient was admitted through the Emergency Department (ED) on 3/8/2011.

The ED physician wrote admitting orders with diagnosis as Pneumonia, Hypernatremia, [DIAGNOSES REDACTED], Dehydration and renal insufficiency.

The attending physician for inpatient services dictated the History and Physical as volume depletion, pneumonia, renal failure, dementia and probable aspiration pneumonia.

the admission nurses assessment documented coarse ronchi in lung sounds, incontinent of bowel and bladder, with indwelling catheter, decubiti to medial coccyx, mental status confused with a Gloscow coma score of 14, severe weakness, and bilateral lower extremities with 2 plus edema.

A review of the nursing care plan initiated on 3/8/3011 by staff # 4 revealed: decreased cardiac output, impaired gas exchange, knowledge deficit of dehydration, and activity tolerance. All interventions noted on the nursing care plan were initiated upon admission by staff #4. There was no on-going nursing care plan or intervention for any need identified through the ED physician or attending physician's diagnosis or the admission nursing assessment other than those established upon admission by staff #4. The facility did not meet the needs of the patient through on-going nursing care planning.

An interview with staff #5 confirmed there was no nursing care plan for incontinence, falls risks, skin care, nutritional needs or renal insufficiency/failure and there was no follow-up assessment or intervention to any of the established care plan needs.

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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HOPKINS COUNTY MEMORIAL HOSPITAL HOPKINS COUNTY MEMORIAL HOSPITAL

115 AIRPORT RD SULPHUR SPRINGS, TX 75482 | Government - Hospital District or Authority

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Report date Number of violations

Sept. 6, 20111 (click for details) Read full report

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No incomplete reports available.

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BRINGING TRANSPARENCY TO FEDERAL INSPECTIONS

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ODESSA REGIONAL HOSPITAL ->

Report No. 1548

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ODESSA REGIONAL HOSPITAL

520 E 6TH STREET ODESSA, TX 79761

Sept. 6, 2011

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

Tag No: A0457

Based on staff interview and review of the clinical record for patient #1, the hospital failed to ensure that 16 of 16 verbal and/or telephone orders were signed by the physician within 48 hours as required.

Findings were:

A review of the physician orders for patient #1 revealed that 16 of 16 verbal and/or telephone orders were signed by the physician between 96 hours at the shortest and 20 days as the longest after the orders were taken by the nursing staff for the respective physician. This was confirmed in interview and by record review with staff #1 in the conference room on 9/6/11.

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PALESTINE REGIONAL MEDICAL CENTER ->

Report No. 1568

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

PALESTINE REGIONAL MEDICAL CENTER 2900 S LOOP 256 PALESTINE, TX 75801 Aug. 24, 2011

VIOLATION: PATIENT RIGHTS: REVIEW OF GRIEVANCES

Tag No: A0119

Based on record review and interview, the Board of Trustees (facility 's governing body) failed to oversee the facility 's grievance process. Patient grievances were not being reported to the Board of Trustees.

Findings include:

Review of facility policy, "Patient Complaints/Grievances, "revealed the following: Data on grievances is incorporated into the hospital's quality assessment and performance improvement program (QAPI). "

AND "Summary reports of grievances are presented to the PI (Performance Improvement) Council and the Board of Directors. The PI Council integrates grievance information into the organization 's performance improvement program."

Review of the facility 's grievance tracking log for 2011 revealed 78 grievances had been recorded as of 8/24/2011.

Review of Quality Committee meeting minutes of January-July 2011 failed to reveal any discussion of facility grievances.

Review of Board of Trustees meeting minutes of January-July 2011 failed to reveal any discussion of facility grievances.

In an interview on 8/24/2011 at 1:15pm in the Administration Conference Room, staff #2 confirmed that grievance information was not being reported to the Quality Committee.

In an interview on 8/24/2011 at 2:43pm in the Administration Conference Room, staff #5 confirmed that grievance information was not being reported to the Board of Trustees. Staff #5 reported that grievance information had not been reported to the Board for at least the past 10 years (staff #5 's tenure at the facility).

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PALESTINE REGIONAL MEDICAL CENTER PALESTINE REGIONAL MEDICAL CENTER

2900 S LOOP 256 PALESTINE, TX 75801 | Proprietary

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Read complete reports
Report date Number of violations
Aug. 24, 20111 (click for details) Read full report May 17, 2011 5 (click for details) Read full report

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Incomplete reports

No incomplete reports available.



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Tag No: A1104

Tag No: A0701

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SURGERY SPECIALTY HOSPITALS OF AMERICA SE HOUSTON ->

Report No. 1574

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SURGERY SPECIALTY HOSPITALS OF AMERICA SE 4301 B VISTA PASADENA, TX Aug. 12, HOUSTON 2011

VIOLATION: EMERGENCY SERVICES POLICIES

EWIERGENCY SERVICES POLICIE

Complaint Intake: TX 458

Based on observation, interview, and record review the hospital failed to ensure a physician was on duty in the emergency treatment area at all times.

Findings Include:

Observation 8/12/11 at 8:30 a.m. revealed a physician was not present in the Emergency Department. The Administrator at this time called the physician (ID# 51) scheduled that day and was told by the physician she was in the pre-operative area doing a History and Physical on a patient. The physician assigned to the emergency department is also the Medical Director of the emergency room.

Observation 8/12/11 at 8:35 a.m. in the pre-operative area revealed the emergency room physician assigned to the emergency room (ID# 51) was not in the pre-operative area doing a History and Physical. On 8/12/11 at 8:37 a.m. the emergency room physician was observed coming from the professional building attached to the hospital.

The emergency room physician (ID# 51) acknowledged 8/12/11 at 8:37 a.m. that she has a physician practice in the professional building and sees patients in her office while being simultaneously assigned to cover the emergency room of the hospital. The emergency room physician further stated that it was her understanding that the physician covering the emergency room could be on call as long as they could respond within 30 minutes.

Record review of a contract titled " Medical Services Agreement " dated August 1st, 1999 between the hospital and physician ID# 51 stated " The M.D. agrees to provide patient care services as defined in Attachment A which is incorporated herein ... " Attachment A stated " Hospital Physicians Coverage: Provide on site coverage 24 hours per day, 7 days per week for in and outpatient medical care. "

During the exit conference 8/12/11 at 2:45 p.m. the Medical Director of the emergency room (ID# 51) stated that it is possible that emergency room physicians may at times leave the hospital to go pick up meals since the hospital does not have a cafeteria.

Record review of the "Governing Board Bylaws "dated 02/2009 stated "Scope of Services: 24-hour Emergency Services."

VIOLATION: MAINTENANCE OF PHYSICAL PLANT

Based on observation, interview and record review the Hospital failed to ensure the hospital environment was maintained for the safety of patients in operating room suite area.

(Operating Room #'s 1, 2, 3, 4, 5, 6, 7, and 8).

Findings include:

Based on interview 8/12/11 at 9:40 a.m. with the Director of OR (ID# 55) revealed they currently use only 6 operating rooms (Operating Room #'s 1, 2, 3, 4, 5, and 6) Operating room # 's 7 and # 8 were out of service due to air condition problems. She stated OR # 8 was currently used for storage. The surveyor was unable to view OR # 4 due to surgery in progress.

OPERATING ROOM # 1

Surveyor on August 12, 2011 at 10:00 AM along with OR Director and Director of Maintenance observed equipment in OR # 1. Return air vent was located behind equipment. Rust was observed on wheel brackets of IV pole.

OPERATING ROOM #2

Surveyor on August 12, 2011 at 10:10 AM along with OR Director and Director of Maintenance observed equipment in OR # 2. Surgical table mattress was observed with tears and worn areas. IV pole was observed to have rust on wheel brackets and bottom panel.

OPERATING ROOM #3

Surveyor on August 12, 2011 at 10:00 AM along with OR Director (ID# 55) and Director of Maintenance (ID# 53) observed equipment in OR # 3 to have surface rust on the wall return air vent and surface rust on metal soiled linen container. OR mattress pads were found to have multiple cracks and worn areas on edges and the top surface that were too many to count. Cracks were approximately? inch along edges of mattress. A blanket warmer was observed in the OR room positioned in front of a return air vent blocking the flow of air.

OPERATING ROOM# 4

Surveyor on August 12, 2011 at 10:15 AM along with OR Director observed stretcher in OR hallway across from room # 4 to have multiple cracks on top surface and edges approximately? inch in length. Visible rust was also observed the entire length of the right side rail.

Surveyor on the morning of August 12, 2011 along with OR Director and Director of Maintenance observed hand wash area across from OR #4 to have sheetrock that was moist and wet (mushy in appearance) and with flaking paint that could not be cleaned.

OPERATING ROOM # 5

Surveyor on August 12, 2011 at 9:50 AM along with OR Director (ID# 55) observed operating table in OR # 5 with multiple chipped paint areas that were too many to count on the bottom of the OR table with visible rust in paint chip areas approximately 1-1? inches by? inches in size. X-ray lead aprons were found to be hanging over the smoke exhaust return vent blocking air flow. Air conditioner/humidity controls were observed by surveyor, OR Director and Director of Maintenance to have exposed wires with no covers. Director of Maintenance, (ID# 53) stated these were old controls that were no longer used and needed to be removed.

OPERATING ROOM #6

Surveyor on August 12, 2011 at 9:40 AM along with OR Director (ID# 55)

observed equipment in OR # 6 to have an accumulation of visible rust on the IV pole. Rust was observed on the surface of the bottom panel of the IV pole and also an accumulation of visible rust on each wheel bracket. Areas of sheetrock patch work were observed on the wall that had not been painted (exposed sheet rock).

OPERATING ROOM #7

Surveyor on morning of August 12, 2011 along with OR Director and Director of Maintenance observed a ceiling area in OR #7 with raw sheetrock exposed (not painted). It was observed that approximately a 4 foot by 3 foot area had been taped and floated. The maintenance director (ID# 53) stated the damage was the result of a water leak which had been repaired and they were in the process of doing repairs to ceiling. OR Director stated OR #7 was closed due to AC service for about the past 2-3 months.

OPERATING ROOM #8

Surveyor on August 12, 2011 at 9:30 AM along with OR Director observed OR #8 to have 4 stretchers with pads, operation surgical instruments, surgical supplies, tables,

X-ray equipment and other equipment stored in the room. OR Director stated that OR # 8 was used only for storage. The air conditioning did not work in the room. OR Director stated the air condition had been out for 3-4 months.

Surveyor on the morning of August 12, 2011 along with OR Director and Director of Maintenance observed multiple areas in the operating rooms and hallways where carts had rubbed against walls causing damage leaving sheetrock exposed and unable to be cleaned.

Surveyor on the morning of August 12, 2011 along with OR Director and Director of Maintenance observed areas of damage to all operating room doors

(#'s 1, 2, 3, 4, 5, 6, 7, 8) where particle board was exposed due to carts and equipment hitting doors resulting in chipped Formica.

Surveyor on the morning of August 12, 2011 along with OR Director observed outside of OR # 2 scrub sink area one box of 30 count Providone-Iodine BD EZ Scrub pads with expiration date 2010 - November.

Surveyor on the morning of August 12, 2011 along with OR Director observed outside of OR # 4 scrub sink area one box of 30 count Providone-Iodine BD EZ Scrub pads with expiration date 2010 - February.

Record review of "Surgery Specialty Hospitals" of America Infection Control plan revised 1/2008 revealed the policy states the Purpose: "The Infection Control Program assists in providing a high level of patient care by reducing the risk of nosocomial infections to patients (both inpatients and outpatients), health care providers and visitors. This is accomplished through surveillance, prevention, control of potential infections and continuous review and evaluation of Infection Control practices. Responsibilities: The assurance of a safe hospital environment, which provides quality care and the necessary resources to prevent and control infections, is the responsibility of the governing Board through the hospital administration team."

Interview with Director of Maintenance (ID# 53) on the morning of August 12, 2011 revealed the facility failed to document and maintain logs of dates for HVAC filter changes in the operating rooms.

Review of the facility 's policy/procedure on "Maintenance and Inspection: Heating, Air Conditioning and Ventilation (HVAC) System" dated 2009 stated "Procedure: Change all in-line filters quarterly and HEPA filters as needed."

Record review of a Performance Improvement Worksheet dated 2011 revealed on 6/28/11 the infection control nurse identified "Operating Room #3 and Operating Room #4 vents rusty." No action has been taken to date (8/12/11).



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4301 B VISTA PASADENA, TX 77504 | Proprietary

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Aug. 12, 20112 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. Incomplete reports

No incomplete reports available.



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METHODIST DALLAS MEDICAL CENTER ->

Report No. 1472

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

METHODIST DALLAS MEDICAL CENTER

1441 NORTH BECKLEY AVENUE DALLAS, TX Aug. 4, 75203 2011

VIOLATION: COMPLIANCE WITH LAWS

Based on observation, review of records and interviews, the hospital failed to meet the Emergency Medical Treatment and Labor Act (EMTALA) statute codified at ?1867 of the Social Security Act (the Act), and the implementing regulations at 42 CFR ?489.24 and the related requirements at 42 CFR 489.20 (1), (q), and (r) from 01/01/11 to 06/29/11.

Findings Included:

Hospital policies and procedures were not adopted and enforced to ensure compliance with the EMTALA requirements;

The dedicated Emergency Department (ED) of the hospital did not provide an appropriate medical screening examination (MSE) by a Qualified Medical Professional (QMP) to determine whether or not an emergency medical condition (EMC) existed to all individuals who came to the ED requesting an examination for a medical condition;

Hospital policies and procedures were not adopted and in place to ensure emergency services are available to meet the needs of the individuals with emergency medical conditions after the initial examination to provide treatment necessary to stabilize an individual by providing on-call services of physicians who are current members of the medical staff or have hospital privileges.

Cross refer: Tag A2400

VIOLATION: GOVERNING BODY

Tag No: A0043

Tag No: A0020

Based on interview and review of records, the hospital failed to have an effective governing body which failed to ensure patient care was provided in a safe and effective manner and comply with state and federal rules.

Findings included:

- 1) The hospital did not protect and promote each patient's rights in that it did not adequately address each patient care complaint or grievance, respect the patient's basic right to respect, dignity, and comfort by providing personal privacy during procedures and examinations, provide a safe environment where care and treatment are provided, prevent personal health information from being disclosed and ensure properly executed informed consents for procedures and treatments.

 Cross refer: A0115 and A0466
- 2) The hospital failed to ensure that each patient who presented for treatment to the hospital had appropriate medical screening examination or treated by a qualifed medical person or member of the medical staff.

 Cross refer: A0353

3) All drugs were not administered upon an order by an authorized practitioner. Cross refer: A0406

4) The hospital failed to adequately maintain a medical record for every individual that presented to the hospital for inpatient and outpatient treatment.

Cross refer: A0431

5) The medical staff failed to monitor and ensure that the ED (Emergency Department) policies and procedures governing the medical care provided in the ED were enforced.

Cross refer: A1104

6) The Governing Body failed to ensure that the hospital was in compliance with 489.24 with EMTALA (Emergency Medical Treatment and Labor Act) in that all patients who presented to the ED were not provided an appropriate MSE (medical screening examination) by a QMP (qualified medical personnel) to determine whether or not an EMC (emergency medical condition) existed. Cross refer: A2400

The Governing Body Bylaws: Reviewed and amended 02/22/11 requires, "The activities, property and affairs of the corporation shall be managed by its Board of Directors...Medical Staff Organization...Hospital Medical Staff...shall...administer its affairs in accordance with the corporate bylaws and policies, including the corporate medical staff bylaws, policies, and rules, and with that System Institution's policies and program requirements...shall approve all appointments...Corporate Medical Board...make recommendations to the Board of Directors on...applications for appointment...privileges...evaluate and monitor quality monitoring and improvement activities and systems for monitoring and evaluating the quality of patient care and improving patient care in the system institutions..."

VIOLATION: MEDICAL RECORD SERVICES

Based on observation, interviews and record reviews the hospital failed to adequately maintain a medical record for every individual that presented to the hospital for inpatient and outpatient treatment.

Tag No: A0431

Tag No: A0450

Findings Included:

1) All medical record entries were either not complete, dated, timed or authenticated by the provider. Cross refer: A0450, A0454 and A0457

2) All medical records did not contain a medical history and physical examination completed for each patient.

Cross refer: A0458

3) All informed consents for procedures and treatments were not properly executed.

Cross refer: A0466

VIOLATION: MEDICAL RECORD SERVICES

Based on review of records and interview, the medical records of 5 of 5 Patients (Patient # 1, #2, #3, #4 and #5) treated in the hospital from 04/18/11 to 06/29/11 were not complete in that each medical record entry was not dated, timed, signed and/or contained the required documentation by the person responsible for providing hospital services for these patients.

Findings Included:

The "Authorization To Release Information, Financial Agreements and Patient Rights" witness signatures were not dated and/or timed for the following patients:

Patient #1 - Witness signature dated 04/18/11 was not timed.

Patient #2 - Witness signature dated 06/29/11 was not timed.

Patient #3 - Witness signature dated 05/04/11 was not timed.

Patient #5 - Witness signature dated 06/05/11 was not timed.

The "Request for Restriction of Information" witness and/or nursing supervisor signatures were not dated, timed and/or completed for the following patients:

Patient #1 - The witness signature dated 06/29/11 was not timed and the signature of the nursing supervisor was incomplete.

Patient #2 - The witness signature dated 06/29/11 was not timed and the signature of the nursing supervisor was incomplete.

Patient #3 - The witness signature dated 05/04/11 was not timed and the signature of the nursing supervisor was incomplete.

Patient #4 - The witness signature dated 05/14/11 was not timed and the signature of the nursing supervisor was incomplete.

Patient #5 - The witness signature dated 06/05/11 was not timed and the signature of the nursing supervisor was incomplete.

The "Consent to Inpatient and/or Outpatient Admission and Treatment" provider/nurse signatures were not dated and/or timed for the following patients:

Patient #4 - The witness signature dated 05/14/11 was not timed.

The "Doctors Orders" physician, provider and/or nurse signatures were not dated and/or timed for the following patients:

Patient #1 - The "MDMC Labor and Delivery Initial Orders" dated 04/18/11 nursing telephone order did not contain a time and the physician signature did not contain a time. The "Referral Order Screens" did not contain a nurse signature time. The "Thrombosis Risk Assessment and Venous Thromboembolism (VTE) Prophylaxis" physician order sheet, not dated, did not contain a physician signature.

The "Inpatient Pneumoccoccal/Influenza Immunization Orders" sheet nurse signature did not contain a date or time.

Patient #2 - The "Doctor Order" sheet dated 06/29/11 contained 3 separate entries (3:40 P.M., 4:30 P.M. and 6:30 P.M.) which were not individually dated. The 3:40 entry contained two orders that was not signed by a physician or nurse. The 4:30 physician signature was dated or timed. The 6:30 entry to discharge home was signed by Resident #36 but not validated or co-signed by a member of the medical staff.

Patient #3 - The "Doctor Order" sheet dated 05/04/11 contained 2 separate entries (2:45 P.M. and 4:10 P.M.) which were not individually dated. The 2:45 P.M. physician signature for authentication of a telephone order (TO) was not dated or timed.

Patient #4 - The "Doctor Order" sheet dated 05/14/11 contained 2 separate entries (5:10 A.M. and 5:20 A.M.) which were signed and not timed or dated by Resident #56. The residents signatures were not validated or co-signed by a member of the medical staff.

Patient #5 - The "Doctor Order" sheet dated 06/05/11 contained 2 separate entries (6:00 A.M. and 6:50 A.M.) which were signed by Resident #57 was incomplete in that the signatures were not validated or co-signed by a member of the medical staff.

The "Doctors Notes" physician, provider and/or nurse signatures were not dated and/or timed for the following patients:

Patient #2 - The entry timed at 4:00 P.M. did not contain a physician attending signature.

Patient #3 - Was incomplete in that it did not not contain any physician notes. The attending physician signed the incomplete notes with a principal diagnosis with no date or time.

Patient #4 - Was incomplete in that it did not contain any physician notes. The attending physician signed the incomplete notes with a principal diagnosis with no date or time.

Patient #5 - Was incomplete in that it did not contain any physician notes or an attending physician signature.

The "Progress Record" provider and/or nurse signatures were not dated and/or timed:

Patient #1 -

The nurse signature dated 04/19/11 was not timed.

The RN Bereavement Coordinator dated 04/19/11 was not timed.

The "Notification to Physician of Pressure Ulcer Progress Record" were incomplete in that the physician signature was missing. Patient #1 - The notification for 04/18/11 and 04/19/11 was missing the physician signature.

The "Shift Totals for Intake and Output" did not contain a date or signature for each entry.

Patient #1 - The entries for 8:00 A.M., 12:00 P.M., 4:00 P.M. and 7:00 P.M. were not signed and dated.

The "Birth Certificate Data Sheet" nurse signatures were not timed:

Patient #1 - The nurse signature dated 04/19/11 was not timed.

The "Home and Discharge Medication List" nurse signatures were not timed:

Patient #1 - The nurse signature dated 04/19/11 was not timed.

The "Discharge Instructions" nurse and patient signatures were not dated and/or timed:

Patient #2 - The nurse and patient signature dated 06/29/11 was not timed.

Patient #3 - The nurse and patient signature dated 05/04/11 was not timed.

Patient #4 - The nurse and patient signature dated 05/14/11 was not timed.

Patient #5 - The nurse and patient signature dated 06/05/11 was not timed.

The "Disclosure and Consent for Medical, Surgical and Diagnostic Procedures" for Anesthesia was incomplete and/or signatures were not dated or timed.

Patient #1 - The request for treatment by the physician contained the department "ACD" (Anesthesia Care Department) instead of an individual physician's name. The physician signature was not dated or timed.

The "Disclosure and Consent for Medical, Surgical and Diagnostic Procedures" for Vaginal Delivery was incomplete and/or signatures were not dated or timed.

Patient #1 - The consent was incomplete in that the planned and completed procedure was Induction of Labor for Intrauterine Fetal Demise with Cytotec. The physician signature was not dated or timed.

The hospital policy "Medical Record Documentation" dated 06/30/11 requires "To ensure a complete legal medical record...All patient medical record entries must be legible, complete, dated, timed and signed in written or electronic form by the person responsible for providing or evaluating the service provided...Documentation completed by non-medical staff members must be countersigned by the responsible physician for the following: All dictated reports, ED record, Orders (PA, CRNA, and midwife only), Progress notes...ED documentation will be authenticated by the responsible physician including but not limited to ED Record and physician orders. An appropriate medical record shall be kept for every patient receiving emergency medical care...A properly executed informed consent form for the operation/procedure must be in the patient's chart before surgery...All orders, including verbal orders, must be dated, timed, and signed by the ordering practitioner or another practitioner involved in the care of the patient...All verbal orders must be signed, dated, and timed within 48 hours...Nursing documentation, including but not limited to nursing assessment, medication reconciliation ..interventions are required...Is not limited to but may include other components for inclusion or monitoring as deemed necessary..."

At 5:00 P.M. on 07/05/11 the CNO (Personnel #1) was interviewed. She confirmed the hospital policies and procedures were not followed for the correct completion, dating and timing of the medical records.

VIOLATION: PATIENT RIGHTS

Based on observation, interviews and record reviews, the hospital did not protect and promote each patient's rights in that it did not adequately address each patient care complaint or grievance, respect the patient's basic right to respect, dignity, and comfort by providing

Tag No: A0115

personal privacy during procedures and examinations, provide a safe environment where care and treatment are provided and prevent personal health information from being disclosed.

Findings Included:

- 1) Patient care complaints were not adequately addressed in 9 of 9 grievances received from a patient's and/or families (Patients #1, #29, #30, #31, #32, #33, #34, #35 and #36) for 5 of 5 months (January 2011 May 2011) in that the hospital failed to provide written notice of its decision, steps taken on behalf of the patient to investigate the grievance, results of the investigation and date of completion to regarding patient care complaints.

 Cross refer: A0123
- 2) Patients in 12 of 12 patient hall beds (Beds 218, 219, 220, 221, 222, 223, 224, 225, 230, 231, 232, and 233) located in the main ED on 06/29/11 were not provided privacy from people that were not involved in their care while being interviewed, assessed, examined and treated.

Cross refer: A0143

- 3) 1 of 1 Patient (Patient #34) was not provided privacy on 03/03/11 by the RN while performing a history and assessment. Cross refer: A0143
- 4) 1 of 1 Patient (Patient #1) personal medical information was disclosed on 05/13/11 to an outside third party organization without prior consent of the patient.

 Cross refer: A0143
- 5) The hospital did not provide a sanitary environment to avoid sources and transmission of infections and communicable diseases in that multiple staff did not dispose of their soiled gloves and wash their hands after treating patients and touching patient equipment. Cross refer: A0144
- 6) The hospital did not provide basic infection control supplies and equipment including hand sanitizer, linen hampers, trash cans and biohazard disposal boxes close to or in proximity of the patient hall beds for the staff to use.

 Cross refer: A0144
- 7) The ED patient hall beds did not have nurse call lights for patient's to notify the nursing staff in the event of an emergency. Cross refer: A0144

VIOLATION: PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION

Based on review of records and interview, the hospital failed to provide written notice of its decision, steps taken on behalf of the patient to investigate the grievance, results of the investigation and date of completion to 9 of 9 grievances received from a patient's and/or families (Patients #1, #29, #30, #31, #32, #33, #34, #35 and #36) for 5 of 5 months (January 2011 - May 2011) regarding patient care complaints.

Tag No: A0123

Findings include:

The "Complaint/Grievance Log " dated "January 2011- May 2011" reflected the following patient care complaints:

- 04/19/11 Patient #1's husband complained that his wife had delivered their child by herself without any assistance from a physician or nurse in her room and her call light for help had been ignored.
- 01/24/11- Patient #29's family complained of the room being filthy, her sister smelled, an IV that was causing her arm to swell, her blood pressure (BP) was not monitored and due to the lack of monitoring by the staff, her sister had a stroke and is now in ICU (Intensive Care Unit).
- 06/02/11 Patient #30 complained about the care provided in the ED. Stated she had come to the ED with multiple complaints (blue diarrhea, elevated blood sugar, rash around the neck, pain in right lower abdomen, and edema in legs). The ED physician only addressed the pelvic pain and was rude to her stating "I don't know what your problem is." The physician prescribed medication she is allergic to.
- 01/11/11 Patient #31 complained about the hospital not giving her medications that she is taking at home and not providing adequate care.
- 03/28/11 Patient #32 complained that during her MRI, the placement of dye did not go through the vein causing her arm to swell. She stated she was crying and calling out for help to no avail and her arm is swollen and disfigured. When she was discharged, she was told to put a hot compress on it and she would be all right. She was upset that no one seemed concerned.
- 02/23/11 Patient #33's daughter complained that patient was found on floor at home and believes patient was a victim of sexual assault. She was concerned why patient was not transferred to another hospital for possible rape treatment and concerned about possible delay with obtaining rape kit and lack of treatment of injuries
- 03/03/11 Patient #34 complained she presented to the ED with complaints of deep back pain and was treated for abdominal pain. States she received discharge information on abdominal pain and informed the staff it was back and not abdominal pain. States she does not know why her information was not listed correctly and questioned the treatment provided. Stated she continued to have back pain and had to return back to the ED to see a different physician. She also complained about being placed in the hallway corridor and was not provided privacy during an interview with a nurse regarding her private health information.
- 04/22/11 Patient #35 complained the nurse was very rude to her and her mother when taking her vital signs. States she came in with a lot of abdominal pain and the RN told her to "shut up and stop being a drama queen" and was told if she had drank the medication another hospital had given her she would not be in this kind of pain. She stated when her mother attempted to provide the nurse with paperwork from the other facility the nurse ignored her and when her mother attempted again the nurse snatched the paperwork from her.

01/07/11 - Patient #36's daughter complained her mother was administered Morphine (narcotic pain medication) in the hospital and discharged with a prescription of Hydrocodone (narcotic pain medication) when her chart showed she is allergic to both Morphine and Hydrocodone. When she notified the physician, he appeared annoyed.

The Hospital Policy, "Complaints/Comments/Grievances" dated 04/30/09 required, "To provide mechanisms for receiving and responding to concerns...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) by a patient, or the patient's representative, regarding the patients care, abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation...related to rights and limitations provided by 42 Code of Federal Regulations...The following types of concerns should be communicated...They include but are not limited to...Significant or unresolved concerns (also called Grievances)...concerns crossing multiple department lines or processes...allegations of harm...should be responded to in writing and substantively address the areas of concern...lf a review and reply cannot be completed within 7 calendar days of receipt...acknowledgement of receipt and a reasonable timeframe to respond to the issues should be communicated to the complainant...complaints about physicians should be forwarded to Medical Staff Services... "

The "Methodist Bylaws", 05/26/09 requires, "The activities, property and affairs of the Corporation shall be managed by its Board of Directors...The System Quality Review Committee...a standing committee of the Board of Directors....shall...regularly review reports from the medical staff and hospital administration regarding the quality of medical services provided...analyze quality initiatives at each System Institution to assure processes are in place to facilitate the implementation of system-wide best practices...monitor progress with quality initiatives...provide, on behalf of the Board, general governance oversight for the quality of service in the respective System Institutions...assure processes are in place at each System Institution to perform the following functions: report regularly to the System Quality Review Committee on the quality of services provided; assist the System Quality Review Committee in implementing system-wide quality improvement initiatives; review processes and methods used by the medical staff and hospital staff to monitor and improve the quality of service in the respective System Institutions; advise the System Quality Review Committee as to whether monitoring and follow-up programs and activities are effective and whether identified deficiencies in the safety, reliability, effectiveness, and acceptability of hospital and medical care are being addressed...Corporate Medical Board...shall...evaluate and monitor quality monitoring and improvement activities and systems for monitoring and evaluating the quality of patient care and improving patient care in the System

At 2:00 P.M. on 07/05/11, the Patient Representative Manager (Personnel #41) was interviewed. She was asked if she is responsible for the Complaint and Grievance process. She stated, "Yes, I am the Manager for Patient Representatives." She was asked if the hospital provided written notice of its decision, steps taken, results of the investigation and date of completion on the grievance's that were received from the patients or family of Patients #1, #29, #30, #31, #32, #33, #34, #35 and #36. She stated, "No." She was asked if the hospital followed the required grievance process. She stated, "No."

VIOLATION: PATIENT RIGHTS: PERSONAL PRIVACY

Based on observation, interviews and record review, the hospital failed to provide, protect and promote patient privacy for:

1) Patients in 12 of 12 patient hall beds (Beds 218, 219, 220, 221, 222, 223, 224, 225, 230, 231, 232, and 233) located in the main ED on 06/29/11 were not provided privacy from people that were not involved in their care while being interviewed, assessed, examined and treated.

Tag No: A0143

- 2) 1 of 1 Patient (Patient #34) was not provided privacy on 03/03/11 by the RN while performing a history and assessment.
- 2) 1 of 1 Patient (Patient #1) personal medical information was disclosed on 05/13/11 to an outside third party organization without prior consent of the patient.

Findings Included:

During a tour of the ED on 06/29/11 at 2:00 P.M., the surveyor accompanied by the CNO (Personnel #1) and the ED Nurse Manager (Personnel #2) observed the main hall was crowded with patients in hall beds with their family members present. The patients in the hall beds were not protected by curtains. The surveyor observed bed numbers posted above the beds in the halls.

The areas and hall adjacent to the Main Nursing Station contained patients in hall beds # 222, 223, 224, 225, 230, 231, 232, and 233. Patients in beds # 232 and 233 were directly stationed on the wall beside glass doors which opened directly to the outside ambulance entrance.

The hall located by Zone 2 of the Main ED contained patient beds # 218, 219, 220, and 221.

The surveyor, CNO and ED Nurse Manager observed multiple personnel interviewing, assessing and examining the patient's in the hall beds. The personnel were also observed starting IV's (intravenous lines), drawing blood for lab work and giving medications without providing any patient privacy while other people not involved in their care were present.

Review of Patient #34's complaint of care to the hosptial dated 03/03/11 reflected, "Patient #34 states during the first visit she was placed in the hallway corridor. States when the RN began asking her medical history she asked the RN to lower her voice as she did not want the gentleman in the next gurney listening to her personal information. States the RN then began to have an attitude. States the RN brought her a gown and told her to put it on. She questioned how and why she was going to put a gown on in the hallway....States when the RN returned she tried to start over and apologize for their rough start; but the nurse just became more agitated and informed the patient she is the one with the attitude...Spoke with RN #55, the patient's initial nurse. RN #55 said when she asked the patient when her last menstrual period was, the patient responded, will you keep your voice down...only other patient in hallway was the gentleman across the hall and she did not know whether or not he could hear what she was saying...said she lowered her voice and continued the assessment...'

Review of patient complaint TX 87 received by Texas Department of State Health Services (TDSHS) reflected the following emails between Patient #1 and Organization #1 on 05/13/11:

- 1) At 7:13 A.M. an email from Patient #1 to Organization #1 reflected, "Could you remind me of when meetings are and also how you
- 2) At 9:20 A.M. an email from Organization #1 to Patient #1 reflected, "Your name and address came to me from Methodist Hospital..."
 3) At 9:41 A.M. an email from Organization #1 to Patient #1 reflected, "It was from Personnel #40 (Patient Representative). She sends us

all the losses at Methodist so we can send the parents our information..."

Review of Patient #1's medical record reflected:

- 1)The "Authorization to Release Information" dated 04/18/11, not timed, did not reflect consent for release of personal information to the third party Organization #1.
- 2)The "Referral Screens" dated 04/18/11, not timed, did not reflect a referral to the third party Organization #1.

 3) The "Doctor's Orders" dated 04/19/11 timed at 4:30 P.M. did not reflect discharge orders for a referral to the third party Organization #1
- 4)The "Discharge Instructions" dated 04/19/11 timed at 6:30 P.M. did not identify any other services were required after discharge home. There was no discharge instructions or teaching documented for referral to grief counseling and no written request to release or disclose patient information to the third party Organization #1 for referral for grief counseling.

The hospital did not have a contract or agreement with the third party Organization #1 to provide continuation of or referral of services for patients or to ensure the agent will not use or disclose the health care information for any other purpose or take appropriate steps to protect the health care information.

The hospital policy "Patient's Rights and Responsibilities" dated 04/30/11 requires, "MHS honors your rights as a patient...As a member of the partnership between you and your healthcare team we respect your right to... Considerate and respectful care. You can expect quality treatment within the scope of our mission, with concern for your personal privacy and dignity...Confidentiality and access to your medical records. You may expect all communications and clinical records pertaining to your care to be treated as confidential and that you should be able to access information contained in your records within a reasonable time frame...Reasonable continuity of care, and to be informed by physicians and other caregivers of available and realistic patient care options when hospital care is no longer appropriate..."

The hospital policy "Control of Patient Information (Including Confidentiality of Medical Records)" dated 01/30/08 requires, "Patient confidentiality should be protected in accordance with law...These guidelines apply to requests for records and to inquires concerning patients. "Medical Information" is defined as information in any form that identifies a patient and relates to the history, diagnosis, treatment or prognosis of a patient...Releases of information without patient consent should normally be accomplished pursuant to a written request...Medical information may generally be released to third parties upon presentation of a valid patient authorization...A properly completed and signed authorization to release patient information...should be retained in the medical record with notation of information released, the date of release and the name of the person releasing the information...'

At 5:00 P.M. on 07/05/11 the CNO (Personnel #1) was interviewed. The CNO confirmed the above findings and verified the hospital is not following policies and procedures for providing and promoting patient privacy. She was asked if the hospital provides patient information to the third party Organization #1 of families who have neonatal deaths. She stated, "Yes. It is part of our continuation of care." She was asked if the hospital has a contract with the Organization #1 to provide continuing care services for patients. She stated, "No." She was asked if the hospital has any agreement or contract to provide private health information to Organization #1. She stated, "No." She was asked if Patient #1's medical record reflected permission to release her private information to Organization #1. She stated, "No."

At 1:00 P.M. on 08/04/11 MD #9 the Attending Physician was interviewed. He was asked if he referred Patient #1 to Organization #1. He stated, "Yes. It is our Standard of Care to refer all fetal demise mothers for grief support. It is a continuation of care we provide. "He was asked if he wrote an order for a referral to Organization #1. He stated, "No."

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on observation, interview and record review, the hospital failed to promote patient rights by providing care in a safe setting by

1) Provide a sanitary environment to avoid sources and transmission of infections and communicable diseases in that multiple staff did not dispose of their soiled gloves and wash their hands after treating patients and touching patient equipment.

Tag No: A0144

- 2) Provide basic infection control supplies and equipment including hand sanitizer, linen hampers, trash cans and biohazard disposal boxes close to or in proximity of the patient hall beds for the staff to use.
- 3) The ED patient hall beds did not have nurse call lights for patient's to notify the nursing staff in the event of an emergency.

Findings Included:

During a tour of the ED on 06/29/11 at 2:00 P.M., the surveyor accompanied by the CNO (Personnel #1) and the ED Nurse Manager (Personnel #2) observed multiple personnel interviewing, assessing and examining the patient's in the hall beds. The personnel were also observed starting IV's (intravenous lines), drawing blood for lab work and giving medications on multiple patients in the main ED hall.

The ED patient hall beds did not have patient call lights, linen hampers, trash cans, biohazard disposal boxes or hand sanitizer posted beside each bed. The hall did not have any hand washing facilities. The surveyor observed multiple personnel wearing gloves and did not remove the gloves and wash their hands after drawing blood or providing patient care prior to touching other equipment.

The hospital "Plan for the Provision of Patient Care" dated FY 2011 requires, "The Board of Directors...has ultimate responsibility for operations...carries out this responsibility through goal-focused allocation of resources, performance improvement, risk management, patient safety...Infection Prevention and Control...to identify, assess, and reduce the risks of acquiring and/or transmitting infections among patient, employees, physicians...is crucial in minimizing morbidity, mortality and the economic burden associated with healthcare associated infections...participate and monitoring...prevent and/or reduce the risk of infections...participate in monitoring of the Environment of Care for infection risks...methods are used to decrease or eliminate exposures...

The hospital policy "Patient's Rights and Responsibilities" dated 04/30/11 requires, "MHD honors your rights as a patient...to provide a safe setting...

At 5:00 P.M. on 07/05/11 the CNO (Personnel #1) was interviewed. The CNO confirmed the above findings and verified the hospital is not following policies and procedures for providing and promoting safe patient care.

VIOLATION: MEDICAL STAFF BYLAWS

Based on observation, interviews and record reviews, the hospital did not enforce the Medical Staff Bylaws by failing to ensure 4 of 5 patients (Patient #1, #2, #4, and #5) who presented for treatment in L&D (Labor and Delivery) from 01/01/11 - 06/29/11 received treatment or MSE's from a physician who is approved by the Governing Body for clinical privileges.

Tag No: A0353

The Medical Residents and RN's who provided MSE's and patient treatment were not directly supervised by a faculty physician or appointed by the Governing Board to provide MSE's as a QMP to determine if an EMC existed.

Findings Included:

Review of the following patient medical records reflected:

Patient #1's medical record dated 04/18/11 reflected the patient was admitted for induction of labor for fetal demise. On 04/19/11 at 3:07 A.M. delivered the baby without the attending physician (MD #9) present. The Nursing "Maternal Review of Systems" dated 04/19/11 timed at 3:07 A.M. reflected "Patient called out stating baby is out...Unit

Secretary asked to page MD #9..."

The "Delivery Summary" dated 04/19/11 timed at 3:08 A.M. reflected, "Delivery Doctor/other: MD #6/Resident #13, Assist: MD #9..."

The Nursing "Maternal Review of Systems" dated 04/19/11 timed at 3:10 A.M. reflected "Resident #13 called and asked to assist...until MD #9 arrives...

The Nursing "Maternal Review of Systems" dated 04/19/11 timed at 3:14 A.M. reflected "Resident #13 at bedside."
The Nursing "Maternal Review of Systems" dated 04/19/11 timed at 3:21 A.M. reflected "MD #9 called and notified that patient has delivered. MD states he is on his way. Resident #13 remains at bedside for anticipated delivery of placenta."

The Nursing "Maternal Review of Systems" dated 04/19/11 timed at 3:43 A.M. reflected, "Morphine Sulfate 6 mg was given SIVP (slow intravenous push)...analgesic medication ordered by Resident #13 and administered to provide relief of pain from imminent placenta delivery." The medical record did not reflect a written order from MD #9 or Resident #13 for Morphine.

The Nursing "Maternal Review of Systems" dated 04/19/11 timed at 3:46 A.M. reflected "MD #9 in room...Resident #13 remains at bedside

to assist in delivery of placenta..."

The "Operative Report" dated 04/19/11 timed at 4:22 A.M. reflected, "Name of Procedure: Induction of Labor. 2. Spontaneous vaginal delivery. 3. Delivery of placenta by extraction. Surgeon: MD #9, Assistant: Resident #13...I was called by nursing to be notified of spontaneous vaginal delivery, which they noted too tight nuchal cord delivery at time of delivery of a male fetus with no signs of life. Resident #13 reports placing a cord clamp and then having cord avulsion with minimal amount of tension on the cord. On my arrival, the patient was not hemorrhaging...'

Patient #2's medical record dated 06/29/11 reflected the patient was admitted to the L&D Unit (Labor and Delivery) for observation of

"leaking/mucus plug."
The "Doctor's Notes" timed at 4:00 P.M. reflected an examination that was not signed by any provider.
The nursing "OB Triage" notes timed at 4:35 P.M. reflected, "Exam by: MD #58" and at 6:20 P.M. reflected, "Exam by: Resident #36."
The medical record did not contain a medical H&P, assessment or discharge summary documented by a physician who is a member of the medical staff.

Patient #4's medical record dated 05/14/11 reflected the patient was admitted to the L&D Unit for observation of "Spotting." The nursing "OB Triage" notes timed at 5:13 A.M. reflected, "Exam by: Resident #56."

The medical record did not contain a medical H&P, assessment, progress notes or discharge summary documented by a physician who is a member of the medical staff.

Patient #5's medical record dated 06/05/11 reflected the patient was admitted to the L&D Unit for observation The nursing "OB Triage" notes timed at 6:36 A.M. reflected, "Exam by: Resident #57."

The medical record did not contain a medical H&P, assessment, progress notes or discharge summary documented by a physician who is

a member of the medical staff.

The Governing Body Bylaws: Reviewed and amended 02/22/11 requires, "The activities, property and affairs of the corporation shall be managed by its Board of Directors...Medical Staff Organization...Hospital Medical Staff...shall...administer its affairs in accordance with the corporate bylaws and policies, including the corporate medical staff bylaws, policies, and rules, and with that System Institution's policies and program requirements...shall approve all appointments...Corporate Medical Board...make recommendations to the Board of Directors on...applications for appointment...privileges...evaluate and monitor quality monitoring and improvement activities and systems for monitoring and evaluating the quality of patient care and improving patient care in the system institutions..." The Governing Body Rules and Regulations did not address the requirements for QMP's to perform MSE's for EMC's.

Medical Staff Bylaws and Rules and Regulations: Dated 05/24/11 requires "The Medical Staff is responsible for the quality of medical care in the system hospitals...Medical Staff shall be interpreted to mean all duly licensed Physicians, Dentists and Podiatrists holding unlimited licenses who are granted medical staff appointment...House Staff shall mean those physicians who are graduates of a medical school...and are pursuing additional training in a system hospital's medical education program...Clinical Privileges shall be interpreted to mean having the right to render specific diagnostic, therapeutic, medical, dental or surgical services in a system hospital...Appointment to the Medical Staff or the granting of temporary privileges shall be extended only to those professionally competent Physicians, Dentists, and Podiatrists who meet the qualifications, standards and requirements set forth in these bylaws and policies...each practitioner shall have only such clinical privileges as have been granted by the Board of Directors as recommended by the Medical Staff in accordance with these bylaws. with these bylaws ...'

The "Medical Staff Policy Manual" dated 05/24/11 requires, "Medical staff appointment is set forth in the bylaws...shall...provide continuous care and supervision of his patient; to abide by the Bylaws, the Policies, the MHS bylaws and all other established standards, policies, and rules of the Medical Staff...and, to participate in fulfilling the requirements for providing emergency care...Degree of Care/Management of Patient by House Staff...The medical record should reflect the involvement of the teaching practitioner in the management of a patient treated by a House Staff Member...House Staff shall not be considered Medical Staff members nor shall the term House Staff be considered a category of Medical Staff membership...Medical Records...There shall be evidence in the medical record that the teaching physician has been involved in the management of a patient treated by a member of the House Staff...Progress Notes...Pertinent progress notes should be recorded at the time of observation, sufficient to permit continuity of care...each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders. An appropriate medical record shall be kept for every natient be clearly identified in the progress notes and correlated with specific orders...An appropriate medical record shall be kept for every patient receiving emergency medical care and shall be incorporated in the patient's hospital record...Each patient's medical record shall be signed by the physician in attendance that is responsible for its clinical accuracy...Emergency Services...the obligations of on-call practitioners...the on-call practitioner must come to the ED when requested by the ED physician, another physician, a nurse...the on-call practitioner shall be physically present in the ED to assist in providing an appropriate MSE, as well as in the ongoing stabilization and treatment of an ED patient...EMC means: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy...with respect to pregnant woman who is having contractions: there is inadequate time to effect a safe transfer to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or the unborn child...Stabilize mean: with respect to EMC, to provide such medical treatment of the condition as may be necessary to assure within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual...with respect to an EMC involving a pregnant woman, that the woman has delivered (including the placenta)...Transfer means: the movement (including discharge) of an... "The Medical Staff Bylaws, Rules and Regulations did not address the requirements for QMP's to perform MSE's for EMC's.

The hospital policy "Supervision of Residents in Obstetrics and Gynecology" dated February, 2008 requires "L&D...Supervising physicians are required to personally assess all patients admitted to L&D and the antepartum unit...Supervising physicians are required to directly supervise...and must be immediately available for supervision of normal spontaneous vaginal deliveries...Summary...A qualified faculty or attending physician is assigned to supervise all resident activities at all times on all services. There is a supervising physician in the hospital 24 hours per day, seven days per week. The supervising physician should directly or indirectly supervise the residents patient care activities depending upon the type of care and PGY level of the resident."

The hospital policy "Specific Duties for Residents", not dated, requires "PGY 1. The first year resident should know how to manage a normal labor and delivery...recognize both acute and chronic conditions...L&D coverage...with supervision at the end of the year..."

The "Resident Physician Agreement" for Resident #13 dated 06/24/10 requires "This Resident Physician Agreement is entered into by and between Methodist Hospitals of Dallas...and Resident #13...to participate in MHS Obstetrics/Gynecology GME (graduate medical education) Training Program during the 2010-2011 training year...principal purpose of this agreement is to provide an educational experience for resident, rather than to provide employment for the resident or service to MHS or its medical staff...Performance of Duties. Resident shall participate in safe, effective, and compassionate patient care, under supervision, and commensurate with his/her level of advancement and responsibility..."

Resident #13's file did not contain a letter of recommendation from the Medical Staff or letter of appointment from the Governing Board determining any residents as Qualified Medical Personnel (QMP) to perform Medical Screening Examinations (MSE's) to determine if an Emergency Medical Condition (EMC) exists for patient's that present to the hospital for emergencies.

The Obstetrics/Gynecology Department Medical Staff Committee Meeting Minutes dated 05/04/11 reflects, "Documentation and communication between attending OB/GYN and resident...Attending and Residents need to document when the attending is present for the procedure and when the attending leaves the procedure...Stand by deliveries requires staff on call must be present at delivery...MD #7 reminded members of the department who participate in attending staff call, that they (the attending staff supervisor) are responsible for the case and well be held accountable...Residency Report...MD #54 reemphasized the importance of attending staff call physician's responsibilities as stated by MD #7..."

At 8:45 A.M. on 06/30/11 the surveyor interviewed Personnel #19, Director of Medical Staff Services. She was asked if the Residents are part of the medical staff and credentialed with privileges. She stated, "No." She verified the hospital policies and procedures and the Medical Staff Rules, Regulations and Bylaws do not allow residents to practice without direct supervision.

At 9:30 A.M. on 06/30/11 the surveyor interviewed MD #7, Assistant Vice President of the Graduate Medical Education Program. He was asked if he is responsible for the Resident's that practice within the hospital. He stated, "Yes." He was asked what area's the Resident's practice within the hospital. He stated, "We have four core programs, OB, Gynecology (GYN), L&D and OR (operating room). The residents answer consultations in the OB/GYN for emergency or unassigned patient consultations. Our clinic is the Golden Cross Clinic across the street and where our residents practice. Our fell owship is located here in the hospital." He was asked if the residents are paid by the hospital to take call. He stated, "They receive a stipend/salary. They are in training and not independent practitioners and practice under an attending physician. They are employees of Methodist Health System and have a contract." He was asked if the hospital or program has policies and procedures for the residents. He stated, "They practice and are subject to the hospital policies and procedures. "He was asked if the residents are part of the medical staff. He stated, "No they are not privileged providers. The work under different levels of supervision which varies to what year they are in. They all have temporary permits to work as residents or students in training."

At 5:00 P.M. on 07/05/11 the CNO (Personnel #1) was interviewed. She verified the above findings and verified the RN's and Medical Residents are not appointed by the Governing Body as QMP's to provide MSE's.

VIOLATION: WRITTEN MEDICAL ODERS FOR DRUGS

Based on observation, interviews and record reviews, the hospital failed to enforce its policy to ensure drugs were administered upon an order of an authorized physician for 1 of 1 patients (Patient #1) on 04/19/11. The nurse administered a narcotic medication upon a verbal order from a medical resident. The medical resident's order was not written and authenticated by the patients attending physician.

Tag No: A0406

Findings Included:

Review of Patient #1's medical record reflected the nursing "Maternal Review of Systems" dated 04/19/11 timed at 3:43 A.M. by RN #14, "Morphine Sulfate 6 mg was given SIVP (slow intravenous push)...analgesic medication ordered by Resident #13 and administered to provide relief of pain from imminent placenta delivery." The medical record did not reflect a written or verbal order from MD #9 or Resident #13 for Morphine.

Medical Staff Bylaws and Rules and Regulations: Dated 05/24/11 requires "The Medical Staff is responsible for the quality of medical care in the system hospitals...Medical Staff shall be interpreted to mean all duly licensed Physicians, Dentists and Podiatrists holding unlimited licenses who are granted medical staff appointment...House Staff shall mean those physicians who are graduates of a medical school...and are pursuing additional training in a system hospital's medical education program...Clinical Privileges shall be interpreted to mean having the right to render specific diagnostic, therapeutic, medical, dental or surgical services in a system hospital...Appointment to the Medical Staff or the granting of temporary privileges shall be extended only to those professionally competent Physicians, Dentists, and Podiatrists who meet the qualifications, standards and requirements set forth in these bylaws and policies...each practitioner shall have only such clinical privileges as have been granted by the Board of Directors as recommended by the Medical Staff in accordance with these bylaws ..."

The "Medical Staff Policy Manual" dated 05/24/11 requires, "Degree of Care/Management of Patient by House Staff...The medical record should reflect the involvement of the teaching practitioner in the management of a patient treated by a House Staff Member...House Staff shall not be considered Medical Staff members nor shall the term House Staff be considered a category of Medical Staff membership...Pertinent progress notes should be recorded at the time of observation, sufficient to permit continuity of care ...each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders...Authentication of Routine Order. A medical staff member's routine orders...shall be reproduced in detail on the order sheet of the patient's record, dated, timed, and signed by the staff member...Medical Records...There shall be evidence in the medical record that the teaching physician has been involved in the management of a patient treated by a member of the House Staff...Each patient's medical record shall be signed by the physician in attendance that is responsible for its clinical accuracy...All orders for treatment shall be in writing...and signed by the person to whom dictated with the name of the Medical Staff member...the ordering or attending practitioner, or any physician with like privileges participating in the patient's care shall authenticate the orders based upon Federal and State law..."

The hospital policy "Medical Record Documentation" dated 06/30/11 requires "To ensure a complete legal medical record ...Documentation completed by non-medical staff members must be countersigned by the responsible physician for the following: All dictated reports, ED record, Orders (PA, CRNA, and midwife only), Progress notes...All orders, including verbal orders, must be dated, timed, and signed by the ordering practitioner or another practitioner involved in the care of the patient...All verbal orders must be signed, dated, and timed within 48 hours...Nursing documentation, including but not limited to nursing assessment, medication reconciliation...interventions are required ...Is not limited to but may include other components for inclusion or monitoring as deemed necessary..."

The hospital policy "Job Description - Staff Nurse" not dated requires "The RN...follows hospital's policies and procedures...follows scope of practice and legal consequences...Implementing clinical and technical aspects of care and physician's orders in compliance with standards of practices and standards of care...Provides a therapeutic environment through safe, accurate, and timely medication and IV administration ...verifying or rectifying patient medication record...completing documentation on correct forms...Medication Administration Record (MAR)...Completing consistently all parts of the documentation system...Knowledgeable about hospital policies, procedures, and nursing care standards and utilizes these when providing nursing care... "

The hospital policy "Medication Handling and Administration" dated 02/28/11 requires "Verbal or telephone orders should be clarified by the person taking the order..." The policy did not address Medical Resident's giving verbal medication orders or the RN taking verbal medication orders from a Resident.

The hospital policy "Supervision of Residents in Obstetrics and Gynecology" dated February, 2008 requires "L&D...Supervising physicians are required to personally assess all patients admitted to L&D and the antepartum unit...Supervising physicians are required to directly supervise...and must be immediately available for supervision of normal spontaneous vaginal deliveries...Summary...A qualified faculty or attending physician is assigned to supervise all resident activities at all times on all services. There is a supervising physician in the hospital 24 hours per day, seven days per week. The supervising physician should directly or indirectly supervise the residents patient care activities depending upon the type of care and PGY level of the resident."

At 8:45 A.M. on 06/30/11 the surveyor interviewed Personnel #19, Director of Medical Staff Services. She was asked if the Residents are part of the medical staff and credentialed with privileges. She stated, "No." She verified the hospital policies and procedures and the Medical Staff Rules, Regulations and Bylaws do not allow residents to practice without direct supervision.

At 9:30 A.M. on 06/30/11 the surveyor interviewed MD #7, Assistant Vice President of the Graduate Medical Education Program. He was asked if the hospital or program has policies and procedures for the residents. He stated, "They practice and are subject to the hospital policies and procedures." He was asked if the residents are part of the medical staff. He stated, "No they are not privileged providers. The work under different levels of supervision which varies to what year they are in. They all have temporary permits to work as residents or students in training."

At 1:30 P.M. on 07/01/11 Resident #13 was interviewed. He was asked to the review the medical record of Patient #1. He was asked if he documented anything in the medical record regarding his practice or findings on Patient #1. He stated, "No." He was asked if he wrote an order for Morphine Sulfate to be given to Patient #1. He stated, "No."

At 2:45 P.M. on 07/05/11 RN #14 was interviewed via telephone. She was asked if she was Patient #1's primary nurse. She stated "Yes." She was asked if Resident #13 was present during the delivery. She stated, "No. He was called and present after the delivery and helped deliver the placenta." She was asked if she received a verbal order from Resident #13 to give 6 mg of Morphine IV to Patient #1. She stated, "Yes."

At 5:00 P.M. on 07/05/11 the CNO (Personnel #1) was interviewed. She was asked to review the medical record of Patient #1. She was asked if the medical record contained a physician order for Morphine Sulfate. She stated, "No. It does not. "She then verified Patient #1 received 6 mg of Morphine IV upon a verbal order from a Medical Resident without a physician order. She was asked if the hospital's policies and procedures were followed for nursing accepting medication orders from someone other than credentialed medical staff. She stated, "No."

Tag No: A0454

VIOLATION: ORDERS DATED AND SIGNED

Based on review of records and interview, the medical records of 5 of 5 Patients (Patient # 1, #2, #3, #4 and #5) treated in the hospital from 04/18/11 to 06/29/11 were not complete in that each physician order was not dated, timed, signed and/or authenticated by the ordering practitioner responsible for providing hospital services for these patients.

Findings included:

The "Doctors Orders" physician, provider and/or nurse signatures were not dated and/or timed for the following patients:

Patient #1 - The "MDMC Labor and Delivery Initial Orders" dated 04/18/11 nursing telephone order did not contain a time and the physician signature did not contain a time. The "Referral Order Screens" did not contain a nurse signature time. The "Thrombosis Risk Assessment and Venous Thromboembolism (VTE) Prophylaxis" physician order sheet, not dated, did not contain a physician signature. The "Inpatient Pneumoccoccal/Influenza Immunization Orders" sheet nurse signature did not contain a date or time.

Patient #2 - The "Doctor Order" sheet dated 06/29/11 contained 3 separate entries (3:40 P.M., 4:30 P.M. and 6:30 P.M.) which were not

individually dated. The 3:40 entry contained two orders that was not signed by a physician or nurse. The 4:30 physician signature was dated or timed. The 6:30 entry to discharge home was signed by Resident #36 but not validated or co-signed by a member of the medical staff.

Patient #3 - The "Doctor Order" sheet dated 05/04/11 contained 2 separate entries (2:45 P.M. and 4:10 P.M.) which were not individually dated. The 2:45 P.M. physician signature for authentication of a telephone order (TO) was not dated or timed.

Patient #4 - The "Doctor Order" sheet dated 05/14/11 contained 2 separate entries (5:10 A.M. and 5:20 A.M.) which were signed and not timed or dated by Resident #56. The residents signatures were not validated or co-signed by a member of the medical staff.

Patient #5 - The "Doctor Order" sheet dated 06/05/11 contained 2 separate entries (6:00 A.M. and 6:50 A.M.) which were signed by Resident #57 was incomplete in that the signatures were not validated or co-signed by a member of the medical staff.

The hospital policy "Medical Record Documentation" dated 06/30/11 requires "To ensure a complete legal medical record...All patient medical record entries must be legible, complete, dated, timed and signed in written or electronic form by the person responsible for providing or evaluating the service provided...Documentation completed by non-medical staff members must be countersigned by the responsible physician for the following: All dictated reports, ED record, Orders (PA, CRNA, and midwife only), Progress notes...ED documentation will be authenticated by the responsible physician including but not limited to ED Record and physician orders. An appropriate medical record shall be kept for every patient receiving emergency medical care...A properly executed informed consent form for the operation/procedure must be in the patient's chart before surgery...All orders, including verbal orders, must be dated, timed, and signed by the ordering practitioner or another practitioner involved in the care of the patient...All verbal orders must be signed, dated, and timed within 48 hours...Nursing documentation, including but not limited to nursing assessment, medication reconciliation ..interventions are required...Is not limited to but may include other components for inclusion or monitoring as deemed necessary..."

At 5:00 P.M. on 07/05/11 the CNO (Personnel #1) was interviewed. She confirmed the hospital policies and procedures were not followed for the correct completion, dating and timing of the medical records.

Tag No: A0457

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

Based on review of records and interview, the medical records of 5 of 5 Patients (Patient # 1, #2, #3, #4 and #5) treated in the hospital from 04/18/11 to 06/29/11 were not complete in that each physician verbal and/or telephone order was not authenticated within 48 hours by the ordering practitioner responsible for providing hospital services for these patients.

Findings Included:

Patient #1 -

The "Doctor Orders" sheet dated 04/19/11 timed at 4:54 A.M. contained a telephone order from MD #9 for "Discontinue Acetaminophen (pain and fever reducer), Ancef (antibiotic) 2 gram IV (intravenous) x 1 dose only." It was electronically signed by MD #9 on 05/18/11 at 12:14 P.M.

The "Doctor Orders" sheet dated 04/19/11 timed at 3:30 P.M. contained a telephone order from MD #9 for "Patient is allowed to do whatever form of testing - genetic testing/autopsy - that she wants." It was electronically signed by MD #9 on 05/18/11 at 12:14 P.M.

The "Doctor Orders" sheet dated 04/19/11 timed at 4:10 P.M. contained a telephone order from MD #9 for "Rh Immune Globin studies stat (blood test for antibodies, immediately)." It was electronically signed by MD #9 on 05/18/11 at 12:14 P.M.

The "Doctor Orders" sheet dated 04/19/11 timed at 4:30 P.M. contained an order written by PA #16 for "Discharge to home, Follow-up with MD #9." It was electronically signed by MD #9 on 05/18/11 at 12:14 P.M.

The "Doctor Orders" sheet dated 04/19/11 timed at 4:45 P.M. contained a telephone order from MD #9 for "Rhogam x 1 dose now (medication to treat blood Rh incompatibility)." It was electronically signed by MD #9 on 05/18/11 at 12:14 P.M.

Patient #2

The "Doctor Order" sheet dated 06/29/11 timed at 6:30 P.M. contained an order by Resident #36 for "OK to discharge home." The order was not signed or validated by a member of the medical staff.

Patient #3

The "Doctor Order" sheet dated 05/04/11 timed at 2:45 P.M. contained a telephone order from MD #43 for "Admit for observation of rule out labor, Electronic fetal monitoring, Recheck cx (cervix) in one hour. If < 5 cm (centimeters), D/C (discharge) home with labor warnings." The order was not dated and timed for validation by the MD within 48 hours.

Patient #4

The "Doctor Order" sheet dated 05/14/11 timed at 5:10 A.M. contained an order by Resident #56 for "Admit for observation of spotting." The order was not signed or validated by a member of the medical staff.

The "Doctor Order" sheet dated 05/14/11 timed at 5:20 A.M. contained an order by Resident #56 for "D/C home with labor precautions." The order was not signed or validated by a member of the medical staff.

Patient #5

The "Doctor Order" sheet dated 06/05/11 timed at 6:00 A.M. contained an incomplete order by Resident #57 for "Admit for observation of ____ (left blank)." The order was not signed or validated by a member of the medical staff.

The "Doctor Order" sheet dated 06/15/11 timed at 6:50 A.M. contained an incomplete order by Resident #57 for "D/C home." The order was not signed or validated by a member of the medical staff.

The hospital policy "Medical Record Documentation" dated 06/30/11 requires "To ensure a complete legal medical record...All patient medical record entries must be legible, complete, dated, timed and signed in written or electronic form by the person responsible for providing or evaluating the service provided...Documentation completed by non-medical staff members must be countersigned by the

responsible physician for the following: All dictated reports, ED record, Orders (PA, CRNA, and midwife only), Progress notes...ED documentation will be authenticated by the responsible physician including but not limited to ED Record and physician orders. An appropriate medical record shall be kept for every patient receiving emergency medical care...A properly executed informed consent form for the operation/procedure must be in the patient's chart before surgery...All orders, including verbal orders, must be dated, timed, and signed by the ordering practitioner or another practitioner involved in the care of the patient...All verbal orders must be signed, dated, and timed within 48 hours...Nursing documentation, including but not limited to nursing assessment, medication reconciliation ..interventions are required...Is not limited to but may include other components for inclusion or monitoring as deemed necessary...'

At 5:00 P.M. on 07/05/11 the CNO (Personnel #1) was interviewed. She confirmed the hospital policies and procedures were not followed for the validation of orders by the admitting physician or member of the medical staff.

VIOLATION: CONTENT OF RECORD

Based on review of records and interview, the medical records of 4 of 5 Patients (Patient #2, #3, #4 and #5) treated in the hospital from 04/18/11 to 06/29/11 did not contain documented evidence that a medical history and physical examination (H&P) was completed for each patient seen or treated in the hospital by a physician who is a member of the medical staff.

Tag No: A0458

Findings Included:

Patient #2's medical record dated 06/29/11 reflected the patient was admitted to the L&D Unit (Labor and Delivery) for observation of "leaking/mucus plug."
The "Doctor's Notes" timed at 4:00 P.M. reflected an examination that was not signed.

The nursing "OB Triage" notes timed at 4:35 P.M. reflected, "Exam by: MD #58" and at 6:20 P.M. reflected, "Exam by: Resident #36." The medical record did not contain a medical H&P, assessment or discharge summary documented by a physician who is a member of the medical staff.

Patient #3's medical record dated 05/04/11 reflected the patient was admitted to the L&D Unit for observation of "R/O (rule out) labor." The nursing "OB Triage" notes timed at 3:49 P.M. reflected, "Exam by: MD #43." The medical record did not contain a medical H&P, assessment, progress notes or discharge summary documented by a physician who is

a member of the medical staff.

Patient #4's medical record dated 05/14/11 reflected the patient was admitted to the L&D Unit for observation of "Spotting."

The nursing "OB Triage" notes timed at 5:13 A.M. reflected, "Exam by: Resident #56."

The medical record did not contain a medical H&P, assessment, progress notes or discharge summary documented by a physician who is a member of the medical staff.

Patient #5's medical record dated 06/05/11 reflected the patient was admitted to the L&D Unit for observation The nursing "OB Triage" notes timed at 6:36 A.M. reflected, "Exam by: Resident #57."

The medical record did not contain a medical H&P, assessment, progress notes or discharge summary documented by a physician who is

a member of the medical staff.

The hospital policy "Medical Record Documentation" dated 06/30/11 requires "To ensure a complete legal medical record...All patient medical record entries must be legible, complete, dated, timed and signed in written or electronic form by the person responsible for providing or evaluating the service provided...Documentation completed by non-medical staff members must be countersigned by the responsible physician for the following: All dictated reports, ED record, Orders (PA, CRNA, and midwife only), Progress notes...documentation will be authenticated by the responsible physician including but not limited to ED Record and physician orders. An appropriate medical record shall be kept for every patient...All orders, including verbal orders, must be dated, timed, and signed by the ardering predictionar as another prostitionar involved in the care of the nation. ordering practitioner or another practitioner involved in the care of the patient..."

The Obstetrics/Gynecology Department Medical Staff Committee Meeting Minutes dated 05/04/11 reflects, "Documentation and

communication between attending OB/GYN and resident...Attending and Residents need to document when the attending is present for the procedure and when the attending leaves the procedure...Stand by deliveries requires staff on call must be present at delivery...MD #7 reminded members of the department who participate in attending staff call, that they (the attending staff supervisor) are responsible for the case and well be held accountable...Residency Report...MD #54 reemphasized the importance of attending staff call physician's responsibilities as stated by MD #7..."

Medical Staff Bylaws and Rules and Regulations: Dated 05/24/11 requires "The Medical Staff is responsible for the quality of medical care in the system hospitals...Medical Staff shall be interpreted to mean all duly licensed Physicians, Dentists and Podiatrists holding unlimited licenses who are granted medical staff appointment...House Staff shall mean those physicians who are graduates of a medical school...and are pursuing additional training in a system hospital's medical education program...Clinical Privileges shall be interpreted to mean having the right to render specific diagnostic, therapeutic, medical, dental or surgical services in a system hospital...Appointment to the Medical Staff or the granting of temporary privileges shall be extended only to those professionally competent Physicians, Dentists, and Podiatrists who meet the qualifications, standards and requirements set forth in these bylaws and policies...each practitioner shall have only such clinical privileges as have been granted by the Board of Directors as recommended by the Medical Staff in accordance with these bylaws ...'

The "Medical Staff Policy Manual" dated 05/24/11 requires, "Medical staff appointment is set forth in the bylaws...shall...provide continuous care and supervision of his patient; to abide by the Bylaws, the Policies, the MHS bylaws and all other established standards, policies, and rules of the Medical Staff...and, to participate in fulfilling the requirements for providing emergency care...Degree of Care/Management of Patient by House Staff...The medical record should reflect the involvement of the teaching practitioner in the management of a patient treated by a House Staff Member...House Staff shall not be considered Medical Staff members nor shall the term House Staff be considered a category of Medical Staff membership...Medical Records...There shall be evidence in the medical record that the teaching physician has been involved in the management of a patient treated by a member of the House Staff...Progress Notes...Pertinent progress notes should be recorded at the time of observation, sufficient to permit continuity of care...each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders...An appropriate medical record shall be kept for every patient receiving emergency medical care and shall be incorporated in the patient's hospital record...Each patient's medical record shall be signed by the physician in attendance that is responsible for its clinical accuracy...'

The hospital policy "Supervision of Residents in Obstetrics and Gynecology" dated February, 2008 requires "L&D...Supervising physicians are required to personally assess all patients admitted to L&D and the antepartum unit...Supervising physicians are required to directly

supervise...and must be immediately available for supervision of normal spontaneous vaginal deliveries...Summary...A qualified faculty or attending physician is assigned to supervise all resident activities at all times on all services. There is a supervising physician in the hospital 24 hours per day, seven days per week. The supervising physician should directly or indirectly supervise the residents patient care activities depending upon the type of care and PGY level of the resident."

At 5:00 P.M. on 07/05/11 the CNO (Personnel #1) was interviewed. She confirmed the medical records did not contain the required medical history and physical examination documentation performed by a member of the hospital's medical staff.

VIOLATION: CONTENT OF RECORD - INFORMED CONSENT

Tag No: A0466

Based on interview and record review, the hospital failed to ensure properly executed informed consents for 1 of 1 patient (Patient #1) who underwent a medical procedure on 04/19/11. The consents for medical procedures did not contain the name of the provider and/or correct intended procedure. The consents were not dated or timed by the physician and witnessed by the RN without the physician being present.

Findings Included:

Review of Patient #1's medical record dated 04/18/11 reflected Patient #1 was admitted for induction of labor for fetal demise under the care of MD #9.

The "Disclosure and Consent" dated 04/18/11 timed at 4:16 P.M. reflected a voluntary consent for "Dr. ACD (Anesthesia Care Department)" to perform "spinal or epidural anesthesia" and was witnessed by RN #10. MD #9 signed the consent without dating or timing the consent form. The medical record reflected MD #9 was not present in the hospital at the time the Disclosure and Consent was obtained by the nurse.

The "Disclosure and Consent" dated 04/18/11 timed at 4:20 P.M. reflected a consent for MD #9 to perform a planned procedure for "vaginal delivery, possible episiotomy, possible use of forceps or use of Vacuum and possible Cesarean Section." The form was witnessed by RN #10. The physician, MD #9 signed the consent form without dating or timing the consent. The consent did not reflect the intended procedure of Induction of Labor with Cytotec. The medical record reflected MD #9 was not present in the hospital at the time the Disclosure and Consent was obtained by the nurse.

The hospital policy "Medical Record Documentation" dated 06/30/11 requires "To ensure a complete legal medical record...All patient medical record entries must be legible, complete, dated, timed and signed in written or electronic form by the person responsible for providing or evaluating the service provided...A properly executed informed consent form for the operation/procedure must be in the patient's chart before surgery..."

The hospital policy "Patient's Rights and Responsibilities" dated 04/30/11 requires, "Information about treatment. You are encouraged to discuss your condition, diagnosis, treatments and prognosis with your physician and other caregivers...Know the identity of your physicians and other caregivers, as well as when those involved are students, residents, or trainees...Informed Consent. You have the right to receive from your physician information needed to make decisions regarding your care, including treatment options and the risks and benefits of those choices..."

The hospital "Disclosure and Consent for Medical, Surgical and Diagnostic Procedures Including Consent for Blood Transfusions" dated 08/30/10 requires "All planned procedures and anticipated procedures should be listed on the consent form...The physician, and if applicable anesthesiologist/anesthetist, is responsible for obtaining the patient consent. The physician, and if applicable anesthesiologist/anesthetist should sign the consent form prior to the procedure certifying that the patient...has been provided information on the risk and hazards, benefits and alternatives to treatment, and had questions answered within the physicians area of expertise and has given consent...The nurse's role is limited to obtaining, at the physician's request, the patient's signature on the appropriate consent form and/or witnessing the execution of a consent form. Any questions concerning the diagnosis, the nature and purpose of treatment, the risks and consequences, the reasonably feasible alternatives, and the prognosis if no treatment is given, should be directed to the physician...should indicate both date and time of signature..."

At 5:00 P.M. on 07/05/11 the CNO (Personnel #1) was interviewed. She was asked to review the medical record of Patient #1. She was then asked to review the Disclosure and Consent for Spinal and Epidural Anesthesia and asked who Dr. ACD is. She stated, "It means the Anesthesia Care Department." She was then asked to review the Disclosure and Consent for MD #9 to perform a Vaginal Delivery and asked if the consent form was properly executed and signed or included the intended procedure for Induction of Labor with Cytotec. She stated, "No." She was asked if nursing and the medical staff followed hospital policies and procedures for the correct completion of disclosure and consents for medical procedures performed. She stated, "No."

VIOLATION: EMERGENCY SERVICES

Tag No: A1100

Based on observation, interviews and record reviews, the hospital's Governing Board failed to ensure the emergency needs of the patients presenting to the hospital were met in that:

- 1) All patients presenting to the Emergency Department (ED) and L&D (Labor and Delivery) from 01/01/11 to 06/29/11 received an appropriate medical screening examination (MSE) to determine whether or not an emergency medical condition (EMC) existed, stabilizing treatment was provided and appropriate transfers were effected if needed. Patient #2, presented to the ED for a potential EMC, did not receive an appropriate MSE to determine if stabilizing treatment was needed prior to transferring the patient to L&D without appropriate qualified medical personnel. The Registered Nurses (RNs) and Medical Residents who performed the MSE in the ED and L&D were not appointed by the Governing Body as Qualified Medical Practitioners (QMP) to provide MSE.
- 2) Adopt and enforce a hospital policy to ensure EMTALA requirements are met in order to provide for all individuals presenting to the ED and L&D for examination of a medical condition an appropriate MSE by a QMP to determine whether or not an EMC exists, provide stabilizing treatment and/or effect an appropriate transfer. Cross refer: A2406

3) Failed to ensure an appropriate MSE for a potential EMC was not delayed for all patients presenting to the L&D (Labor and Delivery) from 01/01/11 to 06/29/11 for 1 of 1 patients (Patient #2) in order to inquire about the patient's method of payment or insurance before determining if stabilizing treatment was required.

Cross refer: A2408

It is determined this deficient practice creates an Immediate Jeopardy situation and places the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

Tag No: A1104

VIOLATION: EMERGENCY SERVICES POLICIES

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interviews, the hospital failed to monitor and ensure the ED policies and procedures governing the medical care provided in the ED are enforced in that 1 of 1 Patient's (Patient #2) presenting to the ED on 06/29/11 with an emergency complaint did not receive an appropriate MSE by a QMP to determine if an EMC existed prior to transferring the patient to the L&D unit with a volunteer who is an unlicensed staff member that is not qualified to monitor or emergently treat the patient in the event the patient should deteriorate during transport.

Findings included:

Patient #2 (MDS) dated [DATE] at approximately 3:30 P.M. with complaints of labor after losing her mucus plug, cramps and having contractions. The medical record did not reflect a MSE by a QMP to determine if an EMC existed prior to sending the patient, accompanied by a hospital volunteer to the L&D unit.

During a tour of the facility at 3:30 P.M. on 06/29/11, the surveyor accompanied by the CNO (Personnel #1) and the ED Nurse Manager (Personnel #2) observed the ED Volunteer (Personnel #53) escorting a pregnant patient (Patient #2) and her husband down the hall. The pregnant patient was holding her stomach and appeared to be in distress. The Volunteer (Personnel #53) stopped at the end of the hall and gave directions to Patient #2 and her husband to the L&D Unit. The Volunteer (Personnel #53) then left Patient #2 and her husband alone to find the L&D area unaccompanied. The CNO (Personnel #1) and the ED Nurse Manager (Personnel #2) verified the escort is a volunteer and not a qualified medical person.

The surveyor, CNO (Personnel #1) and the ED Nurse Manager (Personnel #2) then followed Patient #2 and her husband down the hall to the elevator. The CNO intervened at this point and asked the patient if she needed help. Patient #2 stated she is having contractions and is going to the L&D area. The CNO, ED Manager and the surveyor accompanied Patient #2 in the elevator to the 3rd floor where the L&D is located. The CNO asked the registration clerk to open the door to allow the patient in. The CNO handed the patient off to the L&D Nurses and gave them report. Patient #2 was then placed at the Registration desk inside the L&D area. The surveyor observed the Registration Clerk taking Patient #2's personal information including asking her for a copy of her Identification and Insurance or Medicaid paperwork prior to a medical screening examination (MSE) being performed to determine if an emergency medical condition (EMC) existed.

The surveyor asked Patient #2 if she was checked into the ED and examined first before being sent to L&D. She stated, "No. The person at the desk told the Volunteer to take me to the Labor and Delivery area."

The hospital policy "Patient Transfers" dated 04/30/09 requires, "The Board of Directors...having consulted with the Medical Staff, adopt this policy to comply with state and federal laws...Patient Evaluation. All individuals presenting at the ED shall receive an appropriate MSE to determine whether they have an EMC...Each patient who presents to the ED must be evaluated by: a physician who is present in the hospital at the time the patient presents or is presented, or by a physician on call is: physically able to reach the patient within 30 minutes...accessible by direct, telephone...within 30 minutes, with a RN or PA or other qualified medical personnel as established by the hospital's governing body at the MHS hospital under orders to assess and report the patient's condition to the physician...The MSE should not be delayed in order to inquire about the patient's method of payment or insurance... "

The hospital policy "Response to Medical Emergencies Occurring on Hospital Premises (Code MERT)" dated 12/30/10 requires, "Methodist Dallas Medical Center (MDMC)...will provide a MSE on any person who is not a patient, while on hospital property for any reason, needs emergency medical assistance, to determine whether that person has an EMC...EMC means a medical condition manifesting itself by acute symptoms of sufficient severity...such that the absence of immediate medical attention could reasonably result in: placing the health of the individual, or with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy...MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency exists..."

The hospital policy "Guidelines for Obstetrical (OB) Patients Presenting to the ED" dated 08/30/10 requires "Any OB patient greater than, or suspected to be greater than 20 weeks gestation, presenting to the ED (either ambulatory, by wheelchair, or ambulance) with any of the following, should be transported to L&D as soon as possible, after they are deemed to be stable enough for transport: Symptoms suggestive of labor, rupture of membranes, complications related to the pregnancy, injuries that could endanger the unborn infant...If indicated during the stabilization process, the ED staff may contact L&D for assessment and monitoring of the fetal status..."

The "Plan for Provision of Patient Care" dated FY 2011, requires, "ED...Any individual...who present...for examination or treatment, will be provided an appropriate MSE by an emergency physician or primary care physician...The ED triages all patients using RN's experienced in emergency care. Patients are triaged according to a 5-level tier system which ensures patients are assessed and prioritized to acuity...Women's and Children's Services...patients presenting with actual or potential problems related to pregnancy...can be accessed via Emergency Services, through the outpatient services, through transport, as a direct admit or as a drop-in patient...patients are assessed by the medical staff in accordance with the medical staff Rules and Regulations and by nursing...in accordance with the established reference guideline...Volunteer Services ...provide non-clinical patient services that do not require a license or certificate..."

At 4:00 P.M. on 06/29/11 the surveyor interviewed Personnel #2, the ED Nurse Manager. She was asked if the nurses perform MSE's in the ED. She stated, "No. The nurses perform triage and the physician's do the medical screening." She was asked if the nurses make the determination when the patient's are taken back to the main ED or Fast Track to see a physician. She stated, "Yes. We use the 5 level

triage system. We make the determination based on the triage system who is seen first by the physician." She was asked if the Paramedic checking in the patient's performs triage. She stated, "The paramedic does a quick check based on their complaint and makes the determination which patient needs to see the nurse first." She was asked if it is the ED policy to send patient's to L&D without a medical screening. She stated, "We send all of our patient's that are greater than 20 weeks pregnant to L&D for screening unless they are trauma patients." She was asked if it is the hospital policy to send pregnant patient's to L&D with a volunteer. She stated, "Yes, if the other personnel are busy."

At 5:00 P.M. on 06/29/11 the surveyor interviewed the CNO (Personnel #1). She verified the hospital is not following the required policies and procedures for providing appropriate MSE's with QMP's in the ED and L&D. She was asked if the hospital volunteer is qualified to treat emergent medical conditions. She stated, "No."

Tag No: A2400

Tag No: A2402

Tag No: A2404

VIOLATION: COMPLIANCE WITH 489.24

Based on observation, record reviews and interviews, the hospital failed to comply with 489.24 in that:

1) All patients presenting to the ED from 01/01/11 to 06/29/11 were not provided an appropriate MSE by a QMP to determine whether or not an EMC existed. The medical screening examination of the patients were performed by RN's or Medical Residents who were not determined qualified by hospital bylaws or the medical staff rules and regulations.

Cross Refer: Tag A2406

2) Hospital policies were not adopted or enforced to ensure compliance with EMTALA requirements.

Cross Refer: Tag A2406

3) Hospital policies and procedures were not adopted and in place to ensure emergency services are available to meet the needs of individuals with EMC's after the initial examination.

Cross Refer: Tag A2404

VIOLATION: POSTING OF SIGNS

Based on observation, record review and interview, the hospital did not post the required EMTALA (Emergency Medical Treatment and Labor Act) signage in the Emergency Department (ED) and Labor and Delivery (L&D) Unit where patient's present for Emergency Medical Conditions (EMC) that was prominent and conspicuous and likely to be noticed by all individuals entering the ED or L&D which specified the rights of individuals with respect to examination and treatment of emergency medical conditions and women in labor.

Findings included:

On 06/29/11 at 2:00 P.M., a tour of the ED was conducted with the CNO (Personnel #1) and the ED Nurse Manager (Personnel #2). Upon entry to the ED from the outside entrance into the main waiting room, the surveyor did not observe the required EMTALA signage posting in either English or Spanish. A tour of the main waiting room revealed one small EMTALA sign posted beside the registration area which was not visible from the waiting room. The EMTALA sign was obscured by numerous other postings. The EMTALA sign was not prominent and conspicuous in that it was not clearly visible from a distance of 20 feet. The required Patient Complaint signage was not posted in the main ED.

Continuation of the tour of the ED revealed there was no EMTALA signage posted in the patient triage rooms, patient treatment areas or the ambulance entrances.

After the tour of the Main ED, at 3:30 P.M., the surveyor accompanied by the CNO (Personnel #1) and ED Nurse Manager (Personnel #2) left the Main ED and toured the L&D Unit. The surveyor did not observe any of the required EMTALA postings at the entrance of the L&D area. There was one small sign posted inside of the L&D area on the opposite wall of the registration clerk 's desk which was not clearly visible from 20 feet distance. There was no EMTALA signage posted in the patient triage area or treatment rooms.

On 06/30/11 at 11:00 A.M., during a separate tour of the facility accompanied by Personnel #5, Vice President (VP) of Administration, the surveyor did not observe any of the required EMTALA signage posted in the Front Lobby Entrance, Main Admitting Entrance, or Outpatient Registration areas.

The hospital policies and procedures did not address the required EMTALA Signage postings.

In an interview at 3:30 P.M. on 06/29/11, the CNO (Personnel #1) confirmed the above findings.

In an interview at 11:00 A.M. on 06/30/11, the VP of Administration (Personnel #5) confirmed the above findings.

VIOLATION: ON CALL PHYSICIANS

Based on observation, record review and interview, the hospital failed to:

- 1. Maintain an adequate on-call list of individually named OB/GYN physicians and their alternates who are current members of the medical staff or who have hospital privileges with accurate contact information for 6 of 6 months from 01/01/11 06/30/11 who were available to provide stabilizing treatment to individuals presenting with emergency medical conditions.
- 2. Maintain a written on-call list of physicians and their alternates who were on call for Anesthesia Services for 6 of 6 months from 1/01/11 06/30/11 that are available to provide treatment to individuals presenting with emergency medical conditions.

Findings included:

During a tour of the L&D Department at 3:30 P.M. on 06/29/11, the surveyor was accompanied by the CNO (Personnel #1) and ED Nurse Manager (Personnel #2). The surveyor asked the L&D Charge Nurse (Personnel #33) where the physician on-call schedule is posted. She handed the surveyor a clipboard with a calendars for January 2011 - June 2011. The calendars did not contain the full names of the physicians with their contact information or alternate physician's on-call. She was asked if she had a copy of the on-call schedule for anesthesiology. She stated, "No. Anesthesia will come in and write their name on the dry erase board when they are on call." She was asked if L&D is provided an Anesthesia schedule with the physicians on-call and the physician that is the alternative for back-up call. She stated, "No."

Review of the On-Call Schedules reflected:

Labor and Delivery On-Call Schedule:

The L&D On-Call Attending Physician Schedule dated "January 2011 - June 2011" did not reflect the full name of the on-call physician's with their contact information or any on-call alternate physician's in the event the on-call physician cannot respond.

The On-Call schedules for Faculty dated "January 2011 - June 2011" did not reflect the full name of the on-call physician's with their contact information or any on-call alternate physician's in the event the on-call physician cannot respond.

Labor and Delivery Anesthesiology On-Call Schedule:

The L&D Department did not have any written copies of on-call schedules for Anesthesiology from 01/01/11 through 06/30/11. A Dry Erase Board posted in the department is utilized for the one person on-call for anesthesia for the day. The Dry Erase Board did not contain an alternate anesthesia on-call person with the contact number.

The Obstetrics/Gynecology Department Medical Staff Committee Meeting Minutes:
The 05/04/11 Committee Notes reflects, "Stand by deliveries requires staff on call must be present at delivery...MD #7 reminded members of the department who participate in attending staff call, that they (the attending staff supervisor) are responsible for the case and well be held accountable...Residency Report...MD # 54 reemphasized the importance of attending staff call physician's responsibilities as stated by MD # 7...'

The "Medical Staff Policy Manual" dated 05/24/11 requires, "Medical staff appointment is set forth in the bylaws...shall...provide continuous care and supervision of his patient...Emergency Services...ED Call and Coverage...The Medical Staff Executive Committee (MEC)...shall determine the clinical departments and other services for which an ED call list will be required... to ensure for the provision of adequate on call coverage to meet the needs of patients coming to the system's hospital's emergency department and to provide coverage for the services offered in the system hospital...provide for use...a current list of practitioners within the department who are on call for ED patients who do not request a specific member of the medical staff...each department shall provide such list to the Medical Staff office in a timely, regular an consistent manner...Each practitioner having Active 1 status...shall be required to take emergency department call when assigned...acknowledges the responsibility and expectation of every medical staff member to participate in fulfilling the requirements for providing emergency department call and providing emergency care to patients coming to a system hospital...It is the policy of MHS hospitals to comply with the EMTALA...requires that any patient who presents at the ED must receive an appropriate MSE to determine if that patient has an EMC. If so and except as authorized under EMTALA, the patient's condition must be stabilized...The provisions of EMTALA apply not only to the hospital but also to the practitioners who provide on-call coverage...the obligations of on-call practitioners must come to the ED when requested by the ED physician, another physician, a nurse...the on-call practitioner shall be physicially present in the ED to assist in providing an appropriate MSE, as well as in the ongoing stabilization and treatment of an ED patient...EMC means: a medical condition mainly itself by acute symptoms of sufficient severity including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy...with respect to pregnant woman who is having contractions: there is inadequate time to effect a safe transfer to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or the unborn child...Stabilize mean: with respect to EMC, to provide such medical treatment of the condition as may be necessary to assure within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an EMC involving a pregnant woman, that the woman has delivered (including the placenta)..."

The hospital policy "Patient Transfers" dated 04/30/09 requires, "The Board of Directors...having consulted with the Medical Staff, adopt this policy to comply with state and federal laws...Patient Evaluation. All individuals presenting at the ED shall receive an appropriate MSE to determine whether they have an EMC...Each patient who presents to the ED must be evaluated by: a physician who is present in the hospital at the time the patient presents or is presented, or by a physician on call..."

The hospital policy "Response to Medical Emergencies Occurring on Hospital Premises (Code MERT)" dated 12/30/10 requires, "Methodist Dallas Medical Center (MDMC)...will provide a MSE on any person who is not a patient, while on hospital property for any reason, needs emergency medical assistance, to determine whether that person has an EMC...EMC means a medical condition manifesting itself by acute symptoms of sufficient severity...such that the absence of immediate medical attention could reasonably result in: placing the health of the individual, or with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy...MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency exists...

The "Plan for Provision of Patient Care" dated FY 2011, requires, "Methods Used to Assess and Meet Patient Care Needs: Patients are assessed by the medical staff in accordance with the medical staff Rules and Regulations...ED...Any individual...who presents...for examination or treatment, will be provided an appropriate MSE by an emergency physician or primary care physician...Women's and Children's Services...patients presenting with actual or potential problems related to pregnancy...can be accessed via Emergency Services, through the outpatient services, through transport, as a direct admit or as a drop-in patient...patients are assessed by the medical staff in accordance with the medical staff Rules and Regulations..."

Tag No: A2406

In an interview at 3:30 P.M. on 06/29/11, the CNO (Personnel #1) confirmed the above findings and verified the hospital policies and procedures were not followed for on-call physicians.

VIOLATION: MEDICAL SCREENING EXAM

Based on observation, interviews and record reviews, the hospital's Governing Board failed to:

1) Ensure all patients presenting to the Emergency Department (ED) and L&D (Labor and Delivery) from 01/01/11 to 06/29/11 received an appropriate medical screening examination (MSE) to determine whether or not an emergency medical condition (EMC) existed, stabilizing treatment was provided and appropriate transfers were initiated if needed. Patient #2 presented to the ED for a potential EMC did not receive an appropriate MSE to determine if stabilizing treatment was needed prior to transferring the patient to L&D without appropriate qualified medical personnel.

The Registered Nurses (RNs) and Medical Residents who performed the MSE in the ED and L&D were not appointed by the Governing Body as Qualified Medical Practitioners (QMP) to provide MSE.

2) Adopt and enforce a hospital policy to ensure EMTALA requirements are met in order to provide for all individuals presenting to the ED and L&D for examination of a medical condition an appropriate MSE by a QMP to determine whether or not an EMC exists, provide stabilizing treatment and/or effect an appropriate transfer.

It is determined this deficient practice creates an Immediate Jeopardy situation and places the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

Findings Included:

During a tour of the facility at 3:30 P.M. on 06/29/11, the surveyor accompanied by the CNO (Personnel #1) and the ED Nurse Manager (Personnel #2) observed the ED Volunteer (Personnel #53) escorting a pregnant patient (Patient #2) and her husband down the hall. The pregnant patient was holding her stomach and appeared to be in distress. The Volunteer (Personnel #53) stopped at the end of the hall and gave directions to Patient #2 and her husband to the L&D Unit. The Volunteer (Personnel #53) then left Patient #2 and her husband alone to find the L&D area unaccompanied. The CNO (Personnel #1) and the ED Nurse Manager (Personnel #2) verified the escort is a volunteer and not a qualified medical person.

The surveyor, CNO (Personnel #1) and the ED Nurse Manager (Personnel #2) then followed Patient #2 and her husband down the hall to the elevator. The CNO intervened at this point and asked the patient if she needed help. Patient #2 stated she is having contractions and is going to the L&D area. The CNO, ED Manager and the surveyor accompanied Patient #2 in the elevator to the 3rd floor where the L&D is located. The CNO asked the registration clerk to open the door to allow the patient in. The CNO handed the patient off to the L&D Nurses and gave them report. Patient #2 was then placed at the Registration desk inside the L&D area. The surveyor observed the Registration Clerk taking Patient #2's personal information including asking her for a copy of her Identification and Insurance or Medicaid paperwork prior to a medical screening examination (MSE) being performed to determine if an emergency medical condition (EMC) existed.

The surveyor asked Patient #2 if she was checked into the ED and examined first before being sent to L&D. She stated, "No. The person at the desk told the Volunteer to take me to the Labor and Delivery area."

RN #4 escorted Patient #2 to the patient care area to be assessed. RN #4 was asked if she does the medical screening for the L&D patients. She stated, "Yes. The nurses do it if the patient's have a private physician. They will ask us to check the patient and call them back with what the exam looked like. We let them know and if everything is ok then we discharge them home. If the patient is without a physician, we call the resident to examine them and they are listed under MD #54. He is the attending over the resident program."

The surveyor then interviewed the L&D Charge Nurse (RN #33). She was asked if the resident or physician performs the medical screening for patient's that present to the L&D. She stated, "No. The RN's do the medical screening." She was asked what the responsibilities of the Triage Nurse are. She stated, "The triage nurse gets the patient's to sign the consents, fills out the doctor's order sheet, performs maternal vital signs (VS), monitors the fetal heart rate (HR), uterine contractions, pain and medical history." She was asked if the attending physician comes in to see the patient when he is notified one of his or her patient's have presented to L&D. She stated, "No. Not all the time. They have privileges to see the fetal strip on a computer." She was asked if the residents perform care on the patients. She stated, "Yes, with help of the attending."

Review of the ED or OB/GYN Nursing Staff files did not contain letters of recommendation from the Medical Staff or letters of appointment from the Governing Board determining any nurses as QMP's to perform MSE's to determine if an EMC exists for patient's that present to the hospital for emergencies.

The ED or OB/GYN Nursing Staff files did not contain specific QMP competencies or evaluations to perform MSE's for EMC's.

The Obstetrics/Gynecology Department Medical Staff Committee Meeting Minutes dated 05/04/11 reflects, "Documentation and communication between attending OB/GYN and resident...Attending and Residents need to document when the attending is present for the procedure and when the attending leaves the procedure...Stand by deliveries requires staff on call must be present at delivery...MD #7 reminded members of the department who participate in attending staff call, that they (the attending staff supervisor) are responsible for the case and well be held accountable...Residency Report...MD #54 reemphasized the importance of attending staff call physician's responsibilities as stated by MD #7..."

The Governing Body Bylaws: Reviewed and amended 02/22/11 requires, "The activities, property and affairs of the corporation shall be managed by its Board of Directors...Medical Staff Organization...Hospital Medical Staff...shall...administer its affairs in accordance with the corporate bylaws and policies, including the corporate medical staff bylaws, policies, and rules, and with that System Institution's policies and program requirements...shall approve all appointments...Corporate Medical Board...make recommendations to the Board of Directors on...applications for appointment...privileges...evaluate and monitor quality monitoring and improvement activities and systems for monitoring and evaluating the quality of patient care and improving patient care in the system institutions..." The Governing Body Rules and Regulations did not address the requirements for QMP's to perform MSE's for EMC's.

Medical Staff Bylaws and Rules and Regulations: Dated 05/24/11 requires "The Medical Staff is responsible for the quality of medical care in the system hospitals...Medical Staff shall be interpreted to mean all duly licensed Physicians, Dentists and Podiatrists holding unlimited licenses who are granted medical staff appointment...House Staff shall mean those physicians who are graduates of a medical school...and are pursuing additional training in a system hospital's medical education program...Clinical Privileges shall be interpreted to mean having the right to render specific diagnostic, therapeutic, medical, dental or surgical services in a system hospital...Appointment to the Medical Staff or the granting of temporary privileges shall be extended only to those professionally competent Physicians, Dentists, and Podiatrists who meet the qualifications, standards and requirements set forth in these bylaws and policies...each practitioner shall have only such clinical privileges as have been granted by the Board of Directors as recommended by the Medical Staff in accordance

with these bylaws ..."

The "Medical Staff Policy Manual" dated 05/24/11 requires, "Medical staff appointment is set forth in the bylaws...shall...provide continuous care and supervision of his patient; to abide by the Bylaws, the Policies, the MHS bylaws and all other established standards, policies, and rules of the Medical Staff...and, to participate in fulfilling the requirements for providing emergency care...Degree of Care/Management of Patient by House Staff...The medical record should reflect the involvement of the teaching practitioner in the management of a patient treated by a House Staff Members...House Staff shall not be considered Medical Staff members nor shall the term House Staff be considered a category of Medical Staff membership...Medical Records...There shall be evidence in the medical record that the teaching physician has been involved in the management of a patient treated by a member of the House Staff...Progress Notes...Pertinent progress notes should be recorded at the time of observation, sufficient to permit continuity of care...each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders...An appropriate medical record shall be kept for every patient receiving emergency medical care and shall be incorporated in the patient's hospital record...Each patient's medical record shall be signed by the physician in attendance that is responsible for its clinical accuracy...Emergency Services...the obligations of on-call practitioners...the on-call practitioner must come to the ED when requested by the ED physician, another physician, a nurse...the on-call practitioner shall be physically present in the ED to assist in providing an appropriate MSE, as well as in the ongoing stabilization and treatment of an ED patient...EMC means: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the health of

The hospital policy "Patient Transfers" dated 04/30/09 requires, "The Board of Directors...having consulted with the Medical Staff, adopt this policy to comply with state and federal laws...Patient Evaluation. All individuals presenting at the ED shall receive an appropriate MSE to determine whether they have an EMC...Each patient who presents to the ED must be evaluated by: a physician who is present in the hospital at the time the patient presents or is presented, or by a physician on call is: physically able to reach the patient within 30 minutes...accessible by direct, telephone...within 30 minutes, with a RN or PA or other qualified medical personnel as established by the hospital's governing body at the MHS hospital under orders to assess and report the patient's condition to the physician...The MSE should not be delayed in order to inquire about the patient's method of payment or insurance... "

The hospital policy "Response to Medical Emergencies Occurring on Hospital Premises (Code MERT)" dated 12/30/10 requires, "Methodist Dallas Medical Center (MDMC)...will provide a MSE on any person who is not a patient, while on hospital property for any reason, needs emergency medical assistance, to determine whether that person has an EMC...EMC means a medical condition manifesting itself by acute symptoms of sufficient severity...such that the absence of immediate medical attention could reasonably result in: placing the health of the individual, or with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy...MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency exists..."

The hospital policy "Guidelines for Obstetrical (OB) Patients Presenting to the ED" dated 08/30/10 requires "Any OB patient greater than, or suspected to be greater than 20 weeks gestation, presenting to the ED (either ambulatory, by wheelchair, or ambulance) with any of the following, should be transported to L&D as soon as possible, after they are deemed to be stable enough for transport: Symptoms suggestive of labor, rupture of membranes, complications related to the pregnancy, injuries that could endanger the unborn infant...If indicated during the stabilization process, the ED staff may contact L&D for assessment and monitoring of the fetal status..."

The "Plan for Provision of Patient Care" dated FY 2011, requires, "ED...Any individual...who present...for examination or treatment, will be provided an appropriate MSE by an emergency physician or primary care physician...The ED triages all patients using RN's experienced in emergency care. Patients are triaged according to a 5-level tier system which ensures patients are assessed and prioritized to acuity...Women's and Children's Services...patients presenting with actual or potential problems related to pregnancy...can be accessed via Emergency Services, through the outpatient services, through transport, as a direct admit or as a drop-in patient...patients are assessed by the medical staff in accordance with the medical staff Rules and Regulations and by nursing...in accordance with the established reference guideline...Volunteer Services ...provide non-clinical patient services that do not require a license or certificate..."

The hospital policy "Supervision of Residents in Obstetrics and Gynecology" dated February, 2008 requires "L&D...Supervising physicians are required to personally assess all patients admitted to L&D and the antepartum unit...Supervising physicians are required to directly supervise...and must be immediately available for supervision of normal spontaneous vaginal deliveries...Summary...A qualified faculty or attending physician is assigned to supervise all resident activities at all times on all services. There is a supervising physician in the hospital 24 hours per day, seven days per week. The supervising physician should directly or indirectly supervise the residents patient care activities depending upon the type of care and PGY level of the resident."

At 4:00 P.M. on 06/29/11 the surveyor interviewed Personnel #2, the ED Nurse Manager. She was asked if the nurses perform MSE's in the ED. She stated, "No. The nurses perform triage and the physician's do the medical screening." She was asked if the nurses make the determination when the patient's are taken back to the main ED or Fast Track to see a physician. She stated, "Yes. We use the 5 level triage system. We make the determination based on the triage system who is seen first by the physician." She was asked if the Paramedic checking in the patient's performs triage. She stated, "The paramedic does a quick check based on their complaint and makes the determination which patient needs to see the nurse first." She was asked if it is the ED policy to send patient's to L&D without medical screening. She stated, "We send all of our patient's that are greater than 20 weeks pregnant to L&D for screening unless they are trauma patients." She was asked if it is the hospital policy to send pregnant patient's to L&D with a volunteer. She stated, "Yes, if the other personnel are busy."

At 5:00 P.M. on 06/29/11 the surveyor interviewed the CNO (Personnel #1). She verified it is not the hospital policy to send a patient unescorted to the L&D without a qualified medical person. She was asked if the hospital Governing Body has approved and appointed the ED and L&D RN's as QMP's to perform MSE's. She stated, "No." She verified the hospital is not following the required policies and procedures for providing appropriate MSE's with QMP's in the ED and L&D.

At 8:45 A.M. on 06/30/11 the surveyor interviewed Personnel #19, Director of Medical Staff Services. She was asked if the Residents are part of the medical staff and credentialed with privileges. She stated, "No." She verified the hospital policies and procedures and the Medical Staff Rules, Regulations and Bylaws do not allow residents to practice without direct supervision.

At 9:30 A.M. on 06/30/11 the surveyor interviewed MD #7, Assistant Vice President of the Graduate Medical Education Program. He was asked if he is responsible for the Resident's that practice within the hospital. He stated, "Yes." He was asked what area's the Resident's practice within the hospital. He stated, "We have four core programs, OB, Gynecology (GYN), L&D and OR (operating room). The residents answer consultations in the OB/GYN for emergency or unassigned patient consultations. Our clinic is the Golden Cross Clinic across the street and where our residents practice. Our fell owship is located here in the hospital." He was asked if the residents are paid by the hospital to take call. He stated, "They receive a stipend/salary. They are in training and not independent practitioners and practice under an attending physician. They are employees of Methodist Health System and have a contract." He was asked if the hospital or program has policies and procedures for the residents. He stated, "They practice and are subject to the hospital policies and procedures. "He was asked if the residents are part of the medical staff. He stated, "No they are not privileged providers. The work under different levels of supervision which varies to what year they are in. They all have temporary permits to work as residents or students in training."

VIOLATION: DELAY IN EXAMINATION OR TREATMENT

Based on observation, interviews and record reviews, the hospital's Governing Board failed to ensure an appropriate MSE for a potential EMC was not delayed for all patients presenting to the L&D (Labor and Delivery) from 01/01/11 to 06/29/11 for 1 of 1 patients (Patient #2) in order to inquire about the patient's method of payment or insurance before determining if stabilizing treatment was required.

Tag No: A2408

It is determined this deficient practice creates an Immediate Jeopardy situation and places the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

Findings Included:

During a tour of the facility at 3:30 P.M. on 06/29/11, the surveyor accompanied by the CNO (Personnel #1) and the ED Nurse Manager (Personnel #2) observed the ED Volunteer (Personnel #53) escorting a pregnant patient (Patient #2) and her husband down the hall. The pregnant patient was holding her stomach and appeared to be in distress. The Volunteer (Personnel #53) stopped at the end of the hall and gave directions to Patient #2 and her husband to the L&D Unit. The Volunteer (Personnel #53) then left Patient #2 and her husband alone to find the L&D area unaccompanied. The CNO (Personnel #1) and the ED Nurse Manager (Personnel #2) verified the escort is a volunteer and not a qualified medical person.

The surveyor, CNO (Personnel #1) and the ED Nurse Manager (Personnel #2) then followed Patient #2 and her husband down the hall to the elevator. The CNO intervened at this point and asked the patient if she needed help. Patient #2 stated she is having contractions and is going to the L&D area. The CNO, ED Manager and the surveyor accompanied Patient #2 in the elevator to the 3rd floor where the L&D is located. The CNO asked the registration clerk to open the door to allow the patient in. The CNO handed the patient off to the L&D Nurses and gave them report. Patient #2 was then placed at the Registration desk inside the L&D area. The surveyor observed the Registration Clerk taking Patient #2's personal information including asking her for a copy of her Identification and Insurance or Medicaid paperwork prior to a medical screening examination (MSE) being performed to determine if an emergency medical condition (EMC) existed.

The surveyor asked Patient #2 if she was checked into the ED and examined first before being sent to L&D. She stated, "No. The person at the desk told the Volunteer to take me to the Labor and Delivery area."

RN #4 escorted Patient #2 to the patient care area to be assessed. RN #4 was asked if she does the medical screening for the L&D patients. She stated, "Yes. The nurses do it if the patient's have a private physician. They will ask us to check the patient and call them back with what the exam looked like. We let them know and if everything is ok then we discharge them home. If the patient is without a physician, we call the resident to examine them and they are listed under MD #54. He is the attending over the resident program."

The surveyor then interviewed the L&D Charge Nurse (RN #33). She was asked if the resident or physician performs the medical screening for patient's that present to the L&D. She stated, "No. The RN's do the medical screening." She was asked what the responsibilities of the Triage Nurse are. She stated, "The triage nurse gets the patient's to sign the consents, fills out the doctor's order sheet, performs maternal vital signs (VS), monitors the fetal heart rate (HR), uterine contractions, pain and medical history." She was asked if the attending physician comes in to see the patient when he is notified one of his or her patient's have presented to L&D. She stated, "No. Not all the time. They have privileges to see the fetal strip on a computer." She was asked if the residents perform care on the patients. She stated, "Yes, with help of the attending."

At 4:00 P.M. on 06/29/11 the surveyor interviewed Personnel #2, the ED Nurse Manager. She was asked if the nurses perform MSE's in the ED. She stated, "No. The nurses perform triage and the physician's do the medical screening." She was asked if the nurses make the determination when the patient's are taken back to the main ED or Fast Track to see a physician. She stated, "Yes. We use the 5 level triage system. We make the determination based on the triage system who is seen first by the physician." She was asked if the Paramedic checking in the patient's performs triage. She stated, "The paramedic does a quick check based on their complaint and makes the determination which patient needs to see the nurse first." She was asked if it is the ED policy to send patient's to L&D without medical screening. She stated, "We send all of our patient's that are greater than 20 weeks pregnant to L&D for screening unless they are trauma patients." She was asked if it is the hospital policy to send pregnant patient's to L&D with a volunteer. She stated, "Yes, if the other personnel are busy."

At 5:00 P.M. on 06/29/11 the surveyor interviewed the CNO (Personnel #1). She verified the hospital policies and procedures were not followed in regards to inquiring about the patient's method of payment or insurance prior to providing MSE's.



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TEXAS HEALTH HARRIS METHODIST HURST-EULESS-BEDFORD ->

Report No. 1538

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

TEXAS HEALTH HARRIS METHODIST HURST-EULESS-BEDFORD

1600 HOSPITAL PARKWAY BEDFORD, TX 76022 Aug. 3, 2011

VIOLATION: PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES

Tag No: A0122

Based on interview and record review, the facility did not follow their grievance process, in that, they did not meet their policy's specified time frames for a grievance, that "requires a written response or acknowledgement of receipt within seven days," for 1 of 1 patients (Patient #1).

Findings included:

It was reported that complaints were made regarding three hospitalization s for Patient #1 during 2010 (07/29/10, 07/30/10 and 11/24/10), and there had been no response from anyone.

Risk Management data revealed a verbal complaint to the facility was made on 09/28/10, through a telephone call to the facility's business office. The complaint was routed to the Risk Manager (Personnel #2) that day, and was listed on the facility's grievance log for that date. Copies of correspondence between the facility Risk Manager and Patient #1, recorded the first response to the 09/28/10 grievance, was a letter sent 14 days later, on 10/12/10 from the Risk Manager (Personnel #2).

In an interview at 2:45 PM on 08/02/11 with the Risk Manager (Personnel #2), when asked if the first response to the 09/28/10 grievance regarding Patient #1 was within the 7 day timeframe required by the facility, she said "no," and verified this letter had been sent 14 days later, on 10/12/10.

Policy & Procedure:

The facility's "Patient Grievance Management" policy, last revised 03/09, noted the following:

5.1 "...the following complaints are considered a grievance, and require a written response or acknowledgement of receipt within seven (7) days:"

5.1.1 "Verbal or written complaints regarding patient abuse, neglect or harm to the patient when in the hospital."



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Tag No: A0395

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PROVIDENCE MEMORIAL HOSPITAL ->

Report No. 1453

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

PROVIDENCE MEMORIAL HOSPITAL 2001 N OREGON ST EL PASO, TX 79902 July 22, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on review of the clinical record for Patient #1, staff interviews, and facility investigation, a psychosocial assessment was not completed when Patient #1 was admitted to the hospital. Patient #1 attempted suicide in the hospital on the day after admission and died the next day as a result of injuries from the suicide attempt. By omitting the psychosocial assessment, the patient was deprived of the opportunity to discuss, request or receive treatment for his depression and recent suicide attempt at home.

Findings were:

Review of the clinical record for Patient #1 revealed that he was admitted to the hospital on 7-11-11 for complaints of abdominal pain and chronic diarrhea. Review of the nursing admission assessment and history conducted at 1:30 pm on 7-11-11, revealed there was no psychosocial assessment or suicide assessment completed with this patient. This was confirmed in an interview with Staff #1 and Staff #2. The patient attempted suicide by hanging himself with a cord while in the hospital bathroom and was found unresponsive. Review of the clinical record for Patient #1, the facility 's investigation, and staff interviews, revealed that the patient had been depressed and had attempted suicide by hanging at home prior to this hospital admission. This information was not revealed to the hospital staff until after the attempted suicide; however this information might have been elicited from the patient had a psychosocial assessment been conducted per policy, yet the patient was not afforded this opportunity. By omitting the psychosocial assessment, the patient was deprived of the opportunity to discuss, request or receive treatment and precautionary measures related to his depression and recent suicide attempt at home.

Review of facility policies and the facility 's investigation revealed that the psychosocial assessment is a required component of an admission to the hospital. This was confirmed in an interview with Staff #1 and Staff #2.

VIOLATION: RN SUPERVISION OF NURSING CARE

Based on review of the clinical record for Patient #1, staff interviews, and facility investigation, a psychosocial assessment was not completed when Patient #1 was admitted to the hospital, which did not afford Patient #1 the opportunity to discuss, request or receive treatment and precautionary measures related to his depression and recent suicide attempt at home. Patient #1 attempted suicide in the hospital on the day after admission and died the next day as a result of injuries from the suicide attempt.

Findings were:

Review of the clinical record for Patient #1 revealed that he was admitted to the hospital on 7-11-11 for complaints of abdominal pain and chronic diarrhea. Review of the nursing admission assessment and history at 1:30 pm on 7-11-11, revealed there was no psychosocial assessment or suicide assessment completed with this patient. This was confirmed in an interview with Staff #1 and Staff #2. Patient #1 attempted suicide by hanging himself with a cord while in the bathroom and was found unresponsive. After resuscitation, the patient was transferred to the Intensive Care Unit in a comatose state and never regained consciousness. On 7-13-11, life support was withdrawn at 9:10 pm, and the patient 's death occurred at 9:31 pm.

Review of t	facility policies and the facility '	s investigation	revealed that the	psychosocial	assessment	is a required	component of	f an
admission.	This was confirmed in an inter	view with Staff	#1 and Staff #2.	-		·	•	



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July 22,

Tag No: A0450

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HUMBLE SURGICAL HOSPITAL, LLC ->

Report No. 1783

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

HUMBLE SURGICAL HOSPITAL, LLC

1475 FM 1960 BYPASS RD E UNKNOWN, TX None

VIOLATION: MEDICAL RECORD SERVICES

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview the facility failed ensure 12 of 36 medical records reviewed were accurate and completed in a timely manner. (Patient #'s 1, 3, 5, 8, 9, 11, 26, 27, 31, 32, 33, 36).

Findings include:

Patient ID # 1 was seen in the emergency department on 3/27/11. The emergency room physician record was not signed by a physician. Patient ID #3 was seen in the emergency department on 2/5/11. A physician order for a Stat X-ray was ordered but the order was not timed. Further, the nursing notes stated a nurse gave Tylenol but the medication administration record did not reflect Tylenol as being administered to the patient.

Patient ID # 5 was seen in the emergency department on 6/11/11. The medical record did not have any discharge instructions.

Patient ID # 8 was seen in the emergency room on [DATE]. The medical record did not have a nursing triage sheet.

Patient ID # 9 was admitted on [DATE] and had surgery. The operative report dated 1/27/11 was not signed by a physician. A telephone order for Dilaudid on 1/28/11 was not signed by a physician.

Patient # 11 had an outpatient procedure done on 6//20/11. The operative report was not signed at the time of this review.

Patient # 26 had a procedure on on 5/3/11. The operative report was not signed at the time of this review.

Patient # 27 had an outpatient procedure done on 5/24/11. There was no operative report in his chart at the time of review. Patient # 31 had an outpatient procedure done on 6/10/11. The operative report was not signed at the time of review.

Patient # 32 had an outpatient procedure done on 5/16/11. There was no operative report in the chart at the time of review.

Patient # 33 had an outpatient procedure done on 6/28/11. The operative report was not signed at the time of review. Patient # 36 had a procedure done on 4/17/11. The operative report was not signed at the time of review.

Review of facility's medical record policy titled "Medical Records Completion Requirements" Policy number RC 01. (no date) Policy states "It is the policy of the medical staff to maintain complete medical records on all of the hospital's patients, including but not limited to each patient's history and physical examination, operative notes, discharge summaries, and a comprehensive audit of all the patients medical records to ensure that they are complete." # 4 states " Medical records must be completed and signed within thirty (30) days of discharge".

Interview with Employee # 100 medical record person on 7/14/11 at 230 PM revealed that the facility is aware of the incomplete medical records and the physicians involved have been notified.

VIOLATION: PHARMACEUTICAL SERVICES Tag No: A0490 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

Based on interview and record review the Hospital failed to provide pharmaceutical services to meet the needs of patient ID# 9.

Findings include:

The Medical Record of Patient ID# 9 reflected that this was a [AGE] year-old patient that had back surgery on 1/27/11. Two days after surgery on 1/29/11 the patient was found unresponsive, had a cardiac arrest, was transferred to another hospital and was pronounced dead at the emergency room of the receiving hospital. The autopsy report showed the patient died accidentally as a result of "combined sedative effect."

Record review of patient ID# 9's medical record reflected there were physician orders for a total of Nine Central Nervous System depressants at the time of patient ID# 9's death (Hydrocodone, Morphine, Valium, Dilaudid, Fentanyl, Neurotin, Wellbutrin, Benadryl, and Soma). Narcotics were ordered by intravenous pump infusion, by patch to absorb into the body, intravenously, intramuscularly, and orally.

Hydrocodone: Opiate Narcotic Analgesic Morphine: Potent Opiate Analgesic Valium: Benzodiazepine (muscle relaxant) Dilaudid: Potent Opiate Analgesic Fentanyl: Potent Narcotic Analgesic Neurotin: Used to relieve pain Wellbutrin: Depression Benadryl: Sleep or itching Soma: Muscle Relaxant

Interview 7/13/11 at 2:20 p.m. with the Consultant Pharmacist (ID# 67) revealed he reviewed patient ID# 9's medication profile on 1/28/11 (the day before patient ID# 9 died). No concerns were noted. The Pharmacist stated that after his review of the patient record a Consultant Pain Specialist Physician called in verbal telephone orders on 1/28/11 for medication changes. The Pharmacist had left the hospital on [DATE] before the new orders were called in.

The Pharmacist stated he did not personally review the medical record for patient ID# 9 after his death but the nurse (ID# 76) assigned to the pharmacy reviewed the medication orders. The Pharmacist stated that he did review the report of the pharmacy nurse but he did not make any formal recommendations to the Governing Body. The Consultant Pharmacist stated he visits the hospital once per week, the minimum Licensure requirements of the Texas State Board of Pharmacy for Hospitals.

The pharmacy nurse (ID# 76) acknowledged 7/14/11 at 11 a.m. that she reviewed the medical record of patient ID# 9 and identified several errors relating to medication administration but no recommendations were made by the pharmacy staff, only a report of the errors was submitted to Administration.

Record review of a "Pharmacy medication report on patient ID# 9" stated "The following errors were found after review of the medication record:"

- -Lactated Ringers solution not documented on the medication administration record. Not sure when it was discontinued but was told that the Lactated Ringers was discontinued and the Patient Controlled Anesthesia was the only fluid going. Orders were Lactated Ringers at 90 ml per hour to convert to saline lock when tolerating well.
- -Pepcid 20 mg was ordered IV or PO every 12 hours....None was ever documented as being given on the medication administration record....
- -Valium 5 mg PO / IV was written but both IV and PO were written on the same line on the medication administration record so when times were recorded it was not clear which route was given until you compare with narcotic sign out record...the IV route was given until you compare with narcotic sign out records show it was given IV the first 3 doses.....
- -Reglan 10 mg po three times daily ordered times three doses on 1/27/11 was shown to have only received one dose at 6 a.m. on 1/28/11.
- -Colace 100 mg po twice daily orders were written on 1/27/11 but the medication administration record shows no colace was ever given. It is on the medication administration record to be given as ordered but none documented.
- -Dulcolax 10 mg po every night was ordered unless loose stools and is written on the medication administration record to be given at bedtime but no documentation that any dulcolax was ever given.
- -Benadryl 25 mg or 50 mg po ordered on [DATE] every 6 hours as needed for itching / sleep....when written on the medication administration record the dosages should be on two separate lines indicating if 25 mg or 50 mg was given...documentation on the medication administration record that benadryl was given but dosage amount not documentedwas 25 mg given or 50 mg given?
- -Ambien 10 mg po at bedtime ordered on [DATE] and written that way on the medication administration record but no ambien was given or signed out on the in-patient narcotic sheet.
- -Vicodin Extra Strength (7.5mg / 325 mg hydrocodone) ordered on [DATE] to give 1 or 2 tabs every 4 to 6 hours as needed for moderate pain. We do not carry the Extra Strength (7.5 mg) Vicodin....we only have 5 mg / 500 mg Vicodin. When written on the medication administration record it was written as we have it (5 mg / 500 mg) but the surgeon should have been notified of the dosage we carry and written as an order that the dosage was OK.....can not find where surgeon was ever contacted...therefore orders were not carried over to medication administration record correctly. Also the 1 or 2 tabs were on the same line and there is no documentation if one or two tabs

were given. If you go to the narcotic record you then find out two tabs were given...not documented on the medication administration record.

- -Norco 10 / 325 administer 1 or 2 tabs ordered on [DATE] every 4 to 6 hours as needed for moderate pain. The one or two tabs were written on the same line on the medication administration record so when Norco was given there is no record if one or two tabs were given. You have to look on the narcotic sign out record to find out that 2 tabs were always given.
- -Orders written on 1/27/11 to continue home meds.....meds were not brought in by family until 1/28/11 and were identified in the pharmacy and returned to in-patient area and locked up in patient drawer. Meds were given as ordered 1/28/11 except Zyrtec was listed to be given at bedtime but it was given at 12:00....not sure if this was because he did not receive it the night before because he had not brought in home meds until 1/28/11. On 1/29/11 the medication administration record shows that 5 home meds were to be given at 0900 but no documentation was made if meds were given that morning.
- -On 1/28/11 orders from the Consultant Pain Specialist at 1:30 p.m. for Soma 350 mg three times daily. The medication administration record show it was given at 2 p.m. but the next two doses were circled and were not given according to the medication administration record and narcotic sign out record...The 10 p.m. dose circled states held because patient sleeping however medication administration record shows patient did receive Norco po and Morphine 10 mg IM at the same time at 10 p.m.
- -Neurontin 600 mg po four times daily ordered on [DATE] by the Pain Specialist and patient received dose at 3:15 p.m. and 9 p.m. but no doses are documented as being given on the morning of 1/29/11 as was ordered.
- -Dilaudid Patient Controlled Analgesia pump was ordered at 1:30 p.m. to be decreased to 1/2 the previous amount and shows this was done between 3:45 p.m. and 4 p.m. on 1/28/11. (over two hours later)
- -The Norco order on 1/28/11 to be given if OK with the Pain Management Physician was continued but no orders seen from the Pain Management Physician to continue the Norco was OK and it was given until 6 a.m. on 1/29/11.
- -On 1/28/11 at 11:30 p.m. the patient was ordered to have have Valium 5 mg po but Valium 10 mg IV was signed out and documented on the narcotic sheet as given but not shown on the medication administration record.

The above "Pharmacy medication report on patient ID# 9" failed to address

- 1) The excessive amounts of Central Nervous System Depressants administered to the patient during his stay in the hospital from 1/27/11 to 1/29/11 until his death.
- 2) The duplication of narcotic orders

Review of the medication list for patient ID# 9 revealed the following Central Nervous Depressants were administered to the patient:

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1:00 p.m. Dilaudid Patient Controlled pump started
1:40 p.m. Valium 5 mg IV
1:40 p.m. Benadryl 25 mg po
5:30 p.m. Morphine 10 mg IM
5:30 p.m. Vicodin 10 mg po
7:00 p.m. Norco 20 mg po
7:30 p.m. Benadryl 25 mg po
7:40 p.m. Valium 5 mg IV
8:30 p.m. Morphine 10 mg IM
11:30 p.m. Morphine 10 mg IM
12 a.m. Norco 20 mg po
1:00 a.m. Valium 5 mg IV
2:30 a.m. Morphine 10 mg IM
3:00 a.m. Benadryl 25 mg po
4:00 a.m. Norco 20 mg po
6:00 a.m. Morphine 10 mg IM
7:00 a.m. Valium 5 mg IV
9:00 a.m. Norco 20 mg po
10:00 a.m. Morphine 3 mg IV
10:00 a.m. Robaxin 750 mg po
11:25 a.m. Valium 5 mg po
12:00 p.m. Wellbutrin XL 300 mg po
2:00 p.m. Novaratio 600 mg po
3:15 p.m. Neurontin 600 mg po
3:35 p.m. Valium 5 mg po
4:00 p.m. Duragesic Patch 50 mcg applied
4:00 p.m. Dilaudid pump rate decreased
4:35 p.m. Morphine 3 mg IV
6:00 p.m. Norco 20 mg po
7:00 p.m. Benadryl 25 po
7:00 p.m. Morphine 10 mg IM
7:30 p.m. Morphine 3 mg IV
7:30 p.m. Valium 5 mg po
9:00 p.m. Neurontin 600 mg po
10:00 p.m. Morphine 10 mg lM
10:00 p.m. Norco 20 mg po
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10:30 p.m. Morphine 3 mg IV 11:00 p.m. Valium 5 mg po

1/29/11 1:00 a.m. Benadryl 25 mg po 1:00 a.m. Morphine 10 mg IM 1:30 a.m. Morphine 3 mg IV 2:00 a.m. Norco 20 mg po 3:30 a.m. Valium 5 mg po 4:00 a.m. Morphine 10 mg IM 4:30 a.m. Morphine 3 mg IV 6:00 a.m. Norco 20 mg po

Record review of the physician orders for patient ID# 9 revealed a duplication of narcotic orders as follows:

Physician Orders 1/27/11 at 11:30 a.m.:

- -"Valium 5 mg PO / IV every 6 hours as needed" (the physician did not mark if he wanted the Valium administered orally or intravenously, so therefore the nursing staff gave Valium both ways (orally and intravenously) at intervals of less than 6 hours apart) The Physician order also did not stipulate the reason to give this medication, the order stated "as needed."
- -Vicodin (hydrocodone) 7.5 mg, 1 2 tabs every 4 6 hours as needed for moderate pain or for break through pain
- -Norco 10 mg (generic hydrocodone) 1 2 tabs every 4 6 hours as needed for moderate pain or for break through pain
- -Morphine 10 mg IM every 3 4 hours as needed for severe pain or for break though pain

Physician Orders 1/28/11 at 9:45 a.m.:

-Morphine 3 mg IV every 3 - 4 hours as needed for break though pain

(The Morphine was ordered intramuscularly and intravenously and was a duplication of a narcotic order for "break through pain." The hydrocodone was ordered in a brand name form and generic form and was also a duplicate narcotic order)

Record review of a document titled "Pharmacy Requirements When a Patient is admitted to the In-patient Unit" (no date) stated "When a patient is admitted to the in-patient unit - records need to be completed and interactions checked before any medications are administered......All this needs to be done because we do not have a Full Time Pharmacist and Pharmacy. The Pharmacist comes in once a week and reviews all the patient charts and pharmacy."

Record review of a contract between the hospital and the consultant pharmacist dated 7/1/10 stated "Services: The services to be provided will include review of medication records, orders and Quality Assurance as required by the Texas State Board of Pharmacy, compliance with Medicare Regulations, Inservices and, if desired, the establishment of a formulary for the hospital."

VIOLATION: UNUSABLE DRUGS NOT USED

Based on observation, interview, and record review revealed the hospital failed to ensure the following:

1) Multi-dose vials of medications that had been previously opened were not dated as to when they were first opened in operating room number 's 4 and 5.

Tag No: A0505

- 2) Single dose vials of medication that had been previously opened were not discarded in operating room number 's 4 and 5.
- 3) Expired medications were not removed from stock in operating room #5

Findings include:

Observation 7/13/11 at 1 p.m. revealed the following medications:

OR # 4 Inside the Anesthesia drug cart.

- 1 Nimbex 5 ml single dose vial (neuromuscular blocking drug or skeletal muscle relaxant) The vial had been previously opened.
- 1 Rocuronium 5 ml single dose vial (provide skeletal muscle relaxation during surgery or mechanical ventilation). The vial had been previously opened.
- 1 Etomidate 10ml single dose vial (a short-acting, hypnotic nonbarbiturate IV agent for induction of general anesthesia). The vial had
- been previously opened.

 2 Esmolol HCL 10 ml single dose vial (Short-term management of supraventricular tachyarrhythmias and noncompensatory sinus tachycardia). The vial had been previously opened.

1 - Dexamethasone multi-dose vial (This medication is a corticosteroid hormone. It decreases your body's natural defensive response and reduces symptoms such as swelling and allergic-type reactions). The vial had been previously opened and was not dated as to when it was first opened.

OR # 5 Inside the Anesthesia drug cart:

- 4 vials Neo-Synephrine 10 mg/ml (This medicine may used to treat very low blood pressure or serious heart problems such as irregular heartbeat). The vial had been previously opened and was
- 1 vial Phenylephrine Hydrochloride Solution opened 2/23/11
- 1 vial Phenylephrine Hydrochloride Solution expired 06/2011
- 1 vial Nimbex 2mg/ml (Used as an adjunct to general anesthesia, or sedation to relax skeletal muscles, and to facilitate tracheal

intubation and mechanical ventilation). The vial had been previously opened and was labeled single dose vial.

6 vials -Hydrochloride 20mg/ml 1 ml (single dose) expired 3-2011 (Directly relaxes vascular smooth muscle to cause peripheral vasodilation, decreasing arterial BP and peripheral vascular resistance).

1 pre filled syringe- 50% Magnesium Sulfate 5grams/10ml expired 1 May 2011. (Indicated for immediate control of life threatening convulsions in the treatment of severe)

- 1 -Marican 0.25% multi-dose vial (Used to prevent or relieve pain, used after surgery to relieve pain). The vial had been previously opened and was not dated as to when it was first opened.
- 1 Prefilled syringe -Epinephrine1:10,000 1 mg (0.1mg/ml) expired April 2011 (Drug of choice for treating bronchoconstriction and hypotension resulting from anaphylaxis as well as all forms of cardiac arrest. Rapid injection produces a rapid increase in systolic pressure, ventricular contractility, and heart rate)

OR # 5 Inside a locked drawer.

1 Vial - Dexamethasone Sodium Phosphate 4mg/ml multi-dose vial (used to treat conditions such as arthritis http://www.medicinenet.com/script/main/art.asp?articlekey=7776, blood/hormone/immune system disorders, allergic reactions, certain skin and eye conditions, breathing problems, certain bowel disorders, and certain cancers). The vial had been previously opened and was not dated as to when it was first opened.

Record review of a policy titled " Medication Management Dating of Sterile Containers " (no date) stated " Single Dose Vials: Discard 24 hours after opening. " The policy further stated " Multiple dose vials: Discard 28 days after opening. Must be labeled with date, time and initials of person opening."

The Operating Room Nursing Director (ID# 93) stated 7/13/11 at 1 p.m. that only the contract anesthesia personnel have the combination number for the anesthesia carts.

VIOLATION: GOVERNING BODY Tag No: A0043

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the Hospital failed to have an effective Governing Body. The Governing Body failed to ensure the hospital 's Policies and Bylaws were adhered to as follows:

1) Failed to ensure that the Medical Staff is accountable to the Governing Body for the quality of care provided to patient ID# 9. The Governing Body failed to conduct physician peer reviews on two physicians (ID# 56 and 62) that prescribed narcotic orders for patient ID# 9 resulting in the death of the patient as a result of "combined sedative effects."

(Cross reference deficiency A0263 - Quality Assessment)

2) Failed to provide supervision of nursing care by a Registered Nurse as per hospital policy

(Cross reference deficiency A0385 - Nursing Services)

3) Failed to provide pharmaceutical services to meet the needs of patient

(Cross reference deficiency A0490 - Pharmaceutical Services)

4) Failed to provide Emergency Services to meet the emergency needs of patients in accordance with acceptable standards of practice.

(Cross reference deficiency A1100 - Emergency Services)

Findings include:

Patient ID# 9

Medical record review revealed this was a [AGE] year old male that was admitted on [DATE]. According to the consent form and operative report dated 1/27/11 the patient had the following surgical procedure: "Transforaminal Interbody Lumbar Fusion." The surgeon was physician ID# 62 and the "assistant" was physician ID# 56 according to the operative report.

Record review of a history and physical dated 1/29/11 for patient ID# 9 written by the surgeon (ID# 62) caring for this patient stated "I received a phone call earlier this afternoon that the patient had coded on the floor and cardiopulmonary resuscitation (CPR) had been initiated. He had been transferred to a Northeast Hospital for further resuscitation. Unfortunately, he was not resuscitated. "

Record review of the autopsy report for patient ID# 9 dated 3/31/11 stated

"Cause of death: Hypertensive cardiovascular disease complicated by combined sedative effects of fentanyl, diazepam, diphenhydramine, and hydrocodone with diffuse alveolar damage and acute bronchopneumonia. Manner of Death: Accidental. "

The Medical Record for patient ID# 9 showed that the Surgeon (ID# 62) consulted a Pain Specialist physician (ID# 56) on 1/28/11 due to the patients continued complaint of pain after surgery. The Pain Specialist Physician called in verbal telephone orders on 1/28/11 to adjust narcotic pain medication and Central Nervous System Depressants without evaluating the patient on 1/28/11.

Review of the physician orders for patient ID# 9 revealed the patient had concurrent orders for a total of Nine different "Central Nervous" System Depressants" at the time of his death. (Hydrocodone, Morphine, Valium, Dilaudid, Fentanyl, Neurotin, Wellbutrin, Benadryl, and

Interview 7/15/11 at 1:30 p.m. with the Medical Director (ID# 73) revealed he was notified about the death of patient ID# 9 on 1/29/11. The Medical Director stated that the case was discussed in a Quality Assurance meeting but nothing was formally documented. The Medical Director stated there were several concerns relating to the patient's death. One concern was about a a pain medicine physician (ID# 56) being consulted and calling in verbal telephone orders for pain medication and not physically evaluating patient ID# 9 on 1/28/11. Another concern was " a nurse medicating the daylights out of this guy. " The Nurse was suspended.

The Medical Director stated he had not seen the autopsy report. The Medical Director further stated that physician / nurse peer reviews for the two physicians (ID# 58 and 62) and nurse (ID# 96) caring for patient ID# 9 have not been done to date because they are still awaiting the toxicology reports to see if the patient died of a narcotic overdose or aspiration. The Medical Director stated he was not aware the hospital received the autopsy / toxicology report on May 15th, 2011 per the Administrator and was not aware the findings showed accidental death due to combined sedative effects.

The Medical Director also stated "he did not initially know that an LVN (Licensed Vocational Nurse) was caring for patient ID# 9 when he coded and thought that was an isolated incident" (having only an LVN in the hospital as nursing staff). The Medical Director stated that during a Quality Assurance meeting it was discussed changing the rule to having two Registered Nurses on the floor at all times. The Medical Director was not aware the current practice of the hospital remains with staffing only a Licensed Vocational Nurse at times to care for patients without a Registered Nurse available in the hospital to supervise care.

Record review of Governing Body Bylaws (no date) revealed the following:

" The Governing Body of the Facility, hereto referred as the Board of Manager, shall assume full legal responsibility for governing the organizations total operations to support safe and quality patient care, treatment and services.....Medical Director: The Medical Director shall be responsible for the professional and ethical standards of the Medical Staff and shall be the liaison with the Medical Staff."

Further review of the Governing Body Bylaws in section 7.3 titled "Committees" stated the following: "7.3.5: Provide ongoing review of information available regarding the competence of Medical Staff Members and Allied Health Professionals. 7.3.10: Review and access the quality of care provided by Medical Staff Members. 7.3.11: Serve as the peer review committee when required under applicable State Law and perform all duties associated therewith."

Record review of the only Medical Executive Meeting held in 2011 on April 18th revealed discussion in the meeting minutes that stated "Incident reports binder and discussion." An incident report for patient ID# 9 stated "Peer review was performed on this case on February 10th, 2011, in the absence of the toxicology report and the autopsy. This review is preliminary and should be followed up on when the autopsy is received."

Physician peer reviews were not conducted for the two physicians (Physician ID#'s 56 and 62) caring for patient ID# 9 per interview with the Administrator on 7/13/11 at 1:40 p.m. The Administrator stated the hospital was awaiting the autopsy report they received on 5/15/11 before conducting physician peer reviews. The Administrator stated the case of patient ID# 9 was discussed in the Medical Executive Meeting but nothing was formally written in the minutes.

Record review of a policy titled " Plan For the Provision of Care " (no date) stated " Experienced Registered Nurses who are Team Leaders work to address department specific issues and are present 24 hours during the week, 24 hours on holidays, and 24 hours on weekends. "Further review of a policy titled "Assignment of Care" (no date) stated "Purpose: To establish a guideline for making patient care assignments. Unit will be staffed according to the following census: 1 - 3 in-patients / observation patients will be cared for by (1) RN (Registered Nurse). Patient ID# 9 was the only in-patient on 1/29/11 and was being cared for by a Licensed Vocational Nurse at the time of his arrest.

PHARMACY

Record review of patient ID# 9's medical record reflected there were physician orders for a total of Nine Central Nervous System depressants at the time of patient ID# 9 's death. The autopsy report showed the patient died accidentally as a result of "combined sedative effect."

Although the Consultant Pharmacist (ID# 67) was aware of the amount of narcotics and Central Nervous System depressants prescribed to this patient, the pharmacist stated 7/13/11 at 2:20 p.m. no formal recommendations were made to the hospital after the death of patient ID# 9. Also the pharmacy nurse (ID# 76) acknowledged 7/14/11 at 11 a.m. that she reviewed the medical record of patient ID# 9 and identified errors relating to medication administration but no recommendations were made by the pharmacy staff, only a report of the errors was submitted to Administration.

Record review of a document titled "Pharmacy Requirements When a Patient is admitted to the In-patient Unit" (no date) stated "When a patient is admitted to the in-patient unit - records need to be completed and interactions checked before any medications are administered.......All this needs to be done because we do not have a Full Time Pharmacist and Pharmacy. The Pharmacist comes in once a week and reviews all the patient charts and pharmacy."

EMERGENCY SERVICES

The Code record dated 1/29/11 for patient ID# 9 reflected that the emergency room Physician and a Paramedic responded to the code on the nursing unit and left the emergency room unattended. The emergency room Physician (ID# 66) stated 7/15/11 at 3:25 p.m. she instructed the staff to call " 911 " to get more help " and to transfer the patient to a higher level of care. The hospital did not address the need for more staffing or the need to stabilize the patient before calling "911." No patients were in the emergency room at the time of the

The Ambulance record for patient ID# 9 dated 1/29/11 stated that when the paramedics arrived (ten minutes after the patient was found unresponsive) the patient was found cyanotic (blue), the breathing tube was not properly inserted, the intravenous line was not functional and the patient was bleeding onto the floor from the intravenous line. The hospital did not address the need for inservices / competencies regarding code situations.

VIOLATION: QAPI Tag No: A0263

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the hospital failed to have an effective quality assessment and performance improvement program. The Quality Assurance program failed to identify problems and take corrective actions associated with patient ID# 9 's death.

(Cross reference deficiency A0043 - Governing Body)

(Cross reference deficiency A0385 - Nursing Services)

(Cross reference deficiency A0490 - Pharmaceutical Services)

(Cross reference deficiency A1100 - Emergency Services)

Findings Include:

The Medical Record of Patient ID# 9 reflected that this was a [AGE] year-old patient that had back surgery on 1/27/11. Two days after surgery on 1/29/11 the patient was found unresponsive and had a cardiac arrest, was transferred to another hospital and was pronounced dead at the emergency room of the receiving hospital.

Review of Quality Assurance meeting minutes dated 4/18/2011, a summary of the Incident and a Root Cause Analysis for patient ID# 9 provided by the Administrator revealed the following problems were not identified by the Quality Assurance committee regarding patient ID# 9's death on 1/29/11, therefore no actions were taken to prevent a similar occurrence:

- 1) The Medical Record for patient ID# 9 showed that the Surgeon (ID# 62 consulted a Pain Specialist physician (ID# 56) on 1/28/11 due to the patients continued complaint of pain after surgery. The Consultant Pain Specialist Physician called in verbal telephone orders on 1/28/11 to adjust narcotic pain medication and Central Nervous System Depressants without coming to the hospital and evaluating the patient on 1/28/11.
- 2) There were physician orders for a total of Nine Central Nervous System depressants at the time of patient ID# 9 's death according to physician orders. The autopsy report showed the patient died accidentally as a result of "combined sedative effect." Physician peer reviews were not conducted for the two physicians (Physician ID#'s 56 and 62) caring for patient ID# 9 per interview with the Administrator on 7/13/11 at 1:40 p.m. The Administrator stated the hospital was awaiting the autopsy report they received on 5/15/11 before conducting physician peer reviews.
- 3) Although the Consultant Pharmacist (ID# 67) was aware of the amount of narcotics and Central Nervous System depressants prescribed to this patient, the pharmacist stated 7/13/11 at 2:20 p.m. no formal recommendations were made to the hospital after the death of patient

ID# 9. Also the pharmacy nurse (ID# 76) acknowledged 7/14/11 at

- 11 a.m. that she reviewed the medical record of patient ID# 9 and identified errors relating to medication administration but no recommendations were made by the pharmacy staff, only a report of the errors was submitted to Administration. The "Pharmacy medication report on patient ID# 9" failed to address the following:
- A) The excessive amounts of Central Nervous System Depressants administered to the patient during his stay in the hospital from 1/27/11 to 1/29/11 until his death.
- B) The duplication of narcotic pain orders (Morphine and Hydrocodone)
- 4) The Code record dated 1/29/11 for patient ID# 9 reflected that the emergency room Physician and the Paramedic responded to the code on the nursing unit and left the emergency room unattended. The emergency room Physician (ID# 66) stated 7/15/11 at 3:25 p.m. she instructed the staff to call " 911 " to get more help " and to transfer the patient to a higher level of care. The hospital did not address the need for more staffing or the need to stabilize the patient before calling "911."
- 5) The Ambulance record for patient ID# 9 dated 1/29/11 stated that when the paramedics arrived (ten minutes after the patient was found unresponsive) the patient was found cyanotic (blue), the breathing tube was not properly inserted, the intravenous line was not functional and the patient was bleeding onto the floor from the intravenous line. The hospital did not address the need for inservices / competencies regarding code situations.
- 6) Staffing roster on 1/29/11 showed that a Licensed Vocational Nurse (LVN) was assigned as the only staff nurse in the hospital when the patient arrested. Review of the LVN 's personnel file showed this nurse was an agency nurse and her personnel file did not reflect any documentation of the hospital providing orientation. The hospital did identify the agency LVN sent to cover the shift on 1/29/11 was not familiar with the hospital. The hospital's corrective action stated "assure staff is competent and qualified for the type of patient care needed." Record review of 3 additional agency LVN personnel files (ID#'s 97, 98, 99) revealed they have worked at the hospital since the incident on 1/29/11 (May, June, and July 2011) and their personnel files also lacked documentation of hospital orientation. The Hospital has not ensured that current agency Licensed Vocational Nurses working in the hospital have documentation of orientation.
- 7) Nursing records and staffing reports reflected that on 1/29/11 at 7 a.m. a Licensed Vocational Nurse (LVN ID# 70) was the only staff nurse in the hospital assigned to care for this in-patient (ID# 9). Patient ID# 9 was the only in-patient in the hospital on [DATE]. A Registered Nurse was not available in the hospital on [DATE] to supervise patient care. The Medical Director stated 7/15/11 at 1:30 p.m. that during a Quality Assurance meeting it was discussed changing the rule to having two Registered Nurses on the floor at all times but

no changes were made to staffing patterns. The Medical Director was not aware the current practice of the hospital remains with staffing only a Licensed Vocational Nurse at times to care for patients without a Registered Nurse available in the hospital to supervise care. The only staff on duty 1/29/11 when patient ID# 9 was found unresponsive was an emergency room physician, a paramedic, a Licensed Vocational Nurse and a security guard. The hospital has not changed its staffing practices since the death of patient ID# 9.

Record review of a policy titled "Job Description - Licensed Vocational Nurse" dated 6/10/10 stated "Under the general supervision of the Registered Nurse staff, nurse provides direct nursing care in accordance with established policies and procedures of the hospital."

Record review of a policy titled "Assignment of Care" (no date) stated "Purpose: To establish a guideline for making patient care assignments. Unit will be staffed according to the following census: 1 - 3 in-patients / observation patients will be cared for by (1) RN (Registered Nurse). Patient ID# 9 was the only in-patient on 1/29/11.

8) Interview 7/15/11 at 1:30 p.m. with the Medical Director (ID# 73) revealed he was notified about the death of patient ID# 9 on 1/29/11. The Medical Director stated there were several concerns relating to the patient's death. One concern was about " a nurse (ID# 96) medicating the daylights out of this guy. " Record review of a "Summary of Incident" for patient ID# 9 revealed that Registered Nurse ID #96 was suspended on 2/1/11. The hospital did not conduct a nursing peer review of this nurse.

Record review of the Governing Body Bylaws (no date) in section 7.3 titled "Committees " stated the following: " 7.3.5: Provide ongoing review of information available regarding the competence of Medical Staff Members and Allied Health Professionals. 7.3.10: Review and access the quality of care provided by Medical Staff Members. 7.3.11: Serve as the peer review committee when required under applicable State Law and perform all duties associated therewith."

Record review of a policy titled "Performance Improvement Risk Management / Patient Safety Plan" (no date) stated "Purpose: In accordance with mission, vision, and values, Humble Surgical Hospital is committed to providing high quality healthcare services in a safe environment." A section titled "Medical Executive Committee" stated "The Medical Executive Committee, composed of elected / appointed Medical Staff leaders and Administration, meets to provide oversight for all medical care rendered to patients at Humble Surgical Hospital. Medical staff peer review activities are performed according to Bylaws." Another section titled "Intense Analysis" stated "When indicated, an intense analysis is performed to identify processes needing improvement and to minimize the occurrence / recurrence of adverse outcomes....Some examples of processes and events requiring analysis include.......Sentinel Events."

On page 16 of the Performance Plan it stated "When addressing sentinel events, root cause analysis and near misses, patient notification of events, etc., reporting must be completed within 45 days of the event." The Root Cause Analysis for patient ID# 9 failed to identify the above listed problems.

Tag No: A0385

VIOLATION: NURSING SERVICES

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the Hospital failed to ensure nursing services were supervised by a Registered Nurse in the Emergency Department and the In-patient medical / surgical unit.

Findings include:

Nursing records and staffing reports reflected that on 1/29/11 from 7 a.m. to

1 p.m. a Licensed Vocational Nurse (LVN ID# 70) was the only staff nurse in the hospital assigned to care for this one in-patient (ID# 9). A Registered Nurse was not available in the hospital on [DATE] to supervise the LVN.

The Administrator confirmed 7/13/11 at 1:40 p.m. the hospital was only staffed with an LVN, Physician, Paramedic and Security Guard on 1/29/11.

Nursing notes by the LVN on 1/29/11 at 12:40 p.m. stated "Wife alerted writer patient had urinated on self, BP 128/68, Heart rate 70, difficulty arousing patient, sternal rubs attempted without response, emergency room physician notified of non-response. See Code Record. " The " Cardiopulmonary Resuscitation Record " revealed the code team consisted of a physician (ID# 66), a paramedic (ID# 68), and the LVN (ID# 70). A Registered Nurse was not available in the hospital to supervise the code of this patient.

Record review of a policy titled "Assignment of Care" (no date) stated "Purpose: To establish a guideline for making patient care assignments. Unit will be staffed according to the following census: 1 - 3 in-patients / observation patients will be cared for by (1) RN (Registered Nurse). Patient ID# 9 was the only in-patient on 1/29/11.

The Administrator (ID# 60) acknowledged 7/12/11 at 12 noon the Hospital occasionally staffs the in-patient unit with an LVN (Licensed Vocational Nurse). The Administrator stated a Registered Nurse is always on-call. The Administrator further stated that the emergency room is staffed with a physician and a paramedic.

Review of staffing records for May, June, and July 2011 revealed LVN's were assigned to care for in-patients without Registered Nurse supervision.

The Director of In-Patient Services (ID# 59) confirmed 7/15/11 at 2 p.m. that the following dates had one Licensed Vocational Nurse assigned to work the medical surgical unit with a Registered Nurse on-call.

Review of documentation from a contracted staffing agency confirmed the dates and times of assigned contracted LVN's from the staffing agency. Also, the daily hospital Census reports listed the census for each day.

Dates of In-Patient Medical/Surgical Unit staffing with an LVN as the only nurse on a shift to care for patients each day:

05/06/2011 (LVN # 99 was assigned to care for three observation patients) 05/09/2011 (LVN # 99 was assigned to care for three observation patients)

05/13/2011 (LVN # 99 was assigned to care for one in-patient and one observation patient)

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05/16/2011 (LVN # 99 was assigned to care for three observation patients) 05/17/2011 (LVN # 99 was assigned to care for one in-patient)
05/19/2011 (LVN # 99 was assigned to care for one in-patient)
05/27/2011 (LVN # 98 was assigned to care for one observation patient) 06/09/2011 (LVN # 98 was assigned to care for one observation patient) 06/13/2011 (LVN # 98 was assigned to care for three observation patients)
06/14/2011 (LVN # 98 was assigned to care for one observation patient)
06/17/2011 (LVN # 98 was assigned to care for three observation patients)
07/01/2011 (LVN # 97 was assigned to care for two in-patients)
07/02/2011 (LVN # 97 was assigned to care for two in-patients)
07/03/2011 (LVN # 97 was assigned to care for one in-patient) 07/12/2011 (LVN # 97 was assigned to care for one in-patient)
07/13/2011 (LVN # 97 was assigned to care for four in-patients)
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Record review of a policy titled "Job Description - Licensed Vocational Nurse" dated 6/10/10 stated "Under the general supervision of the Registered Nurse staff, nurse provides direct nursing care in accordance with established policies and procedures of the hospital."

emergency room

The Administrator (ID# 60) acknowledged 7/12/11 at 12 noon that the Hospital and the emergency room is only staffed with a physician and a paramedic in the evenings and on weekends if there are no in-patients in the hospital. The Administrator stated that a Registered Nurse is always on-call.

Record review of emergency room patient record #'s 1, 2, 3, 6, 7, and 8 revealed only a paramedic and a physician treated these patients. A nurse was not available to supervise care.

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ER Patient ID# 1 was treated 3/27/11
ER Patient ID# 2 was treated 3/20/11
ER Patient ID# 3 was treated 2/5/11
ER Patient ID# 6 was treated 10/10/10
ER Patient ID# 7 was treated 2/5/11
ER Patient ID# 8 was treated 4/17/11
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The Nursing ER Director (ID# 59) verified a Registered Nurse was not in the hospital when ER patient #'s 1, 2, 3, 6, 7, and 8 presented to the emergency room . The Nursing Director further stated that a Registered Nurse is always on-call but the hospital does not have a policy or protocol defining how soon the RN would need to respond to the hospital if notified.

Tag No: A0701

VIOLATION: MAINTENANCE OF PHYSICAL PLANT

Based upon observations, interviews and record reviews the hospital failed to maintain a clean/sanitary environment.

Heavy build-up [1/8 inch] of dust/lint on horizontal surfaces in the following areas. (Medical/Surgical Unit patient rooms 6 of 6, Emergency Department treatment room, Operating rooms 2, 3, 4, 5 of 6, Pre-Operative area beds 2, 3, 4, 5. PACU (Post Anesthesia Care Unit) - bed 5 & 7, on top of blanket warmer.

Finding Include:

During tour of hospital the following were observed on 07/12/2011 at 1200 PM:

Pre-operative area with nursing director (#61) Room #s 2, 3, 4, 5 were observed to have heavy dust / lint build-up (1/8 inch) on the horizontal surfaces of the cardiac monitors, paper towel/sharp dispensers, wall mounted suction canisters, TV and underneath the stretchers.

PACU (Post Anesthesia Care Unit) with nursing director (#64) on 07-12-2011 at 1215 PM. Surveyor observed heavy dust / lint build-up (1/8 inch) on top horizontal surface of blanket warmer located in rear of area unit. Room # 's 5 & 7 - Observed by surveyor dust on wall suction canister tops, top of cardiac monitors, on top of black box medication box mounted on walls for patients and the bottom of stretchers.

Medical / Surgical Unit (In-Patient Unit- 1-6 rooms) All rooms were found to have dust / lint build-up (1/8 inch) on top of cardiac monitors, pictures frames, top of lights above the beds, window blinds, window seals, and white writing boards mounted on the wall in patient rooms.

emergency room #1 was found to have heavy dust / lint build-up on top of wall mounted procedure lamp used for suturing patients.

Operating Room # 's 5 of 6 were observed with employee (#65). All operating suites observed were found to have heavy dust / lint buildup (1/8 inch) on horizontal anesthesia gas cart, anesthesia column for gas and electric outlets, white writing boards mounted on walls, wall mounted x-ray viewing lamp, return air vent and the top of the suction canisters.

Review of Humble Surgical Hospital Policy: Infection Control - Housekeeping in the Surgical Suites. Policy Number IC 14. (no date) Policy

stated the following:
"Purpose: To ensure a safe environment for patients and personnel. To maintain a clean orderly Operating Suite. To provide timely turnover in achieving a pathogen-free environment. Policy: A daily routine will be followed to assure optimum control of environment. Procedure: General Duties (f) Damp dust all flat surfaces, (h) Check operating Room tables; spot lights and room for cleanliness each morning before opening supplies. C. Terminal Daily Cleaning (b) Wash overhead surgical lights using disinfectant.

The Administrator acknowledged 7/13/11 at 2 p.m. the hospital has recently changed contract cleaning services.

The Infection Control nurse (ID# 64) stated 7/14/11 at 1:30 p.m. the hospital does not conduct surveillance rounds of the environment.

VIOLATION: EMERGENCY SERVICES

Based on interview and record review the hospital failed to meet the emergency needs of patients in accordance with acceptable standards of practice. The Hospital failed to:

1) Provide Registered Nurse supervision of care for patients presenting to the emergency room

2) Provide adequate staffing in the emergency department (the ER was left unattended when an in-patient coded on the nursing unit on 1/29/11)

Tag No: A1100

3) Provide competent emergency room staff

- 4) Provide stabilization of a patient's condition before calling "911."
- 5) Provide on-call schedule of surgeons for the emergency department

Findings include:

The Administrator (ID# 60) acknowledged 7/12/11 at 12 noon the Hospital staffs the Hospital / emergency room with a physician and a paramedic when there are no in-patients in the hospital. The Administrator stated a Registered Nurse is always on-call.

A Code record dated 1/29/11 for patient ID# 9 reflected that the emergency room Physician and the Paramedic responded to the code on the nursing unit and left the emergency room unattended (no patients were currently in the ER at the time of the code.)

The emergency room Physician (ID# 66) stated 7/15/11 at 3:25 p.m. she instructed the staff to call " 911 " to get more help " and to transfer the patient to a higher level of care. The hospital did not address the need for more staffing or the need to stabilize the patient before calling "911."

The Administrator confirmed 7/13/11 at 1:40 p.m. the hospital was only staffed with an LVN, Physician, Paramedic and Security Guard on 1/29/11.

The Ambulance record for patient ID# 9 dated 1/29/11 stated that when the paramedics arrived (ten minutes after the patient was found unresponsive) the patient was found cyanotic (blue), the breathing tube was not properly inserted, the intravenous line was not functional and the patient was bleeding onto the floor from the intravenous line. The hospital did not address the need for inservices / competencies regarding code situations.

The emergency room Physician (ID# 66) acknowledged 7/15/11 at 3:25 p.m. that "during the code of patient ID# 9 intubation was unsuccessful twice and the third time she was successful placing the breathing tube but it must have become dislodged during cardiopulmonary resuscitation."

Record review of emergency room patient record #'s 1, 2, 3, 6, 7, and 8 revealed only a paramedic and a physician treated these patients.

ER Patient ID# 1 was treated 3/27/11

ER Patient ID# 2 was treated 3/20/11

ER Patient ID# 3 was treated 2/5/11

ER Patient ID# 6 was treated 10/10/10

ER Patient ID# 7 was treated 2/5/11

ER Patient ID# 8 was treated 4/17/11

The Nursing ER Director (ID# 59) verified a Registered Nurse was not in the hospital when ER patient #'s 1, 2, 3, 6, 7, and 8 presented to the emergency room. The Nursing Director further stated that a Registered Nurse is always on-call but the hospital does not have a policy or protocol defining how soon the RN would need to respond to the hospital if notified.

Interview 7/15/11 at 3 p.m. with the Administrator revealed the Emergency Department does not maintain any on-call schedules for surgeons. The Administrator stated the only call schedule is a back-up emergency room physician schedule.

The emergency room Physician (ID# 101) on duty 7/15/11 acknowledged at 3:15 p.m. that the emergency room does not have an on-call schedule for surgeons at Humble Surgical Hospital. The ER Physician stated that all surgeries at Humble Surgical Hospital are scheduled and elective and if any patients presented to the emergency room requiring emergency surgery they would be transferred to another hospital.

Record review of a policy titled "EMTALA, Stabilization and Transfer Policy" (no date) stated "Policy: The Emergency Department will adhere to the EMTALA Patient Transfer Policy and any applicable laws of EMTALA." (Emergency Medical Treatment and Active Labor Act (EMTALA)

Federal Tag A2404 ?489.24(j)(1)

Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians.



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Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. Incomplete reports

No incomplete reports available.



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Report No. 1498

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

METROPLEX HOSPITAL 2201 S CLEAR CREEK ROAD KILLEEN, TX 76542

July 5, 2011

Tag No: A0144

Tag No: A0395

VIOLATION: CONTRACTED SERVICES

Tag No: A0083

Based on interviews and review of the clinical record and facility investigation the Governing body failed to be responsible for all services in the hospital, specifically physicians and pharmacists who may and have over ridden a medication alert for patient #1.

Findings were

Interview with Staff #4, on 7-5-11 at 2:05 pm revealed that when entering the order, Staff #8, a physician, did not select " standard dosing " decision support functionality for the Computerized Physician Order entry system (CPOE) to adjust the dosage according to age, height, weight or other standards already entered into the CPOE, but Staff #8 entered each aspect of the order manually, increasing the risk for error. The order Staff #8 entered did not include the proper solution, just the vial, so the Staff #6 canceled the order and re-entered the order exactly as Staff #8 entered the order, amending only the proper solution to be an IV administration. Staff #4 stated that the CPOE would provide an alert related to inappropriate dosing based on above noted parameters. There was an alert when this order was entered that Staff #8 saw and bypassed. The alert stated that the dose was incorrect, but Staff #8 selected the reason, " Patient 's condition warrants dose. " The pharmacist also received an alert that the dose was inappropriate, but the pharmacist also overrode the alert and sent a 100 cc mini-bag of normal saline and a 500 mg vial of Vancomycin. Two people, the physician and the pharmacist bypassed an automatic alert regarding the incorrect dose of the medication.

This was confirmed in interview with the Pharmacy director and Risk manager on 7/5/11 in the medical records meeting room.

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on review of the clinical record, the facility report and interview with staff, patient #1 received a dose of Vancomycin (an antibiotic) 10 times the recommended amount for his weight and therefore failed to receive safe care at the hospital.

Findings were:

On 5/22/11 patient #1 presented to the emergency department with a complaint of "fever, crying since last night, nasal congestion, decreased appetite and fussiness". On 5/22/11 at 1731 a dose of 500 mg of Vancomycin was administered to patient #1, however the pediatric dosage for weight was 50 mg. The patient developed a red rash over his body. After this occurrence the patient required admission to the floor for rehydration and to be observed for symptoms from the overdose. Both a physician and a pharmacist over rode alerts in the medication ordering system that could have prevented the medication from reaching the patient. There were no policies in the Emergency department for the double verification of a pediatric dose of any medication. The parents of patient #1 requested a transfer to another acute care hospital as they did not feel safe at this hospital.

The above was confirmed in interview with the risk manager and emergency department director on 7/5/11.

VIOLATION: RN SUPERVISION OF NURSING CARE

Based on review of the medical record for Patient #1, Staff #7, a nurse, administered a medication for Patient #1 that was an incorrect dosage for the patient 's age, height, and weight without clarifying the order with the ordering physician, and the nurse administered the medication at an incorrect rate of infusion.

Findings were:

Review of the medical record for Patient #1 revealed he was a 7 week old male and that measurements entered at 2:36 pm on 5-22-11 were: height per tape measure was 54 centimeters, weight on baby scale of 5.25 kilograms. Staff #8, a physician, ordered Vancomycin 100 mg/kg IV, 100 mL/hour, which was ten times the appropriate dose for an infant. Staff #7, a registered nurse reviewed and accepted the order. Staff #6, a pharmacist, dispensed the medication. Administration of the medication by Staff #7 began at 5:31 pm and was discontinued at 6:24 pm, for a total administration time of 53 minutes, which was a more rapid administration for a small infant and not the administration time of one hour as ordered.

Interview with Staff #3, Emergency Department Director revealed that Staff #7 thought the wrong dose had been ordered, but Staff #7 did not question it or review it with another nurse. When the mixed dose arrived on the unit, Staff #7 assumed it was okay because the pharmacy sent the medication. Staff #3 stated that there was no policy in place for nurses to double check pediatric doses prior to administration in the ED, and that there is no policy for double checking pediatric doses or orders.

Staff #3 confirmed the entry in the medical record showing that the Vancomycin, ordered to be administered over one hour, was administered between 5:31 pm and 6:24 pm, a total of 53 minutes. Staff #3 did not know if the entire medication was infused over one hour and the documentation was incorrect, or if the medication infusion was stopped early and not completed. Staff #3 stated the infusion was ended for billing purposes, and the documentation related to the time of the Vancomycin was to allow the ED to bill for the infusion. Staff #3 stated that the infusion had to be completed in the ED, as this procedure would not be paid for once the patient was transferred to the floor and the ED nurses had to document that the saline lock was placed before the patient transfer to the floor for billing purposes. Staff #3 confirmed that 100 ml/hr in an infant this size is a large dose and that Staff #7 should have questioned the order, especially since the administration should have been via syringe pump as piggybacks are hardly ever done on babies.

VIOLATION: CONTENT OF RECORD - OTHER INFORMATION

Based on review of the clinical record for patient #1 and interview with staff #3, veracity of documentation of the time of completion of the intravenous line and placement time of the saline lock was not assured. In addition the hospital failed to follow Policy #PCADM 136, Safety Standards: Sentinel Event Policy-Disclosure.

Tag No: A0467

Findings were:

-On 5/22/11 patient #1, a six week old male was ordered an intravenous antibiotic solution to run for one hour. Documentation revealed that the solution began to infuse at 1731 and ended at 1824, which would indicate the antibiotic solution ran for 53 minutes. Interview with staff #3 revealed that the documentation of the infusion was for the emergency room billing; the infusion has to be documented as ending in the ER as an infusion won 't be paid for on the floor and staff had to document the saline lock was placed before transfer to the floor.

-Hospital Policy #PCADM 136, Safety Standards: Sentinel Event Policy-Disclosure required action step #5 states that facts will be reviewed and shared with the patient, guardian, or representative without unnecessary delay. Required action step #7 requires the individual who has the discussion with the patient or patient 's representative to document the discussion with the patient, guardian, and/or representative in the patient 's medical record. Documentation to include: 1. date, time, and place of the discussion, 2. names and relationship to the patient of those present, 3. the unanticipated outcome discussed and a concise summary of the discussion, 4. steps taken to ameliorate the clinical consequences, 5. any offer of assistance or referrals (including persons or agencies) and the patient, family members or legal guardian 's response, 6. questions posed by the patient, family members or legal guardian and the answers provided, and 7. any follow-up phone calls or conversations with patient/family. Documentation of this notification was not included within the medical record of patient #1.

The above was confirmed in interview with the risk manager and emergency department director on 7/5/11.

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July 5, 20114 (click for details) Read full report

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No incomplete reports available.

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PARKLAND HEALTH AND HOSPITAL SYSTEM ->

Report No. 1459

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

PARKLAND HEALTH AND HOSPITAL SYSTEM

5201 HARRY HINES BLVD DALLAS, TX 75235

July 1, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on review of records and interview, the hospital failed to ensure that 1 of 1 patient (Patient #1) received care in a safe setting. Patient #1 received treatment that included cognitive re-training in the hospital's inpatient rehabilitation unit for a traumatic brain injury and left the hospital by himself on 06/29/11. Patient #1 did not return to the hospital until 06/30/11 when he was brought back by the security personnel. This incident could have caused Patient #1 increased injuries and a set-back to his physical and mental progress that was made during his rehabilitation.

Findings included:

The "History and Physical" of Patient #1, [AGE], included that Patient #1 was admitted on [DATE] after being involved in an "auto versus pedestrian" motor vehicle accident. He had frontal contusions, a traumatic brain injury, and a fracture of the lumbar transverse process. On 05/17/11 Patient #1 had a left sided decompressive craniectomy and evacuation of a hematoma. Treatment included neurological monitoring.

The 06/03/11 "History and Physical" indicated Patient #1 was admitted to the rehabilitation unit for a "comprehensive intradisciplinary rehabilitation program" that included medication administration, wound care, discharge planning, therapy for mobility and transfers, occupational therapy for self care, swallowing, and cognitive treatment. Patient #1 was "unable to follow safety precautions due to his injury...family will be staying with him 24 hrs/day to assist...not terribly agitated, and seems...well with just redirection...protective helmet for patient ..."

On 06/29/11 at 08:21 AM, the physician noted Patient #1 was still confused and trying to go out per the nurse. Patient #1's sister said he was much more calm and not agitated any more. Tentative discharge was for 07/01/11. The family's questions were answered and Patient #1's cognitive impairment was discussed in addition to his poor safety awareness and need for 24 hour supervision 7 days a week at the time of discharge. Patient #1 had met his rehab inpatient goals.

On 06/29/11 at 08:34 AM, Patient #1's speech therapy progress note indicated that he continued to show steady small gains with functional communication skills in speech therapy. He showed "more consistent participation with structured and unstructured tasks with decreased need for redirection...some improvement with general effectiveness with communication exchange with contextual familiar topics however continues to require...cues for redirection of fluent empty utterances with conversational exchange...decreased insight into deficits and attempts at self-correction require cues from listener..." Patient #1 was to continue 24 hour supervision after discharge.

On 06/29/11 at 08:40 AM, the nurse's notes indicated Patient #1 was agitated and wanted to leave the unit. Lorazepam was administered and he was gently guided back to his room.

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

On 06/29/11 at 08:00 PM, Registered Nurse #12 noted Patient #1's assessment was completed and he denied the need for pain medication. At 08:30 PM, Patient #1 got out of his enclosed bed and "...walked up and down in his room and hallway for a while refusing to take medication to calm him down." Registered Nurse #12's 09:00 PM notes indicated that Patient #1 "...tried to leave the floor but was repeatedly accompanied back to his room but this time...walked out of the floor despite attempts to keep him from leaving the floor ...security was called and Dr...notified..." At 12:00 Midnight, Patient #1 was "...still not back in room."

The physician's 06/30/11 11:20 AM progress notes revealed, "fortunately was found by police and brought back."

During a telephone interview on 07/01/11 at approximately 12:15 PM, Registered Nurse #12 was asked if she cared for Patient #1 at the time he left the hospital on [DATE]. Registered Nurse #12 said that she was Patient #1's primary nurse on 06/29/11 from 7:00 PM to 7:00 AM. When she came on the shift she had questioned why Patient #1 was no longer on a 1 to 1 with a sitter. She was told he was thought to be getting better. During her shift, Patient #1 got out of his enclosed bed and walked towards the door. He also walked up and down in his room. He went into the hall and walked towards the exit, the alarm went off, and he went back to his room. Patient #1 had attempted to leave the unit three times, but was coaxed back to his room. After the third time, Patient #1 again came out of his room and kept walking, and didn't come back. When Patient #1 went through the door the fourth time, the alarm went off. Registered Nurse #12 said that security arrived and did not see Patient #1, and nobody had followed Patient #1.

The hospital's "Patients' Rights and Responsibilities" administration policy of June 2009, revised March 2011, noted, "Patients have the right to...be cared for with respect and kindness...privacy, and to be cared for in a safe way in a safe place..."

VIOLATION: STAFFING AND DELIVERY OF CARE

Tag No: A0392

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of records and interviews, the hospital failed to provide adequate numbers of personnel to meet the safety needs of 1 of 1 patient (Patient #1) who received treatment that included cognitive re-training in the hospital's inpatient rehabilitation unit for a traumatic brain injury and left the hospital by himself on 06/29/11. Personnel was not available to follow Patient #1 and Patient #1 did not return to the hospital until 06/30/11 when he was brought back by the security personnel. This incident could have caused Patient #1 increased injuries and a set-back to the physical and mental progress that was made during his inpatient rehabilitation hospitalization.

Findings included:

The "History and Physical" of Patient #1, [AGE], included that Patient #1 was admitted on [DATE] after being involved in an "auto versus pedestrian" motor vehicle accident. He had frontal contusions, a traumatic brain injury, and a fracture of the lumbar transverse process. On 05/17/11 Patient #1 had a left sided decompressive craniectomy and evacuation of a hematoma. Treatment included neurological monitoring.

The 06/03/11 "History and Physical" indicated Patient #1 was admitted to the rehabilitation unit for a "comprehensive intradisciplinary rehabilitation program" that included medication administration, wound care, discharge planning, therapy for mobility and transfers, occupational therapy for self care, swallowing, and cognitive treatment. Patient #1 was "unable to follow safety precautions due to his injury...family will be staying with him 24 hrs/day to assist...not terribly agitated, and seems...well with just redirection...protective helmet for patient ..."

On 06/29/11 at 08:21 AM, the physician noted Patient #1 was still confused and trying to go out per the nurse. Patient #1's sister said he was much more calm and not agitated any more. Tentative discharge was for 07/01/11. The family's questions were answered and Patient #1's cognitive impairment was discussed in addition to his poor safety awareness and need for 24 hour supervision 7 days a week at the time of discharge. Patient #1 had met his rehab inpatient goals.

On 06/29/11 at 08:34 AM, Patient #1's speech therapy progress note indicated that he continued to show steady small gains with functional communication skills in speech therapy. He showed "more consistent participation with structured and unstructured tasks with decreased need for redirection...some improvement with general effectiveness with communication exchange with contextual familiar topics however continues to require...cues for redirection of fluent empty utterances with conversational exchange...decreased insight into deficits and attempts at self-correction require cues from listener..." Patient #1 was to continue 24 hour supervision after discharge.

On 06/29/11 at 08:40 AM, the nurse's notes indicated Patient #1 was agitated and wanted to leave the unit. Lorazepam was administered and he was gently guided back to his room.

On 06/29/11 at 08:00 PM, Registered Nurse #12 noted Patient #1's assessment was completed and he denied the need for pain medication. At 08:30 PM, Patient #1 got out of his enclosed bed and "...walked up and down in his room and hallway for a while refusing to take medication to calm him down." Registered Nurse #12's 09:00 PM notes indicated that Patient #1 "...tried to leave the floor but was repeatedly accompanied back to his room but this time...walked out of the floor despite attempts to keep him from leaving the floor ...security was called and Dr...notified..." At 12:00 Midnight, Patient #1 was "...still not back in room."

The physician's 06/30/11 11:20 AM progress notes revealed, "fortunately was found by police and brought back."

On 07/01/11 at approximately 12:30 PM, a review of the staffing information for 06/29/11 7:00 PM to 11:00 PM was conducted with the Unit Manager, Registered Nurse #2. The staffing grid was applied to the 06/29/11 16 patient census. Three nurses and two patient care assistants were available for the 16 patients. This was one less patient care assistant than should have been in attendance at the approximate time Patient #1 left the hospital. Registered Nurse #2 agreed that staffing was less than the hospital's staffing requirement for the unit and patient census of 16 during the time Patient #1 left the hospital.

During a telephone interview on 07/01/11 at approximately 12:15 PM, Registered Nurse #12 was asked if she cared for Patient #1 at the time he left the hospital on [DATE]. Registered Nurse #12 said that she was Patient #1's primary nurse on 06/29/11 from 7:00 PM to 7:00 AM. When she came on the shift she had questioned why Patient #1 was no longer on a 1 to 1 with a sitter. She was told he was thought to be getting better. During her shift, Patient #1 got out of his enclosed bed and walked towards the door. He also walked up and down in his room. He went into the hall and walked towards the exit, the alarm went off, and he went back to his room. Patient #1 had attempted to leave the unit three times, but was coaxed back to his room. After the third time, Patient #1 again came out of his room and kept

walking, and didn't come back. When Patient #1 went through the door the fourth time, the alarm went off. Registered Nurse #12 said that security arrived after security was called, and did not see Patient #1, and nobody had followed Patient #1. Registered Nurse #12 said that she had to go back to care for her patients and nobody was able to follow Patient #1.

The "Staffing Plan" procedure #19-29 written June 2011 noted, "Nurse staffing requirements are based on the needs of each patient care unit and shift and on evidence relating to patient care needs...assignments are based on the staff competency and patient acuity...additional considerations include...patient and family needs...safety...charge nurse or designee shall continuously monitor all assignments and take corrective action when indicated...call-ins or unfilled shifts will be supplemented with part-time, float pool staff, management staff, requesting an additional day of work from off duty employees, or voluntary overtime staff..."

The hospital's "Patients' Rights and Responsibilities" administration policy of June 2009, revised March 2011, noted, "Patients have the right to...be cared for with respect and kindness...privacy, and to be cared for in a safe way in a safe place..."

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PLAZA MEDICAL CENTER OF FORT WORTH ->

Report No. 1551

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

PLAZA MEDICAL CENTER OF FORT WORTH

900 EIGHTH AVENUE FORT WORTH, TX 76104

July 1, 2011

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on review of records and interview, the governing body failed to ensure that a physician was on call at all times in that 1 of 1 patient (Patient #1) did not receive pain medication in a timely manner after Physician #9's answering service was contacted by Nurse #1. On 04/11/11 at 01:25 AM, Nurse #1 requested Physician #9 to return an answering service request for a call back to discuss Patient #1's pain medication. Patient #1 did not receive the pain medication until 05:36 AM (approximately 4 hours after Physician #9 was first contacted).

Findings included:

The Discharge Summary (dictated/transcribed 04/21/11) noted that Patient #1, [AGE], was admitted on [DATE] with lumbar stenosis and mechanical instability. On 04/07/11, Patient #1 had a lumbar decompressive laminectomy L4-5 and L5-S1 with medial facetectomies, bilateral foraminotomies and discectomies at L4-5 and L5-S1.

The "History and Physical" unchanged as of 04/07/11 noted that Patient #1 had allergies that included morphine and Demerol.

The nursing notes indicated that on 04/11/11 at 01:25 AM, Patient #1 requested pain medication. Nurse #1 called the physician's answering service. Subsequent calls were placed to the answering service at 02:03 AM, 02:29 AM, and 03:10 AM by Nurse #1. At 04:00 AM, Patient #1 was "screaming out loud...demanding for her pain meds (medications)..." At 04:30 AM, Nurse #1 placed another call to the "answering service."

Physician #9 called back at 04:46 AM regarding the pain medication for Patient #1 and ordered Demerol. The 04/11/11 "Medication Discharge Summary" indicated that Patient #1 refused the Demerol three times. At 05:10 AM, Physician #9 was paged regarding Patient #1 being allergic to "Demerol..." At 05:36 AM, Norco was given to Patient #1 per the physician's orders. This was approximately 4 hours after Nurse #1 called Physician #9's answering service the first time.

During an interview at approximately 10:45 PM on 07/01/11, the Associate Chief Nursing Officer (Personnel #10) was asked if there were guidelines for a physician's response to a request for return contact by a nurse. Personnel #10 said that the Medical Staff had rules regarding this and there were protocols to follow if the physician was not able to be reached.

The "Medical Staff Rules and Regulations" reviewed by the Medical Executive Committee 04/13/10 and adopted by the Board of Trustees on 04/26/10 included that "Each practitioner must assure timely, adequate, professional care for his patients in the hospital by being available or having available through his office an alternate practitioner..."

The "Chain-of-Command and Administrative Call" policy #ADMIN106 revised October 2010, included that, "No more than two (2) calls will

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

be made to the physician prior to invoking the Chain-of-Command..."

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of records and interview, the hospital failed to provide 1 of 1 patient (Patient #1) care in a safe setting in that Patient #1 did not receive appropriate management of pain. Patient #1 asked for pain medication at 01:25 AM on 04/11/11 and did not receive the medication until approximately 4 hours later, at 05:36 AM. In addition, Physician #9 prescribed a medication that Patient #1's medical record indicated she was allergic to prior to Physician #9 giving an order for the correct pain medication. This practice could have presented the risk of potential harm to Patient #1.

Tag No: A0144

Tag No: A0386

Findings included:

The Discharge Summary (dictated/transcribed 04/21/11) noted that Patient #1, [AGE], was admitted on [DATE] with lumbar stenosis and mechanical instability. On 04/07/11, Patient #1 had a lumbar decompressive laminectomy L4-5 and L5-S1 with medial facetectomies, bilateral foraminotomies and discectomies at L4-5 and L5-S1.

The "History and Physical" unchanged as of 04/07/11 noted that Patient #1 had allergies that included morphine and Demerol.

The nursing notes indicated that on 04/11/11 at 01:25 AM, Patient #1 requested pain medication. Nurse #1 called the physician's answering service. Subsequent calls were placed to the answering service at 02:03 AM, 02:29 AM, and 03:10 AM by Nurse #1. At 04:00 AM, Patient #1 was "screaming out loud...demanding for her pain meds (medications)..." At 04:30 AM, Nurse #1 placed another call to the "answering service."

Physician #9 called back at 04:46 AM regarding the pain medication for Patient #1 and ordered Demerol. The 04/11/11 "Medication Discharge Summary" indicated that Patient #1 refused the Demerol three times. At 05:10 AM, Physician #9 was paged regarding Patient #1 being allergic to "Demerol..." At 05:36 AM, Norco was given to Patient #1 per the physician's orders. This was approximately 4 hours after Nurse #1 called Physician #9's answering service the first time.

During an interview at approximately 10:00 PM on 07/01/11, Registered Nurse #4 was asked what she remembered about Patient #1. RN #4 reviewed Patient #1's nursing notes and stated that she remembered that Patient #1 wouldn't listen and was screaming. She had wanted pain medication from her nurse who was contacting the physician.

The hospital's "Patient's Rights and Responsibilities" policy #ADMIN03, revised August 2009, included that "The patient has a right to appropriate assessment and management of pain. The patient can expect information about pain and pain relief measures, and a concerned staff committed to pain management."

VIOLATION: ORGANIZATION OF NURSING SERVICES

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of records and interview, the hospital failed to have a well-organized nursing service with a plan of administrative authority in that 1 of 1 patient (Patient #1) who requested pain medication on 04/11/11 at 01:25 AM did not receive the medication until 05:36 AM (approximately 4 hours after the first call to the physician's answering service by Nurse #1 and more than 2 subsequent attempts at contacting Patient #1's physician for pain management).

Findings included:

The Discharge Summary (dictated/transcribed 04/21/11) noted that Patient #1, [AGE], was admitted on [DATE] with lumbar stenosis and mechanical instability. On 04/07/11, Patient #1 had a lumbar decompressive laminectomy L4-5 and L5-S1 with medial facetectomies, bilateral foraminotomies and discectomies at L4-5 and L5-S1.

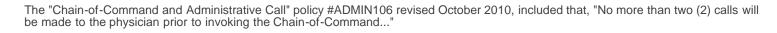
The "History and Physical" unchanged as of 04/07/11 noted that Patient #1 had allergies that included morphine and Demerol.

The nursing notes indicated that on 04/11/11 at 01:25 AM, Patient #1 requested pain medication. Nurse #1 called the physician's answering service. Subsequent calls were placed to the answering service at 02:03 AM, 02:29 AM, and 03:10 AM by Nurse #1. At 04:00 AM, Patient #1 was "screaming out loud...demanding for her pain meds (medications)..." At 04:30 AM, Nurse #1 placed another call to the "answering service."

Physician #9 called back at 04:46 AM regarding the pain medication for Patient #1 and ordered Demerol. The 04/11/11 "Medication Discharge Summary" indicated that Patient #1 refused the Demerol three times. At 05:10 AM, Physician #9 was paged regarding Patient #1 being allergic to "Demerol..." At 05:36 AM, Norco was given to Patient #1 per the physician's orders. This was approximately 4 hours after Nurse #1 called Physician #9's answering service the first time.

During an interview at approximately 10:45 PM on 07/01/11, the Associate Chief Nursing Officer (Personnel #10) was asked if there were guidelines for a physician's response to a request for return contact by a nurse. Personnel #10 said that the Medical Staff had rules regarding this and protocols to follow if the physician was not able to be reached.

The "Medical Staff Rules and Regulations" reviewed by the Medical Executive Committee 04/13/10 and adopted by the Board of Trustees on 04/26/10 included that "Each practitioner must assure timely, adequate, professional care for his patients in the hospital by being available or having available through his office an alternate practitioner..."





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PLAZA MEDICAL CENTER OF FORT WORTH

900 EIGHTH AVENUE FORT WORTH, TX 76104 | Proprietary

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July 1, 20113 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

Report date Number of incomplete reportsNumber of violations Oct. 17, 20111 1

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DALLAS REGIONAL MEDICAL CENTER ->

Report No. 1556

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

DALLAS REGIONAL MEDICAL CENTER

1011 NORTH GALLOWAY AVENUE MESQUITE, TX 75149

June 29, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on interview and record review the hospital failed to ensure the triage RN [Registered Nurse] [Staff #9] provided care in a safe setting as evidenced by not properly assessing/evaluating and triaging 1 of 2 patient's [Patient #1], who was emergently brought to the ED [Emergency Department] for altered mental status, low blood pressure and atrial fibrillation. [Patient #1] suffered a cardiac arrest approximately thirty one minutes after arrival to the ED. [Patient #1] was triaged as a level 3 by Staff #9.

Findings Included:

The Patient Care Report dated 02/11/11 from the Fire Department for [Patient #1] reflected, "Patient history CHF [Congestive Heart Failure], high blood pressure, general weakness...age 81...blood pressure at 15:25 PM 56/42, heart rate 100...blood pressure at 15:45 PM 78/56, heart rate 92...oxygen saturation 93%...EKG done...A-Fib [Atrial Fibrillation]...narrative...patient at assisted living center. Staff noticed patient with [AMS]altered mental status. Patient vitals checked and B/P [Blood Pressure] found to be low. On arrival patient found to be sitting in wheelchair acting lethargic. ENRT [In route to] hospital pt [Patient] heart rate dropped with snoring respirations and loss of bladder control. Diverted to closer hospital. Pt B/P rose with Trendelenburg positioning...care transferred to hospital at 15:54 PM..." The receiving nurse Staff #9 signed the report.

The initial assessment form dated 02/11/11 timed at 16:00 PM reflected, "Arrival mode ambulance-stretcher...chief complaint altered mental status...disorientation yes...vital signs...T [Temperature] 96.4, P [Pulse] 123, R [Respirations] 20, B/P 112/97, O2 [Oxygen] 95% RA [Room Air]...triage level 3..."

The adult assessment dated [DATE] timed at 19:13 PM reflected, "Patient assigned to room 3...arrived by stretcher...patient moved to room at 16:00 PM...time of primary assessment 16:00 PM...psychosocial...patient demonstrates normal behavior appropriate for age and situation...is able to ambulate independently, and can perform all activities of daily living without assistance. Patient's nutritional status appears normal. The patient demonstrates the ability and willingness to learn...Safety...patient is at risk for fall as evidenced by confusion...patient is at risk for skin breakdown as evidenced by immobile due to chronic wellness, confusion, being elderly, incontinence...Brief Mental Status...patient has altered mental status...Cardiovascular...EKG was performed on 02/11/11 at 16:20 PM by nurse...after EKG was done it was taken to MD [Medical Doctor] right away and upon return to room son at the door and informed [Staff #9] his mother was not breathing...code was called and CPR [Cardiopulmonary Resuscitation] was begun..."

The ECG dated 02/11/11 timed at 16:20 PM reflected, "Nonspecific intraventricular block, ACUTE MI...abnormal ECG..."

The code flow sheet dated 02/11/11 timed at 16:31 PM CPR was started at 16:31 PM and code terminated 17:08 PM..." [Patient #1] subsequently passed away.

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

On 06/28/11 at approximately 12:30 PM Staff #9 was interviewed. Staff #9 was asked if he looked at the EMS report for [Patient #1]. Staff #9 stated "I never look at the report." Staff #9 stated he felt [Patient #1] was triaged appropriately. The surveyor referred to Staff #9's documentation which indicated [Patient #1] was able to ambulate, demonstrated ability/willingness to learn, at risk for falls evidenced by confusion and patient had altered mental status. Staff #9 was asked about the inconsistency of his documentation. Staff #9 did not offer an explanation.

On 06/28/11 at 2:35 PM Nursing Director of ED Staff #5 was interviewed. Staff #5 was asked based on the EMS [Emergency Medical System] patient care record and [Patient #1's] medical record what level of triage would [Patient #1] fall under. Staff #5 stated the triage nurse assessment and history of the event was inconsistent. Staff #5 stated [Patient #1] should have been triaged at a ESI [Emergency Severity Index] of 1 or 2 based on the EMS report and the patient's condition upon arrival, AMS [Altered Mental Status], vital signs, and what occurred during transport to the hospital.

On 06/29/11 at 12:08 PM Staff #13 was interviewed. Staff #13 stated he hooked [Patient #1] up to the monitor. He stated [Patient #1] did not look well. He stated he left the room to get the IV [Intravenous] supplies. Staff #13 stated when he was returning to the room Staff #9 left room to get the physician. Staff #13 stated he usually does the EKG when the patient comes in but this time the nurse did it. Staff #13 stated the ambulance paramedics told the nurse [Patient #1] was declining and did not look well.

Staff #5 provided the hospital ESI [Emergency Severity Index] 5-tier triage process currently used by the hospital on [DATE] at approximately 2:30 PM. The document reflected the following: "1) ESI-1 (Resuscitation)...definition...at risk of dying now if care is not received/directly to a bed...conditions include, but are not limited to...code. arrest, seizures, altered mental status, unconscious, delirious, major trauma and severe respiratory distress...2) ESI-2 (Emergent)...definition...high risk/patient condition that can not wait/directly to a bed...conditions include, but are not limited to...difficulty breathing, confused/lethargic/disoriented...3) ESI-3 (Urgent)...definition...check danger zone vital signs, two or more resources expected...conditions include, but are not limited to...moderate dyspnea, psychosis, bleed without decreased vital signs, nausea, vomiting, diarrhea, vaginal bleeding and flank pain..."

The policy entitled, "Patient Rights and Responsibilities" with a revision date of 04/01/11 reflected, "Patients have a right to receive care in a safe setting...patients have the right to appropriate assessment and management of pain..."

Tag No: A0395

VIOLATION: RN SUPERVISION OF NURSING CARE

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the hospital failed to ensure the triage RN [Registered Nurse] [Staff #9] properly assessed/evaluated and triaged 1 of 2 patient's [Patient #1] who was emergently brought to the ED [Emergency Department] for altered mental status, low blood pressure and atrial fibrillation. [Patient #1] suffered a cardiac arrest approximately thirty one minutes after arrival to the ED. [Patient #1] was triaged as a level 3 by Staff #9.

Findings Included:

The Patient Care Report dated 02/11/11 from the Fire Department for [Patient #1] reflected, "Patient history CHF [Congestive Heart Failure], high blood pressure, general weakness...age 81...blood pressure at 15:25 PM 56/42, heart rate 100...blood pressure at 15:45 PM 78/56, heart rate 92...oxygen saturation 93%...EKG done...A-Fib [Atrial Fibrillation]...narrative...patient at assisted living center. Staff noticed patient with [AMS]altered mental status. Patient vitals checked and B/P [Blood Pressure] found to be low. On arrival patient found to be sitting in wheelchair acting lethargic. ENRT [In route to] hospital pt [Patient] heart rate dropped with snoring respirations and loss of bladder control. Diverted to closer hospital. Pt B/P rose with Trendelenburg positioning...care transferred to hospital at 15:54 PM..." The receiving nurse Staff #9 signed the report.

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Staff #5 provided the hospital ESI [Emergency Severity Index] 5-tier triage process currently used by the hospital on [DATE] at approximately 2:30 PM. The document reflected the following: "1) ESI-1 (Resuscitation)...definition...at risk of dying now if care is not received/directly to a bed...conditions include, but are not limited to...code. arrest, seizures, altered mental status, unconscious, delirious, major trauma and severe respiratory distress...2) ESI-2 (Emergent)...definition...high risk/patient condition that can not wait/directly to a bed...conditions include, but are not limited to...difficulty breathing, confused/lethargic/disoriented...3) ESI-3 (Urgent)...definition...check danger zone vital signs, two or more resources expected...conditions include, but are not limited to...moderate dyspnea, psychosis, bleed without decreased vital signs, nausea, vomiting, diarrhea, vaginal bleeding and flank pain..."

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MEMORIAL HERMANN HOSPITAL SYSTEM ->

Report No. 1499

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MEMORIAL HERMANN HOSPITAL SYSTEM

1635 NORTH LOOP WEST HOUSTON, TX June 24, 77008 2011

Tag No: A2406

VIOLATION: MEDICAL SCREENING EXAM

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the Hospital failed to comply with CFR 489.24 requirements. The hospital failed to provide an appropriate medical screen (a pelvic fracture was missed upon exam). 1 of 25 emergency room patients were reviewed. (ID# 1)

Findings include:

Patient ID# 1 was seen in the emergency department at Memorial Hermann Southwest hospital on [DATE]. According to the emergency room record the patient fell from a tree and sustained acute fractures to the right humerus and left wrist. The patient was uninsured. The patient was discharged home to follow-up with an orthopedic surgeon three days later. The patient presented to another hospital and was also diagnosed with pelvis fracture in addition to the other fractures.

Patient #1 (MDS) dated [DATE] at 3:51 p.m. and was treated by emergency room physician ID# 52. The demographic sheet listed the patient as " self pay. " The triage sheet stated chief complaint " fall from tree, approximately 10 feet, complaints of right shoulder pain and left hand pain."

Radiology reports were as follows:

Right Humerus: Fracture of the midshaft of the right humerus.

Left wrist: Fracture of the styloid process of the distal left radius; Fracture of the carpal navicular bone; Fracture of the styloid process of the distal left ulna.

The emergency room physician (ID# 52) record stated "Clinical Impression: Right humerus fracture, left carpal fracture, left distal radium fracture. Thumb spica splint left arm and sling right arm. Disposition: Home, Improved, Stable. "The patient was given a prescription for pain medication and discharged home to follow-up with an orthopedic surgeon three days later.

Interview 6/23/11 at 3 p.m. with the patient 's wife (ID# 91) revealed her husband does not speak English and she was the one that took him to the emergency room at Memorial Hermann Southwest Hospital. She stated that after discharge from the emergency room at Memorial Hermann Hospital her husband's condition progressively worsened. "His left hand was getting worse and he could not feel his fingers and he was constantly in pain. Also his right arm was continuing to swell." The patient's wife stated that her husband could not stand the pain any longer so she took him to the County Hospital on May 29th, 2011 (two days after being seen at Memorial Hermann Hospital).

The wife stated they felt there was no reason to go back to Memorial Hermann Hospital since they did not do anything. She said he was

admitted to the County Hospital for four days and had surgery.

THE COUNTY HOSPITAL RECORD / admitted [DATE] and discharged [DATE]

The emergency room record at the County Hospital (ID# 90) revealed the patient (MDS) dated [DATE] at 5:30 p.m. The Chief complaint stated " [AGE] year old male fell from a tree 3 days ago, initially seen (Memorial Hermann Southwest Hospital) and had x-rays but put only in right arm sling. Told that both arms were broken. Memorial Hermann told the patient to follow up with orthopedics but the patient was hurting too much. "

The History and Physical dated 5/30/11 stated: " [AGE] year old male who presents with right upper extremity, left lower extremity, pelvis pain status post fall from tree about 2 floors 3 days ago. Presented to outside hospital, told he had fracture, and sent to an orthopedic surgeon. Patient notes no attempt at reduction or splinting at outside hospital was ever made. Patient was told had fracture injuries that would warrant treatment by an orthopedic surgeon and discharged to home without treatment. Patient notes the facility was Memorial Hermann Southwest. " The County Hospital's plan stated " Open reduction internal fixation right humerus, open reduction internal fixation left wrist scaphoid, radial styloid, perilunate dislocation. "

An x-ray report on 5/30/11 at the County Hospital revealed that patient ID# 1's wrist was "minimally dislocated."

The following are the radiology reports for patient ID# 1 at the County Hospital:

5/30/11: Left wrist and forearm series:

- -Acute minimally displaced fractures through the radial styloid process and ulnar styloid process.
- -Normal articulation of the radius and lunate with posterior dislocation of the remaining carpal bones posteriorly compatible with perilunate dislocation
- -Scaphoid is rotated and not well visualized. A scaphoid waist fracture cannot be excluded.

5/30/11: Right humerus and elbow series:

-Acute comminuted fracture through the right humeral mid diaphysis

The operative report for patient ID# 1 dated 6/1/11 stated the humerus fracture was debrided and reduced. "The 9-hole plate was placed. Four bone screws were placed on either side of the plate."

The discharge summary dated 6/2/11 stated "Procedures: Status Post open reduction right humerus, open reduction internal fixation left scaphoid, open reduction percutaneous pinning of the left carpus, left sacral fracture, pelvis fracture."

Interview 6/23/11 at 1:25 p.m. with the Assistant Director of Radiology (ID# 54) at the initial hospital (Memorial Hermann Hospital Southwest) revealed that the radiologist misread the initial x-ray report of the left wrist for patient ID# 1 on 5/27/11 and failed to report the minimal displacement of the wrist fracture on the radiology report.

Interview 6/24/11 at 11:15 a.m. with the orthopedic surgeon (ID# 56) that was on call 5/27/11 at Memorial Hermann Hospital revealed that he was called about patient ID# 1. The Doctor stated that he did not come to the emergency room to see the patient but reviewed his X-rays online. The Doctor stated that he felt he could manage the fractured wrist on an outpatient basis. The Orthopedic Surgeon did not have any recall about the acute fracture of the patient 's humerus but acknowledged after reviewing the films today that the fracture probably required surgery to pin the fractured humerus.

Record review of a policy at Memorial Hermann Hospital Southwest titled "Transfer Policy-Emergency Services and Patient Transfers "dated 7/21/10 stated "Patient's Rights and General Provisions: Medical Screening: The hospital recognizes the right of an individual to receive, within the capabilities of the Hospital's staff and facilities: An appropriate medical screening examination; Necessary stabilizing treatment; If necessary, an appropriate transfer to another facility."

Record review of the on-call schedules at Memorial Hermann hospital on [DATE] revealed that a surgical team was on call that date. Also, orthopedic surgeon ID# 56 was also on call and available 5/27/11.

Record review of the hospital census for May 27, 2011 revealed the hospital was at 70% capacity with a total of 316 patients. The hospital is licensed for 625 beds. The Risk Manager, (ID# 51) acknowledged 6/24/11 at 10:30 a.m. the hospital had the capacity to admit patient ID# 1 on 5/27/11 if he required admission to a hospital.

Tag No: A2409

VIOLATION: APPROPRIATE TRANSFER

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the Hospital failed to comply with CFR 489.24 requirements. The hospital discharged a patient with an emergency medical condition (failed to stabilize a fractured arm). (Patient ID# 1)

Findings include:

Patient ID# 1 was seen in the emergency department at Memorial Hermann Southwest hospital on [DATE]. According to the emergency room record the patient fell from a tree and sustained acute fractures to the right humerus and left wrist. The patient was discharged home to follow-up with an orthopedic surgeon three days later. The patient's fractures were not appropriately stabilized before being discharged from the emergency room / hospital.

Patient #1 (MDS) dated [DATE] at 3:51 p.m. and was treated by emergency room physician ID# 52. The triage sheet stated chief complaint " fall from tree, approximately 10 feet, complaints of right shoulder pain and left hand pain."

Radiology reports were as follows:

Right Humerus: Fracture of the midshaft of the right humerus.

Left wrist: Fracture of the styloid process of the distal left radius; Fracture of the carpal navicular bone; Fracture of the styloid process of the distal left ulna.

The emergency room physician documented on 5/27/11 at 6:03 p.m. that orthopedic surgeon ID# 56 agreed to see the patient in his office on 5/31/11 (three days later).

The emergency room physician (ID# 52) record stated " Clinical Impression: Right humerus fracture, left carpal fracture, left distal radium fracture. Thumb spica splint left arm and sling right arm. Disposition: Home, Improved, Stable. " The patient was given a prescription for pain medication and discharged home to follow-up with an orthopedic surgeon three days later.

THE COUNTY HOSPITAL RECORD / admitted [DATE] and discharged [DATE]

The emergency room record at the County Hospital (ID# 90) revealed the patient (MDS) dated [DATE] at 5:30 p.m. The Chief complaint stated " [AGE] year old male fell from a tree 3 days ago, initially seen (Memorial Hermann Southwest Hospital) and had x-rays but put only in right arm sling. Told that both arms were broken. Memorial Hermann told the patient to follow up with orthopedics but the patient was hurting too much. "

The History and Physical dated 5/30/11 stated: " [AGE] year old male who presents with right upper extremity, left lower extremity, pelvis pain status post fall from tree about 2 floors 3 days ago. Presented to outside hospital, told he had fracture, and sent to an orthopedic surgeon. Patient notes no attempt at reduction or splinting at outside hospital was ever made. Patient was told had fracture injuries that would warrant treatment by an orthopedic surgeon and discharged to home without treatment. Patient notes the facility was Memorial Hermann Southwest. " The County Hospital's plan stated " Open reduction internal fixation right humerus, open reduction internal fixation left wrist scaphoid, radial styloid, perilunate dislocation. "

An x-ray report on 5/30/11 at the County Hospital revealed that patient ID# 1's wrist was "minimally dislocated."

The following are the radiology reports for patient ID# 1 at the County Hospital:

5/30/11: Left wrist and forearm series:

- -Acute minimally displaced fractures through the radial styloid process and ulnar styloid process.
- -Normal articulation of the radius and lunate with posterior dislocation of the remaining carpal bones posteriorly compatible with perilunate dislocation
- -Scaphoid is rotated and not well visualized. A scaphoid waist fracture cannot be excluded.

5/30/11: Right humerus and elbow series:

-Acute comminuted fracture through the right humeral mid diaphysis

The operative report for patient ID# 1 dated 6/1/11 stated the humerus fracture was debrided and reduced. "The 9-hole plate was placed. Four bone screws were placed on either side of the plate."

The discharge summary dated 6/2/11 stated "Procedures: Status Post open reduction right humerus, open reduction internal fixation left scaphoid, open reduction percutaneous pinning of the left carpus, left sacral fracture, pelvis fracture."

Interview 6/23/11 at 1:25 p.m. with the Assistant Director of Radiology (ID# 54) at the initial hospital (Memorial Hermann Hospital Southwest) revealed that the radiologist misread the initial x-ray report of the left wrist for patient ID# 1 on 5/27/11 and failed to report the minimal displacement of the wrist fracture on the radiology report.

Interview 6/24/11 at 11:15 a.m. with the orthopedic surgeon (ID# 56) that was on call 5/27/11 at Memorial Hermann Hospital revealed that he was called about patient ID# 1. The Doctor stated that he did not come to the emergency room to see the patient but reviewed his X-rays online. The Doctor stated that he felt he could manage the fractured wrist on an outpatient basis. The Orthopedic Surgeon did not have any recall about the acute fracture of the patient 's humerus but acknowledged after reviewing the films today that the fracture probably required surgery to pin the fractured humerus.

Record review of a policy at Memorial Hermann Hospital Southwest titled "Transfer Policy-Emergency Services and Patient Transfers "dated 7/21/10 stated "Patient's Rights and General Provisions: Medical Screening: The hospital recognizes the right of an individual to receive, within the capabilities of the Hospital's staff and facilities: An appropriate medical screening examination; Necessary stabilizing treatment; If necessary, an appropriate transfer to another facility."

Record review of the on-call schedules at Memorial Hermann hospital on [DATE] revealed that a surgical team was on call that date. Also, orthopedic surgeon ID# 56 was also on call and available 5/27/11.

Record review of the hospital census for May 27, 2011 revealed the hospital was at 70% capacity with a total of 316 patients. The hospital is licensed for 625 beds. The Risk Manager, (ID# 51) acknowledged 6/24/11 at 10:30 a.m. the hospital had the capacity to admit patient ID# 1 on 5/27/11 if he required admission to a hospital.



Training

Resources

Tag No: A0454

Tag No: A0457

Jobs

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WADLEY REGIONAL MEDICAL CENTER ->

Report No. 1503

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

WADLEY REGIONAL MEDICAL CENTER

1000 PINE STREET TEXARKANA, TX 75501June 23, 2011

VIOLATION: ORDERS DATED AND SIGNED

Based on record review, the facility failed to assure all orders were dated and timed. Six instance of undocumented date or time were

based on record review, the facility falled to assure all orders were dated and timed. Six instance of undocumented date of time were observed in one of one patient chart.

Findings include:

Review of patient #1's medical record revealed the following missing dates and times:

- -Admission orders with no documented date
- -Admission orders with no documented time
- -No date on verbal order countersignature on 5/29/2011
- -No time on verbal order countersignature on 5/29/2011
- -No date on verbal order countersignature on 5/30/2011
- -No time on verbal order countersignature on 5/30/2011

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

Based on record review, the facility failed to assure verbal orders were authenticated within 48 hours. Three instances of unauthenticated verbal orders were found in one of one patient chart.

Findings include:

Review of patient #1 's medical record revealed the following:

- -Verbal order written on 6/02/11 was not authenticated
- -Verbal order written on 6/10/11 was not authenticated x 2



Training

Resources

Jobs

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BRINGING TRANSPARENCY TO FEDERAL INSPECTIONS

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WESTBURY COMMUNITY HOSPITAL, LLC ->

Report No. 1779

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

WESTBURY COMMUNITY HOSPITAL, LLC 5556 GASMER HOUSTON, TX 77035 June 23, 2011

VIOLATION: PATIENT RIGHTS: INFORMED CONSENT Tag No: A0131

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and review of 1 of 1 clinical record the patient there was a failure to protect the patient's right to make informed decisions by not providing education on medications administered. Findings:

Review of the clinical record reflected the patient was admitted to the facility on [DATE]. On 5/17/11 Geodon 20mg IM PRN for agitation was ordered. The patient was given IM Geodon as follows:

5/17/11 2355

5/18/11 1415 5/19/11 1000

5/19/11 1000

5/21/11 1530

5/23/11 0145

5/30/11 1200

5/31/00 0911 6/6/11 0130

The record had no evidence of patient education on Geodon. This was verified by the director of nursing at 10:20am on 6/23/11.

VIOLATION: ORGANIZATION OF NURSING SERVICES

Tag No: A0386

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, review of hospital policy and review of 1 of 1 clinical record the director of nursing failed to direct and monitor nursing by failing to ensure occurrence reports were filed for the administration of emergency medications, restraint, patient aggression, patient falls and failure to provide the patient with education on medications.

Findings:

- 1. Review of hospital policy titled: Occurrence Reporting
- 3.0 "An occurrence report should be filed for any of the following occurrence."

- 2.6 " An occurrence involving hostile action by a patient."
- 2.14 " Patient/visitor falls."
- 2.18 "Use of chemical restraint, drug, medication when used to manage patient's behavior."
- 2. Review of the patient's clinical record reflected the use the use of chemical restraints.:

On the following dates/times Haldol/Ativan/Benadryl IM "Now" was administered as an emergency medication:

5/19/11 11:00pm 5/20/11 8:00pm 5/22/11 1:32am

5/22/11 10:00am

No occurrence report was filed.

Geodon IM was administered for as a PRN for aggression as follows:

5/17/11 2355 5/18/11 1415 5/19/11 1000 5/21/11 1530 5/23/11 0145 5/30/11 1200 5/31/11 0941 6/6/11 0130

No occurrence report was filed.

3. The clinical record reflected the patient fell on [DATE] 5/29/11 0100 " fell off toilet lying on floor screaming." No occurrence report was filed.

The lack of filing occurrence reports for the above was verified by the director of nursing at 10:10am on 6/23/11.

4. Cross Refer to A0131



Training

Resources

Tag No: A0154

Jobs

HospitalInspections.org

BRINGING TRANSPARENCY TO FEDERAL INSPECTIONS

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<u>Texas</u> -> EAST TEXAS MEDICAL CENTER ->

Report No. 1486

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

EAST TEXAS MEDICAL CENTER1000 SOUTH BECKHAM STREET TYLER, TX 75701 June 22, 2011

VIOLATION: PATIENT RIGHTS Tag No: A0115

Based on patient records review, the facility failed to provide the least restrictive environment for 1 of 1 patients. Documentation revealed the patient was mechanically restrained 20 hours total without evidence of imminent danger to self or others. While mechanically restrained, the patient had 1:1 staff, police officer present and medication administered for agitation. Of the 20 hours the patient was in restraint, documentation shows the patient was asleep for 7 1/2 hours. The facility failed to ensure the right of the patient to be free from seclusion. Pt was secluded in pt room in body net restraints with police officer and 1:1 staff present. The facility also failed to follow it's own policy to ensure patient was free from restraints and failed to ensure a psychiatric evaluation was done. Further review revealed the facility failed to document and administer medications as prescribed by physician. Nursing also failed to document assessment of patient's behavior to justify need for PRN medication. The facility also failed to develop a written care plan addressing the needs of a psychiatric patient in restraints.

REFER TO TAG A154, A160, A162, A164, A166

VIOLATION: USE OF RESTRAINT OR SECLUSION

Based on Patient record review and interview, the facility failed to follow it's own policy to ensure 1 of 1 patients was 1) free from restraints and 2) failed to ensure a psychiatric evaluation was done on 1 of 1 patients' reviewed.

Example: Facility Policy #1

Administrative Manual - Suicide Precautions Code 19-16 Page #1

(The facility policy 19-16 corresponds to page #3 1.10 of the facilities approved Medical Staff Rules and Regulations as noted below) For the protection of patient's, the medical, and nursing staffs, and the Hospital, certain principles are to be met in the care of the potentially suicidal patient:

a.) Any patient developing suicidal intent after admission to the Hospital shall be transferred to the facility of their choice, as appropriate, where suitable facilities are available.

b.) Any Patient known or suspected to be suicidal must have consultation by a member of the psychiatric medical staff.

c.) When time comes for a suicidal patient to be transferred from a critical care unit, the patient will be transferred to an appropriate psychiatric setting where suitable facilities are available for follow-up care.

Statement of Policy:

Patients admitted through the emergency room for medical or surgical problems requiring treatment following a suicidal attempt, and/or inpatients expressing suicidal ideation with medical or surgical conditions prohibiting transfer to a psychiatric hospital, will be subjected to the precautions described in the following procedure.

Page #2 Procedure

Any patient meeting the above criteria is to be observed according to assigned level of observation as follows: Level I - Frequent Observation:

* Patient has thoughts of suicide but no plan to do self harm

Level II - Constant Observation"

- * Patient has thought of suicide and has a plan to do self harm.
- * Patient shall be in view of a staff member at all times; there shall be supportive documentation of observation and verbal contact to back up this observation.

Level III - Special Constant Observation

- * Patient had thoughts of suicide and has means, mode and method or has already attempted self harm.
- * The patient shall be attended on a 1:1 staff/patient ratio due to verbalization of intent to harm self; or following medical stabilization post suicide attempt, and awaiting psychiatric evaluation prior to transfer to a psychiatric facility, the patient can be transferred from the intensive care unit to unit appropriate for the patient's condition. Page #3 Suicide precautions
- 1. The levels of observation may be ordered by the attending physician or initiated by a Registered Professional Nurse:

a.) the physician writing the order for "suicide precautions" should also write the level of observation.

b.) the Registered Nurse may initiate the assignment of the level and shall document the rational for establishing that level: and he/she shall immediately notify the attending physician of the level of observation chosen, documenting as verbal order physician concurrence, or alternate level ordered;

c.) the level of observation may be changed only upon order of the physician;

d.) the designated level of observation shall continue on all three shifts for a 24 hour period of time, after which the patient will be released by the attending physician or his appropriately appointed designee.

2. Patients will be assigned to the appropriate floor based on the comprehensive assessment of their unique needs.

- 3. There shall be psychiatric consultation and evaluation on all patients under suicide precautions; refer to Page #1 of this policy, Medical Staff rules and Regulations.
- 4. There shall be concurrent documentation in the medical record to verify that suicide precautions are maintained during each shift.

Page #4

- 5. Patients assigned to any of the observation levels shall not be allowed to leave the unit without constant staff accompaniment. (i.e.
- 6. Patients may not remain on suicide precautions for longer than 24 hours; without a documented re-evaluation by the attending physician and the Registered Nurse responsible for the patient; and only the attending physician on call may discontinue suicide precautions documenting his/her assessment on the patient's current clinical state upon which the order to discontinue the precautions is based.

Review of the medical record revealed the patient's History and Physical was dictated by an ACNP, FNP (Advanced Cardiac Nurse Practitioner, Family Nurse Practitioner) and signed by the Internal Medical physician who accepted the patient. There is no documentation a psychiatric medical staff member interviewed/consulted this patient while the patient was in the Acute Care Facility.

On 6/22/2011 at 9:30 AM, a review of the patient's medical record revealed: On 6/05/2011 at 1850 hours (hrs) the patient called 911. The patient (Pt) arrived at 1917 hrs in the Emergency Department (ED). He was escorted by city police under an Emergency Detention Without Warrant (EDW). The patient tested positive for Cocaine, Benzodiazipines and Canniboids. The patient voiced suicidal ideation with a plan to the police officer who brought him in and the Crisis worker from the local Mental health Authority who evaluated him in the Emergency Department at 2129 hrs. The Crisis Worker's documented recommendation was to transfer the patient to a State Mental Health Facility or local Behavioral Health Care facility. The record reflects the State Mental Health Facility had a bed available and the patient was cleared to transfer pending the doctor to doctor clearance on 6/5/2011. There was no physician to physician documentation found in the patient

The Patient's medical record reflects the review of systems was conducted in the ED on 6/5/2011 at 1947 hrs, by the the ED physician whose specialty is emergency medicine. This Document titled "ED Physician Note" includes a section titled "PSYCH" and includes the following:

Behavior: uncooperative (would not speak with physician)

Appearance: Avoids eye contact, Affect/mood: Depressed,

Insight: With in Normal Limits (WNL),

Thought content: WNL, Hallucinations: NONE .

The mental status exam was not filled out by the ED physician.

The admission documentation revealed an order for 23 hour observation, needs sitter. Intravenous (IV)orders for normal saline 150 milliliters a hour (ML/HR) was ordered. Suicide precautions was ordered on the document entitled "Emergency Department/Pulmonary Specialist Admission Orders.

The medical record reflects the patient was admitted from the ED into the hospital's medical surgical unit on 6/6/2011 at 0730 hrs and the patient's care was transferred to an Internal Medicine Physician. The nurses narrative reflects "Assessment complete per system review, VSS (Vital Signs Stable), no concerns or needs voiced. Pt under suicide precautions, sitter at bedside. Will continue to monitor". The nursing assessment system review included information under the psychological/Social section: Behavior/Affect: Appropriate to age/situation.

Willing to communicate: Yes

Anxiety: NO Fatigue: NO

Noncompliance: Yes Despondency: Yes

Review of the facility policy CODE 18-08 for Restraint revealed the following: Page #1 of 7; Purpose:To ensure a patient's right to be free from the use of any form of restraint or seclusion is protected. To ensure the immediate physical safety of the patient, a staff member, or others.

Policy:

Paragraph #1; All patients have the right to be free from physical abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion of any form, imposed as as means of coercion, discipline, convenience, or retaliation by the staff.... Paragraph #2; Seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

Paragraph #3; The decision to use a restraint is not driven by diagnosis, but by a comprehensive individual patient assessment. This

comprehensive individual patient assessment is used to determine whether the use of less restrictive measures poses a greater risk that the risk of using a restraint or seclusion.

Paragraph #4; Restraint or seclusion may only be employed while the unsafe situation continues. Once the unsafe situation ends, or the patient's needs have been addressed using less restrictive methods, the decision to discontinue the use of restraint or seclusion should be discontinued by an RN or physician.

Page #3 of 7 Definitions:

Restraint-any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely.

Chemical restraint-a drug or medication when it is used as a restriction to manage the patient's behavior or restrict he patient's freedom of

movement and is not a standard or dosage the the patient's condition.
Seclusion- the involuntary confinement of a patient alone is a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior. Seclusion is practiced in the Behavioral Health

- Page #5 Behavioral (violent and aggressive behavior)

 * Restraint that is primarily used to protect the patient against injury to self or others because of an emotional or behavioral disorder.
- * Restraint that is used for the management of violent or self destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.
- A) Make attempts to de-escalate the situation by:
- 1.) secure the environment
- 2.) Address the behavior and discuss it
- 3.) Ask what would make the situation better
- 4.) Avoid power struggles
- 5.) Do not lie or threaten the patient
- 6.) Give the patient choices and tell them you will honor their choices
- 7.) Notify your supervisor 8.) Call Code "White"
- B) Initial orders
- 1.) Requires an order by a physician, and allows an RN to place the patient in restraint emergently and then call for an order.
- 2.) Requires the physician to examine the patient within an hour of application.
- 3.) The care plan will be initiated and modified as needed.
- C.) Orders for Behavior uses can not be written for a time period that exceeds the following:
- *4 hrs for 18 years or older * 2 hrs for 9-17 years of age
- *1 hr for less than 9 years of age
- 1.) A physician must see the patient, assess the patient, and write a new order
- Monitor every 15 minutes for the following:
 Signs of injury associated with restraint application
- * Nutrition and hydration
- * Circulation and Range of Motion
- * Vital signs
- * Hygiene and elimination
- * Physical and psychosocial status and comfort
- * Readiness for discontinuing restraint/seclusion
- 3.) Criteria for release:
- * Ímminent danger no longer exists
- * Least restrictive interventions are successful

The Emergency Detention Without Warrant (EDW) reads in part as follows:

- (d) A peace officer who takes a person into custody under Subjection
- (a) shall immediately transport the apprehended person to:
- (1) the nearest appropriate inpatient mental health facility; or
- (2) a mental health facility deemed suitable by the local mental health authority if an appropriate mental health facility is not available.

The facility, in which the patient was taken by the police officer, was licensed as an Acute Care Facility without a Mental health Care Unit on campus.

The facilities General Nursing Orientation section G Module 15 Use of Restraint page #8 slide #43

- * There must be evidence that there is "Imminent" danger to the patient or others in order to justify the need for applying a restraint or
- seclusion for behavioral reasons.

 * Threatening to do something is not acceptable. Patients must be in the "act of" or "process of attempting" to do something that could result in injury or damage to self, others or to you.

Further review of the patient's medical record reveals 6/6/2011 at 0925 hrs the following nurses narrative: "Patient shouting out obscenities and stating that he is leaving because he hasn't seen a Doctor and no longer wishes to harm himself. Pt requested to use the phone to call police, and called and asked if he had any warrants. Pt state that he is leaving now and if any one gets in his way he will hurt us. Pt then left room and walked to elevator. Securify called and notified of Pt's EDW (Emergency Detention Warrant). Pt could not be found on hospital grounds".

Further patient record review reveals the following nurses narrative: 6/6/2011 10:30 "Pt brought back to unit by city PD (Police Department). Pt taken back to room and Dr. called for restraint orders. Pt stating he will just leave again after the police leave. Pt has EDW (Emergency Detention Without Warrant) and was educated on why we could not let him leave. Pt threatening everyone with their life"

Further review of nurse narrative reveals 6/6/2011 at 1100 hrs "City police and facility security applying wrist and ankle restraints per doctors orders. Pt agitated and shouting threats"

A phone interview with Police officer #9, the Day Sergeant for the City Police Department, revealed city police officer #10 documented the pt was picked up off campus. The patient told the officer he no longer wanted to hurt himself. The officer and his partner returned the patient to the hospital, to his room and hospital security obtained Nylon restraints that were placed on the patient's wrists and ankles by

the police officer and the hospital security officer. There was no physicians order for wrist and ankle restraints found in the patient medical record.

On 6/6/2011 at 11:02 AM a Doctors order was written as follows: Ativan 1 mg (milligram) PO (by mouth) IM (intramuscular), IV (intravenously), q 30 (every thirty minutes) prn (as needed) agitation. 1st dose now hold if sedated."

On the same page and below the hand written physician order for medication, the following Physician's telephone order was written: 6/6/2011 1045 hrs Behavioral restraints X 24 hrs (hours) See restraint protocol.

A review of the restraint/seclusion physician order form that is used in the facilities behavioral health unit reveals the following physician's order for "physical hold to body net beginning at 11:00 AM. The Behavioral criteria for release from restraint was "Psychiatry declares no longer danger to self or others". The patient was NEVER seen by a Psychiatrist for consult or evaluation for release of restraint during his 38 hour Inpatient admission.

The only documentation by the internal medicine physician who was the attending physician reads as follows: 6/6/11 1057 hrs, "Pt examined, agree with choice placement arrange at Rusk tomorrow after 24 hrs of detox from substance abuse".

After review of the patient's medical record, at no time was there documentation the patient physically aggressed toward any staff member, visitor, Police officer or himself. There was no documentation of imminent danger. There is also no documentation of any intervention of less restrictive nature other than the facility supplied sitter. The criteria for Behavioral restraint type is documented by the attending physician as "Physical hold to Body Net". There was never a physician's order for ankle and wrist restraints. The patient was never evaluated by a psychiatric medical staff member during his hospitalization as required by hospital policy Code 19-16. There was no comprehensive assessment by either the admitting physician or the Registered Nurse before or after any restraint was applied or released. There was no level of suicide precaution written by the admitting physician or the receiving physician. The patient was not transferred for 38 hours. There was no physician's order to remove the patient from suicide precautions and no re-evaluation by the physician documented.

Tag No: A0160

Tag No: A0162

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on record review the facility failed to document and administer medications as prescribed by physician in 1 of 1 patient records reviewed. Nursing also failed to document assessment of patient's behavior to justify need for PRN medication for 1 of 1 patients reviewed.

On 6/22/2011 at 10:00 AM in the board room the patient's record revealed that, after the patient had eloped from the medical surgical unit on 6/6/2011 and was returned by city police at 10:45 AM the same day, the physician wrote an order that reads as follows: 6/6/2011 1102 hrs Ativan 1 mg PO/ IM/IV q 30 minutes PRN agitation first dose now, hold if sedated. Review of the Medication Administration Record (MAR) documented the initial dose of Ativan was given on 6/6/2011 at 1220 hrs. 1 hour and 20 minutes after the "Now" dose of medication was ordered.

The patient received a total of 5 doses of Ativan on 6/6/2011. A review of the Restrain/Seclusion monitoring log revealed the documented behavior that warranted IM Ativan at 12:30 on 6/6/2011 was yelling and talking to staff. Further review of the same record revealed a second dose was given on 6/6/2011 at 1310 for "yelling and talking with staff." Continued review of the Restraint/ Seclusion monitoring log reveals a third dose was given PO on 6/6/2011 at 1830. The documented behavior was "quiet and talking with staff."

Continued review reflects On 6/6/2011 at 2155 the patient received Ativan 1 mg IM for throwing things. The restraint/seclusion monitoring log does not document behaviors for the dose given on 6/6/2011 at 2100 hrs. This dose was recorded on the medication administration record as PO and the nurses narrative which records; "Pt getting agitated. Pushed bedside table in my direction spilling a glass of water onto the floor. Informed the patient I was going to give him an IM Ativan shot to help him relax. Pt compliant and held still while receiving injection"

The patient's medical record documented one dose of Ativan that was given on 6/6/2011 at 1830 hrs to the patient while he was quiet and talking with staff and one does was given 6/6/2011 at 2100 hrs without behavioral documentation recorded on the Behavioral monitoring log. The record does reflect a polysubstance abuse patient sat compliantly for an IM dose of Ativan which was documented on the MAR as given PO.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on record review and interview the facility failed to ensure the right of the patient to be free from seclusion in 1 of 1 patient record reviewed. Pt was secluded in pt room in body net restraints with police officer and 1:1 staff

On 6/6/2011 at 10:00 AM the patients medical record revealed on 6/6/2011 at 0730 hrs patient was calm and was admitted to a medical surgical unit. At 0925 hrs the nurses narrative of the patient's medical record reflects the patient left the unit via the elevator and was returned to the unit by City police and Facility security at 1030 hrs the same day. The medical record reflects the patient was placed into wrist and ankle restraints at 1100 hrs in his room. Further review of the nurses narrative reflects the patient is still in restraint at 1445 hrs. The pt has now been in restraints 4 hours and 45 minutes.

Further review of medical record reveals a new restraint order was written a 1500 hrs to end at 1900 hrs. This order was not signed by the physician and there was no documentation that an assessment was done by the physician when restraint orders were renewed.

There is no nurses narrative for the hours between 1500 and 1830 on 6/6/2011, however the restraint/seclusion monitoring log documents the patient as sleeping and restrained. The medical record shows the following entry: "staff met with pt and discussed with him his behavior leading up to restraints and what we need him to do if restraints are removed. Pt will need to remain in hospital room until RSH (Rusk State Hospital) comes to get him in the am and not to be inappropriate with staff. Pt voiced that he would stay here and act good. Restraints released at this time will continue to monitor"

The record showed the patient was calm until 1930 hrs when he walked off the unit. He was returned to the unit once again by city police at 2030 hrs the same day and restraints were reapplied.

A review of the restraint/seclusion order form revealed an order for restraint/seclusion for 4 hours beginning at 2000 hrs and ending at 0000 hrs. The order was signed by a physician but there was no documented evaluation by the physician of the necessity of the restraint.

A review of the nurses narrative of the patient's medical record does not reflect what type of restraint, however the Restraint/Seclusion log documents a body net was applied. The city police officer stayed on the unit along with the facility's sitter. The patient record reflected he was cooperative when he returned yet was returned to his room and ordered in mechanical restraint, facility sitter in the room and city police officer on the unit.

Further review revealed a restraint/seclusion order for 4 hours from 6/7/2011 0000 hrs to 0400 hrs. This order was not signed. There was no documentation that an assessment was done by the physician when restraint orders were renewed.

Review of orders revealed a restraint/seclusion order for 4 hours on 6/7/2011 from 0400 hrs to 0800. The order was signed by a physician but there was no documented evaluation done by the physician of the necessity of the restraint.

The patient was restricted to the confines of his room with mechanical restraint, chemical restraint, facility sitter and city police, during the hours of 11:00 to 21:50 on 6/6/2011. There was no documentation the facility evaluated the patient for suicidal risk. There was no documentation there was ever a risk of imminent danger from the patient toward staff members, visitor, police or himself. The patient was restrained for the convenience of the staff. There was no documentation that less restrictive intervention was attempted other than conversation from the staff at 18:30 on 6/6/2011 explaining if the patient would remain In HIS ROOM and not be inappropriate with staff the restraints would be released.

On 6/21/2011 at 8:00 AM a phone interview with staff #3 confirmed "patients on EDW (Emergency Detention Without Warrant)leave all the time and we bring them back to their room"

Tag No: A0164

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on 1 of 1 patient records review, The facility failed to provide the least restrictive environment for 1 of 1 patients. Documentation revealed the patient was mechanically restrained 20 hours total without evidence of imminent danger to self or others. While mechanically restrained, the patient had 1:1 staff, police officer and medication administered for agitation. Of the 20 hours the patient was in restraint, documentation shows the patient was asleep for 7 1/2 hours.

Review of the facilities General Nursing Orientation printed 3/2011 Section G Module 15 page #8 slide #43 reads as follows: "There must be evidence that there is "imminent" danger to the patient or others in order to justify the need for applying a restraint or seclusion for behavioral reasons. Threatening to do something is not acceptable. Patient's must be in the "act of" or "process of attempting" to do something that could result in the injury or damage to self, others or you."

There was no documentation that patient was in the "act of" or "process of" doing harm to any one. He was in the "act of" or "process of" attempting to leave the facility.

On 6/6/2011 at 10:30 Am in the board room the facility restraint policy CODE 18-08 was reviewed as follows: Purpose To ensure a patient's right to be free from the use of any form of restraint or seclusion is protected. To ensure the immediate physical safety of the patient, staff member, or others.

Policy All patient's have the right to be free from physical restraint or mental abuse, and corporal punishment. All patient's have the right to

Policy All patient's have the right to be free from physical restraint or mental abuse, and corporal punishment. All patient's have the right to be free from restraint seclusion of any form, imposed as a means of coercion, discipline, convenience, or retaliation by the staff.

Restraint or seclusion may be imposed to ensure the immediate physical safety of the patient, staff member or others and must be discontinued at the earliest possible time.

Definitions:

Restraint; any manual method, or physical or mechanical device, material or equipment that immobilizes or reduced the ability of a patient to move his arms, legs, body, or head freely.

Chemical Restraint; A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment of dosage for the patient's condition.

Seclusion: The involuntary confinement, of a patient alone in a room or from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self destructive behavior. Seclusion is practiced in Behavioral health units only

On 6/22/2011 at 10:30 AM, in the board room the patient's medical record was reviewed, it revealed the following: On 6/6/2011 at 0925 hrs the patient walked off the unit AMA (against medical advice). At 1030 hrs documentation revealed the "Patient brought back to unit by city police, taken back to room and Dr. called for restraint orders. Pt stating he will just leave again after the police leave. Pt has an EDW and was educated on why we couldn't let him leave. Pt threatening everyone with their life. On 6/6/2011 at 1100 hrs documentation records "city police and facility security applying wrist and ankle restraints per doctors orders. Pt agitated and shouting threats.

Further review of the patient's medical record revealed, a physician's order for Ativan 1 mg PO/IM/IV Q 30 minutes for agitation "now" was not ordered when the patient was admitted to the hospital. The Ativan was not ordered in anticipation of treating drug abuse and/or withdrawal, rather the Ativan was ordered to calm an angry man who left the hospital AMA and was brought back to the hospital against his will. This order was written on 6/6/2011 at 1102 hrs after the patient was returned to the unit on 6/6/2011 at 1030 hrs and threatened to leave again as soon as police left. A telephone order for a physical hold to bed net was the only other intervention physician ordered. However, the nurses narrative documents the patient being restrained by police and security by applying wrist and ankle restraints. The patient was understandably agitated and shouting out threats.

There was no evaluation by a Registered Nurse documenting the need for the initial dose of Ativan. There is no documentation in the nurses narrative that the initial dose of Ativan IM was given, however the restraint /seclusion monitoring log record the dose given at 1230 hrs and the MAR records the initial dose of Ativan at 1220 hrs. There was no nursing documentation of alternative interventions considered prior to giving the Ativan IM. Further nursing documentation revealed after the patient awoke at 1800 hrs he asked for some thing to eat and to be released. Documentation records "the patient has been sleeping since 1515 hrs". The medical record does not indicate the patient was released from restraints, even while asleep as required by State hospital regulation Y2172 (b) If the individual is determined to be asleep, the clinically competent registered nurse will instruct authorized staff to immediately release the individual from restraint or unlock the seclusion room door. Authorized staff will maintain continuous face-to-face observation until the individual is awake

and re-evaluated by the clinically competent Registered Nurse and the hospitals' policy Code 18-08 reads "Restraint/Seclusion may be imposed to ensure the immediate physical safety of the patient, staff member or others and must be discontinued at the earliest possible time.

Continued review of the patient's medical record restraint/seclusion monitoring log reveals on 6/6/2011 at 1830 hrs the patient was given a PRN medication for agitation, yet the nurses narrative records 6/6/2011 at 1800 hrs records the patient woke up asking for something to eat and to be released. At 1830 hrs the record indicates the restraints were removed and at 1841 hrs "Pt sitting up in bed watching TV. No distress noted, he is calm."

Continued review of the patient's medical record reveals 6/6/2011 at 1930 hrs "Pt walking off unit with sitter in "tail" Called out to pt to not leave floor and followed off unit down stairs. Staff RN calling security to notify. Pt ran out exit through loading dock and took off down the street". The patient was returned to the unit by city police at 2030 hrs. The Patient's medical record reads "Pt escorted back to room by police and security. Sitter in room. Restraints reapplied. Pt cooperative at this time. States he was at his buddy's house and smoked a cigarette. Discussed poc for this shift. Police remain on the unit." On 6/6/2011 at 2150 documentation reveals "Pt getting agitated. Pushed bedside table in my direction spilling a glass of water onto the floor. Informed pt I was going to give him an Ativan shot to help him relax. Pt compliant and held still while receiving injection". Pt was restrained in a bed net at the time he pushed the bedside table toward the staff.

Nurses narrative ends at 2150 hrs on 6/6/2011. There was no further nurses narrative for release of restraints or assessment of effectiveness of Ativan. There is no nurse narrative until 0730 6/7/2011 when the nurses narrative reads; "rec'd patient sitting at bedside with sitter and police officer in the room". A review of the restraint/seclusion monitoring log documents the patient was last released from restraint at 1830 hrs on 6/6/2011. The restraint/seclusion monitoring log had no documentation past 0645 on 6/7/2011. Nurses narrative records the patient was discharged at 0920 hrs transported by police to Rusk State Hospital.

Review of the Restraint Orders Monitoring Logs revealed, restraint orders for 4 hour duration were renewed 5 times for a total of 20 hours, the patient was asleep for 7 1/2 hours of the 20 hours. Review of hospital policy "Code 18-08" titled "Restraints revealed the following: "Restraint or seclusion may be imposed to ensure the immediate physical safety of the patient, staff member or others and must be discontinued at the earliest possible time." There was no documentation the patient was evaluated by a Registered Nurse once he was observed asleep. There is no documentation that while asleep the patient was released from restraint.

There was no documentation the patient was released from the wrist and ankle restraints when given an initial dose of IM Ativan. There was no documentation the patient was released from the wrist and ankle restraints when documentation revealed he was placed in a bed net. There was no documentation in the nurses narrative or the restraint/seclusion monitoring log the patient was released from wrist and ankle restraints or bed net restraint until 1830 hrs on 6/6/2011. There was no documentation the patient attempted harm to himself. There was no documentation the patient attempted harm to others during this episode.

Tag No: A0166

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on document review the facility failed to develop a written care plan addressing the needs of a psychiatric patient and failed to evaluate and update the restraints in 1 of 1 patient's reviewed. .

On 6/15/2011 at 11:00 AM the patient's medical record was reviewed for care planning and the following was identified:

There was no Nursing Care Plan for this patient, who was admitted with Polysubstance intoxication, for withdrawal from Polysubstance abuse.

There was no Nursing Care Plan documented for this patient for suicide precautions.

There was no Nursing Care Plan documented for this patients for the use of mechanical restraints.

There was no Nursing Care Plan for this patient for least restrictive interventions.

There was no Nursing Care Plan for this patient's discharge to Rusk State Hospital.

There was no documented nursing care plan with interventions, assessments or updates for any identified patient care need.

Case Management discharge plan dated 6/5/2011 hrs until 6/22/2011-Tentative discharge to state mental health facility.



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CHRISTUS ST MICHAEL HEALTH SYSTEM ->

Report No. 1571

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

CHRISTUS ST MICHAEL HEALTH SYSTEM

2600 ST MICHAEL DR TEXARKANA, TX 75504

June 22, 2011

VIOLATION: RN SUPERVISION OF NURSING CARE

Tag No: A0395

Based on record review and interview, the facility failed to assure neurologic (neuro) assessments were conducted as per physician order for one of one patient.

Findings include:

Review of the medical record revealed an order for " neuro checks every 2 hours times 24 hours, then every shift, " on the Stroke/TIA Admission Orders, written on 5/23/2009 at 2:25pm and initiated at 4:02pm. There was no subsequent order regarding neurologic checks.

Review of the document titled, "Neurological Assessment Sheet, "revealed neurological checks completed at the following times: 5/23/2009- at 4:02pm, 8:00pm, 10:00pm, and midnight (no check at 6:00pm) 5/24/2009- at 2:00am, 6:00am, 8:00am, noon, and 4:00pm (no check at 4:00am, 10:00am, 2:00pm, or 6:00pm)

In an interview in the Administrative Library on 6/22/11 at 2:00pm, staff#1 confirmed the missing neurologic checks on the Neurological Assessment Sheet.

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CHRISTUS ST MICHAEL HEALTH SYSTEM CHRISTUS ST MICHAEL HEALTH SYSTEM

2600 ST MICHAEL DR TEXARKANA, TX 75504 | Voluntary non-profit - Private

View hospital's federal Hospital Compare record

Report date Number of violations

June 22, 20111 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

Report date Number of incomplete reportsNumber of violations Nov. 19, 20121



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JPS HEALTH NETWORK ->

Report No. 1468

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

JPS HEALTH NETWORK

1500 S MAIN ST FORT WORTH, TX 76104

June 9, 2011

VIOLATION: PATIENT RIGHTS: INFORMED CONSENT

Tag No: A0131

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the hospital failed to inform/communicate with 1 of 1 patient [Patient #1's] legal guardian regarding altered skin integrity sustained during the inpatient stay. [Patient #1] sustained altered skin integrity to the left hand, face, neck, thigh, left heel and left arm skin graft. The legal guardian did not find out about the altered skin integrity until after [Patient #1] was discharged and admitted to the inpatient hospice facility.

Findings Included:

The physician discharge summary dated 04/05/11 reflected, "[AGE] year old female with a history of traumatic brain injury, subdural hematoma with craniotomy in the past who was brought in from a nursing home for altered mental status and unresponsiveness...the patient was intubated in the emergency room ...she was found to have Pneumonia, UTI [Urinary Tract Infection], and Sepsis, and was treated with antibiotics...the patient continued to be unresponsive during her stay...unable to be weaned from the vent due to her poor prognosis and mental status...guardian contacted and options of tracheostomy...versus hospice were discussed...it was decided care would be withdrawn...comfort care measures initiated and patient discharged to....hospice care center..."

The physician's orders dated 03/26/11 timed at 10:15 AM reflected, "CT abdomen, pelvis with contrast stat..."

The nursing note dated 03/26/11 timed at 5:29 PM reflected, "IV [Intravenous] L [Left] hand, 18 single lumen...reddened, swollen, ecchymotic, removed...IV dye extravasated...pressure dressing applied wrapped in warm blanket and elevated..."No documentation indicating [Patient #1's] guardian was informed.

The nursing note dated 03/27/11 timed at 4:15 AM reflected, "Wound #1, blister...L [Left] hand...oozing serous drainage...cracked/blisters/broken; length 7 cm [Centimeters], Width 10 cm, dressing dry and intact..."

The nursing note dated 03/28/11 timed at 7:37 AM reflected, "Wound #1, blister...left hand....drainage serous..."

The physician progress note dated 03/30/11 timed at 04:44 reflected, "Spoke with patient's guardian regarding patient's decompensation...informed that she is starting to have multi-organ failure despite efforts...guardian expressed her desire to continue every thinkable measure in efforts to treat the patient...we will commence with RotoProne bed...we will discuss with guardian regarding any major changes in patient's status..." No documentation was found indicating the guardian was notified of altered skin integrity for [Patient #1] throughout her inpatient stay.

The nursing note dated 03/30/11 timed at 05:27 AM reflected, "Doctor...at bedside to evaluate patient...orders received to RotoProne patient at this time due/to declining respiratory status..."

The physician's orders dated 03/30/11 timed at 05:30 AM reflected, "RotoProne Bed."

The nursing notes dated 03/30/11 timed at 05:00 AM to 04/01/11 timed at 08:00 AM reflected, [Patient #1] was on the RotoProne bed.

The nursing note dated 04/01/11 timed at 10:00 AM reflected, [Patient #1] was removed from the RotoProne bed and placed on "total care/waffle overlay..."

The nurse's note dated 04/03/11 timed at 5:30 PM reflected, "Wound #1...blister left hand...drainage serous...Wound #2....blister to face..."

The nurse's note dated 04/03/11 timed at 8:25 PM reflected, "Wound #1...blister left hand...Wound #2...blister face..."

The nurse's note dated 04/04/11 timed at 3:29 PM reflected, "Wound #1...blister left hand...at 3:48 PM Wound #2...abrasion face..."

The nursing note dated 04/05/11 timed at 12:08 PM reflected, "Wound #1...blister left hand...Wound #2 type face, location abdomen...Wound #3...blister left thigh...." No documentation was found indicating [Patient #1's] skin changes were reported to the legal quardian.

The inpatient hospice notes dated 04/05/11 reflected, "Abrasions to face and right neck...left heel pressure ulcer stage I, three centimeters in length, 2.5 centimeters wide, depth none...left thigh blister, 9 centimeters in length, five centimeters wide...filled with yellow fluid...dressing placed over blister to collect fluid and drainage if it ruptures...left hand 8.5 centimeters in length, 7.5 centimeters wide...beefy red, slough 90% [percent]...drainage serosanguineous yellow and red, moderate amount...left arm on graft site...blister filled with yellow fluid, 2.5 centimeters in length, 2.0 centimeters wide....right wrist serous drainage, yellow...appears to be site of multiple blood collections...skin around sites also draining yellow liquid..."

On 06/09/11 at approximately 2:15 PM, Staff #5 was interviewed. Staff #5 was asked to review the medical record. Staff #5 stated she could find no documentation indicating [Patient #1's] guardian was notified of the altered skin integrity.

On 06/10/11 at 10:30 AM Staff #11 was interviewed. Staff #11 was asked if [Patient #1's] altered skin integrity was documented. Staff #11 stated she did not document, nor did she tell the guardian. She stated she spoke with the guardian towards the end of [Patient #1's] stay about her declining condition.

On 06/10/11 at 7:30 PM [Patient #1's] responsible party was interviewed. The responsible party stated she was unaware [Patient #1] had multiple skin problems while in the hospital. The responsible party stated when she went to the hospice she was surprised by the abrasions, blisters and condition of [Patient #1's] skin. The responsible party stated she was not notified by hospital personnel regarding the condition of [Patient #1's] skin.

The policy entitled, "Patient Notification of Unexpected Outcomes or Errors" with an effective date of 03/21/08 reflected, "Disclosure of outcomes of care including unanticipated outcomes...is made to the patient. If the patient is deemed incapable of understanding...the surrogate decision maker substitutes for the patient...the individual designated as the primary communicator with the patient and/or family documents in the patient's medical record what was communicated and any response by the patient and/or family or other discussion..."

The policy entitled, "Nursing Clinical Documentation" with an effective date of 09/14/10 reflected, "Document the name and title of staff notified about specific events or patient's change of condition. Include physicians and family members...entries in the nursing record are concise, pertinent, and related to the plan of care. All entries support or elaborate on nursing care provided, findings, and/or result...the patient's significant other(s) are involved in the assessment process as necessary or appropriate...nursing observations and care provided..."

Tag No: A0395

VIOLATION: RN SUPERVISION OF NURSING CARE

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the hospital failed to ensure 1 of 1 patient [Patient #1's] altered skin integrity to the left hand, face, neck, thigh, left heel and left arm skin graft sites was identifed, evaluated and/or provided treatment by the RN [Registered Nurse] unit nurse and/or RN wound nurse during [Patient #1's] inpatient stay.

Findings Included:

The physician discharge summary dated 04/05/11 reflected, "[AGE] year old female with a history of traumatic brain injury, subdural hematoma with craniotomy in the past who was brought in from a nursing home for altered mental status and unresponsiveness...the patient was intubated in the emergency room ...she was found to have pneumonia, UTI [Urinary Tract Infection], and sepsis, and was treated with antibiotics...the patient continued to be unresponsive during her stay...unable to be weaned from the vent due to her poor prognosis and mental status...guardian contacted and options of tracheostomy...versus hospice were discussed...it was decided care would be withdrawn...comfort care measures initiated and patient discharged to....hospice care center..."

The physician's orders dated 03/26/11 timed at 10:15 AM reflected, "CT abdomen, pelvis with contrast stat..."

The physician's orders dated 03/27/11 to 04/05/11 reflected no documentation indicating treatment was ordered for [Patient #1's] altered skin integrity.

The nursing note dated 03/26/11 timed at 5:29 PM reflected, "IV [Intravenous] L [Left] hand, 18 single lumen...reddened, swollen, ecchymotic, removed...IV dye extravasated...pressure dressing applied wrapped in warm blanket and elevated..." No documentation was found indicating physician orders for treatment was obtained.

The nursing note dated 03/27/11 timed at 4:15 AM reflected, "Wound #1, blister...L [Left] hand...oozing serous drainage...cracked/blisters/broken; length 7 cm [Centimeters], Width 10 cm, dressing dry and intact..."

The nursing note dated 03/28/11 timed at 7:37 AM reflected, "Wound #1, blister...left hand....drainage serous..."

The wound nurse progress note dated 03/28/11 timed at 10:20 AM reflected, "Consulted for low Braden score. No skin breakdown per RN [Registered Nurse]...will follow weekly...on low Braden interventions for now reconsult if any further skin/wound needs..." No assessment was found addressing the left hand IV site which was red, swollen and ecchymotic.

The physician progress note dated 03/30/11 timed at 04:44 reflected, "Spoke with patient's guardian regarding patient's decompensation...informed that she is starting to have multi-organ failure despite efforts...guardian expressed her desire to continue every thinkable measure in efforts to treat the patient....we will discuss with guardian regarding any major changes in patient's status..."

The physician's orders dated 03/30/11 timed at 05:30 AM reflected, "RotoProne Bed."

The nursing notes dated 03/30/11 timed at 05:00 AM to 04/01/11 timed at 08:00 AM reflected, [Patient #1] was on the RotoProne bed.

The nursing note dated 04/01/11 timed at 10:00 AM reflected, [Patient #1] was removed from the RhotoProne bed and placed on "total care/waffle overlay..."

The nursing note dated 04/03/11 timed at 5:30 PM reflected, "Wound #1...blister left hand...drainage serous...Wound #2....blister to face..."

The nursing note dated 04/04/11 timed at 3:29 PM reflected, "Wound #1...blister left hand...at 3:48 PM Wound #2...abrasion face..."

The wound care nursing note dated 04/04/11 timed at 14:00 PM reflected, "Follow-up for low Braden consult...low Braden interventions in place...per RN no skin breakdown....continue current skin management..." No evaluation of [Patient #1's] skin was completed.

The nursing note dated 04/05/11 timed at 12:08 PM reflected, "Wound #1...blister left hand...Wound #2 type face, location abdomen...Wound #3...blister left thigh...." No treatment orders were found which addressed the wounds documented.

The inpatient hospice notes dated 04/05/11 reflected, "Abrasions to face and right neck...left heel pressure ulcer stage I, three centimeters in length, 2.5 centimeters wide, depth none...left thigh blister, 9 centimeters in length, five centimeters wide...filled with yellow fluid...dressing placed over blister to collect fluid and drainage if it ruptures...left hand 8.5 centimeters in length, 7.5 centimeters wide...beefy red, slough 90% [percent]...drainage serosanguineous yellow and red, moderate amount...left arm on graft site...blister filled with yellow fluid, 2.5 centimeters in length, 2.0 centimeters wide..."

On 06/08/11 at 3:40 PM Staff #4 was interviewed. Staff #4 was asked to review [Patient #1's] medical record. Staff #4 stated only trauma patients are seen head to toe by the wound care. Staff #4 stated [Patient #1] had a low Braden score. She stated she spoke to the primary nurse and reported [Patient #1] had no skin alterations as documented in both of her note entries. Staff #4 stated she did not perform a skin assessment on [Patient #1]. Staff #4 stated the nurses should have called and requested a skin consult when new issues occurred.

On 06/09/11 at approximately 2:15 PM, Staff #5 was interviewed. Staff #5 was asked to review the medical record. Staff #5 stated she could find no treatment orders for [Patient #1's altered skin integrity. Staff #5 stated no head to toe skin assessment was documented.

On 06/10/11 at 7:30 PM [Patient #1's] responsible party was interviewed. The responsible party stated she was unaware [Patient #1] had multiple skin problems while in the hospital. The responsible party stated when she went to the hospice she was surprised by the abrasions, blisters and condition of [Patient #1's] skin.

The policy entitled, "Skin Management Program" with an effective date of 02/20/07 reflected, "Identification of opportunities to promote and improve client care...promotion of educational opportunities for clients, families, and health care providers regarding cost effective skin care management...documentation of wound, treatment and recommendations in the physician's progress notes...all wounds are staged, regardless of cause this includes but is not limited to surgical wounds, stasis ulcers, burns, and pressure areas...the ET Nurse receives referrals from nursing services and physicians...the ET nurse monitors care and e-evaluates the clients skin management program as appropriate...the client's family is involved in skin care issues and speciality bed decisions..."

RotoProne Therapy System [Prone Positioning]manufactuers documents reflected, "The RotoProne Therapy System allows an immobile patient to be positioned from a supine position [lying on one 's back] to a prone position [lying face down]. This therapy allows the patient 's caregivers options in helping to treat lung complications, such as ARDS [Acute Respiratory Distress System], in a critically ill patient ...the patient will be lying face down, supported by special foam positioning packs which can be customized to the patient 's size. A mask designed to decrease pressure will support the patient 's face ...the patient may have swelling of the face, lips, eyes, hands, feet and/or chest ...patients who are proned may develop pressure sores on the body and face ... "

Tag No: A0396

VIOLATION: NURSING CARE PLAN

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the hospital failed to ensure 1 of 3 patients [Patient #1's] nursing care plan was current and addressed altered skin integrity to the left hand, face, neck, thigh, left heel and left arm skin graft.

Findings Included:

The physician discharge summary dated 04/05/11 reflected, "[AGE] year old female with a history of traumatic brain injury, subdural hematoma with craniotomy in the past who was brought in from a nursing home for altered mental status and unresponsiveness...the patient was intubated in the emergency room ...she was found to have pneumonia, UTI [Urinary Tract Infection], and sepsis, and was treated with antibiotics...the patient continued to be unresponsive during her stay...unable to be weaned from the vent due to her poor prognosis and mental status...guardian contacted and options of tracheostomy...versus hospice were discussed...it was decided care would be withdrawn...comfort care measures initiated and patient discharged to....hospice care center..."

The nursing note dated 03/26/11 timed at 5:29 PM reflected, "IV [Intravenous] L [Left] hand, 18 single lumen...reddened, swollen, ecchymotic, removed...IV dye extravasated...pressure dressing applied wrapped in warm blanket and elevated..."

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The wound nurse progress note dated 03/28/11 timed at 10:20 AM reflected, "Consulted for low Braden score. No skin breakdown per RN [Registered Nurse]...will follow weekly...on low Braden interventions for now reconsult if any further skin/wound needs...".

The nursing note dated 03/30/11 timed at 05:27 AM reflected, "Doctor...at bedside to evaluate patient...orders received to RotoProne patient at this time due/to declining respiratory status..."

The nursing note dated 04/03/11 timed at 5:30 PM reflected, "Wound #1...blister left hand...drainage serous...Wound #2...blister to face..."

The nursing note dated 04/04/11 timed at 3:29 PM reflected, "Wound #1...blister left hand...at 3:48 PM Wound #2...abrasion face..."

The wound care nursing note dated 04/04/11 timed at 14:00 PM reflected, "Follow-up for low Braden consult...low Braden interventions in place...per RN no skin breakdown....continue current skin management..."

The nursing care plan with a review date of 04/04/11 reflected no care plan which addressed [Patient #1's] altered skin integrity.

The nursing note dated 04/05/11 timed at 12:08 PM reflected, "Wound #1...blister left hand...Wound #2 type face, location abdomen...Wound #3...blister left thigh...." documented.

The inpatient hospice notes dated 04/05/11 reflected, "Abrasions to face and right neck...left heel pressure ulcer stage I, three centimeters in length, 2.5 centimeters wide, depth none...left thigh blister, 9 centimeters in length, five centimeters wide...filled with yellow fluid...dressing placed over blister to collect fluid and drainage if it ruptures...left hand 8.5 centimeters in length, 7.5 centimeters wide...beefy red, slough 90% [percent]...drainage serosanguineous yellow and red, moderate amount...left arm on graft site...blister filled with yellow fluid, 2.5 centimeters in length, 2.0 centimeters wide..."

On 06/09/11 at 1:10 PM Staff #1 was asked to review [Patient #1's] care plan for documentation which addressed skin integrity. Staff #1 stated the careplan did not address [Patient #1's] altered skin integrity.

The policy entitled, "Continuum of Care Plan" with a revision date of 06/17/08 reflected, "Enhance the patient's/family's ability to participate in and follow through with the plan of care....the patient's physical and psycho-social status...summary of care provided and progress towards goal..."



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<u>TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO -></u>

Report No. 1569

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

TEXAS HEALTH PRESBYTERIAN HOSPITAL **PLANO**

6200 W PARKER RD PLANO, TX 75093

June 9, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on record review and interview, the facility failed to provide 1 of 1 patient (Patient #1) a safe setting in that he was able to elope from the facility. The patient used a picnic table that was next to a fence to jump over the fence and elope while he was on elopement precautions.

Findings included:

- 1) Patient #1's physician orders dated 05/19/11 reflected he was on close observation precautions and elopement precautions. The elopement precautions were based on the patient's history of running away.
- 2) The facility entitled "Safety Precautions" reflected that patients on close observation and elopement precautions were to be accompanied outside by two staff members.
- 3) In an interview at 09:30 AM on 06/09/11 the Charge Nurse (Employee #2) was asked if the patient was outside with two staff members when he eloped. She confirmed that she had returned to the building leaving only one staff member outside with the patient. She confirmed that the patient eloped without adequate supervision.

- Facility Policy, "Safety Precautions"
 "...Procedures...III. Close Observations ...2. Two staff are required to escort patients on CO's outside for fresh air ...

 [Expressed Procedures when the patient is at risk for eloping from IV. Elopement Precautions (EP's) 1. Elopement Precaution (EP's) occurs when the patient is at risk for eloping from the unit and/or has a
- history of running away...

 2. Two staff are required to escort patients on EP's outside for fresh air ..."

Facility Patient Rights Policy

"Basic Rights for all patients ...3. You have the right to a clean and humane environment in which you are protected from harm ..."

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TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO TEXAS HEALTH PRESBYTERIAN HOSPITAL PLANO

6200 W PARKER RD PLANO, TX 75093 | Voluntary non-profit - Private

View hospital's federal Hospital Compare record

Report date Number of violations

June 9, 20111 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. Incomplete reports

No incomplete reports available.



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MEMORIAL HERMANN BAPTIST BEAUMONT HOSPITAL ->

Report No. 1517

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

MEMORIAL HERMANN BAPTIST BEAUMONT 3080 COLLEGE STREET BEAUMONT, HOSPITAL

TX 77701

May 24, 2011

VIOLATION: PATIENT RIGHTS: NOTICE OF RIGHTS

Tag No: A0117

Tag No: A0130

Based upon record review and interview, the facility failed to ensure 1 of 1 (#1) patient's legal guardian was provided written information related to patient's rights for patient #1.

Review of patient #1's medical record revealed patient was a [AGE] year old male involuntarily admitted on [DATE] with a diagnosis of major depression with suicidal ideation, Alzheimer's Disease, and bi-polar disorder. Review of the admission paperwork in the medical record revealed 1.) Authorization and Assignments Consent, 2.) Joint Notice of Privacy Practices Acknowledgment Form., 3.) Patient's Responsibility Form, 4.) An Important Message From Medicare About Your Rights, 5.) Password Program Authorization Form, 6.) Acknowledgement of Receipt of Patient Rights Pamphlet. All of these forms had "Refused to Sign" on the signature line and was signed by two staff as witnesses.

Review of the Patient Bill of Rights Pamphlet revealed a section titled "Your Right To Know Your Rights" that contained the following information: "You have the right, under the rules by which this hospital is licensed, to be given a copy of these rights before you are admitted to the hospital as a patient. If you so desire, a copy should also be given to the person of your choice. If a guardian has been appointed for you or you are under 18 years of age, a copy will also be given to your guardian, parent, or conservator.

Review of the patient's medical record revealed a copy of the patient's guardianship documents. The guardianship documents revealed patient's daughter had been appointed full guardianship of the patient and the patient shall be declared totally incapacitated without the authority to exercise any rights or powers for himself.

Further review of the medical record revealed no documentation that patient's guardian was given the admission, rights, password, or privacy information to review and sign on the patient's behalf.

An interview was conducted with the Director of Senior Care on 5/24/11 at 2:30 pm in the board room. The Director of Senior Care reviewed the record and confirmed there was no documents signed by the guardian.

VIOLATION: PATIENT RIGHTS: PARTICIPATION IN CARE PLANNING

Based upon record review and interview, the facility failed to ensure patient #1's guardian participated in the development and implementation of the treatment plan of patient #1.

Review of the treatment plan for patient #1 revealed a section on page 2 of the Treatment Plan Problem List that contained the following

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

statements to be signed and dated: "I, (a signature line for patient's signature) a patient at Baptist Hospital of Southeast Texas-Behavioral Health Center (along with appropriate family members or significant others), participated in the development of my treatment and discharge plans. This information has been discussed with me in a fashion I understand. I hereby agree to participate in and cooperate with my treatment and discharge plan. I, (a signature line for healthcare provider's signature), have explained this plan of treatment to the patient and/or family member or significant other in terms he/she/they understand, to the best of my ability." These statements were left blank on patient #1's treatment plan.

Review of physician progress notes revealed a note written by the Discharge Planner on 3/23/11 that stated "Daughter will attend treatment team this Friday". Further review of the medical record revealed no evidence that patient's daughter attended treatment team meeting at any time. No documentation was found in the medical record that patient's daughter was given notification of date and time of treatment team meetings.

An interview was conducted on 5/24/11 at 11:30 am with the Director of Senior Care. The Director confirmed there was no evidence that patient's daughter was notified of date and time of treatment team meetings as well as no evidence that patient's daughter participated in treatment planning.

VIOLATION: REASSESSMENT OF DISCHARGE PLANNING PROCESS

Based upon record review and interview, the facility failed to follow its own policy for reassessment of the discharge plans and documenting each contact with or on behalf of the patient for 1 of 1(#1) patients reviewed.

Review of the policy and procedure #ADM.7.1.0007 titled Discharge Planning revealed the following: "Section D. Documentation - The discharge planning and social services provided are documented in the designated area of the patient's medical record following each contact with or on behalf of the patient. Documentation should be brief and concise and should include dates of services, source of referral, plan of service and outcome. Each contact with patient or family should be noted. If contacts are very extensive they may be summarized periodically. If for some reason a requested service cannot be provided, this should be indicated. The discharge plan itself will be documented and will include an evaluation of the availability of appropriate services to meet the patient's identified needs. discharge documentation should include discharge date, discharge destination and arrangements made."

Review of patient's medical record revealed two documents related to Discharge Planning. A form titled "Master Treatment Plan-Discharge Planning" revealed a form completed by the Director of Social Services dated 3/21/11(2 days after admission). The form was divided into sections with a checklist and a place for comments under each section. The sections were completed as follows: LIVING ARRANGEMENTS/PLACEMENT - Nursing Home was checked and comments added were "Not sure if patient to return to a previous nursing home or a new placement." REFERRALS/RECOMMENDATIONS: Psychiatrist and Primary Care Physician were checked and no comments written. CRITERIA FOR DISCHARGE: No imminent risk of harm to self/others. ASSISTANCE WITH MEDICATIONS/TRANSPORTATION: Hospital staff will arrange or assist. This was the only documentation of any discharge planning found in the chart prior to the day of discharge (5/4/11). The other document found was the discharge instructions dated 5/4/11. The Discharge Instruction form had documentation that patient was to go by ambulance to a local nursing home. The form also had documentation that all instructions were given to the receiving nursing home and report had been called to the nursing home.

Review of physician's progress notes revealed a note written by the discharge planner dated 3/23/11 (4 days after admission) that included the following statements: "Sent packet to Lufkin nursing home. Staff called back and doubts they will accept patient. Also received call back from Veterans Administration Hospital in Houston. Doctor is refusing the patient @ this time." Further review of medical record revealed no other documentation that discharge planning assessment and reassessment was done.

An interview was conducted with the Discharge Planner on 5/24/11 at approximately 2:00 pm. The Discharge Planner reported she made contact with many facilities to arrange placement but she did not document those contacts in the medical record. The Discharge Planner also reported she did not keep notes of the calls and contacts she made.

VIOLATION: REASSESSMENT OF A DISCHARGE PLAN

Based upon record review and interview, the facility failed to ensure the discharge plan for 1 of 1 (#1) patients was reassessed for changes in care needs and appropriateness of the discharge placement.

REFER TO TAG A-843

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Tag No: A0821

Tag No: A0843

Based upon record review and interview, the facility failed to document in the medical record that a list of post-hospital care services was provided to the guardian of 1of 1(#1) patients.

Review of the medical record for patient #1 revealed no documentation that the patient's guardian (daughter) was provided a list of post hospital placement options.

An interview was conducted with the Discharge Planner on 5/24/11 at approximately 2:00 pm. The Discharge Planner reported she had numerous conversations with the patient's guardian (daughter) about placement alternatives but failed to document those discussions in the medical record or maintain notes about those contacts.





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ST DAVID'S SOUTH AUSTIN MEDICAL CENTER ->

Report No. 1559

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

ST DAVID'S SOUTH AUSTIN MEDICAL CENTER

901 WEST BEN WHITE BLVD AUSTIN, TX May 23, 78704 2011

VIOLATION: RN SUPERVISION OF NURSING CARE

Tag No: A0395

Based on review of the clinical record and interview with staff, it was determined that the nursing care and nursing staff assignments were not appropriate to meet the patients needs:

Findings were:

On admission on 1-14-2010, patient's skin was documented as having no breakdown. On 1-26-2010, nursing progress notes documented there was a potential for Stage 2 pressure ulcer. On 1-27-2010, the wound care nurse was asked to see the patient regarding a sacral ulcer, which measures 3 cm x 1.5 cm, covered with yellow slough. Nursing provided care for the pressure ulcer until the patient was discharged to the nursing home.

Interview with the Chief Nursing Officer and Quality Manager confirmed the above findings on 5-23-2011 in the conference room.

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TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON ->

Report No. 1564

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

TEXAS HEALTH PRESBYTERIAN HOSPITAL DENTON

3000 N I-35 DENTON, TX 76201

May 19, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on interview and record review, the hospital failed to ensure Radiology Personnel provided a safe environment for 1 of 3 patients reviewed [Patient #1]. [Patient #1] received a CT Scan with IV [Intravenous] contrast. Radiology personnel failed to report an extravasation of the contrast media during the procedure to the nurse and/or Radiologist on duty. [Patient #1] was not assessed by the nurse and/or Radiologist and did not receive care in a safe setting. [Patient #1] was sent home from [Hospital #1] after the procedure and developed complications related to the IV [Intravenous] contrast media.

Findings Included:

[Hospital #1's] radiology consultation request dated 01/25/11 reflected, "CT of chest and abdomen with IV contrast..."

[Hospital #1's] Radiology Report dated 03/29/11 timed at 14:05 PM and 13:51 PM reflected, "State school patient...unsuccessful IV access. Oral contrast not administered...non contrasted axial images through the entire abdomen ...at 13:51 PM ...non contrasted thin axial images through the entire chest..." No documentation was found indicating IV dye was injected.

[Hospital #1's] study note/preliminary Report dated 03/29/11 timed at 9:28 AM documented by [Staff #4] reflected, "IV infiltrated, and no other IV access available, done without, reason pain." No further documentation was found from the Technician indicating type, amount of contrast injected, status of patient and who was notified to assess the patient.

[Hospital #2's] Discharge summary dated 04/17/11 timed at 15:39 PM reflected, "[AGE] year old male undergoing workup for bronchiectasis to have a CT at [Hospital #1]...patient had an IV placed but contrast was extravagated approximately 40 milliliters into arm and axillary portion of chest. Patient had swelling of the arm with blisters upon arriving back to home. Patient was transferred to [Hospital #2] for evaluation. Seen by trauma service who took patient for [DIAGNOSES REDACTED] ...tolerated...seen by pulmonary services...patient returned to surgery for closure of his and in stable condition...discharged home 04/06/11..."

[Hospital #2's] physician assessment dated [DATE] timed at 15:11 PM reflected, "Patient arrived by ambulance. Patient seen outside hospital for CT of chest. Received IV contrast via IV in the right hand. After returning home experienced swelling in his right arm...patient is experiencing moderate pain...severe contractures in all extremities especially the upper extremities. Right arm is markedly swollen three fourths of the way up ending about mid/upper humerus...unable to palpate a pulse in arm because of soft tissue swelling but capillary refill is good. Evidence of prior IV start site in right hand...exams right humerus findings...contrast extravasation, extends into the distal aspect of the upper arm...right forearm...extensive soft tissue infiltration of contrast both anterior and posterior...right hand findings....dense contrast extravasation along dorsum of hand extending into wrist...extensive extravasation of contrast ..."

[Hospital #2's] physician progress and procedure note dated 03/29/11 timed at 20:13 PM reflected, "16:00 PM contacted [Hospital #1]

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

stated technician reported patient experienced approximately 40 milliliters high pressure extravasation into right hand during CT Scanphysician agrees to consult as patient is at high risk based on x-rays that shows a large degree of extravasation, we suspect greater than 40 milliliters...for [DIAGNOSES REDACTED] ...17:30 PM patient to go to OR [Operating Room]...clinical impression IV contrast extravasation right upper extremity, swelling right upper extremity, and [DIAGNOSES REDACTED] ..."

On 05/19/11 at 11:55 AM Staff #2 was interviewed. Staff #2 stated the emergency room physician from [Hospital #2] called him regarding [Patient #1]coming in with an extravasation from the IV contrast media earlier administered at [Hospital #1] on 03/29/11. Staff #2 stated he spoke with the CT Technician and the technician reported the IV infiltrated and 40 ml of contrast media was extravasated. Staff #2 stated the technician did not follow the procedure for extravasation. He stated the technician did not notify the nurse and/or the Radiologist on duty to assess the patient after the extravasation.

On 05/19/11 at 1:00 PM, Staff #4 was interviewed. Staff #4 was asked what the hospital policy was when extravasation occurs. Staff #4 stated he was supposed to notify the nurse on duty and/or the Radiologist. Staff #4 was asked if he notified the nurse and/or the Radiologist. He stated "No, he thought it was just a small extravasation and they were busy. He stated no contrast media was on the scan. Staff #4 stated he told the individual who was with the patient to apply warm compresses to the site.

On 05/20/11 at 2:54 PM Staff #3 was interviewed. Staff #3 stated she reviewed [Patient #1's] medical record. The surveyor asked Staff #3 if she was aware [Patient#1] sustained an extravasation after contrast media was administered 03/29/11 during [Patient #1's] visit to [Hospital #1]. She stated, "No." She stated no one told her or she would have looked at the patient. Staff #3 stated she was unaware [Patient #1] had complications related to the extravasation. She stated the technician never said anything to her. Staff #3 stated the technician should have reported it so she could have assessed the patient.

[Hospital #1's] policy entitled, "Patient Rights and Responsibilities" with a revision date of 01/2009 reflected, "It is responsibility of all hospital staff to know and support patient's rights...to provide care and interaction and to support these rights and responsibilities...reasonable continuity of care...the right to appropriate assessment and management of pain..."

VIOLATION: SAFETY POLICY AND PROCEDURES

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the hospital failed to ensure 1 of 3 patients [Patient #1] who received a CT Scan with IV [Intravenous] contrast dye was provided an environment free from hazards. Radiology personnel failed to report an extravasation for 1 of 3 patient's [Patient #1]. The hospital further failed to follow hospital policy and procedures designed to protect the patient.

Tag No: A0535

Findings Included:

[Hospital #1's] radiology consultation request dated 01/25/11 reflected, "CT of chest and abdomen with IV contrast..."

[Hospital #1's] Radiology Report dated 03/29/11 timed at 14:05 PM and 13:51 PM reflected, "State school patient...unsuccessful IV access. Oral contrast not administered...non contrasted axial images through the entire abdomen ...at 13:51 PM ...non contrasted thin axial images through the entire chest..." No documentation was found indicating IV dye was injected.

[Hospital #1's] study note/preliminary report dated 03/29/11 timed at 9:28 AM documented by [Staff #4] reflected, "IV infiltrated, and no other IV access available, done without, reason pain." No further documentation was found from the Technician indicating type, amount of contrast injected, status of patient and who was notified to assess the patient.

[Hospital #2's] Discharge summary dated 04/17/11 timed at 15:39 PM reflected, "[AGE] year old male undergoing workup for bronchiectasis to have a CT at [Hospital #1]...patient had an IV placed but contrast was extravagated approximately 40 milliliters into arm and axillary portion of chest. Patient had swelling of the arm with blisters upon arriving back to home. Patient was transferred to [Hospital #2] for evaluation. Seen by trauma service who took patient for [DIAGNOSES REDACTED] ...tolerated...seen by pulmonary services...patient returned to surgery for closure of his and in stable condition...discharged home 04/06/11..."

[Hospital #2's] physician assessment dated [DATE] timed at 15:11 PM reflected, "Patient arrived by ambulance. Patient seen outside hospital for CT of chest. Received IV contrast via IV in the right hand. After returning home experienced swelling in his right arm...patient is experiencing moderate pain...severe contractures in all extremities especially the upper extremities. Right arm is markedly swollen three fourths of the way up ending about mid/upper humerus...unable to palpate a pulse in arm because of soft tissue swelling but capillary refill is good. Evidence of prior IV start site in right hand...exams right humerus findings...contrast extravasation, extends into the distal aspect of the upper arm...right forearm...extensive soft tissue infiltration of contrast both anterior and posterior...right hand findings....dense contrast extravasation along dorsum of hand extending into wrist...extensive extravasation of contrast ..."

[Hospital #2's] physician progress and procedure note dated 03/29/11 timed at 20:13 PM reflected, "16:00 PM contacted [Hospital #1] stated technician reported patient experienced approximately 40 milliliters high pressure extravasation into right hand during CT Scanphysician agrees to consult as patient is at high risk based on x-rays that shows a large degree of extravasation, we suspect greater than 40 milliliters...for [DIAGNOSES REDACTED] ...17:30 PM patient to go to OR [Operating Room]...clinical impression IV contrast extravasation right upper extremity, swelling right upper extremity, and [DIAGNOSES REDACTED] ..."

On 05/19/11 at 11:55 AM Staff #2 was interviewed. Staff #2 stated the emergency room physician from [Hospital #2] called him regarding [Patient #1] coming in with an extravasation from the IV contrast media earlier administered at [Hospital #1] on 03/29/11. Staff #2 stated he spoke with the CT Technician and the technician reported the IV infiltrated and 40 ml of contrast media was extravasated. Staff #2 stated the technician did not follow the procedure for extravasation. He stated the technician did not notify the nurse and/or the Radiologist on duty to assess the patient after the extravasation.

On 05/19/11 at 1:00 PM, Staff #4 was interviewed. Staff #4 was asked what the hospital policy was when extravasation occurs. Staff #4 stated he was supposed to notify the nurse on duty and/or the Radiologist. Staff #4 was asked if he notified the nurse and/or the Radiologist. He stated "No, he thought it was just a small extravasation and they were busy. He stated no contrast media was on the scan. Staff #4 stated he told the individual who was with the patient to apply warm compresses to the site.

On 05/20/11 at 2:54 PM Staff #3 was interviewed. Staff #3 stated she reviewed [Patient #1's] medical record. The surveyor asked Staff #3 if she was aware [Patient#1] sustained an extravasation after contrast media was administered 03/29/11 during [Patient #1's] visit to [Hospital #1]. She stated, "No." She stated no one told her or she would have looked at the patient. Staff #3 stated she was unaware [Patient #1] had complications related to the extravasation. She stated the technician never said anything to her. Staff #3 stated the technician should have reported it so she could have assessed the patient.

The Policy and Procedure: entitled "Intravenous Contrast Administration in Medical Imaging" undated reflected, under the section entitled, "Extravasation Guidelines" reflected, "Extravasation of contrast media is toxic to the surrounding tissues, particularly the skin and can produce an acute inflammatory response. Ulceration and necrosis may result and can be identified as early as six hours after the injury. [DIAGNOSES REDACTED] may occur if enough contrast material is extravasated...when extravasation occurs, notify the radiologist or department nurse. If radiologist not available, notify the ED physician and/or primary care physician. The radiology technologist or department nurse will document the location of the extravasation, the type and amount of contrast, the appearance of the site as well as the patient 's symptoms...immediate treatment for contrast extravasation includes elevation of the affected extremity and application of warm compresses. In most cases the patient 's body will absorb the contrast without any negative sequale...surgical consult may be indicated under the direction of the radiologist or primary care physician. The American College of Radiology recommends an immediate surgical consult for...increased swelling or pain after 2 to 4 hours, altered tissue perfusion as evidenced by decreased capillary refill at any time after extravasation has occurred, change in sensation in the affected limb and skin ulceration or blistering..."

The Hospital policy entitled, "Operating of Medical Imaging Equipment" with a revision date of 06/02/06 reflected, "All radiation-producing equipment controlled by Medical Imaging services shall be used under the direction of the radiologist and by trained, licensed radiologic technologists..."

Tag No: A0546

VIOLATION: RADIOLOGIST RESPONSIBIITIES

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the hospital failed to ensure the Radiologist on duty supervised the ionizing radiology services provided for 1 of 3 patients [Patient #1] who received an IV with contrast dye for the chest and abdomen. The Radiologist on duty was not aware an extravasation had occurred causing the IV dye to disperse into the surrounding tissue of the right hand and arm which resulted in [Patient #1] emergently transferred to a secondary hospital [Hospital #2]. This failure resulted in [Patient #1] having to undergo draining of the IV dye and an of the right hand and arm.

Findings Included:

[Hospital #1's] radiology consultation request dated 01/25/11 reflected, "CT of chest and abdomen with IV contrast..."

[Hospital #1's] Radiology Report dated 03/29/11 timed at 14:05 PM and 13:51 PM reflected, "State school patient...unsuccessful IV access. Oral contrast not administered...non contrasted axial images through the entire abdomen ...at 13:51 PM ...non contrasted thin axial images through the entire chest..." No documentation was found indicating IV dye was injected

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[Hospital #2's] physician assessment dated [DATE] timed at 15:11 PM reflected, "Patient arrived by ambulance. Patient seen outside hospital for CT of chest. Received IV contrast via IV in the right hand. After returning home experienced swelling in his right arm...patient is experiencing moderate pain...severe contractures in all extremities especially the upper extremities. Right arm is markedly swollen three fourths of the way up ending about mid/upper humerus...unable to palpate a pulse in arm because of soft tissue swelling but capillary refill is good. Evidence of prior IV start site in right hand...exams right humerus findings...contrast extravasation, extends into the distal aspect of the upper arm...right forearm...extensive soft tissue infiltration of contrast both anterior and posterior...right hand findings....dense contrast extravasation along dorsum of hand extending into wrist...extensive extravasation of contrast ..."

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[Hospital #1]. She stated, "No." She stated no one told her or she would have looked at the patient. Staff #3 stated she was unaware [Patient #1] had complications related to the extravasation. She stated the technician never said anything to her. Staff #3 stated the technician should have reported it so she could have assessed the patient.

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METHODIST CHARLTON MEDICAL CENTER ->

Report No. 1563

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

METHODIST CHARLTON MEDICAL CENTER

3500 W WHEATLAND ROAD DALLAS, TX May 18, 75237 2011

Tag No: A0043

VIOLATION: GOVERNING BODY

Based on interview and review of records, the governing body failed to ensure patient care was provided in a safe and effective manner and comply with state and federal rules.

Findings included:

- 1) Nursing services did not have supervisory personnel for each nursing unit to provide, when needed, the immediate availability of an RN to provide care for any patient in the event of an emergency. By failing to follow the nurse staffing level requirements, there was a potential for diminished quality of care provided to patients. Cross reference: A392
- 2) Medication Adverse Events and possible patient equipment malfunction were not identified, investigated and reported as required by state and federal law. Cross reference: A263, A276, A287, A311, A410, and A508
- 3) The hospital-wide Quality Assessment and Performance Improvement (QAPI) program did not monitor or evaluate compliance with hospital policies to reduce and identify adverse events and medication errors. The QAPI Program did not identify potential and actual safety practices that put the hospital's patient population at risk for injury. Cross reference: A263, A267, A276, A287, A310, A410, and
- 4) The Governing Body failed to ensure patient rights were met in the grievance process. Cross reference: A123

The "Methodist Bylaws", 05/26/09 requires, "The activities, property and affairs of the Corporation shall be managed by its Board of Directors...The System Quality Review Committee...a standing committee of the Board of Directors....shall...regularly review reports from the medical staff and hospital administration regarding the quality of medical services provided...analyze quality initiatives at each System Institution to assure processes are in place to facilitate the implementation of system-wide best practices...monitor progress with quality initiatives...provide, on behalf of the Board, general governance oversight for the quality of service in the respective System Institutions...assure processes are in place at each System Institution to perform the following functions: report regularly to the System Quality Review Committee on the quality of services provided; assist the System Quality Review Committee in implementing system-wide quality improvement initiatives; review processes and methods used by the medical staff and hospital staff to monitor and improve the quality of service in the respective System Institutions; advise the System Quality Review Committee as to whether monitoring and follow-up programs and activities are effective and whether identified deficiencies in the safety, reliability, effectiveness, and acceptability of hospital and medical care are being addressed...Corporate Medical Board...shall...evaluate and monitor quality monitoring and improvement activities and systems for monitoring and evaluating the quality of patient care and improving patient care in the System Institutions..."

At 10:00 A.M. on 05/17/11, the Director of Quality (Personnel #2) was interviewed. She verified the above findings.

VIOLATION: PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of records and interview, the hospital failed to provide written notice of its decision, steps taken, results of the investigation and date of completion to 7 of 7 grievances received from patients and/or families (Patients #1, #2, #3, #4, #6, #7, and #8) regarding patient care.

Tag No: A0123

Findings include:

The "Complaint/Grievance Log " dated "September 2010 - April 2011" showed:

09/21/10 - Patient #1 complained of the ED (Emergency Department) not having a technician available to do a CT Scan (computerized tomography), the physician releasing him to go home despite being unable to move any of his limbs and concerns regarding the physician's report.

02/14/11 - Patient #2's family complained about the nurses being rude, security was called on the family and the morphine was dripping faster than it was supposed to be.

03/01/11 - Patient #7's family complained about the nurse discontinuing the intravenous fluids and TPN (total parental nutrition) and contaminating them. The family also complained about not being able to see their daughter in ICU (intensive care unit).

03/23/11 - Patient #4's daughter complained that her mother was discharged too soon. Her mother was discharged on [DATE] and was found dead in her home on 03/14/11.

03/28/11 - Patient #8's daughter complained the communication board was not being updated, the staff taking too long to answer the call for assistance when calling for pain medication or asking for PRN (as needed) medication, addressing her mother's high blood pressure and problems with weekend staffing.

04/20/11 - Patient #6's family complained that they felt like the staff was retaliating against the patient after complaining to the floor manager about the lack of care the patient received.

04/25/11 - Patient #3's daughter complained that her mother was upset, angry and crying when the nurse was too rough and uncompassionate when drawing blood by tying the tourniquet too tight and slapping her mother's arm.

The Hospital Policy, "Complaints/Comments/Grievances" dated 04/30/09 required, "To provide mechanisms for receiving and responding to concerns...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) by a patient, or the patient's representative, regarding the patients care, abuse or neglect, issues related to the hospital's compliance with the CMS Hospital Conditions of Participation...related to rights and limitations provided by 42 Code of Federal Regulations...The following types of concerns should be communicated...They include but are not limited to...Significant or unresolved concerns (also called Grievances)...concerns crossing multiple department lines or processes...allegations of harm...should be responded to in writing and substantively address the areas of concern...If a review and reply cannot be completed within 7 calendar days of receipt...acknowledgement of receipt and a reasonable timeframe to respond to the issues should be communicated to the complainant...complaints about physicians should be forwarded to Medical Staff Services... '

At 10:00 A.M. on 05/17/11, the Director of Quality (Personnel #2) was interviewed. She was asked if she is responsible for the Risk Management process. She stated, "Yes, I supervise the Risk Manager and the Quality Management." She was asked if the hospital provided written notice of its decision, steps taken, results of the investigation and date of completion on the grievances that were received from the patients or family of Patients #1, #2, #3, #4, #6, #7, and #8. She stated, "No." She was asked if the hospital followed the required grievance process. She stated, "No." She was asked if Patient #1's complaint regarding physician services was forwarded to Medical Staff Services as required. She stated, "No."

VIOLATION: QAPI **Tag No:** A0263

Based on interview and review of records, the hospital Performance Improvement Program failed to identify the following:

- 1) Adverse Drug Event involving continuous IV narcotic infusion and possible medical device error was not identified and investigated.
- 2) The hospital did not have a Safety Committee or an appointed Safety Officer.3) The hospital Patient Safety Program did not perform root cause analysis for reduction of medication errors.
- 4) The written notice of it's decision, steps taken, results of investigation and date of completion for patient grievances involving patient care was not complete.

Findings included:

The "Plan for Improving Organization Performance" dated 2010 requires, "This plan defines Methodist Health System's processes and accountability for improving operational and clinical performance...Evaluation and improvement of services will be viewed using a framework including the following characteristics: safe, effective, efficient, timely, equitable, and patient centered....To ensure there are systematic processes for monitoring, analyzing, and improving performance related to the services provided...To identify and prioritize processes and systems which have the greatest potential for improving the quality and safety of services...To plan for and implement actions to improve services and to evaluate results of those improvement actions...To integrate and coordinate performance improvement activities...To provide educational opportunities...To effectively disseminate the findings from performance improvement activities to the appropriate persons and/or committees...to comply with standards from...Medicare/Medicaid, Texas Department of Health and Human Services, other licensing and regulatory bodies...The executive staff and leadership will identify goals for performance improvement annually...Prevention of harm or improved safety...Data will be available for consideration in the establishment and prioritization of performance improvement intributes...performance in proving the performance in the extension of the performance improvement in the establishment and prioritization of performance improvement in the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioritization of the performance improvement in the establishment and prioriti performance improvement initiatives...occurrence report data...high risk or problem prone processes...patient complaints...Performance Improvement Scope...will focus on trhe measurement, assessment, and improvement of care, services, and key processes in the following areas...Patient Safety Program...Provision of Care, Treatment and Services of Patients...Medication Management...Medical Equipment

Management...Management of Human Resources...Nursing...Authority, Accountability & Communication...The Methodist Health System's Board of Directors...is vested with the responsibility to ensure that a plan for improving organization performance is in place..."

During an interview on 05/17/11 at 10:00 A.M. with the Director of Quality (Personnel #2), she verified the above listed items were not identified in the Performance Improvement Program.

Cross Reference:

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on interview and record review, the hospital did not implement policies and procedures for Performance Improvement activities by failing to:

- 1. Analyze 1 of 1 adverse drug events that involved an overdose of the narcotic Morphine in 1 of 1 patients (Patient #2).
- 2. Develop the hospital policies to minimize drug errors with continuous intravenous narcotic infusions.

By failing to analyze the adverse drug event, the hospital did not implement a plan of correction to prevent similar medication errors from happening in the future.

Findings included:

Review of Patient #2's medical record revealed:

The "Doctor's Order" sheet dated 02/13/11 timed at 11:40 A.M. revealed, "1. Morphine drip bolus 2 mg (milligrams) IV then start 2 mg/hr (milligrams per hour). Titrate up by 1 mg every 30 minutes for respiratory distress or pain. Maximum 10 mg/hr...."

The "Nurses Notes" dated 02/14/11 timed at 7:00 A.M. revealed, "Son stated patient was gurgling as if he had phlegm he could not cough up. Informed him I would give patient Atropine gtts (drops) to help with secretions. Med was given. Noted, however, patient was unresponsive. Snoring as if in deep sleep with respiratory rate of 9-10/min. SpO2 (oxygen level) 70%. Placed patient on 100% NRB mask (non rebreather mask) and SpO2 increased to 95%. Patient remained unresponsive to verbal and tactile stimuli. V/S (vital signs) stable 153/66 - 86 - 98.7, strong pulse felt. Checked Morphine drip and setting were changed to 25 ml/hr and almost all of remaining med was gone. Infusion stopped and MD (Personnel #21) paged. Spoke to and informed MD (Personnel #21) of incident. Order received for Narcan (medication to reverse effects of narcotics) IV. Med given. Patient responded to med in less than 1 min. Awake, alert, but confused. Informed house supervisor of incident..."

The Quality Assurance Performance Improvement (QAPI) and Pharmacy and Therapeutics (P&T) Committee notes dated February 2011 through May 2011 did not reflect any references or reports for the narcotic medication error and/or possible medication device error which resulted in patient harm.

The "Occurrence Report" dated 02/14/11 reflected, "Outcome: No harm - Intervention or monitoring required ..."

The hospital did not have a "Medication Occurrence Report" filled out on this incident.

The Hospital Policy, "Occurrence Report", dated 10/30/07, required, "To provide a mechanism for response/intervention, monitoring, trending, and prevention follow-up of occurrences and near misses...will be investigated to identify processes underlying the potential apparent cause...and to identify those process changes that might reduce the likelihood of a similar sentinel event occurring in the future...Each situation must be evaluated...Adverse Drug Event is any incident in which the use of a medication at any dose, a medical device...may have resulted in an adverse outcome in a patient...An event or potential event...should be...forwarded to the Risk Manager...should begin an initial assessment...conduct a timely, through and credible root cause analysis...implement improvements to reduce risk, monitoring the effectiveness of those improvements, action plan within 45 calendar days of the event or of becoming aware of the event...It is the responsibility of Risk Management to supply the Safety Committee with a summary of patient incidents...Instructions: An occurrence is any event not consistent with routine patient care...A Near Miss is a SIGNIFICANT unintended event in the system of care, which could have resulted in a SERIOUS unanticipated outcome...An Unanticipated Outcome is a result that differs significantly from what was expected by the healthcare provider...to be result of a treatment, medication or procedure...If the occurrence is medical equipment related, secure the equipment and notify Biomed...If the occurrence is medicated related, you must fill out the Medication Occurrence Report Form ...Follow-Up Instructions...Notify...Pharmacy...Biomed...Secure and tag equipment, supplies or medication items if they are related to the occurrence..."

The Hospital Policy, "Disclosure of Unanticipated Outcome Information", dated 05/15/06 required, "Unanticipated Outcomes (UO's) and Near Misses are analyzed through the quality review and occurrence reporting processes of the Quality Review Committee in order to identify actions that will limit, if possible, reoccurrence...All equipment and supplies that might be implicated in the event or near miss should be retained...The Quality Review Committee oversees the investigation of UO's and Near Misses in the hospital and the implementation of processes to assist in the reduction of the causes of such UO's and Near Misses in the future..."

The Hospital Policy, "Continuous Intravenous Narcotic Infusion For Management of Severe Pain in the Adult Patient" dated 08/30/10 did not address safety requirements while infusing continuous narcotics to prevent inadvertent overdose or tampering with the infusion pump.

At 2:40 P.M. on 05/16/11, the Risk Manager (Personnel #6) was interviewed. She was asked if she is responsible for reviewing and investigating occurrences and variances for the hospital. She stated, "Yes." She was asked if it is hospital policy to refer medication errors and adverse drug events to the Pharmacist. She stated, "Yes." She was then asked to review the Occurrence Report for the narcotic overdose on Patient #2. She was asked if the narcotic overdose was an Unanticipated Outcome or Near Miss. She stated, "I did not consider it a Near Miss because there was no harm." She was asked if there was an intervention performed by the nurse in Patient #2's behalf after the Morphine overdose. She stated, "Yes, Narcan was given to reverse the overdose." She was then asked if an overdose of Morphine would be considered an Unanticipated Outcome. She stated, "Yes." She was asked if she had identified the overdose as an Unanticipated Outcome and performed the required investigation or Root Cause Analysis to identify and prevent such occurrences from happening again as required by hospital policy and procedure. She stated, "No." She was asked if she had referred the adverse drug event to Pharmacy or the P&T Committee for investigation. She stated, "No." She was then asked if she had referred the adverse event to the Quality Review or Safety Committee as required. She stated, "No."

At 10:00 A.M. on 05/17/11, the Director of Quality (Personnel #2) was interviewed. She was asked if she is responsible for the hospital QAPI. She stated, "Yes." She was asked if she is responsible for the Risk Management process. She stated, "Yes, I supervise the Risk Manager and the Quality Management." She was asked to review the occurrence report for Patient #2. She was then asked if the hospital followed the required policies for the Risk Management and QAPI Process. She stated, "No." She was asked if an investigation or Root Cause Analysis had been performed on the Morphine overdose. She stated, "No." She was asked if the incident had been referred to the P&T or Quality Review Committees for investigation and review to prevent this type of occurrence from happening again. She stated, "No." She was asked to produce the past year of the Hospital Safety Committee meeting notes. She stated, "We do not have a Hospital Safety Committee at this facility. It is a corporate wide Safety Committee." She was asked if the hospital followed the Safe Medical Device Reporting policy and procedure and reported incident involving the Alaris IV pump to the FDA as required. She stated, "No."

At 10:40 A.M. on 05/17/11, the Director of Pharmacy (Personnel #14) was interviewed. She was asked if the pharmacy has a policy for safety measures to prevent overdose when providing continuous intravenous narcotic infusions. She stated, "No."

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on interview and review of records, the hospital Performance Improvement Program failed to monitor the safety and quality of patient care in that 1 of 1 Adverse Drug Events involving continuous IV narcotic infusion and possible medical device error on 1 of 1 patient (Patient #2) was not identified and investigated to prevent additional errors from occurring in the future.

Findings included:

Review of Patient #2's medical record revealed:

The "Doctor's Order" sheet dated 02/13/11 timed at 11:40 A.M. revealed, "1. Morphine drip bolus 2 mg (milligrams) IV then start 2 mg/hr (milligrams per hour). Titrate up by 1 mg every 30 minutes for respiratory distress or pain. Maximum 10 mg/hr...."

The "Nurses Notes" dated 02/14/11 timed at 7:00 A.M. revealed, "Son stated patient was gurgling as if he had phlegm he could not cough up. Informed him I would give patient Atropine gtts (drops) to help with secretions. Med was given. Noted, however, patient was unresponsive. Snoring as if in deep sleep with respiratory rate of 9-10/min. SpO2 (oxygen level) 70%. Placed patient on 100% NRB mask (non rebreather mask) and SpO2 increased to 95%. Patient remained unresponsive to verbal and tactile stimuli. V/S (vital signs) stable 153/66 - 86 - 98.7, strong pulse felt. Checked Morphine drip and setting were changed to 25 ml/hr and almost all of remaining med was gone. Infusion stopped and MD (Personnel #21) paged. Spoke to and informed MD (Personnel #21) of incident. Order received for Narcan (medication to reverse effects of narcotics) IV. Med given. Patient responded to med in less than 1 min. Awake, alert, but confused. Informed house supervisor of incident..."

The Quality Assurance Performance Improvement (QAPI) and Pharmacy and Therapeutics (P&T) Committee notes dated February 2011 through May 2011 did not reflect any references or reports for the narcotic medication error and/or possible medication device error which resulted in patient harm.

The "Occurrence Report" dated 02/14/11 reflected, "Outcome: No harm - Intervention or monitoring required ..."

The hospital did not have a "Medication Occurrence Report" filled out on this incident.

The Hospital Policy, "Occurrence Report", dated 10/30/07, required, "To provide a mechanism for response/intervention, monitoring, trending, and prevention follow-up of occurrences and near misses...will be investigated to identify processes underlying the potential apparent cause...and to identify those process changes that might reduce the likelihood of a similar sentinel event occurring in the future...Each situation must be evaluated...Adverse Drug Event is any incident in which the use of a medication at any dose, a medical device...may have resulted in an adverse outcome in a patient...An event or potential event...should be...forwarded to the Risk Manager...should begin an initial assessment...conduct a timely, through and credible root cause analysis...implement improvements to reduce risk, monitoring the effectiveness of those improvements, action plan within 45 calendar days of the event or of becoming aware of the event....It is the responsibility of Risk Management to supply the Safety Committee with a summary of patient incidents...Instructions: An occurrence is any event not consistent with routine patient care...A Near Miss is a SIGNIFICANT unintended event in the system of care, which could have resulted in a SERIOUS unanticipated outcome...An Unanticipated Outcome is a result that differs significantly from what was expected by the healthcare provider...to be result of a treatment, medication or procedure...If the occurrence is medical equipment related, secure the equipment and notify Biomed...If the occurrence is medicated related, you must fill out the Medication Occurrence Report Form ...Follow-Up Instructions...Notify...Pharmacy...Biomed...Secure and tag equipment, supplies or medication items if they are related to the occurrence..."

The Hospital Policy, "Disclosure of Unanticipated Outcome Information", dated 05/15/06 required, "Unanticipated Outcomes (UO's) and Near Misses are analyzed through the quality review and occurrence reporting processes of the Quality Review Committee in order to identify actions that will limit, if possible, reoccurrence...All equipment and supplies that might be implicated in the event or near miss should be retained...The Quality Review Committee oversees the investigation of UO's and Near Misses in the hospital and the implementation of processes to assist in the reduction of the causes of such UO's and Near Misses in the future..."

At 10:00 A.M. on 05/17/11, the Director of Quality (Personnel #2) was interviewed. She was asked if she is responsible for the hospital QAPI. She stated, "Yes." She was asked to review the occurrence report for Patient #2. She was then asked if the hospital followed the required policies for the QAPI Process. She stated, "No." She was asked if an investigation or Root Cause Analysis had been performed on the Morphine overdose. She stated, "No." She was asked if the incident had been referred to the P&T or Quality Review Committees for investigation and review to prevent this type of occurrence from happening again. She stated, "No." She was asked if the hospital followed the Safe Medical Device Reporting policy and procedure and reported incident involving the Alaris IV pump to the FDA as required. She stated, "No."

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on review of records and interviews, the hospital did not identify 1 of 1 medication adverse event (Patient #2) and perform a root cause analysis to identify potential processes for prevention and reduction of medication errors and adverse events. The failure to identify

medication errors and adverse events placed the patient population at risk for further harm or injury.

Findings included:

Review of Patient #2's medical record revealed:

The "Doctor's Order" sheet dated 02/13/11 timed at 11:40 A.M. revealed, "1. Morphine drip bolus 2 mg (milligrams) IV then start 2 mg/hr (milligrams per hour). Titrate up by 1 mg every 30 minutes for respiratory distress or pain. Maximum 10 mg/hr...."

The "Nurses Notes" dated 02/14/11 timed at 7:00 A.M. revealed, "Son stated patient was gurgling as if he had phlegm he could not cough up. Informed him I would give patient Atropine gtts (drops) to help with secretions. Med was given. Noted, however, patient was unresponsive. Snoring as if in deep sleep with respiratory rate of 9-10/min. SpO2 (oxygen level) 70%. Placed patient on 100% NRB mask (non rebreather mask) and SpO2 increased to 95%. Patient remained unresponsive to verbal and tactile stimuli. V/S (vital signs) stable 153/66 - 86 - 98.7, strong pulse felt. Checked Morphine drip and setting were changed to 25 ml/hr and almost all of remaining med was gone. Infusion stopped and MD (Personnel #21) paged. Spoke to and informed MD (Personnel #21) of incident. Order received for Narcan (medication to reverse effects of narcotics) IV. Med given. Patient responded to med in less than 1 min. Awake, alert, but confused. Informed house supervisor of incident..."

The Quality Assurance Performance Improvement (QAPI) and Pharmacy and Therapeutics (P&T) Committee notes dated February 2011 through May 2011 did not reflect any references or reports for the narcotic medication error and/or possible medication device error which resulted in patient harm.

The "Occurrence Report" dated 02/14/11 reflected, "Outcome: No harm - Intervention or monitoring required ..."

The hospital did not have a "Medication Occurrence Report" filled out on this incident.

The Hospital Policy, "Occurrence Report", dated 10/30/07, required, "To provide a mechanism for response/intervention, monitoring, trending, and prevention follow-up of occurrences and near misses...will be investigated to identify processes underlying the potential apparent cause...and to identify those process changes that might reduce the likelihood of a similar sentinel event occurring in the future...Each situation must be evaluated...Adverse Drug Event is any incident in which the use of a medication at any dose, a medical device...may have resulted in an adverse outcome in a patient...An event or potential event...should be...forwarded to the Risk Manager...should begin an initial assessment...conduct a timely, through and credible root cause analysis...implement improvements to reduce risk, monitoring the effectiveness of those improvements, action plan within 45 calendar days of the event or of becoming aware of the event...It is the responsibility of Risk Management to supply the Safety Committee with a summary of patient incidents...Instructions: An occurrence is any event not consistent with routine patient care...A Near Miss is a SIGNIFICANT unintended event in the system of care, which could have resulted in a SERIOUS unanticipated outcome...An Unanticipated Outcome is a result that differs significantly from what was expected by the healthcare provider...to be result of a treatment, medication or procedure...If the occurrence is medical equipment related, secure the equipment and notify Biomed...If the occurrence is medicated related, you must fill out the Medication Occurrence Report Form ...Follow-Up Instructions...Notify...Pharmacy...Biomed...Secure and tag equipment, supplies or medication items if they are related to the occurrence..."

The Hospital Policy, "Disclosure of Unanticipated Outcome Information", dated 05/15/06 required, "Unanticipated Outcomes (UO's) and Near Misses are analyzed through the quality review and occurrence reporting processes of the Quality Review Committee in order to identify actions that will limit, if possible, reoccurrence...All equipment and supplies that might be implicated in the event or near miss should be retained...The Quality Review Committee oversees the investigation of UO's and Near Misses in the hospital and the implementation of processes to assist in the reduction of the causes of such UO's and Near Misses in the future..."

At 2:40 P.M. on 05/16/11, the Risk Manager (Personnel #6) was interviewed. She was asked if she is responsible for reviewing and investigating occurrences and variances for the hospital. She stated, "Yes." She was asked if it is hospital policy to refer medication errors and adverse drug events to the Pharmacist. She stated, "Yes." She was then asked to review the Occurrence Report for the narcotic overdose on Patient #2. She was asked if the narcotic overdose was an Unanticipated Outcome or Near Miss. She stated, "I did not consider it a Near Miss because there was no harm." She was asked if there was an intervention performed by the nurse in Patient #2's behalf after the Morphine overdose. She stated, "Yes, Narcan was given to reverse the overdose." She was then asked if an overdose of Morphine would be considered an Unanticipated Outcome. She stated, "Yes." She was asked if she had identified the overdose as an Unanticipated Outcome and performed the required investigation or Root Cause Analysis to identify and prevent such occurrences from happening again as required by hospital policy and procedure. She stated, "No." She was asked if she had referred the adverse event to the Quality Review or Safety Committee for investigation. She stated, "No."

At 10:00 A.M. on 05/17/11, the Director of Quality (Personnel #2) was interviewed. She was asked if she is responsible for the hospital QAPI. She stated, "Yes." She was asked if she is responsible for the Risk Management process. She stated, "Yes, I supervise the Risk Manager and the Quality Management." She was asked to review the occurrence report for Patient #2. She was then asked if the hospital followed the required policies for the Risk Management and QAPI Process. She stated, "No." She was asked if an investigation or Root Cause Analysis had been performed on the Morphine overdose. She stated, "No." She was asked if the incident had been referred to the P&T or Quality Review Committees for investigation and review to prevent this type of occurrence from happening again. She stated, "No." She was asked to produce the past year of the Hospital Safety Committee meeting notes. She stated, "We do not have a Hospital Safety Committee at this facility. It is a corporate wide Safety Committee." She was asked if the hospital followed the Safe Medical Device Reporting policy and procedure and reported incident involving the Alaris IV pump to the FDA as required. She stated, "No."

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on review of records and interviews, the Governing Body failed to ensure the hospital-wide Quality Assessment and Performance Improvement (QAPI) program was implemented in that it did not identify, monitor or evaluate adverse events and medication errors in 1 of 1 medication adverse events (Patient #2).

Findings:

Review of Patient #2's medical record revealed:

The "Doctor's Order" sheet dated 02/13/11 timed at 11:40 A.M. revealed, "1. Morphine drip bolus 2 mg (milligrams) IV then start 2 mg/hr (milligrams per hour). Titrate up by 1 mg every 30 minutes for respiratory distress or pain. Maximum 10 mg/hr...."

The "Nurses Notes" dated 02/14/11 timed at 7:00 A.M. revealed, "Son stated patient was gurgling as if he had phlegm he could not cough up. Informed him I would give patient Atropine gtts (drops) to help with secretions. Med was given. Noted, however, patient was unresponsive. Snoring as if in deep sleep with respiratory rate of 9-10/min. SpO2 (oxygen level) 70%. Placed patient on 100% NRB mask (non rebreather mask) and SpO2 increased to 95%. Patient remained unresponsive to verbal and tactile stimuli. V/S (vital signs) stable 153/66 - 86 - 98.7, strong pulse felt. Checked Morphine drip and setting were changed to 25 ml/hr and almost all of remaining med was gone. Infusion stopped and MD (Personnel #21) paged. Spoke to and informed MD (Personnel #21) of incident. Order received for Narcan (medication to reverse effects of narcotics) IV. Med given. Patient responded to med in less than 1 min. Awake, alert, but confused. Informed house supervisor of incident..."

The Quality Assurance Performance Improvement (QAPI) and Pharmacy and Therapeutics (P&T) Committee notes dated February 2011 through May 2011 did not reflect any references or reports for the narcotic medication error and/or possible medication device error which resulted in patient harm.

The "Occurrence Report" dated 02/14/11 reflected, "Outcome: No harm - Intervention or monitoring required ..."

The hospital did not have a "Medication Occurrence Report" filled out on this incident.

The Hospital Policy, "Occurrence Report", dated 10/30/07, required, "To provide a mechanism for response/intervention, monitoring, trending, and prevention follow-up of occurrences and near misses...will be investigated to identify processes underlying the potential apparent cause...and to identify those process changes that might reduce the likelihood of a similar sentinel event occurring in the future...Each situation must be evaluated...Adverse Drug Event is any incident in which the use of a medication at any dose, a medical device...may have resulted in an adverse outcome in a patient...An event or potential event...should be...forwarded to the Risk Manager...should begin an initial assessment...conduct a timely, through and credible root cause analysis...implement improvements to reduce risk, monitoring the effectiveness of those improvements, action plan within 45 calendar days of the event or of becoming aware of the event...It is the responsibility of Risk Management to supply the Safety Committee with a summary of patient incidents...Instructions: An occurrence is any event not consistent with routine patient care...A Near Miss is a SIGNIFICANT unintended event in the system of care, which could have resulted in a SERIOUS unanticipated outcome...An Unanticipated Outcome is a result that differs significantly from what was expected by the healthcare provider...to be result of a treatment, medication or procedure...If the occurrence is medical equipment related, secure the equipment and notify Biomed...If the occurrence is medicated related, you must fill out the Medication Occurrence Report Form ...Follow-Up Instructions...Notify...Pharmacy...Biomed...Secure and tag equipment, supplies or medication items if they are related to the occurrence..."

The "Methodist Bylaws", 05/26/09 requires, "The activities, property and affairs of the Corporation shall be managed by its Board of Directors...The System Quality Review Committee...a standing committee of the Board of Directors....shall...regularly review reports from the medical staff and hospital administration regarding the quality of medical services provided...analyze quality initiatives at each System Institution to assure processes are in place to facilitate the implementation of system-wide best practices...monitor progress with quality initiatives...provide, on behalf of the Board, general governance oversight for the quality of service in the respective System Institutions...assure processes are in place at each System Institution to perform the following functions: report regularly to the System Quality Review Committee on the quality of services provided; assist the System Quality Review Committee in implementing system-wide quality improvement initiatives; review processes and methods used by the medical staff and hospital staff to monitor and improve the quality of service in the respective System Institutions; advise the System Quality Review Committee as to whether monitoring and follow-up programs and activities are effective and whether identified deficiencies in the safety, reliability, effectiveness, and acceptability of hospital and medical care are being addressed...Corporate Medical Board...shall...evaluate and monitor quality monitoring and improvement activities and systems for monitoring and evaluating the quality of patient care and improving patient care in the System Institutions..."

At 10:00 A.M. on 05/17/11, the Director of Quality (Personnel #2) was interviewed. She was asked if she is responsible for the hospital QAPI. She stated, "Yes." She was then asked if the hospital followed the required policies for QAPI Process. She stated, "No." She was asked if an investigation or Root Cause Analysis had been performed on the Morphine overdose. She stated, "No." She was asked if the incident had been referred to the P&T or Quality Review Committees for investigation and review to prevent this type of occurrence from happening again. She stated, "No."

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on review of records and interviews, the Patient Safety Program was not implemented in that the governing body did not ensure prevention and reduction of medical errors and adverse events in that 1 of 1 medication adverse events (Patient #2) was not identified and investigated to identify process changes that might reduce the likelihood of a similar event from occurring in the future.

Findings:

Review of Patient #2's medical record revealed:

The "Doctor's Order" sheet dated 02/13/11 timed at 11:40 A.M. revealed, "1. Morphine drip bolus 2 mg (milligrams) IV then start 2 mg/hr (milligrams per hour). Titrate up by 1 mg every 30 minutes for respiratory distress or pain. Maximum 10 mg/hr...."

The "Nurses Notes" dated 02/14/11 timed at 7:00 A.M. revealed, "Son stated patient was gurgling as if he had phlegm he could not cough up. Informed him I would give patient Atropine gtts (drops) to help with secretions. Med was given. Noted, however, patient was unresponsive. Snoring as if in deep sleep with respiratory rate of 9-10/min. SpO2 (oxygen level) 70%. Placed patient on 100% NRB mask (non rebreather mask) and SpO2 increased to 95%. Patient remained unresponsive to verbal and tactile stimuli. V/S (vital signs) stable 153/66 - 86 - 98.7, strong pulse felt. Checked Morphine drip and setting were changed to 25 ml/hr and almost all of remaining med was gone. Infusion stopped and MD (Personnel #21) paged. Spoke to and informed MD (Personnel #21) of incident. Order received for Narcan (medication to reverse effects of narcotics) IV. Med given. Patient responded to med in less than 1 min. Awake, alert, but confused. Informed house supervisor of incident..."

The Quality Assurance Performance Improvement (QAPI) and Pharmacy and Therapeutics (P&T) Committee notes dated February 2011

through May 2011 did not reflect any references or reports for the narcotic medication error and/or possible medication device error which resulted in patient harm.

The "Occurrence Report" dated 02/14/11 reflected, "Outcome: No harm - Intervention or monitoring required ..."

The hospital did not have a "Medication Occurrence Report" filled out on this incident.

The Hospital Policy, "Occurrence Report", dated 10/30/07, required, "To provide a mechanism for response/intervention, monitoring, trending, and prevention follow-up of occurrences and near misses...will be investigated to identify processes underlying the potential apparent cause...and to identify those process changes that might reduce the likelihood of a similar sentinel event occurring in the future...Each situation must be evaluated...Adverse Drug Event is any incident in which the use of a medication at any dose, a medical device...may have resulted in an adverse outcome in a patient...An event or potential event...should be...forwarded to the Risk Manager...should begin an initial assessment...conduct a timely, through and credible root cause analysis...implement improvements to reduce risk, monitoring the effectiveness of those improvements, action plan within 45 calendar days of the event or of becoming aware of the event...It is the responsibility of Risk Management to supply the Safety Committee with a summary of patient incidents...Instructions: An occurrence is any event not consistent with routine patient care...A Near Miss is a SIGNIFICANT unintended event in the system of care, which could have resulted in a SERIOUS unanticipated outcome...An Unanticipated Outcome is a result that differs significantly from what was expected by the healthcare provider...to be result of a treatment, medication or procedure...If the occurrence is medical equipment related, secure the equipment and notify Biomed...If the occurrence is medicated related, you must fill out the Medication Occurrence Report Form ...Follow-Up Instructions...Notify...Pharmacy...Biomed...Secure and tag equipment, supplies or medication items if they are related to the occurrence..."

The Hospital Policy, "Disclosure of Unanticipated Outcome Information", dated 05/15/06 required, "Unanticipated Outcomes (UO's) and Near Misses are analyzed through the quality review and occurrence reporting processes of the Quality Review Committee in order to identify actions that will limit, if possible, reoccurrence...All equipment and supplies that might be implicated in the event or near miss should be retained...The Quality Review Committee oversees the investigation of UO's and Near Misses in the hospital and the implementation of processes to assist in the reduction of the causes of such UO's and Near Misses in the future..."

At 2:40 P.M. on 05/16/11, the Risk Manager (Personnel #6) was interviewed. She was asked if she is responsible for reviewing and investigating occurrences and variances for the hospital. She stated, "Yes." She was asked if it is hospital policy to refer medication errors and adverse drug events to the Pharmacist. She stated, "Yes." She was then asked to review the Occurrence Report for the narcotic overdose on Patient #2. She was asked if the narcotic overdose was an Unanticipated Outcome or Near Miss. She stated, "I did not consider it a Near Miss because there was no harm." She was asked if there was an intervention performed by the nurse in Patient #2's behalf after the Morphine overdose. She stated, "Yes, Narcan was given to reverse the overdose." She was then asked if an overdose of Morphine would be considered an Unanticipated Outcome. She stated, "Yes." She was asked if she had identified the overdose as an Unanticipated Outcome and performed the required investigation or Root Cause Analysis to identify and prevent such occurrences from happening again as required by hospital policy and procedure. She stated, "No." She was asked if she had referred the adverse drug event to Pharmacy or the P&T Committee for investigation. She stated, "No." She was then asked if she had referred the adverse event to the Quality Review or Safety Committee as required. She stated, "No."

At 10:00 A.M. on 05/17/11, the Director of Quality (Personnel #2) was interviewed. She was asked if she is responsible for the hospital QAPI. She stated, "Yes." She was asked if she is responsible for the Risk Management process. She stated, "Yes, I supervise the Risk Manager and the Quality Management." She was asked to review the occurrence report for Patient #2. She was then asked if the hospital followed the required policies for the Risk Management and QAPI Process. She stated, "No." She was asked if an investigation or Root Cause Analysis had been performed on the Morphine overdose. She stated, "No." She was asked if the incident had been referred to the P&T or Quality Review Committees for investigation and review to prevent this type of occurrence from happening again. She stated, "No." She was asked to produce the past year of the Hospital Safety Committee meeting notes. She stated, "We do not have a Hospital Safety Committee at this facility. It is a corporate wide Safety Committee." She was asked if the hospital followed the Safe Medical Device Reporting policy and procedure and reported incident involving the Alaris IV pump to the FDA as required. She stated, "No."

VIOLATION: STAFFING AND DELIVERY OF CARE

Based on review of records and interview, the hospital did not have a Supervisory RN (Registered Nurse) immediately available on each nursing unit to provide nursing care to 1 of 1 (F4E unit) Medical Surgical inpatient units where patients were present for 4 of 4 shifts from 02/13/11- 02/14/11.

Tag No: A0392

The RN Charge Nurse had patient assignments and did not have at least one RN immediately available in the event of an emergency where patients were present.

The lack of adequate nurse staffing created a potential for patient harm.

Findings included:

Review of Patient #2's medical record reflected he was admitted to the hospital's F4E Medical-Surgical (Med-Surg) inpatient unit on 02/13/11 for hospice care. The nursing notes revealed the patient was receiving continuous intravenous (IV) Morphine via an IV pump. On 02/14/11 at 7:00 A.M., Personnel #19 documented that Patient #2 received an overdose of Morphine when the IV pump was changed from the ordered 2 ml/hr (milliliters per hour) to 25 ml/hr.

Review of the "Daily Assignment Sheet" dated 02/13/11, 7:00 P.M. - 7:00 A.M. reflected the RN Charge Nurse (Personnel #19) was assigned patient rooms #3, #4, #33, and #37.

The "Daily Assignment Sheet" further revealed the RN Charge Nurse had the following assignments:

02/13/11, 7:00 A.M. - 7:00 P.M. shift, the RN Charge Nurse (Personnel #22) was assigned patient rooms #21, #31, #32 and #33.

02/14/11, 7:00 A.M. - 7:00 P.M. reflected the RN Charge Nurse (Personnel #23) was assigned patient rooms #17, #18, #20 and #22.

02/14/11, 7:00 P.M. - 7:00 A.M. reflected the RN Charge Nurse (Personnel #24) was assigned patient rooms #15, #17, #32 and #33.

The "Department of Nursing Plan for Staffing" not dated, requires, "Staffing patterns have been developed for each unit...Nursing Supervisor reevaluates staffing at a minimum of each shift...Staffing plans for each nursing unit are determined by: patient requirements, staff expertise, intensity and variability of care, number of patient visits/census, safe practice,...patient needs, staff skill mix, volume, and nursing judgement...The staffing plans shall be consistent with standards established by...regulatory and accrediting bodies...monitoring of the use of personnel resources will be done on a shift-by-shift basis by the Charge Nurse..."

The "Nurse Staffing Plan" dated 12/30/09 requires, "To comply with those portions of Chapter 257 of the Texas Health Safety Code and those state regulations promulgated in connection with such chapter...all hospitals within the system comply with Texas laws and rules as related to nurse staffing...The Nurse Staffing Plan is determined...number of patients (including admissions, discharges, and transfers); Patient characteristics, including intensity and variability; scope of services provided; departmental characteristics; nursing staff characteristics (education, skill mix, skill/competency, tenure, support staff utilization)..."

The "Plan for the Provision of Patient Care", not dated, requires, "The department director has 24 hour accountability for the operational, administrative and financial responsibility of the nursing departments and is accountable to ensure that staffing and shift coverage is sufficient within patient care areas...The RN professional staff supervises patient care. The charge nurse has accountability for patient care on their respective shift, and is responsible for patient care assignments based upon staff skill mix and the acuity level of the patients..."

During an interview with the RN Charge Nurse (Personnel #19) on 05/18/11 at 9:30 A.M., she verified she was the RN Charge Nurse on 02/13/11 - 02/14/11 for F4E Medical Surgical inpatient unit. Personnel #19 was asked if she was the primary care nurse for Patient #2 during the 7:00 P.M. - 7:00 A.M. shift when the medication error occurred. She stated, "Yes."

During an interview with the CNO (Personnel #1) on 05/16/11 at 3:00 P.M., she verified the above findings.

VIOLATION: HOSPITAL PROCEDURES

The hospital failed to enforce the policies and procedures for reporting 1 of 1 medication errors to the hospital QAPI (quality assurance and performance improvement) program that involved an overdose of the narcotic Morphine on a continuous IV infusion on 1 of 1 patients (Patient #2).

Tag No: A0410

Findings included:

Review of Patient #2's medical record revealed:

The "Doctor's Order" sheet dated 02/13/11 timed at 11:40 A.M. revealed, "1. Morphine drip bolus 2 mg (milligrams) IV then start 2 mg/hr (milligrams per hour). Titrate up by 1 mg every 30 minutes for respiratory distress or pain. Maximum 10 mg/hr...."

The "Nurses Notes" dated 02/14/11 timed at 7:00 A.M. revealed, "Son stated patient was gurgling as if he had phlegm he could not cough up. Informed him I would give patient Atropine gtts (drops) to help with secretions. Med was given. Noted, however, patient was unresponsive. Snoring as if in deep sleep with respiratory rate of 9-10/min. SpO2 (oxygen level) 70%. Placed patient on 100% NRB mask (non rebreather mask) and SpO2 increased to 95%. Patient remained unresponsive to verbal and tactile stimuli. V/S (vital signs) stable 153/66 - 86 - 98.7, strong pulse felt. Checked Morphine drip and setting were changed to 25 ml/hr and almost all of remaining med was gone. Infusion stopped and MD (Personnel #21) paged. Spoke to and informed MD (Personnel #21) of incident. Order received for Narcan (medication to reverse effects of narcotics) IV. Med given. Patient responded to med in less than 1 min. Awake, alert, but confused. Informed house supervisor of incident..."

The Quality Assurance Performance Improvement (QAPI) and Pharmacy and Therapeutics (P&T) Committee notes dated February 2011 through May 2011 did not reflect any references or report for the narcotic medication error and/or possible medication device error which resulted in patient harm.

The "Occurrence Report" dated 02/14/11 reflected, "Outcome: No harm - Intervention or monitoring required..."

The hospital did not have a "Medication Occurrence Report" filled out for this incidence.

The Hospital Policy, "Occurrence Report ", dated 10/30/07, required, "To provide a mechanism for response/intervention, monitoring, trending, and prevention follow-up of occurrences and near misses...will be investigated to identify processes underlying the potential apparent cause...and to identify those process changes that might reduce the likelihood of a similar sentinel event occurring in the future...Each situation must be evaluated...Adverse Drug Event is any incident in which the use of a medication at any dose, a medical device...may have resulted in an adverse outcome in a patient...An event or potential event...should be...forwarded to the Risk Manager...should begin an initial assessment...conduct a timely, through and credible root cause analysis...implement improvements to reduce risk, monitoring the effectiveness of those improvements, action plan within 45 calendar days of the event or of becoming aware of the event...It is the responsibility of Risk Management to supply the Safety Committee with a summary of patient incidents ...Instructions: An occurrence is any event not consistent with routine patient care...A Near Miss is a SIGNIFICANT unintended event in the system of care, which could have resulted in a SERIOUS unanticipated outcome...An Unanticipated Outcome is a result that differs significantly from what was expected by the healthcare provider...to be result of a treatment, medication or procedure...If the occurrence is medical equipment related, secure the equipment and notify Biomed...If the occurrence is medicated related, you must fill out the Medication Occurrence Report Form...Follow-Up Instructions...Notify...Pharmacy...Biomed...Secure and tag equipment, supplies or medication items if they are related to the occurrence..."

The Hospital Policy,"Disclosure of Unanticipated Outcome Information", dated 05/15/06 required, "Unanticipated Outcomes (UO's) and Near Misses are analyzed through the quality review and occurrence reporting processes of the Quality Review Committee in order to identify actions that will limit, if possible, reoccurrence...All equipment and supplies that might be implicated in the event or near miss should be retained...The Quality Review Committee oversees the investigation of UO's and Near Misses in the hospital and the implementation of processes to assist in the reduction of the causes of such UO's and Near Misses in the future..."

On 05/16/11 at 3:00 P.M, the CNO (Personnel #1) was interviewed. She was asked if the the Nursing Department identified the medication adverse event and reported it in the QAPI process. She stated, "No." She was asked if the Nursing Department followed the policies and procedures for identifying and reporting medication adverse events. She stated, "No.

VIOLATION: REPORTING ADVERSE EVENTS

The hospital failed to enforce the policies and procedures for reporting adverse drug events in 1 of 1 patients (Patient #2) to the hospital QAPI program that involved an overdose of the narcotic Morphine on a continuous IV infusion pump.

Tag No: A0508

Findings included:

Review of Patient #2's medical record revealed:

The "Doctor's Order" sheet dated 02/13/11 timed at 11:40 A.M. revealed, "1. Morphine drip bolus 2 mg (milligrams) IV then start 2 mg/hr (milligrams per hour). Titrate up by 1 mg every 30 minutes for respiratory distress or pain. Maximum 10 mg/hr...."

The "Nurses Notes" dated 02/14/11 timed at 7:00 A.M. revealed, "Son stated patient was gurgling as if he had phlegm he could not cough up. Informed him I would give patient Atropine gtts (drops) to help with secretions. Med was given. Noted, however, patient was unresponsive. Snoring as if in deep sleep with respiratory rate of 9-10/min. SpO2 (oxygen level) 70%. Placed patient on 100% NRB mask (non rebreather mask) and SpO2 increased to 95%. Patient remained unresponsive to verbal and tactile stimuli. V/S (vital signs) stable 153/66 - 86 - 98.7, strong pulse felt. Checked Morphine drip and setting were changed to 25 ml/hr and almost all of remaining med was gone. Infusion stopped and MD (Personnel #21) paged. Spoke to and informed MD (Personnel #21) of incident. Order received for Narcan (medication to reverse effects of narcotics) IV. Med given. Patient responded to med in less than 1 min. Awake, alert, but confused. Informed house supervisor of incident..."

The Quality Assurance Performance Improvement (QAPI) and Pharmacy and Therapeutics (P&T) Committee notes dated February 2011 through May 2011 did not reflect any references for the narcotic medication error and/or possible medication device error which resulted in patient harm.

The "Occurrence Report" dated 02/14/11 reflected, "Outcome: No harm - Intervention or monitoring required ..."

The hospital did not have a "Medication Occurrence Report" filled out on this incident.

The Hospital Policy, "Occurrence Report", dated 10/30/07, required, "To provide a mechanism for response/intervention, monitoring, trending, and prevention follow-up of occurrences and near misses...will be investigated to identify processes underlying the potential apparent cause...and to identify those process changes that might reduce the likelihood of a similar sentinel event occurring in the future...Each situation must be evaluated...Adverse Drug Event is any incident in which the use of a medication at any dose, a medical device...may have resulted in an adverse outcome in a patient...An event or potential event...should be...forwarded to the Risk Manager...should begin an initial assessment...conduct a timely, through and credible root cause analysis...implement improvements to reduce risk, monitoring the effectiveness of those improvements, action plan within 45 calendar days of the event or of becoming aware of the event...It is the responsibility of Risk Management to supply the Safety Committee with a summary of patient incidents...Instructions: An occurrence is any event not consistent with routine patient care...A Near Miss is a SIGNIFICANT unintended event in the system of care, which could have resulted in a SERIOUS unanticipated outcome...An Unanticipated Outcome is a result that differs significantly from what was expected by the healthcare provider...to be result of a treatment, medication or procedure...If the occurrence is medical equipment related, secure the equipment and notify Biomed...If the occurrence is medicated related, you must fill out the Medication Occurrence Report Form ...Follow-Up Instructions...Notify...Pharmacy...Biomed...Secure and tag equipment, supplies or medication items if they are related to the occurrence..."

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At 10:40 A.M. on 05/17/11, the Director of Pharmacy (Personnel #14) was interviewed. She was asked if the Pharmacy tracks medication errors and adverse drug events in the QAPI process. She stated, "Yes." She was asked if the Pharmacy policies and procedures required medication errors and adverse drug events to be reported to the QAPI Committee. She stated, "Yes." She was asked if she had received a Medication Occurrence report involving the adverse medication event. She stated, "No." She was asked if the adverse drug event with the Morphine drip on Patient #2 was reported to the QAPI or P&T Committee. She stated, "No."



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Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

No incomplete reports available.



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Tag No: A0117

Tag No: A0806

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PALESTINE REGIONAL MEDICAL CENTER ->

Report No. 1567

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

PALESTINE REGIONAL MEDICAL CENTER 2900 S LOOP 256 PALESTINE, TX 75801 May 17, 2011

VIOLATION: PATIENT RIGHTS: NOTICE OF RIGHTS

Based on record review and interview the facility failed to insure the rights of the patient/patient's representative upon discharge from the facility as evidenced by 1 of 1 patient discharged.

On 5/17/2011 at 9:30 Am in the administrative office the patient record was reviewed and the record revealed *Activity date: 4/30 2011 Time: 0928 Discharge instructions home health to continue. Accompanied at discharge: Family. Mode of discharge: Wheelchair. Destination Home*

Further review of the patient's medical record revealed the Patient was admitted from an Assisted living facility with a diagnosis of Alzhimer's Dementia. The patient's admission documentation was signed by the patient's Power of Attorney (POA) for medical decisions.

On 5/17/2011 at 9:45 AM in the administrative office the Patient's POA was contacted by phone. The POA was asked if she had been notified by hospital staff of the physician's decision to discharge. The POA stated "No". The POA was asked is she had been present for the discharge. The POA stated "No". The POA was asked if any other family member might have been present at the time of discharge to transport the patient from the facility. The POA stated "No". The POA went on to say the Assisted Living facility contacted her to tell her of the discharge.

Upon discharge there was no documentation the POA was notified of the physician's order to discharge nor was there any documentation the POA had been involved in the discharge process.

The patient was not discharged home as documented in the patient's medical record but was discharged to the Assisted living facility she had been admitted from.

VIOLATION: DISCHARGE PLANNING NEEDS ASSESSMENT

Based on record review and interview the facility failed to provide appropraite discharge planning based on 1 of 1 patient's discharge.

On 5/17/2011 in the administration office at 9:30 AM the patient record was reviewed and the record revealed *Activity date: 4/30 2011 Time: 0928 Discharge instructions home health to continue. Accompanied at discharge: Family. Mode of discharge: Wheelchair. Destination Home*

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the discharge.

Upon discharge there was no documentation the POA was notified of the physician's order to discharge nor was there any documentation the POA had been involved in the discharge process.

The patient was not discharged home as documented in the patient's medical record but was discharged to the Assisted living facility she had been admitted from.

Further conversation with the POA revealed they had been notified by the Assisted Living that the hospital had faxed the new medication orders to their pharmacy and they would need to pick them up. Upon arrival at the pharmacy the POA was told the coumadin order could not be filled because the order received from the hospital was lacking the quantity of coumadin to be dispensed.

On 5/17/2011 at 1:15 PM in the patient's pharmacy the pharmacist confirmed the coumadin order could not be filled because the order was incomplete. He confirmed that no one was able to provide help to complete the order when the hospital Emergency Department had been contacted.

On 5/17/2011 at 1:15 PM while in the patient's pharmacy a copy of the order received from the hospital was reviewed and found to lack the quantity of coumadin to be dispensed.

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

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Tag No: A0144

Tag No: A0392

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview the facility failed to provide patient care in a safe setting based on 1 of 1 patient records reviewed.

On 5/17/2011 at 10:00 AM in the administration office the patient's medical record was reviewed. The patient's medical record revealed an incomplete Admission Medication Reconciliation form. The medication reconciliation form list the following medications: ASA, Brovana, Exelon, Flovent, Lasix, Megestrol, Metoprolol, Mucinex, (Page 1). Nexium, Plavix, Sertraline, Simvastatin, Singulair, Spiriva, Synthroid, Ventolin, Zolpidem. (page 2). There was no documentation of strength, frequency or route. There was no documentation of last dose given or if any medication was to be continued in the hospital. There was no documentation of verification of the medication list from the Assisted Living facility the patient had been admitted from. There was documentation of a stated weight of 51.82 kg and allergies were listed as ASA, PCN. (Note the first medication listed as taken by the patient is ASA)

Further review of the patient's medical record revealed the following documentation: *Emergency Department Administration Record: Ativan 1 mg ordered at 1940 hours and administered at 1945 to the Left glut* further documentation reveals this order was repeated at 2022 hours. There was no documentation on the Emergency Department Ongoing Nursing Assessment notes as to why the injection was required to be given. There was no assessment documented on the Emergency Department Medication Administration Record of the patient's condition as improved, worsened, or unchanged from the firsts injection. There was no documentation why the second injection was required. There was no assessment documented on the Emergency Department Medication Administration Record after the second injection of the patient's condition improved, worsened or unchanged.

Further review of the patient's medical record revealed the Emergency Department Fall/Entrapment risk Assessment was not completed. The only documentation on the assessment, which was written in the score column, was *fall protection in place*. There was no documentation for Age, Mental Status, Elimination, Impairments, BP, Gait/Mobility, Current Medication, Predisposition Conditions.

Further review of the patient's inpatient records reveals on 4/26/2011 at 1930 hours Physicians orders included *No NSAIDS, ASA or IM injections* the Physicians Orders also included *Home meds as ordered on medication sheet*. The Patient's home medication sheet included ASA. On 4/27/2011 at 0900 hours ASA 81 mg was administered by the nurse on duty. On 4/28/2011 ASA 81 mg was administered by the nurse on duty. An order for Geodon 20 mg IM is documented as received at 2120 hours and administered 1 time only for agitation 4/26/11 at 2125 by the nurse on duty. There is no follow up documentation.

Further review of the patient's inpatient medical record reveals the admission nurses assessment documented Activity Date 4/26/11 Time: 2140 Alzheimer's Disease: N (N=No) (admission diagnosis Alzheimer's dementia), COPD: N (admission diagnosis COPD). The shift assessment dated [DATE] (No time documented) recorded Braden score of 13 along with the statement: Score is 18 or less: N

On 5/17/2011 at 11:30 PM in the administration office the Assistant Director of Nurses confirmed the Emergency Department Admission forms were incomplete and Emergency Department nurse had documented very little.

VIOLATION: STAFFING AND DELIVERY OF CARE

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on document review and interview the facility failed to provide patient needs based on accurate assessments as evidenced by 1 of 1 patient medical record reviewed.

On 5/17/2011 at 10:00 AM in the administration office the patient's medical record was reviewed. The patient's medical record revealed an incomplete Admission Medication Reconciliation form. The medication reconciliation form listed the following medications: ASA, Brovana, Exelon, Flovent, Lasix, Megestrol, Metoprolol, Mucinex, (Page 1). Nexium, Plavix, Sertraline, Simvastatin, Singulair, Spiriva, Synthroid, Ventolin, Zolpidem. (page 2). There was no documentation of strength, frequency or route. There was no documentation of last dose given or if any medication was to be continued in the hospital. There was no documentation of verification of the medication list from the Assisted Living facility the patient had been admitted from. There was documentation of a stated weight of 51.82 kg and allergies were listed as ASA, PCN. (Note the first medication listed as taken by the patient is ASA)

Further review of the patient's medical record revealed the following documentation: *Emergency Department Administration Record: Ativan 1 mg ordered at 1940 hours and administered at 1945 to the Left glut* further documentation reveals this order was repeated at 2022 hours. There was no documentation on the Emergency Department Ongoing Nursing Assessment notes as to why the injection was required to be given. There was no assessment documented on the Emergency Department Medication Administration Record of the patient's condition as improved, worsened, or unchanged from the firsts injection. There was no documented assessment why the second injection was required. There was no assessment documented on the Emergency Department Medication Administration Record after the second injection of the patient's condition improved, worsened or unchanged.

Further review of the patient's medical record revealed the Emergency Department Fall/Entrapment risk Assessment was not completed. The only documentation on the assessment, which was written in the score column, was *fall protection in place*. There was no assessment of documented criteria for Age, Mental Status, Elimination, Impairments, BP, Gait/Mobility, Current Medication, Predisposition Conditions.

Further review of the patient's inpatient records reveals on 4/26/2011 at 1930 hours Physicians orders included *No NSAIDS, ASA or IM injections* the Physicians Orders also included *Home meds as ordered on medication sheet*. The Patient's home medication sheet included ASA. On 4/27/2011 at 0900 hours ASA 81 mg was administered by the nurse on duty. On 4/28/2011 ASA 81 mg was administered by the nurse on duty. An order for Geodon 20 mg IM is documented as received at 2120 hours and administered 1 time only for agitation 4/26/11 at 2125 by the nurse on duty. There is no assessment documented regarding the conflict in medication orders and no clarification.

Further review of the patient's inpatient medical record reveals the admission nurses assessment documented Activity Date 4/26/11 Time: 2140 Alzheimer's Disease: N (N=No) (admission diagnosis Alzheimer's dementia), COPD: N (admission diagnosis COPD). The shift assessment dated [DATE] (No time documented) recorded Braden score of 13 along with the statement: Score is 18 or less: N

On 5/17/2011 at 11:30 PM in the administration office the Assistant Director of Nurses confirmed the Emergency Department Admission forms were incomplete and Emergency Department nurse had documented very little.

On 5/17/2011 at 11:30 AM in the administrative office an overall review of documentation in the patient's medical record reveals incomplete, inaccurate and contradictory nursing documentation.

VIOLATION: PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES

Based on record review and interview the facility failed to act on grievance resolution within it's policy parameters based on 1 of 1 grievance reviewed.

On 5/17/2011 at 9:30 AM in the administrative office the complaint/grievance tracking log was reviewed it reviewed the patient's grievance was log in as received 5/2/2011.

Tag No: A0122

On 5/17/2011 at 9:20 AM in the administrative office the facility policy SECTION 6.5 PATIENT COMPLAINT/GRIEVANCES was reviewed. Under section I POLICY B. The facility will respond in writing to all grievances within seven (7) working days. Under section III PROCEDURE 3. b. The target for completion of investigation of all other grievances shall be seven (7) working days of receipt of the grievance. 4. An acknowledgement of the receipt of the filing will be provided to the patient and /or their legal representative within two (2) working days.

On 5/17/2011 at 9:30 AM in the administrative office the Director of Quality Management was asked if the grievance logged in for 5/2/2011 had been resoled. She answered no she was still investigating it. The Director was asked if a letter had been sent to the complainant at 7 days? The Director answered I don't know. When asked if a letter had been sent to acknowledge the receipt of the grievance and the answer was I don't think so.



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Report No. 1458

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

PARKLAND HEALTH AND HOSPITAL SYSTEM

5201 HARRY HINES BLVD DALLAS, TX M 75235 2

May 12, 2011

VIOLATION: PATIENT RIGHTS

Tag No: A0115

Based on interview and record review, the hospital failed to ensure that the rights of patients as delineated under this Condition of Participation were met as evidenced by the following:

- 1) No physician's orders were written for the physical restraint of Patient #1. Patient #1 was restrained twice while being held to the floor in a prone [face down] position and medicated each time with Haldol, Ativan and Benadryl IM (Intramuscular). Patient #1 was later found unresponsive in the seclusion room and subsequently died; and
- 2) Restraint/seclusion training was not current for one of 9 hospital personnel [Staff #9]. The hospital further failed to ensure 3 of 3 direct care staff [Staff #6, #7, and #8] were competent in the application of a physical restraint for 1 of 1 patient [Patient #1].

Cross Refer to Tags, 0168 and 0194

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Tag No: A0168

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the hospital failed to ensure that there are restraint orders by a physician for 1 of 1 patient [Patient #1] who was physically restrained by hospital personnel.

Findings Included:

The Emergency Services Summary Report for Patient #1 dated 02/10/11 timed at 2:04 AM reflected, "patient arrived escorted by police on Peace Officer Application for Emergency Detention...chief complaint paranoid..."

The physician note dated 02/10/11 timed at 02:23 AM reflected, "paranoid, no known allergies...past medical history, paranoid schizophrenia, tobacco use, [DIAGNOSES REDACTED], obesity and lipid disorder...skin negative for rash, neurological negative for dizziness and headaches...cardiovascular positive for palpitations...patient is nervous/anxious..."

The nurses note for Patient #1 dated 02/10/11 timed at 02:34 AM reflected, "Per psych [Psychiatric] tech [Technician] the patient's right hand looks already red and patient accused him "you did put something in my hand." Patient became more paranoid also refusing his blood pressure to be checked. Patient stated, "I am refusing medical treatment and I want to leave right now...patient was ordering the

staff to open the door for him so he could go out of the unit and leave. Patient is getting more agitated and not following verbal redirection from the staff. Patient is also getting belligerent and tried to fight with the staff. Placed into seclusion at 02:30 AM medicated with Haldol 5 mg [Milligrams] IM [Intramuscular], Ativan 2 mg and Benadryl 25 mg per physician order as emergency medications. Reason for seclusion and criteria for release explained..."

The nurses note dated 02/10/11 timed at 03:25 AM reflected, "3 psych tech's were holding the patient down using SAMA [Satori Alternatives to Managing Aggression] techniques while in the seclusion room and staff were trying to talk to the patient to cooperate. When patient calmed down, psych tech's departed the room...and a couple of minutes later he was noted to be unresponsive. Dr...notified..."

The physician progress note dated 02/10/11 timed at 03:39 AM reflected, "The patient was given a second dose of Haldol 5 mg, Ativan 1 mg, and Benadryl 25 mg IM around 03:20 AM since he continued to bang on the door and he attempted to fight with psych tech's. The patient did struggle with staff members as he was taken out of the center seclusion room where he tore up the tile...the patient required three psychiatric tech's to restrain him as he was kicking, yelling, and swinging his fists when he entered the new seclusion room. After he calmed down the psych technicians departed the room and a couple of minutes later he was noted to be unresponsive...Dr. notified..."

The Hospital Restraint/Seclusion death report worksheet for Patient #1 dated 01/10/11 timed at 04:23 AM [date error] under the section entitled, "Patient died " reflected, "died while in restraint/seclusion, or both" The section entitled "Type: check all that apply" reflected, "physical restraint and seclusion checked." The section entitled, "If physical restraint, select type" the section reflected, "Take downs and other physical holds." Section C of the same document reflected, "reason for restraint/seclusion use...patient tore tile from floor, hit/kicked staff members...patient was transferred to another seclusion room..."

No physician restraint orders were found in the medical record.

On 05/04/11 at 12:11 AM Staff #7 was interviewed. Staff #7 was asked to describe the events which involved Patient #1. Staff #7 stated Patient #1 began to swing at the staff. Staff #7 stated himself and another hospital staff had to restrain Patient #1. Staff #7 stated the patient was placed on his stomach for the administration of an injection the first time for several minutes. The second time the hospital staff had to take the patient down was when he had to be removed from the seclusion room where he had pulled up a piece of tile and made a weapon out of it. Patient #1 was then placed in a different seclusion room. Staff #7 stated the second time Patient #1 was taken down, his arms were crossed in front of him and he was placed on his stomach [prone]. Staff #7 stated the nurse gave a second injection while he was on his stomach. The patient continued to struggle and the tech's continued to hold Patient #1 down. The physician came in and told the tech's to let the patient up. Staff #7 stated he was not sure of the exact time the patient was held down but it was at least ten to fifteen minutes. Staff #7 stated Patient #1 was released and was okay when he left.

On 05/04/11 at 11:30 AM Staff #3 was interviewed. Staff #3 was asked if physician restraint orders were obtained for Patient #1. Staff #3 stated, "No."

On 05/04/11 at 10:15 PM Staff #9 was interviewed. Staff #9 was asked how long Patient #1 was held down the first time he received an injection, and what position Patient #1 was placed in. Staff #9 stated maybe five minutes the technicians held Patient #1 down and he was placed on his stomach. Staff #9 stated the second time the patient was placed on his stomach for a second injection. The patient was still struggling with the technicians. Staff #9 was asked if he obtained physician restraint orders for Patient #1. Staff #9 stated, "No."

On 05/05/11 at 1:05 AM Staff #12 was interviewed. Staff #12 was asked if the second time Patient #1 was taken down did he inform the tech's to let Patient #1 up and release him. Staff #12 stated, "Yes." Staff #12 was asked what position Patient #1 was placed in and how long did the tech's hold him down. Staff #12 stated Patient #1 was on his stomach. He stated the tech's restrained him for ten to fifteen minutes. Staff #12 was asked if he wrote restraint orders. He stated, "No."

On 05/05/11 at 3:00 PM Staff #8 was interviewed. Staff #8 stated he attempted to do vital signs and bloodwork on Patient #1. The patient became agitated and refused care. The patient did not accept redirection and tried to hit the hospital staff. The first time the patient was taken down the patient's arms were crossed in front of his chest and he was placed on his stomach for an injection. The tech's held him down for approximately five to ten minutes and left him in the seclusion room. The second time three staff had to take Patient #1 down was when he was being moved to a different seclusion room because he had pulled up a piece of tile and was banging on the door of the seclusion room. Patient #1 would not go compliantly and attempted to hit the staff. The patient's arms were crossed in front of his chest and he was placed on his stomach. He received a second shot. The tech's restrained him about 10 to 15 minutes after the injection. The physician came in and told the tech's to let him up.

The policy entitled, "Non-Violent/Non-Self Destructive and Violent/Self Destructive Restraints" with a revision date of 08/10 was reviewed. The section entitled, "General Guidelines Related to Restraint Use" reflected, "Clinical justification for the use of restraints. The actual behavior justifying the use of a restraint must be documented...alternative measures tried, attempted and considered...a current LIP [Licensed Independent Practitioner] order depending upon the reason for the restraint...type of restraint used and evidence that the least restrictive restraint was chosen...results of all monitoring, reassessments and related interventions related to the restraint use..."

Tag No: A0194

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the hospital failed to ensure all staff were trained in restraint and/or seclusion application for 1 of 9 training records reviewed [Staff #9]. The hospital further failed to ensure 3 of 3 direct care staff [Staff #6, #7 and #8] were competent in the application of physical restraint for 1 of 1 patient [Patient #1].

Findings Included:

The physician note for Patient #1 dated 02/10/11 timed at 02:23 AM reflected, "paranoid, no known allergies...past medical history, paranoid schizophrenia, tobacco use, [DIAGNOSES REDACTED], obesity and lipid disorder...skin negative for rash, neurological negative for dizziness and headaches...cardiovascular positive for palpitations...patient is nervous/anxious..."

The nurses note dated 02/10/11 timed at 02:34 AM reflected, "Per psych [Psychiatric] tech [Technician] the patient's right hand looks already red and patient accused him "you did put something in my hand." Patient became more paranoid also refusing his blood pressure to be checked. Patient stated, "I am refusing medical treatment and I want to leave right now...patient was ordering the staff to open the door for him so he could go out of the unit and leave. Patient is getting more agitated and not following verbal redirection from the staff. Patient is also getting belligerent and tried to fight with the staff. Placed into seclusion at 02:30 AM medicated with Haldol 5 mg [Milligrams] IM [Intramuscular], Ativan 2 mg and Benadryl 25 mg per physician order as emergency medications. Reason for seclusion and criteria for release explained..."

The nurses note dated 02/10/11 timed at 03:25 AM reflected, "3 psych tech's were holding the patient down using SAMA [Satori Alternatives to Managing Aggression] techniques while in the seclusion room and staff were trying to talk to the patient to cooperate. When patient calmed down, psych tech's departed the room and a couple of minutes later he was noted to be unresponsive.

The physician progress note dated 02/10/11 timed at 03:39 AM reflected, "The patient was given a second dose of Haldol 5 mg, Ativan 1 mg, and Benadryl 25 mg IM around 03:20 AM since he continued to bang on the door and he attempted to fight with psych tech's. The patient did struggle with staff members as he was taken out of the center seclusion room where he tore up the tile...the patient required three psychiatric tech's to restrain him as he was kicking, yelling, and swinging his fists when he entered the new seclusion room. After he calmed down the psych tech's departed the room and a couple of minutes later he was noted to be unresponsive...Dr. notified..."

The nurses notes dated 02/10/11 timed at 04:29 AM reflected, "At 03:32 observed Patient #1 to be lying in a prone position in seclusion room #1...observed right arm to be lying beneath him with his right hand pointed toward the ceiling. Per psych tech's, the patient had been moved from seclusion room #2 to seclusion room #1 as he had pulled up some tile/baseboard in room #2...the patient's hand was very mottled in appearance...the patient did not respond to verbal/tactile stimuli. He was turned from his stomach to a supine position. The patient's face was cyanotic, a radial pulse was present, but no spontaneous respirations...physician notified...CPR [Cardiopulmonary Resuscitation]..."

On 05/03/11 at 1:30 PM Staff #5 was interviewed. Staff #5 was asked what his job was at the hospital. Staff #5 stated he was a psychiatric technician and he trained staff the SAMA [Satori Alternatives to Managing Aggression] training program. Staff #5 stated he was not present when Patient #1 was admitted . Staff #5 stated hospital staff were taught not to lay a patient prone, on their stomach and/or face down. He stated if the patient was placed on their stomach they were to be repositioned right away in the side lying position so their airway was maintained. Hospital staff were to place the patient in a basket hold with the patient's arms crossed in front of their body, then sit the patient on the floor. The second person was to hold the legs. If they were to receive an injection the hip area was available for use. Staff #5 was asked to play the training DVD showing the basket hold. The surveyor observed the basket hold and was visualized as described. Staff #5 stated the purpose of the training was to contain movement, not placing the patient face down prevents possible medical compromise. Staff #5 was asked whether he has retrained any of the staff involved since the incident with Patient #1. Staff #5 stated, "No."

On 05/04/11 at 12:11 AM Staff #7 was interviewed. Staff #7 was asked to describe the events which involved Patient #1. Staff #7 stated Patient #1 began to swing at the staff. Staff #7 stated himself, and Staff #6 and Staff #8 had to restrain Patient#1 and take him down. Staff #7 stated the patient was placed on his stomach for the administration of an injection the first time for several minutes. The second time hospital staff had to take the patient down was when he had to be removed from the seclusion room where he had pulled up a piece of tile and made a weapon out of it. Patient #1 was then placed in a different seclusion room by Staff #6, #7 and #8. Staff #7 stated the second time the patient was taken down his arms were crossed in front of him and he was placed on his stomach [prone]. Staff #7 stated the nurse gave a second injection while he was on his stomach. The patient continued to struggle and the tech's continued to hold him down. The physician came in and told the tech's to let the patient up. Staff #7 stated he was not sure of the exact amount of time the patient was restrained but it was at least ten to fifteen minutes. The surveyor asked Staff #7 what type of restraint training he has had. Staff #7 stated he has had SAMA [Satori Alternatives to Managing Aggression] training. Staff #7 was asked what position according to the SAMA training were patient's to be placed in when taken down or given an injection. Staff #7 offered no response.

On 05/04/11 at 12:10 PM Staff #1 was asked by the surveyor for the restraint training for [Staff #6, #7, #8 and #9]. Staff #1 provided the training files. Staff #1 stated she could not find current training for Staff #9. All other staff training for Staff #6, #7 and #8 were current.

On 05/04/11 at 10:15 PM Staff #9 was interviewed. Staff #9 was asked if he had current restraint training. Staff #9 stated his restraint training had expired. Staff #9 was asked how long Patient #1 was held down the first time he received an injection, and what position Patient #1 was placed in. Staff #9 stated maybe five minutes the tech's held him down. He was positioned on his stomach. Staff #9 stated the second time Patient #1 was placed on his stomach for a second injection and when he left the seclusion room Patient #1 was still struggling with the tech's. Staff #9 was asked how the nurses monitor the technicians during a take down and/or restraint to ensure proper techniques were used. Staff #9 stated the tech's got control of the patient and then he administered the medication. He stated he left to chart.

On 05/05/11 at 1:05 AM Staff #12 was interviewed. Staff #12 was asked if the second time Patient #1 was taken down did he inform the technicians to let Patient #1 up and release him. Staff #12 stated, "Yes." Staff #12 was asked what position Patient #1 was placed in, and how long did the technicians hold him down. Staff #12 stated Patient #1 was on his stomach, and the tech's restrained Patient #1 for ten to fifteen minutes.

On 05/05/11 at 3:00 PM Staff #8 was interviewed. Staff #8 stated he attempted to do vital signs and bloodwork on Patient #1. The patient became agitated and refused care. The patient did not accept redirection and tried to hit the hospital staff. The first time the patient was taken down the patient's arms were crossed in front of his chest and he was placed on his stomach for an injection. The tech's held him down for approximately five to ten minutes and left Patient #1 in the seclusion room. The second time three tech's [Staff #6, #7 and #8] had to take Patient #1 down when he was being moved to a different seclusion room because he had pulled up a piece of tile and was banging on the door of the seclusion room. The patient would not go compliantly and attempted to hit the staff. The patient's arms were crossed in front of his chest and he was placed on his stomach. He received a second shot. The tech's held Patient #1 down about 10 to 15 minutes after the injection. The physician came in and told the tech's to let him up. Staff #8 was asked what position the patient should be placed in when a take down occurs. Staff #8 stated staff put the patient's on their stomach [prone].

On 05/05/11 at 5:10 PM Staff #13 was interviewed. Staff #13 stated she was looking in the seclusion room window along with the technician. She stated the technician told her [Patient #1] was remedicated. She stated when she looked in something did not seem right with the patient. The patient was face down [prone] on his stomach. The patients right arm was under him crossed to the other side. The

other hand was by his side. She stated she could not find respirations, the physician responded, and a code blue was called. Staff #13 stated the training she had indicated the patients were to be placed on their side not on their stomach.

The policy entitled, "Non-violent/Non-self Destructive and Violent/self Destructive Restraints" with a revision date of 08/10 under the section entitled, "Training" reflected, "Staff competency in restraint management will be maintained...at a minimum, physicians, other licensed independent practitioners...authorized to order restraint or seclusion by hospital policy..."

VIOLATION: RN SUPERVISION OF NURSING CARE

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the hospital failed to ensure the RN [Registered Nurse] supervised and evaluated the nursing care provided by the Psychiatric Technicians for 1 of 1 patient [Patient #1] who was physically restrained while in seclusion. The RN failed to monitor the physical condition, the safe application of restraints and the psychological well-being of Patient #1 during and after being physically restrained two times within approximately 35 minutes. Patient #1 sustained two focal abrasions to the left forehead while in the psychiatric ED [Emergency Department] and died shortly after being physically and chemically restrained.

Tag No: A0395

Findings Included:

The psychiatric physician note for Patient #1 dated 02/10/11 timed at 02:23 AM reflected, "paranoid, no known allergies...past medical history, paranoid schizophrenia, tobacco use, [DIAGNOSES REDACTED], obesity and lipid disorder...skin negative for rash, neurological negative for dizziness and headaches...cardiovascular positive for palpitations...patient is nervous/anxious..." No documentation was found indicating [Patient #1] had abrasions to his forehead on admission.

The nurses note dated 02/10/11 timed at 02:34 AM reflected, "Per psych [Psychiatric] tech [Technician] the patient's right hand looks already red and patient accused him "you did put something in my hand." Patient became more paranoid also refusing his blood pressure to be checked. Patient stated, "I am refusing medical treatment and I want to leave right now...patient was ordering the staff to open the door for him so he could go out of the unit and leave. Patient is getting more agitated and not following verbal redirection from the staff. Patient is also getting belligerent and tried to fight with the staff. Placed into seclusion at 02:30 AM hours and medicated with Haldol 5 mg [Milligrams] IM [Intramuscular], Ativan 2 mg and Benadryl 25 mg per physician order as emergency medications. Reason for seclusion and criteria for release explained..."

The physician progress note for Patient #1 dated 02/10/11 timed at 02:57 AM reflected, "The patient was calm upon arrival and became abruptly agitated...due to his paranoia he began to accuse others of persecuting him and he tried to abruptly leave the seclusion area and tried to fight with the psychiatric tech's so he was emergently medicated with Haldol 5 mg, Ativan 2 mg and Benadryl 25 mg IM once and placed in closed door seclusion...while in seclusion patient remained paranoid and pulled a piece of tile off the seclusion room wall...he did have to be remedicated with Haldol 5 mg, Ativan 1 mg and Benadryl 25 mg IM once...unable to contract for safety...remains in imminent danger of harm to himself and others...we will proceed with OPC [Order of Protective Custody] and inpatient level of care for further stabilization..."

The nurses note dated 02/10/11 timed at 03:25 AM reflected, "3 psych tech's were holding the patient down using SAMA [Satori Alternatives to Managing Aggression] techniques while in the seclusion room and staff were trying to talk to the patient to cooperate. When patient calmed down, psych tech's departed the room and a couple of minutes later he was noted to be unresponsive. Dr...notified..."

The nurses notes dated 02/10/11 timed at 04:29 AM reflected, "At 03:32 observed the patient to be lying in a prone position in seclusion room #1...observed right arm to be lying beneath him with his right hand pointed toward the ceiling. Per psych tech's, the patient had been moved from seclusion room #2 to seclusion room #1 as he had pulled up some tile/baseboard in room #2...the patient's hand was very mottled in appearance...the patient did not respond to verbal/tactile stimuli. He was turned from his stomach to a supine position. The patient's face was cyanotic, a radial pulse was present, but no spontaneous respirations...physician notified...CPR [Cardiopulmonary Resuscitation]...staff from the main ED [Emergency Department] arrived, patient lifted onto a stretcher, CPR continued and transferred to main ED.

The Medical ED [Emergency Department] physicians physical exam note dated 02/10/11 timed at 04:10 reflected, "Patient received Haldol 10 mg, Benadryl 50 mg and Ativan 3 mg during his psychiatric ER [emergency room] stay. Last medication administered at 3:20 AM....patient noted to be unresponsive at 3:40 AM and code called...patient in asystole since arrival to main ED. Patient received four cycles of epinephrine and 4 cycles of atropine, one ampule of calcium chloride and one ampule of sodium bicarbonate...total duration of CPR [Cardiopulmonary Resuscitation] approximately 20 minutes...time of death 3:56 AM...review of systems....head small left sided frontal abrasion/contusion..."

The Medical Examiners report dated 02/10/11 timed at 1:00 PM reflected, "Two focal abrasions are located in the left forehead...a slight subscapular hemorrhage underlies the previously described abrasions...a focal contusion is located on the left forearm and right wrist..."

On 05/04/11 at 11:30 AM Staff #3 was interviewed. Staff #3 was asked if an event report was completed for Patient #1 which addressed the abrasions to Patient #1's forehead. Staff #3 stated, "No."

On 05/04/11 at 10:15 PM Staff #9 was interviewed. Staff #9 was asked if he observed any skin problems such as abrasions on Patient #1's forehead when he arrived. Staff #9 stated he did not notice any abrasions on his face. Staff #9 was asked how long Patient #1 was held down the first time he received an injection and what position Patient #1 was placed in. Staff #9 stated maybe five minutes the tech's held Patient #1 down and he was placed on his stomach. Staff #9 stated the second time the patient was placed on his stomach for an injection. He stated when he left the Patient #1 was still struggling with the tech's. Staff #9 was asked how he monitored the technicians during a take down/restraint and ensured proper techniques were used. Staff #9 stated the tech's get control of the patient and then the nurse gave the medication and left. Staff #9 stated he left the tech's holding Patient #1 down and went to chart.

The policy entitled, "Non-violent/Non-self Destructive and Violent/Self Destructive Restraints "with a revision date of 08/10 reflected under the section entitled, "Restraint", "Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to freely move his/her ars, legs, body or head...the section of the policy entitled, "Qualified Registered Nurse"

reflected, "A registered nurse who has received training and demonstrates knowledge in the specific needs of patient population...identifying staff and patient behaviors as well as environmental factors that my trigger circumstances that require the use of restraints...identifying the risk of restraint use in vulnerable patient populations such as cognitively or physically limited patients...monitoring the physical and psychological well-being of the patient in restraints...safe application of restraints...Based on this training, the RN is authorized to initiate restraint or seclusion, and/or perform evaluations or re-evaluations of patients in restraint or seclusion and to assess their readiness for discontinuation or establish the need to secure a new order." The section entitled, "General guidelines related to Restraint Use" reflected, "The type of restraint...assessment of the patient and the situation have been completed...medical and nursing leadership ofhospital approve the use of therapeutic restraint for patient safety...they are also committed to preventing, reducing, and eliminating excessive or inappropriate use of restraint and seclusion..." Staff #9 left the tech's while they were restraining and struggling with Patient #1 and went to "chart."

The policy entitled, "Nursing Documentation" with a revision date of 05/09 reflected, "Pertinent observations concerning treatments and patient outcome will be recorded...findings/observations/interventions applicable to the patient will be documented...a need, which warrants nursing action or interventions, must be documented in the chart...notes should include, but are not limited to the following: actions taken, patient response and any other information deemed necessary...care and/or treatment provided by all health care professionals will be based on each patient's specific needs...all relevant physical...needs will be the determining factor for the assessment process..."

Training

Resources

Tag No: A0175

Tag No: A0168

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Report No. 1558

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

LONGVIEW REGIONAL MEDICAL CENTER 2901 N FOURTH ST LONGVIEW, TX 75605 May 4, 2011

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on record review and interview, the facility failed to assure one of one patient in behavioral restraints was monitored according to hospital policy.

Findings include:

Review of policy F80.0, "Use of Restraints," revealed the following: "Licensed nursing staff will re-assess the patient and every 15 minutes thereafter. Assessment and re-assessment findings will be documented. The assessment and re-assessment includes: signs of injury associated with application of restraint, circulation, ROM (range of motion) of extremities, vital signs, nutrition/hydration, hygiene/elimination, physical and psychological status and comfort, readiness for discontinuation of restraint. "(page 9, paragraph 4)

Review of patient #1 's medical record revealed the patient was placed in behavioral restraints 10:00pm on 3/22/11 until 1:00am on 3/23/11. Restraints were in place for a total of three hours, while the patient was in the Emergency Department. Restraint re-assessments were not documented per facility policy

During an interview on 5/3/11 at 11:45am in the Quality Office, staff #1 confirmed that patient #1 was restrained. Staff #1 also confirmed restraint re-assessments were not documented per facility policy.

During an interview on 5/3/11 at 12:00 noon in the Quality Office, staff #2 confirmed that patient #1 was restrained. Staff #2 also confirmed restraint re-assessments were not documented per facility policy.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on record review and interview, the facility failed to assure a physician order was in place for use of behavioral restraints in one of one restrained patient.

Findings include:

Review of policy F80.0, "Use of Restraints," revealed the following: "Upon notification, the primary physician or licensed independent practitioner reviews with the RN (Registered Nurse) the physical and psychological status of the patient. Together they determine whether restraints are required and the physician supplies the order, verbal or written." (page 9, paragraph 1)

Review of patient #1 's medical record revealed the patient was placed in behavioral restraints 10:00pm on 3/22/11 until 1:00am on 3/23/11. Restraints were in place for a total of three hours, while the patient was in the Emergency Department. No physician order for restraints was documented.

During an interview on 5/3/11 at 11:45am in the Quality Office, staff #1 confirmed that patient #1 was restrained, that a physician order was required for initiation of restraints, and that there was no documented physician order on patient #1 's chart.

During an interview on 5/3/11 at 12:00 noon in the Quality Office, staff #2 confirmed that patient #1 was restrained, that a physician order was required for initiation of restraints, and that there was no documented physician order on patient #1 's chart.

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LONGVIEW REGIONAL MEDICAL CENTER LONGVIEW REGIONAL MEDICAL CENTER

2901 N FOURTH ST LONGVIEW, TX 75605 | Proprietary

View hospital's federal Hospital Compare record

Report date Number of violations

May 4, 20112 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. Incomplete reports

No incomplete reports available.



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MEDICAL CENTER OF PLANO ->

Report No. 1542

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

MEDICAL CENTER OF PLANO

3901 W 15TH ST PLANO, TX 75075

April 28, 2011

Tag No: A0122

VIOLATION: PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES

Based on interviews and record review, the facility did not follow their grievance process, in that, they did not meet their policy's specified time frames for this grievance, where: 1) "the grievance will be reviewed and an investigation initiated within seven days of receipt of grievance," and 2) "a written response of the hospital's decision will be sent as soon as possible (but no later than 30 days) ...if the investigation takes longer than 30 days to resolve, the patient (or complainant) will be kept informed either verbally or in writing, with an anticipated date of completion, for 1 of 1 patients (Patient # 1).

Findings included:

The complainant reported that he/she had initially voiced his/her grievance regarding Patient #1 at the neurosurgeon's (Personnel #12's) office, while being informed of the autopsy report, regarding the death of Patient #1, four days after a scheduled surgery on 09/21/10. The complainant said he/she spoke to the Vice President (VP) of Risk Management (Personnel #2), who told him/her they would hold a Root Cause Analysis meeting, and about 2 weeks later, he/she received a call from the VP's office, advising him/her that this meeting was being scheduled to "find out what went wrong." The complainant said that when he/she asked when he/she would hear back with the results, he/she was told the week of December 6, 2010, but never heard from them again (by the time he/she submitted the complaint to the department on 01/10/11).

Policy & Procedure:

The facility's "Patient Grievance & Complaint Resolution Process" policy, last revised 06/09 which was in use at the time of this incident, noted the following under Procedure:

- B. "Upon receipt of a patient grievance, the person receiving the information will document the grievance and forward it to the Director of Guest Services."
- C. "The Director of Guest Services will work with the Department Director to coordinate a response to the person filing the grievance within 7 days, by letter or verbally with the following information:

? Acknowledgement of the receipt of the grievance.

- ? Grievance will be reviewed and an investigation initiated within seven days of receipt of grievance.
- ? A written response of the hospital's decision will be sent as soon as possible (but no later than 30 days) to the patient and will include name of contact person, steps taken to investigate, the results of the grievance process, and the date of completion. If the investigation takes longer than

30 days to resolve due to complexity, the patient will be kept informed either

verbally or in writing, with an anticipated date of completion.

E. "Quality of care issues...may be managed through the Medical Staff Peer Review

Committee, Nursing Peer Review Committee, and/or the Performance Improvement/Patient Safety Committee "

H. "Any grievance...that may require intense analysis for clinical quality of care

Issues...will be referred via the Director of Quality Services to the Event Analysis Team for review."

- J. At the conclusion of the investigation, a written response will be provided to the patient or his/her legal representative to include:
- ? The results of the grievance process.

- ? Steps included on behalf of the patient to investigate.
- ? Name of contact person.
- ? Date of completion.
- K. All grievances/complaints are forwarded to Guest Services for tracking. In addition, the appropriate Administrative officer will review all patient grievances for appropriateness of response and ultimate resolution."

Interviews:

In an interview at 10:30 AM on 04/28/11 with the Vice President of Health Care Improvement/Risk Management (Personnel #2), she was asked if she had met with the complainant at neurosurgeon's office on 11/12/10, and she said "yes." She stated that the PA (Personnel #13) had called to tell her that the complainant was in their office and very upset over the autopsy report, and had asked if Personnel #13 could come and meet with him/her personally. Personnel #2 said that she had done this, and tried to defuse the situation. She verified that she had said they would do a Root Cause Analysis to look into the situation, and that her office had called the complainant later to let him/her know that this meeting was scheduled. She did not remember if the complainant had been told that he/she would hear results by the week of December 6, 2010, as alleged by the complainant.

In an interview at 3:55 PM on 04/26/11 with the Risk Analyst (Personnel # 4), she was asked if the hospital had documented a formal grievance had been received from the complainant, regarding the death of Patient #1, and she said "no." Personnel # 4 was asked when she first became aware of this grievance, and she said that it was through a telephone call she received from the VP of Risk Management (Personnel #2), on 11/12/10 regarding the complainant's concerns, which she had documented in her personal notes. When asked for documentation of her first interaction with the complainant, she provided a letter she had sent to him/her, dated 11/29/10 which said: "...thank you for your patience as our team has conducted an analysis of the concerns related to [Patient #1's] recent hospitalization. Specifically, we have focused on the care, treatment and services provided to [Patient #1]. As part of our review, your grievance will be routed through the appropriate Medical Staff process...unfortunately, all proceedings are privileged and confidential, and therefore, I will not be able to disclose the outcome with you...," and gave the name and contact telephone number of the Risk Analyst. Personnel #4 verified this response letter was sent 17 days after the initial notification of this grievance on 11/12/10, and was not within the 7 day time frame required by their grievance policy.

When Personnel # 4 was asked for documentation of any further interactions with the complainant, she said she sent a second letter on March 11, 2011, when the hospital's investigation was completed, which read:

"...thank you for your patience as our team concluded the review process related to [Patient #1's] recent hospitalization. We recently received the results of the external Medical Peer Review. Although all proceedings are privileged and confidential, I can assure you a fair and unbiased review was conducted."

Personnel # 4 confirmed there was no documented interaction with the complainant between the dates of these 2 letters, dated 11/29/10 and 03/11/11. She also confirmed that the facility had no record of providing the complainant a response by December 6, 2010 specifically regarding the outcome of the Root Cause Analysis, allegedly promised to the complainant.

When asked why there was so much time between the 1st and 2nd letters to the complainant, the Risk Analyst said the facility had been waiting for the Medical Staff external Peer Review results. She verified the facility had not kept the complainant informed of the complex investigation process during this 3 and 1/2 month period, either verbally or in writing, with an anticipated date of completion, as required by their grievance policy.

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MAYHILL HOSPITAL ->

Report No. 1759

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MAYHILL HOSPITAL 2809 SOUTH MAYHILL ROAD DENTON, TX 76208

April 28, 2011

VIOLATION: PATIENT RIGHTS: PARTICIPATION IN CARE PLANNING

Tag No: A0130

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview, one of one patient's legal guardian (Patient #1) did not participate in the revision of the patient's care plan, in that the patient's condition deteriorated and the patient was transferred to a state mental health facility without the guardian being notified until the transfer had occurred.

Findings included:

- 1) The patient was admitted to the facility on [DATE] with a care plan that included she would discharge to a group home.
- 2) On 03/14/11 the physician wrote "to get the program staff involved in developing after care plan." On 03/15/11 the physician wrote that the patient was near base line and a care plan needed to be in place.

3) On 03/17/11 the case worker wrote at 11:20 AM that she had spoken with the guardian to inform her that the patient would be transferred that day to a state hospital in north Texas.

4) In an interview with the surveyor at noon on 04/28/11 the CNO was asked if there was evidence of the guardian participating in the changed care plan. She confirmed there was not. She was asked if there were any other documents that included a change in the care plan before the day the patient left the facility. She confirmed there were not.



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2809 SOUTH MAYHILL ROAD DENTON, TX 76208 | Proprietary

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Report date Number of violations

April 28, 20111 (click for details) Read full report

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NACOGDOCHES MEDICAL CENTER ->

Report No. 1547

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NACOGDOCHES MEDICAL CENTER

4920 NE STALLINGS DRIVE NACOGDOCHES, TX 75961

April 22, 2011

VIOLATION: NURSING CARE PLAN

Tag No: A0396

Based on record review and interview the facility failed to implement a Plan of Care based on the initial assessment for 1 out of 1 patients (patient # 1). These findings have the potential to cause harm to all patients receiving care at the hospital by failure to implement and follow the plan of care.

Review of the medical record on 04/21/2011 for patient #1, revealed the patient was admitted on [DATE] at 2230 and the initial nursing assessment was completed on 08/04/2010 (No time recorded). The assessment indicated the patient was nutritionally at risk. The documentation revealed that that the Registered Nurse documenting the assessment documented she requested a nutritional consult. There was no evidence the nutritional assessment was conducted until 08/11/2010.

Review of the facility policy titled "Nutritional Screening and Assessment" last revised on 11/01/2010 page 1 (under nursing procedure) states " a nutritional risk screen is completed on the nursing assessment form with in 24 hours of admission. A nutritional assessment consult is sent to the Registered Dietician when any of the criteria in the nutrition risk screen is checked. 1.0 After receiving the referral from the nutritional risk screen, appropriate nutritional intervention it initiated. The nutritional assessment is completed within 24-48 hours after the referral has been received. The policy also states at 3.0 states the dietician is to be consulted for nutrition risk for length of stay greater than 6 days and for new TPN (Total Parental Nutrition) order.

Review of the medical record on 04/21/2011 revealed the dietician preformed an assessment 7 days from the date of admission on 08/11/2010 and continued to followed the patient on 08/12/2010 and documented a total KCAL of 215 in 24 hours. On 08/16/2010 the dietician documented the patient's TPN was reduced to 40 Milliliters (ml) per hour and the total calorie counts was difficult to obtain due to family bring food from home and that the patient was a poor historian. There was no evidence documented the family was educated on recording the amount of food eaten to assist the dietician in determining the needs of the patient. There is a third page that the dietician documented on and recorded a KCAL of 150. There is no evaluation documented by the dietician to assist the other heath care team to know and understand if the patient was receiving adequate nutrition, in addition there was no evidence the dietician included his recommendation or initiated or revised the nutritional plan of care. There is no further documentation or revision of the plan of care to assist this nutritional at risk patient through the date of transfer to a higher level of care on 08/25/2010.

Review of the order entry system used to communicate orders to the Dietician revealed there was no order entered in the system for the nutritional consult. There was no indication the nurse followed through by implementing the plan of care for this nutritionally at risk patient at the time of the assessment on 08/04/2010.

Interview with the Dietician and the Director of Nurses on 04/21/2010 at approximately 09:30 a.m. confirmed the above findings.

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

VIOLATION: ADMINISTRATION OF DRUGS

Based on record review and interview the facility failed to follow the physician order in the administration of Coreg 12.5 Milligrams (mg) in 1 out of 1 patient records reviewed (Patient # 1). These findings have the potential to cause harm to all patients receiving medications in the facility by the facilities failure to follow the physician instructions. In addition review of the admitting orders revealed the physician ordered vital signs to be taken every 4 hours.

Tag No: A0405

Review of the medical record for patient # 1, on 04/21/2011, revealed that the physicians ordered Coreg 12.5 mg on 08/10/2010. The instructions for administration stated "hold the medication if the heart rate is below 60 and the systolic blood pressure is below 100. On the medication record on 08/23/2010 the medication is stamped DISCONTINUED in capital letters, there is no time to indicate when it was discontinued on the record. Review of the physicians order revealed there was not a physicians order to discontinue the medication. On 08/23/2010 the medication was administered at 0900 a.m. by the morning nurse. The medication record contained the warning to hold the medication if the heart rate was below 60 and systolic blood pressure below 100. There was no indication the nurse took the pulse or the blood pressure prior to administration.

Review of the nurse 's notes and the vital sign recorded on 04/21/2010, revealed that on 08/23/2010 the morning nurse did not record any vital signs on the vital signs record or nurses note. I addition there was no documentation to indicated the pulse or blood pressure was taken at or before the 9 am dose of Coreg 12.5 mg. In addition the vital signs are not recorded in the section of the graphic for 8 am or 12 noon on 08/23/2010.

Interview with the Director of Nurses on 04/21/2011 at approximately 10:30 a.m. confirmed the above findings.



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NACOGDOCHES MEDICAL CENTER NACOGDOCHES MEDICAL CENTER

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Tag No: A0450

Tag No: A0457

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WADLEY REGIONAL MEDICAL CENTER ->

Report No. 1502

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WADLEY REGIONAL MEDICAL CENTER1000 PINE STREET TEXARKANA, TX 75501 April 19, 2011

VIOLATION: MEDICAL RECORD SERVICES

Based on record review and interview, the facility failed to assure all orders and progress notes were dated and timed. Thirteen instances of undocumented date or time were observed in one patient chart.

Findings include:

Review of patient #1's medical record revealed the following missing dates and times:

- -Emergency Physician record with no documented time
- -Medical Clearance with no documented date
- -Medical Clearance with no documented time
- -Physician progress with no documented time x3
- -Physician order with no documented date x2
- -Physician order with no documented time x5

In an interview on 4/19/11 at 10:51am in the administrative offices at 12:45pm, staff #1 reviewed the documents listed above and confirmed the missing dates and times.

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

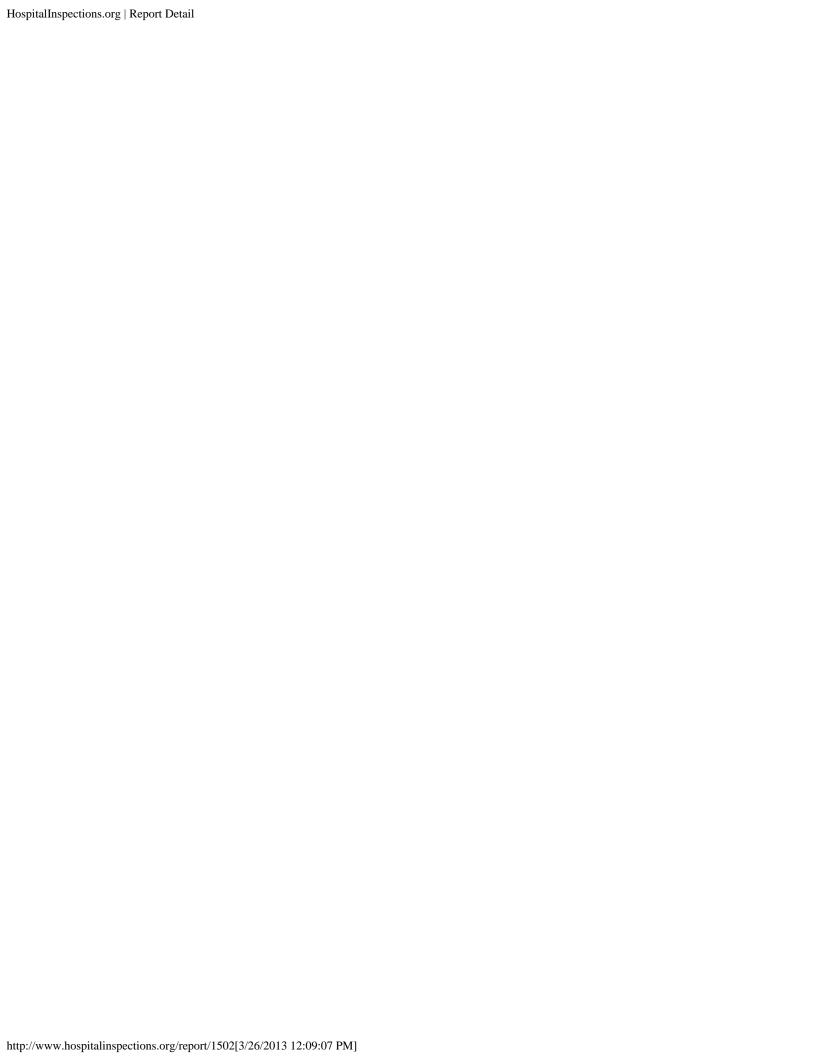
Based on record review and interview, the facility failed to assure verbal orders were authenticated within 48 hours. Two instances of delayed authentication of verbal orders were found in one patient chart.

Findings include:

Review of patient #1 's medical record revealed the following:

- -Verbal order written on 2/23/11 was authenticated on 3/24/11
- -Verbal order written on 2/22/11 was authenticated on 4/06/11

In an interview on 4/19/11 at 10:51am in the administrative offices at 12:45pm, staff #1 reviewed the documents listed above and confirmed the delayed authentication.



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NORTH CYPRESS MEDICAL CENTER ->

Report No. 1760

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NORTH CYPRESS MEDICAL CENTER

21214 NORTHWEST FREEWAY CYPRESS, TX 77429

April 12, 2011

VIOLATION: PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION

Tag No: A0123

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview the facility failed to implement it's grievance policy dated January 2010 to resolve patient complaints concerning quality of care and to inform them in writing the steps that were taken to investigate and resolve the complaint. The facility did not respond in writing to a family's complaints, citing one patient identified in a complaint TX 246. (Patient # 1).

Findings:

Review of complaint narrative written by Complainant J, on behalf of patient # 1 revealed the complainant had the following care concerns:

- (a) Ninety eight (98) years old Patient #1, was given the drug Morphine(pain medication) which had a as needed (PRN) order without the patient asking for pain medications, as a result the patient became very drowsy and dizzy. According to the complainant the facility did not use good judgement.
- (a) Staff did not respond in a timely manner when the patient called for assistance to the rest room.
- (c) the patient fell out of bed and the bed alarm was not activated although the patient was labeled "high risk for fall".
- (d) Complainant spoke to several different staff who told her they would look into her concerns, but no one ever responded.

During a telephone interview on 4/11/11 at 2:30 pm with complainant J, she stated she spoke with administrative staff regarding her concerns but to date no one had responded to her concerns.

Review of the hospitals complaint records revealed no documentation that the complainant had voiced concerns regarding the care and services patient # 1 received.

Review of admission record for patient #1 revealed she was admitted to the facility on on [DATE] and again in March 2011.

Review of nurses notes dated 2/11/11 revealed documentation that the "patient's niece had concerns regarding medication that her aunt was given because she was more confused as compared to earlier". Further review of progress notes and nurses notes for the February and March admissions revealed no documentation in the patient's record that patient or family had other care concerns.

Review of nurses notes dated February 15, 2011 revealed documentation that Staff # 50, "Chief Nursing Officer(CNO) was in the patient's room talking to her niece"

During the investigation the Surveyor verified that Complainant J discussed her concerns with unit and administrative staff, however no one

responded to her concerns.

During an interview with Staff # 51, Quality Coordinator she stated Ms. J, (Complainant) had a discussion with her regarding her dissatisfaction with the nursing staff giving Patient # 1 Morphine when it was not indicated. According to Staff # 51, the complainant stated she felt Morphine was given to the patient to keep her sedated so staff would not have to take her to the rest room during the night. Staff # 51 also stated the complainant told her that staffs were also putting the patient in diaper and her aunt never wore diapers before.

During an interview on 4/12/11 with Staff # 52, Nursing Director she stated she remembered having several discussions with Patient # 1's niece who had concerns regarding her Aunt 's care.

During an interview on 4/12/11 at 11:45 am at the facility with Staff # 50 (CNO) she stated Complainant J , made a complaint to her, that the patient was given Morphine which made her dizzy and that she was never given morphine for her pain before and that the patient did not ask for any pain medication.

According to Staff # 50 she investigated and found there was a PRN (give as needed) order for the morphine. There was also documentation that the patient was in pain. The CNO further stated she did not document the complaint or the investigation and did not respond to the complainant in writing because the patient was an in-patient and the concerns were not considered a grievance.

Review of the facility's grievance policy dated January 2010 revealed that:

"A patient grievance is a formal or informal written or verbal complaint that is made when a patient issue cannot be resolved promptly "on the spot" by staff present. Within 7 days of the grievance, a letter will be submitted to the complainant that includes results of the grievance investigation, corrective action as necessary."

Tag No: A0395

The facility failed to respond to Complainant J in writing.

VIOLATION: RN SUPERVISION OF NURSING CARE

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview the facility failed to ensure that a patient's condition was assessed when she was found lying on the floor in her room; failed to assess for adverse effects after medication was administered per the facility's protocol.

The facility failed to provide documentation that the physician was informed when a patient was found on the bathroom floor in his room. The facility failed to follow their fall protocol to document incidents of falls in the patient's clinical record, citing two (2) of four (4) sampled patients that fell in the facility.

Findings:

During a pre investigation telephone interview on 4/11/11 with Complainant J, she informed the Surveyor that Patient # 1 was admitted in the facility in March 2011 and she arrived at the hospital one morning and was informed the patient was found on the floor. According to Ms. J,she spoke with the nurses and found out that prior to the fall, despite the fact Patient # 1 was on "fall alert" the bed alarm was never activated.

According to Complainant J, Patient # 1 had a "large bruise on her shoulder and along her rib cage which remained tender to touch for a long time". According to the complainant she was not aware that an X-ray of the patient's shoulder was ever done to determine if there was a fracture.

Review of facility 's fall reduction policy dated November 2010 revealed the following information:

The "scope is to effectively identify patients who were at risk for falls, to prevent patient falls and protect patients from injury and to enhance patient safety. All patients are assessed after a fall and the physician notified. Determine level of injury. If unable to determine level of injury at time of the fall, do so with a follow-up of event.

The assessment is documented in the patient 's medical record".

The policy did not clearly instruct staff to conduct a follow up assessment of patients when they fall to ensure that any missed injury at time of initial assessment does not go undetected in order to promote patient safety.

Patient #1

Review of emergency room (ER) records revealed Patient #1 (MDS) dated [DATE] with complaints of lethargy for over a week. She had not had much of an appetite for the past few days. B/P 135/72, Pulse 59, respiration 18. She was oriented to person only. She was admitted to the unit where a physician 's history and physical was completed. The physician diagnosed that the patient had Altered Mental Status and generalized weakness.

Review of the nurses admission notes dated 3/18/11 at 2314 pm documented the patient was coherent but confused and forgetful at times. At 1849 pm there was documentation that the patient was in bed and was on fall risk.

Further review of the nurses 'notes revealed that on 3/23/11 at 0111 an order for CT(Computerized Tomography) of head was made by the physician.

Subsequent nursing documentation revealed documentation that bed alarm was on.

Prior to 3/23/11 at 0301 there was no documentation that the patient 's bed alarm was on, however there was continuous documentation that the patient was confused and forgetful.

There was documentation that Patient # 1 was discharged from the facility on the evening of 3/24/11.

There was no documentation that the patient was found on the floor in her room, nor that the patient was evaluated for injury. There was no documentation of a follow up assessment.

There was documentation that in the early morning of 3/23/11 the physician ordered a CT of head but no mention the patient fell .

The physicians 'discharge summary dated 3/25/11 documented the patient had an episode of fall and had a CT of head which showed no

abnormality.

Review of incident reports for fall revealed there was a fall risk worksheet that was initiated which stated the patient was found lying on the floor next to her bed. There was no assessment documented on the form or medical record. The fall incident was never mentioned on the patient's medical record.

Review of nurses dated 2/13/11 revealed documented that at 2325 pm patient #1 was "still not asleep restless, given Xanax (sedative) to calm her down".

Review of nurses notes dated 2/14/11 at four (4) minutes past midnight revealed documentation that Patient # 1 complained of a " dull pain in her back, especially when she moves " B/P 164/87, heart rate 85, will give pain medication". Documentation at 19 minutes after midnight revealed the patient was given 4 mg of Morphine IV.(less than an hour after the sedative

xanax was administered).

There was no documentation that the patient was ever re assessed for any adverse effects of the Morphine or Xanax.

Review of the facility's Pain Management Policy revised April 2010 documented that the policy's goal is to:

assess, evaluate and manage patient's level of pain upon admission and through out the hospital stay. The policy documented there would be assessment after each pain management intervention once sufficient time has elapsed for the treatment to reach peak effect". There was no documentation that the patient was assessed after the administration of a sedative and pain medication.

Patient # 2

Review of clinical record for Patient # 2 revealed she was [AGE] year old female admitted to the facility on [DATE]. Her chief complaint was syncope several times in the past 5 days especially when getting up.

There was documentation dated 2/11/11 at 1310 that the patient was found sitting on the bathroom floor. She was assisted back to bed. There were no injuries, vital sign blood pressure (B/P) 108/77, and pulse 89. The patient denied pain. Call light placed within reach. Red socks applied instructed to call for assistance. Will monitor.

There was no documentation that the physician was informed or that the staff re-assessed the patient.

During an interview on 4/12/11 with Staff # 53, Director of Risk Management regarding the allegations of patient falling out of bed, she stated she was not aware the patient had fallen until the Surveyor mentioned it. She presented a fall incident which she stated was initiated but was not completed according to the facility 's protocol for completing a fall risk assessment.

Staff # 53 further stated that staff were required to assess all patients after medication is administered. She also stated it is expected that all patients are re-assessed after a fall to ensure no injury was missed.



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MEMORIAL MEDICAL CENTER LIVINGSTON ->

Report No. 1521

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MEMORIAL MEDICAL CENTER LIVINGSTON

1717 HWY 59 BYPASS LIVINGSTON, TX 77351

April 7, 2011

VIOLATION: NURSING CARE PLAN

Tag No: A0396

Based on record review and interview the facility failed to develop and implement a plan of care for prevention of Deep Vein Thrombosis (DVT) (a blood clot in a deep vein in the leg) for 1 out of 1 (#1) records reviewed. These finding have the potential to cause harm to all patients who are high risk for DVT which could result in clots in the lungs.

Review of patient # 1 medical record on 04/07/2011, in the conference room of the facility, the patients medical record contained an assessment form for patients who may be at risk for DVT. The form was completed and the assessment indicated this patient was at risk for developing a DVT. This patient was admitted on [DATE] at 0030 a.m. The form for the DVT prevention was signed by the physician on 07/20/2011 and the record indicated the prevention plan was not implemented until the next day on 07/21/2011. There was no indication the nurse notified the physician at the completion of the assessment when the patient was determined to be at risk so that the DVT protocol could be implemented to prevent DVT's on the day of admission. In addition there is also no indicating in the medical record the protocol was implemented on the day the physician became aware that this patient was at risk of DVT's and that the prevention protocol should be implemented.

Interview with staff # 1 on 04/07/2011 at 04:00 p.m. confirmed the protocol was no implemented when the patient was determined to be at risk for DVTs. In addition she stated the DVT assessment is to be completed with the admission assessment and the plan should be implemented as soon as the patient is determined to be at risk.

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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MEMORIAL MEDICAL CENTER LIVINGSTON MEMORIAL MEDICAL CENTER LIVINGSTON

1717 HWY 59 BYPASS LIVINGSTON, TX 77351 | Voluntary non-profit - Private

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NIX HEALTH CARE SYSTEM ->

Report No. 1495

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NIX HEALTH CARE SYSTEM 414 NAVARRO, SUITE 600 SAN ANTONIO, TX 78205 April 6, 2011

VIOLATION: MEDICAL RECORD SERVICES Tag No: A0450

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

1. Based on review of medical record #1, [AGE] year old male and interview with staff it was observed that the physician progress notes were not timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedure.

Findings:

- a. Reviewed medical record #1, [AGE] year old male it was observed that out of 22 physician progress notes 21 out of the 22 physician progress notes (95%) were not timed and authenticated by the physician progress notes.
- b. Interviewed staff #1, Rehabilitation Nurse Manager and Staff #3, Vice President of Nix Specialty Health Center and showed and explained the physician progress notes. The staff interviewed agreed that physicians should be dating, timing and authenticating all medical entries and could not show that this requirement was met with the physician progress notes.



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SHELBY REGIONAL MEDICAL CENTER ->

Report No. 1575

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SHELBY REGIONAL MEDICAL CENTER 602 HURST STREET CENTER, TX 75935 March 31, 2011

VIOLATION: MEDICAL RECORD SERVICES

Based on record review and interview the facility failed to ensure that all medical records were complete citing 1 of 1 records reviewed.

Findings: Review of medical record for patient #1 on 3/30/2011 revealed that facility "Code Blue Data Sheet" documentation was not complete.

Section 4. Adequate Ventilation: no documentation found.

Section 6. Hear Rhythm: no documentation found.

Section 11. ABG's: no documentation found.

Section 13. Respiratory Therapist present and time of arrival: no documentation found.

Section 14. Length of resuscitation: no documentation found. Section 15. Time resuscitation discontinued: no documentation found.

Section 16. Why is was discontinued: no documentation found.

Section 17. Who made this decision: no documentation found.

Physician Signature/Date: no documentation found.

Nurse Signature/Date: no documentation found.

Presumed cause of arrest(by physician): no documentation found.

Original date of form:8/99 Revised: 4/15/02

Also missing from medical record was "T-Sheet" (form used by physician for documentation based on patient complaint.) This form is used to document all care provided to the patient by the physician.

Interview with Staff #1 and Staff #3 on 3/31/2011 confirmed missing documentation on Code Blue Data Sheet and also confirmed that Staff #7 "T-sheet" could not be located by facility medical records and/or by staff #7 office staff.

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Tag No: A0450

Based on record review and interview the facility failed to ensure that Emergency Department Services were under the direction of a qualified member of the medical staff.

Findings: Review of organizational chart for Shelby Regional Medical Center on 3/31/2011 at 2:00 pm in the administrator office revealed no delineation for Emergency Department Medical Director on chart. The organizational chart was updated November 2010 per documentation on chart.

Interview with staff #1 on 3/30/2011 at 2:00 pm revealed she thought that Medical Director over the Emergency Department was the Chief of Staff for the hospital.

Interview with staff #3 on 3/30/2011 at 2:30 pm revealed that she thought staff #6 was Medical Director over the Emergency Department. Interview with hospital Administrator on 3/31/2011 at 9:00 am revealed that they did not have a Medical Director over the Emergency

Department. He would get staff #6 appointed as soon as possible. Advised administrator the Medical Director of the Emergency Department had to be a member of the medical staff and not just a Courtesy Staff member. Adminstrator confirmed they needed to appoint a member of the medical staff to be Medical Director over the Emergency Department.

VIOLATION: *EMERGENCY SERVICES POLICIES*

Based on record review and interview the facility failed to ensure an ongoing and continuing assessment of the medical care provided in the emergency department. This practice has the potential for possible harm to all patients coming for care at this facility by not assuring the policies are current and revised based on ongoing monitoring by the medical staff and quality assurance activities.

Tag No: A1104

Tag No: A1112

Findings:

Review of Policy and Procedure manual for the emergency department on 3/31/2011 revealed it had not been reviewed and/or updated since 12/2009 by the Director of Nursing and hospital administrator.

Interview with current Director of Nurses on 3/31/2011 at 10:00 am that the current policies and procedures had not been updated or reviewed since 12/2009. Furthermore the policies needed to be updated to meet the needs of the current community population and change in injuries related to workforce changes in area. The area has seen a great increase in oilfield workers this past couple of years and this has the potential to bring in different types of injuries and illness'. Advised that since she took over as Director of Nurses in 11/2010 she has been in the process of updating and redoing the manual to update policies and procedures and also some of the forms used in the emergency department.

VIOLATION: QUALIFIED EMERGENCY SERVICES PERSONNEL

Based on record review and interview the facility failed to establish criteria to delineate the qualifications required for each category of emergency services staff(e.g. emergency physicians, specialist MD/DO and mid-level practitioners. The facility also failed to conduct periodic assessments of its emergency needs in order to anticipate the policies, procedures, staffing, training, and other resources that may be needed to address likely demands. This has the potential to provide an environment for possible patient harm by not having the properly trained staff to meet patients needs.

Findings: Medical Staff Bylaws Section E. ACLS/ATLS Certification: If a Practitioner fails to maintain Advanced Cardiac Life Support certification, the Practitioner's privileges to attend to cardiac patients shall automatically be suspended until such time as certification is achieved. If a Practitioner fails to maintain Advanced Trauma Life Support certification, the Practitioner's privileges to act as Emergency Department Physician shall be automatically suspended until such time as ATLS certification is achieved. Action automatically imposed under this Section does not entitle the Practitioner to hearing and appeal under these bylaws.

Review of the Medical Staff Rules and Regulations and Bylaws on 3/31/2011 revealed only one qualification documented for emergency

room MD/DO and/or mid-level practitioners pertaining to experience and training.

Review of Personnel file for Staff #6 revealed ACLS Certification Part 1 expired May 22, 2010 and ACLS part 2 expired June 12, 2010. No documentation of ATLS found in personnel file.

Review of Personnel file for Staff #7 revealed no documentation of ATLS in personnel file.

Review of Personnel file for Staff #14 revealed no documentation of ATLS in personnel file.

Interview with staff #1 on 3/31/2011 at 9:00 am confirmed the Medical Staff Rules and Regulations/ Bylaws did not specify qualifications for the emergency room MD/DO and/or mid-level practitioners other than the bylaw concerning ACLS/ATLS certification. Also confirmed the personnel files for staff #6, #7, and #14 were missing documentation of completion ATLS and staff #6 had no documentation of current ACLS certification.



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HENDRICK MEDICAL CENTER ->

Report No. 1507

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HENDRICK MEDICAL CENTER

1900 PINE ABILENE, TX 79601

March 29, 2011

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on review of the clinical record of patient #1 and interview with staff, the hospital failed to provide this patient with medication as ordered by the physician.

Findings were;

Review of the clinical record for patient #1 revealed that the physician had written orders for the patient to have his medication "Advair" administered to him on 12-19-10 at 1510. The patient received the first dose of this medication at 1245 on 12/21/10 at 1245. This was 45 hours after the initial order.

The above findings were confirmed in inter view with the Nursing Director in the conference room on 3/29/11.



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Tag No: A0144

Tag No: A0154

Tag No: A0407

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TEXAS SPECIALTY HOSPITAL AT LUBBOCK ->

Report No. 1775

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TEXAS SPECIALTY HOSPITAL AT LUBBOCK

4302 B PRINCTON STREET UNKNOWN, TX March 28, None 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on review of the clinical record of patient #1 and interview with staff, the hospital failed to provide care in a safe setting for this patient as the patient was transported on 2/24/11, to a Cardiologist appointment and left there alone.

Findings were;

During a review of the clinical record of patient #1 this patient was documented by nursing staff as "confused" and by the physician as "has the impulsiveness of a 3 year old". This patient was dropped off for the cardiology appointment alone. There was no one to advocate for the patient at the appointment. There was no assurance of the patient's safety while alone. In addition The patient had on a T-shirt, two hospital gowns and sweatpants with a blanket on his lap. There was no mention of shoes or socks in the record. In February the weather is quite cold in the panhandle of Texas,

The above findings were confirmed in inter view with the Nursing Director and administrator in the conference room on 3/28/11.

VIOLATION: USE OF RESTRAINT OR SECLUSION

Based on review of the clinical record of patient #1, the restraint log and interview with staff, the hospital failed to ensure this patient had physician orders for physical restraints.

Findings were;

Patient #1 was was documented in the Restraint log 2/15 through 2/16 as being restrained by his bilateral wrists, the rationale was that the patient was climbing out of bed pulling off clothes and pulling on tube feeding portable machine. There was not a physician order for this restraint.

On 2/19 the patient was documented as restrained with bilateral wrist and ankle restraints, and a posey vest. There was not a physician order nor rationale for this restraint.

The above findings were confirmed in interview with the Nursing Director and administrator in the conference room on 3/28/11.

VIOLATION: USE OF VERBAL ORDERS

Based on review of the clinical record of patient #1 and interview with staff, the hospital failed to ensure that verbal and/or telephone orders were used infrequently.

Findings were;

http://www.hospitalinspections.org/report/1775[3/26/2013 12:10:42 PM]

A review of the clinical record for patient #1 revealed that of 21 physician orders, 19 of 21 orders were telephone and/or verbal orders. Only two orders were written by the physician. Therefore 19 of 21 orders does not reflect that verbal and/or telephone orders were used infrequently.

The above findings were confirmed in inter view with the Nursing Director and administrator in the conference room on 3/28/11.

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

Tag No: A0457

Based on review of the clinical record of patient #1 and interview with staff, the hospital failed to ensure that all telephone and/or verbal orders were signed by the physician within 48 hours.

Findings were;

Based on review of the medical record for patient #1, there were 19 verbal/telephone orders; of these 12 of 19 failed to be signed within 48 hours of the order. No reason for the delay was offered.

The above findings were confirmed in inter view with the Nursing Director and administrator in the conference room on 3/28/11.

VIOLATION: PATIENT CARE ASSIGMENTS

Tag No: A0397

Based on review of the clinical record of patient #1 and interview with staff, the hospital failed to ensure that the nurse assigned care of this patient was competent in their duties.

FIndings were;

Clinical record review of patient #1 revealed this patient was documented by nursing staff as "confused" and by the physician as "has the impulsiveness of a 3 year old". This patient was dropped off for the cardiology appointment alone. There was no one to advocate for the patient at the appointment. There was no assurance of the patient's safety while alone. In addition The patient had on a T-shirt, two hospital gowns and sweatpants with a blanket on his lap. There was no mention of shoes or socks in the record. In February the weather is quite cold in the panhandle of Texas,

The above findings wer confirmed in inter view with the Nursing Director and administrator in the conference room on 3/28/11.

VIOLATION: RN SUPERVISION OF NURSING CARE

Tag No: A0395

Based on review of the clinical record of patient #1 and interview with staff, the hospital failed to ensure that a registered nurse evaluated the care of patient #1 on the morning of 2/24/11 before he left the hospital.

Findings were;

Clinical record review for patient #1 revealed that on 2/24/11 between 0700 and the time the patient was sent for the Cardiology appointment at 0915, there was not a nursing assessment completed for this patient. While waiting for the appointment the patient suffered a syncopal episode. The patient was admitted to the hospital that afternoon.

The above findings were confirmed in inter view with the Nursing Director and administrator in the conference room on 3/28/11.



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BAYLOR MEDICAL CENTER AT IRVING ->

Report No. 1483

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BAYLOR MEDICAL CENTER AT IRVING

1901 N MACARTHUR BLVD IRVING, TX 75061

March 24, 2011

VIOLATION: TRANSFER OR REFERRAL

Tag No: A0837

Based on review of records and interview, the hospital did not have an effective discharge planning program to facilitate the provision of follow-up care in that the hospital did not furnish a nursing medical report for 1 of 3 patients (Patient #1) discharged to a nursing home in February 2011 with instructions for follow-up care. The hospital nurse called the receiving nursing home to give a medical report after the patient was enroute to the nursing home. This practice presented the risk of potential harm to a patient discharged from the hospital to another health care facility as they may not be prepared to properly care for the patient.

Findings included:

Patient #1, [AGE], was admitted on [DATE]. The "Discharge Summary" (electronically signed 03/03/11) noted that Patient #1 was admitted with "weakness, failure to thrive...underlying dementia...was evaluated and was found to have colon cancer on colonoscopy...underwent a partial colon resection...discharged to a nursing home in stable condition." He was given instructions for discharge medications and discharged on [DATE].

Patient #1's "Discharge/Home Care Instructions" signed by the nurse at 11:00 AM on 02/04/11 noted that Patient #1 was treated for "colon cancer" and was on a mechanical soft diet with activity restrictions. He was to return to a physician for follow-up.

Patient #1's "Ambulance Transport Certification" dated 02/04/11 noted that Patient #1's "... condition requires special handling or treatment...unable to maintain erect sitting position in a chair or wheelchair for the time of transport..."

Patient #1's "Ambulance Trip Details" (Run Number 760, trip number 0013-A, service date 02/04/11 - faxed to hospital on [DATE] for the complaint investigation) noted that the ambulance service was transporting Patient #1 at approximately 12:36 PM and at the nursing home at approximately 12:42 PM.

Patient #1's "Multidisciplinary Re-Assessment Final Chart Copy" noted that on 02/04/11 at 12:30 PM Patient #1's RN (Registered Nurse) documented, "...Report called to...(name of nursing home) transferred by ambulance with all his belongings."

Note: Per the Ambulance Trip Details the patient arrived to the nursing home approximately 10 minutes after the hospital nurse gave report.

During an interview with the Social Worker (Personnel #2) on 03/24/11 at 11:00 AM she stated she assisted with Patient #1's discharge planning. Personnel #2 stated she called the nursing home's nurse's station and was told that they were ready for Patient #2 to come back to the nursing home. Personnel #2 was asked if she called the nursing home before the patient left the hospital and she said that she did and that the patient's hospital nurse was to call the medical report to the nursing home before the patient left the building.

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

During an interview with Patient #2's RN Charge Nurse (Personnel #3) on 03/24/11 at 11:15 AM she was asked to review the discharge paperwork with the surveyor. Personnel #3 stated she was told Patient #1 was accepted to the nursing home. She stated she wrote up the discharge paperwork on 02/04/11 and made a copy of the medical records to go with the patient. She said that she usually went to the patient's nurse and let the nurse know the time the ambulance will come. Personnel #3 stated she did not remember the time the ambulance came for Patient #1 and that she did not call the medical report to the nursing home. She said usually the nursing home facility was called before discharge by the patient's nurse and the paperwork including discharge instructions and copy of the chart went with the patient to the nursing home. She said she "assumed" when the ambulance came to pick up Patient #1 the nurse's report was already called to the nursing home. Personnel #3 stated paperwork was sent to the nursing home with Patient #1 by ambulance.

During an interview on 03/24/11 at approximately 11:30 AM, the RN (Personnel #5) who cared for Patient #1 was asked if she remembered a discharge and transfer to a nursing home for Patient #1 on 02/04/11. Personnel #5 said that she remembered Patient #1 because she "apologized" that she was a little late with the call regarding Patient #1's medical condition when she called the report to the nursing home. Personnel #5 said that she was told by the nursing home that she was calling the report after the patient arrived at the nursing home. Personnel #5 said that she was the only nurse who would have called Patient #1's report of medical information to the nursing home.

The Administrative "Discharge Planning" (policy #15A-100 revised June 2008) noted: "... It is the responsibility of the nurse manager or his/her designee to coordinate the daily discharge planning for each patient on the unit..."

The Social Work Department's "Referrals for Post-Acute Care Services" (policy PC.04.01 revised 01/07/09) noted that if the patient had special care needs, the Social Worker was to "...ask the nurse on the floor to describe the needs to the facility by phone..."



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BAYLOR MEDICAL CENTER AT IRVING **BAYLOR MEDICAL CENTER AT IRVING**

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COZBY-GERMANY HOSPITAL ->

Report No. 1514

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COZBY-GERMANY HOSPITAL 707 N WALDRIP GRAND SALINE, TX 75140 March 17, 2011

VIOLATION: MEDICAL STAFF Tag No: A0338

Based on document review and interview the facility failed to abide by the designated Medical Staff guideline and Governing Body over cite in one of one medical staff termination.

Refer to A 0535

VIOLATION: MEDICAL STAFF BYLAWS

Tag No: A0353

Based on record review and interview the facility failed to abide by the established Medical Staff guidelines with Governing Body over cite in one of one medical staff termination.

On 3/17/2011 at 1:30 PM in the office of the Director of Nurses (DON) the medical staff guidelines were reviewed which indicate the following under Article VII Corrective Action.

Section 1. a. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the medical staff or they be disruptive to the operations of the hospital, corrective action against such practitioner may be requested by any member of the medical staff, by the president of the medical staff, by the Administrator, or by the Governing Body. All requests for corrective action shall be in writing, shall be made to the committee of the whole, and shall be supported by reference to the specific activities or conduct, which constitutes the grounds for the request.

Section 1. b. Whenever the corrective action could be a reduction or suspension of clinical privileges, the committee of the whole shall forward such request to the president of the medical staff wherein the practitioner has such privileges. Upon receipt of such request, the president of the medical staff shall immediately appoint an ad hoc committee to investigate the matter.

On 3/17/2011 at 1:45 PM in the DON's office the DON confirmed that a conversation took place in a open hall way and was over heard by staff. The Medical Director was disruptive and insubordinate to the Administrator. The Administrator was explaining the termination of coworkers earlier in the day had been necessary for the stability of the facility. At which point the Medical Director and Administrator began shouting at each other. The Administrator terminated the Medical Director in the hearing of the staff. There was no due process.

A review of the Medical Director's progress note reads *Having been removed from medical staff by Administrator further orders will be from whom ever he designates effective immediately per administrator* The Medical Directors critical patient was not referred to another physician for care. The hospital functioned, with at least one critical patient, without physician coverage for inpatient care for 5 hours.

The facility did not follow the established medical staff guidelines for corrective action in the termination of the Medical Director. There was no written request for corrective action made to the committee of the whole. Although the Medical Directors conduct was witnessed by the

staff there was no written reference to the disruptive conduct. which would constituted the grounds for request. The committee of the whole never met on this issue. An as hoc committee was never appointed and the event was never investigated. This is reflected in the medical staff meeting minutes. There was no emergency called meeting of the medical staff or governing body and the next regularly scheduled medical staff meeting simply reflects a new Medical Director.

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COZBY-GERMANY HOSPITAL COZBY-GERMANY HOSPITAL

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Report No. 1778

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WESTBURY COMMUNITY HOSPITAL, LLC 5556 GASMER HOUSTON, TX 77035 March 17, 2011

VIOLATION: GOVERNING BODY Tag No: A0043

Based on interview, review of the Quality Improvement Program Plan and review of performance improvement meeting minutes the hospital governing body was ineffective by failing to ensure the implementation of a quality improvement plan that includes all hospital departments. and ensures all quality indicators are being monitored. Findings:

CROSS REFER TO A 0263 CROSS REFER TO A 0267

VIOLATION: QAPI Tag No: A0263

Based on interview and review of hospital documents the hospital governing failed to ensure the implementation of a quality improvement plan that includes all hospital departments and failed to ensure quality indicators were monitored.

Per interview with hospital CEO on 3/17/11 at 10:45am, the hospital added two outpatient clinics to the hospital provider number on 1/13/2011 to include:

Hornwood Outpatient Center, 6648 Hornwood Drive, Houston, TX and

Baytown Outpatient Center, 2001 Cedar Bayou Drive, Baytown, TX
However, review of the Quality Improvement Program Plan did not include the integration of these outpatient services into the hospitalwide Quality Improvement Program. Review of Quality Improvement meeting minutes from 1/13/2011 to 3/1/2011 had no evidence outpatient services were monitored..

CROSS REFER TO A 0267

VIOLATION: MEDICAL STAFF BYLAWS

Tag No: A0353

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, review of medical staff bylaws, review of physician credential files and review of 1 of 1 surgical clinical record, the medical staff failed to enforce its bylaws resulting in a practitioner performing surgery without the delineation of the privilege to perform surgery approved. Findings:

Review of the clinical record reflected the patient, a [AGE] year old female who underwent surgery surgery on 3/11/2011 for removal of a bone in her foot. Present in the surgical suite were personnel #1, #3 and #21. Per personnel #21 at 10am on 3/16/2011 the practitioner who performed surgery on the patient was personnel #3, a doctor of podiatry medicine(DPM). Review of the credential file reflected personnel #3 was given temporary privileges on 3/11/2011. However, personnel #3 performed surgery without being given approval to perform surgery and without query of the national practitioners data bank (NYPD)in violation of medical staff by laws which require both.

Tag No: A0490

VIOLATION: PHARMACEUTICAL SERVICES

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview and record review, facility failed to ensure its pharmaceutical service operationalized its policy and procedure to track schedule 2 control medications during receipt and disposition of control medications; failed to ensure expired medication were not stored with medication in stock for patient usage and failed to document medication administered as prescribed by the physician in 2 of 8 sampled patients reviewed for medication #s, 6 and 44,

Findings:

Review on 03/16/2011 of the facility's current policy and procedure on Controlled Drug Distribution and Accountability (issued 05/2010) directed staff as follows: "The facility has overall responsibility for controlled drugs. Records for controlled drugs shall be filed so they are readily retrievable and receipts and distribution can be established. C-11 records shall be separate from records of C-111 through C-V and non controlled drugs. These records shall be retained for a period of five (5) years. '

The facility's current policy and procedure issued 05/10 directed facility 's staff as follows; "Only the Director of Pharmacy or designee

shall handle the receipt of C 11 drugs. The person handling the receipt of C 11 drugs shall verify the quantities received and enter the quantities on a Perpetual Controlled Drug Inventory Record. The number of items received and the actual date of receipt shall be entered on the pharmacy copy of the DEA Form-

The DEA Form -222 shall be attached to the original invoice (and purchase order if any):
Facility 's current Policy on Controlled Drugs Inventory (perpetual), issued 05/10 directed staff as follows: "A Perpetual Controlled Drug Inventory Record shall be used to aid in accounting for >11 (active, unstable stock as well as inactive, expired or otherwise unusable stock) C - 11 and C111 - CV drugs. A separate binder will be maintained for C-11 drugs and C111 - CV medications. "

On 03/16/2011 11:30 a.m. during tour of the facility's pharmacy, the surveyor requested from the chief pharmacist evidence that controlled drugs receipt and disposition were recorded,

The pharmacist informed the surveyor that her company had recently contracted to service the pharmacy and that she was unable to locate the facility's log documenting receipt and disposition of controlled drugs.

On 03/17/11 at 8:00 a.m. facility's director of clinical services provided copies of invoices and logs to the surveyor On 03/17/11 during reconciliation of facility's C-2 controlled drugs, a DEA form 222 dated 11/17/2010 was observed on file. The surveyor and the chief pharmacist reviewed DEA form 222. DEA form 222 did not have the National Drug Code documented.

Review of form DEA 222 revealed documentation a packet of 10 carpuject Demerol 50 mg/ ml was received by the facility on 11/17/2010.

Review of the controlled drug log provided by the facility's CEO revealed no documentation indicating that the facility had received 10 carpuject Demerol 50 mg medication.

Observation on 03/17/11 at 9:10 a.m. of the facility's C-2 stock of controlled drugs in the pharmacy revealed no evidence of Demerol 50 mg/ ml carpuject in stock.

Expired medication

On 03/16/2011 11:30 a.m. during tour of the facility's pharmacy The following medications were observed in stock in the cupboard which stored C-2 controlled substances:

Alprozolam 2 mg tablets Lot # P, 88 tablets expired on [DATE].

The surveyor immediately informed the chief pharmacist that controlled drug Alprozolam stored with other C-2 medications were expired.

The chief pharmacist said she would inventory the Pixus drug dispensing system to ensure none of the expired medication was in the pixus.

Administration of Medication

Patient #6

Review on 03/16/2011 of patient # 6's clinical record (physician's order and medication administration record) revealed a physician's order dated 12/16/2010 for Lovenox 40 mg subcutaneous daily.

Review of the patient's medication administration record revealed no documentation that Lovenox was administered on 12/17/2010.

On 03/16/2011 at 4:40 p.m. the surveyor reviewed the patient's clinical record with facility's director of nursing. She confirmed that the patient's record did not indicate that Lovenox was administered as prescribed by the physician.

Review on 03/17/2011 of patient # 44's clinical record (Physician's order and medication administration record) revealed the patient was admitted to the facility on [DATE] with diagnosis of paranoids Schizophrenia.

The clinical record revealed a physician's order dated 12/09/2010 for Buspirone 10 mg orally three times daily and and Trazadone 200 mg orally at bedtime.

Review of the patient's medication administration records revealed no documentation that Busperione was administered three times daily

as prescribed by the physician on the following days:

The patient's medication administration records documented that Busperione was administered twice daily on 12/13/2010, 12/18/2010 and 12 /19/2010.

Further review of the the patient's clinical record (medication administration record) revealed Trazadone 200 mg was not documented as administered on 12/19/2010.

On 03/17/2011 at 2:40 p.m. the surveyor reviewed the patient's clinical record (physician's order and medication administration records) with the director of nursing. She confirmed that there was no documentation that the patient was administered his medication as prescribed by the physician.

Tag No: A0494

Cross reference A 494

VIOLATION: PHARMACY DRUG RECORDS

Based on observation, interview and record review, facility failed to ensure its pharmaceutical service operationalized its policy and procedure to track schedule 2 control medications during receipt and disposition of control medications.

Review on 03/16/2011 of the facility 's current policy and procedure on Controlled Drug Distribution and Accountability (issued 05/2010) directed staff as follows: "The facility has overall responsibility for controlled drugs. Records for controlled drugs shall be filed so they are readily retrievable and receipts and distribution can be established. C-11 records shall be separate from records of C-111 through C-V and non controlled drugs. These records shall be retained for a period of five (5) years.

The facility 's current policy and procedure issued 05/10 directed facility's staff as follows; "Only the Director of Pharmacy or designee shall handle the receipt of C 11 drugs.

The person handling the receipt of C 11 drugs shall verify the quantities received and enter the quantities on a Perpetual Controlled Drug

Inventory Record. The number of items received and the actual date of receipt shall be entered on the pharmacy copy of the DEA Form-222.

The DEA Form -222 shall be attached to the original invoice (and purchase order if any):
Facility 's current Policy on Controlled Drugs Inventory (perpetual), issued 05/10 directed staff as follows: "A Perpetual Controlled Drug Inventory Record shall be used to aid in accounting for >11 (active, unstable stock as well as inactive, expired or otherwise unusable stock) C - 11 and C111 - CV drugs. A separate binder will be maintained for C-11 drugs and C111 - CV medications.

On 03/16/2011 11:30 a.m. during tour of the facility's pharmacy, the surveyor requested from the chief pharmacist evidence that controlled drugs receipt and disposition were recorded,

The chief pharmacist informed the surveyor that her company had recently contracted to service the pharmacy and that she was unable to locate the facility's log documenting receipt and disposition of controlled drugs.

The pharmacist said she had requested the log from the out going pharmacist and was told by him that it was in the pharmacy.

On 03/16/2011 at 11:45 a.m. during an interview with facility's chief executive officer, the surveyor informed the CEO that there was no system in place in the pharmacy to track the receipt and disposition of controlled drugs. The CÉO informed the surveyor that he would contact the contracted pharmacist to determine where the log could be found.

On 03/17/11 at 8:00 a.m. facility's director of clinical services provided copies of invoices and logs to the surveyor On 03/17/11 during reconciliation of facility's C-2 controlled drugs, a DEA form 222 dated 11/17/2010 was observed on file. The surveyor and the chief pharmacist reviewed DEA form 222. DEA form 222 did not have the National Drug Code documented. Review of form DEA 222 revealed documentation that a packet of 10 carpuject Demerol 50 mg/ml was received by the facility on 11/17/2010.

Review of the controlled drug log provided by the facility's CEO revealed no documentation indicating that the facility had received 10 carpuject Demerol 50 mg medication.

Observation on 03/17/11 at 9:10 a.m. of the facility's C-2 stock of controlled drugs in the pharmacy revealed no evidence of Demerol 50 mg/ ml carpuject in stock.

During interview with facility's chief pharmacist on 03/17 at 9:00 a.m., the chief pharmacist said she had no Demerol carpuject in stock in the pharmacy and she had no record of where the drug was dispensed.

She said she was not aware that this was delivered to the pharmacy since the log was not made available to her when she assumed the role of chief pharmacist

Further observation on 03/17/11 at 9:15 a.m. of the facility's a medication dispensing system (pixus) revealed 2 Demerol 50/ mg carpuject (national drug code # 0409 - 1178 -30) in stock in the Pixus system located in the Emergency center. A reconciliation of the facility's two other Pixus system revealed no evidence of Demerol 50 mgs/ ml carpuject.

During interview with facility s chief pharmacist on 03/17/11 at 9:30 a.m., the surveyor asked the pharmacist if it was possible to reconcile medication dispensed from the pixus in order to track who received Demerol 50 mg/ ml carpuject.

The pharmacist said the Pixus system was only capable of reconciling up to 31 days and so she was unable to determine where or whom the medication was dispensed to

During an interview on 03/17/2011 at 4:45 a.m. in the conference room the the director of clinical services said staff was reviewing patients' records to determine which patients had received Demerol 50 mg/ ml Carpuject injection.

VIOLATION: INFECTION CONTROL LOG Tag No: A0750

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on record review and interview the facility failed to maintain a log of infections identified in the facility in seven of twelve sampled patients. Citing patients #1, #3, #4, #7, #8, #9, and #45.

Findings

Patient #8

Review on 03/16/20 10 of patient #8's clinical record (demographic data) revealed the patient was admitted to the facility on [DATE] with diagnosis of right lower lobe pneumonia.

The patient's clinical record (physician's order) indicated that the patient was treated with antibiotics of Levaquin 500 mg intravenous piggy back every 24 hours and Rocephin 1 gm intravenous every 24 hours.

The patients clinical record (physician's order) revealed an order dated 12/29/2010 for Zithromax 500 mg orally daily.

Subsequent review on 03/17/2011 of the patient's record revealed a physician's order dated 12/29/2010 for " AFB stain CS X3 "

Review of the patient's clinical record revealed no evidence that the specimen for AFB stain CS X three was collected and sent to the laboratory for analysis.

Review of a nurse's notes dated 12/29/2010 revealed the following entry " Informed for the need for sputum specimen. Respiratory notified of the need to induce sputum. Respiratory in to give nebulizer treatment and attempted to induce sputum - unsuccessful will continue to encourage."

Further review of the patient's clinical record revealed a respiratory therapist progress notes dated 12/29/2010 which indicated the following " Attempted sputum collection Pt unable."

Review of the patient's clinical record revealed no evidence that any other attempts were made to collect sputum specimen X 3 or that the physician was notified that the sputum specimen were not collected.

On 03/17/ 2011 the surveyor reviewed the patient's record with the director of clinical services and requested the laboratory result for the sputum culture and sensitivity X3. None was provided.

Further review of the facility's infection control log provided by the infection control director revealed no documentation indicating an order for culture and sensitivity of the patient's sputum and the result.

The facility's Infection Control Log (IC Log) submitted for review had no infections listed from January 2010 through December 2010. No infections had been documented on the IC Log for the year 2011 through to date of survey.

Facility's policy entitled: "Infection Control Plan" (issued 05/10) stated in part on Page 3:
"B. The Infection Control Coordinator and the Chief Nursing Officer shall be responsible and accountable for the active hospital-wide infection control program including, but not limited to:"g. Review of reported patient infections, as appropriate, for determination as to whether an infection is nosocomial and the potential for preventive measures or interventions to minimize the risk of any further occurrence".

On page 4, the same policy stated in part at #10, the following:

.......The infection Control Program shall function under immediate direction of Administration, Nursing Service, and on at least a consultative basis, the following:e: Pharmacy".

Patients with infections were not identified and listed on the Infection Control Log.

Patients with infections had not been analyzed as required by policy under "Infection Control Plan"

Pharmacy had not provided consult/input to the Infection Control Coordinator when antibiotics were ordered so that infections would be identified and listed on an IC log and an analyses performed on these infections.

The following patients with infections were not listed on the IC Log. Pharmacy failed to communicate to the Infection Control Coordinator when antibiotics were ordered on these patients:

admitting diagnosis was UTI (urinary tract infection). Urine culture was negative. Patient was treated with Levaquin 500 Intravenously (IV) beginning on 8/26/2010, patient was started on Rocephin IV on 8/28/2010.

Patient's sputum sent for culture on 8/29/2010 had many gram positive cocci in pairs and long chains, indicative of possible strep infection.

Patient #4:

Patient was diagnosed with UTI and dehydration. Urine cultured gram negative e-coli on 12/5/10. Patient was started on Bactrim. The culture and sensitivity revealed the e-coli was resistant to this antibiotic. Patient then started on Microbid on 12/7/2010.

Patient #7

Patient was hospitalized from [DATE] through 12/22/2010. Patient was placed on Amoxicillin for "pharyngitis" on 12/18/2010.

Patient #8:

(see surveyor findings above)

Patient #9:

admitted s were 12/30/2010 through 1/10/2011. Urine microscopic/urine culture on 1/2/2011 showed 80,000 colonies/ml of mixed gram positive flora. Patient was started on IV Levaquin on admission. She was placed on oral Levaquin on 1/2/2011.

Patient #45:

admitted from 2/15/11 through 2/25/11. When patient was admitted he had a fever of 101.7. On 2/17/2011, physician ordered "Z-Pack" (zitromycin) "as directed".

Interviews with the Director of Nurses and the Infection Control Coordinator on the afternoon of 3/17/2011 confirmed above patient's infections had not been reviewed/analyzed and should have been listed on the IC Log. It was confirmed also that pharmacy had failed to inform the Infection Control Coordinator when antibiotics were ordered.

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Based on review of the Quality Improvement Program Plan, review of Quality Improvement(QI) meeting minutes, review of the emergency room (ER) log, review of hospital transfer policy and review of Hospital Performance Data Base, the hospital failed to ensure all aspects of the

of the QI plan were monitored. Findings:

1. Review of the QI plan reflected discharges against medical advice(AMA) will be monitored. Review of the ER log for time period 8/8/2010 to 2/18/2011 reflected 10 AMA discharges from the ER. However, review of QI meeting minutes for the same time period had no evidence AMA's were monitored.

Patient ER #:: 25, 26, 53, 81,283,306, 315, 360, 142, and # 58

2. Review of Hospital Transfer Policy at (G)(1) Quality Review Section, reflected medical staff shall review all transfers from the hospital to determine appropriateness of the transfer.

Review of Hospital Performance/ Database Performance Measures, reflected one of the performance measures at (#7) reflected all emergency medical and psychiatric transfers will be monitored.

Review of the ER log for time period 11/21.2010 - 3/10/2010 reflected 21 transfers from the ER

However, review of Quality Improvement Committee meeting minutes for the same time period had no evidence patient transfers were monitored.

Patient ER #: 363, 386, 391, 408, 397, 411, 584, 697, 190, 1031, 648, 20, 1083, 1087, 584, 1101, 316, 1158, 1164, 1177, and #1200.

Lack of monitoring AMA's and all transfers was verified by personnel #34 at 2:20pm on 3/17/2011



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Report No. 1762

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

FIRST STREET HOSPITAL LP 4801 BISSONNET BLVD BELLAIRE, TX 77401 March 15, 2011

VIOLATION: LABORATORY SERVICES Tag No: A0576

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, interview, and record review the Hospital failed to ensure 1 of 7 out-patient emergency departments had a CLIA certificate (Clinical Laboratory Improvement Amendments) prior to performing laboratory studies onsite. (Bellaire Emergency Center)

Findings include:

Observation 3/10/11 at 3 p.m. at Bellaire Emergency Center revealed a laboratory with testing equipment. No CLIA certificate was posted.

The Medical Director (ID# 58) of Bellaire Emergency center acknowledged 3/11/11 at 8:50 a.m. the center did not have a CLIA certificate. The Medical Director stated that the center performs laboratory work onsite for "Internal reasons only." The Medical Director further stated that all laboratory studies are sent out to Hospital ID# 90.

The Chief Executive Officer (CEO) acknowledged 3/10/11 at 3 p.m. the hospital just realized two weeks ago that Bellaire emergency room did not have a CLIA certificate. The CEO could not locate a contract with Hospital ID# 90 to perform laboratory studies for Bellaire emergency center.

Interview 3/11/11 at 9 a.m. with the Medical Laboratory Director (ID# 82) revealed he was aware that Bellaire emergency center did not have a CLIA certificate. The Laboratory Director stated he was not really aware of the arrangements between the out-patient emergency room s and the hospital because he primarily oversees the Hospital laboratory.

Record review of a policy titled "Clinical Laboratory Scope of Services" dated 11/30/06 stated "The responsibilities of the Medical Laboratory Director will include: assuring compliance with the applicable regulations."

The Centers for Medicare and Medicaid web page regarding "Clinical Laboratory Improvement Amendments (CLIA)" stated "CLIA requires all entities that perform even one test, including waived tests......to meet certain Federal requirements. If an entity performs tests for these purposes, it is considered under CLIA to be a laboratory and must register with the CLIA program."

Record review of patient ID# 48 revealed he was treated at Bellaire emergency room on [DATE]. The record revealed laboratory studies were performed at Bellaire emergency center without a CLIA certificate. Laboratory studies included Comprehensive Metabolic panel, complete blood count, and a urinalysis.

VIOLATION: INFECTION CONTROL

Based on observation, interview, and record review the Hospital failed to ensure 3 of 7 out-patient emergency departments implemented quality controls for autoclaves. (St Michael's Sugar Land, St. Michaels Westheimer, and St. Michaels Woodlands)

Tag No: A0747

Tag No: A1076

Findings include:

Infection control activities at 3 out-patient emergency room s were not integrated with the hospital. Three locations were using autoclaves without implementing quality controls.

Observation 3/11/11 at 11:55 a.m. at St. Michaels Emergency center Woodlands revealed an autoclave in the laboratory room.

Interview 3/11/11 at noon with the emergency room technician (ID# 49) revealed the autoclave is used to sterilize surgical instruments for suturing. The technician stated the center does not maintain logs of quality assurance testing for the autoclave and the center did not have a policy for operational standards, such as temperature monitoring or monthly spore testing.

Observation 3/15/11 at 10:30 a.m. at St. Michaels Emergency center Westheimer revealed an autoclave in a storage room.

Interview 3/15/11 at 10:35 a.m. with an emergency room technician (ID# 84) revealed the autoclave is used to sterilize surgical instruments for suturing. The technician stated the center does not maintain logs of quality assurance testing for the autoclave and the center did not have a policy for operational standards, such as temperature monitoring or monthly spore testing.

Observation 3/11/11 at 3:00 p.m. at St. Michaels Emergency center Sugar Land revealed an autoclave in the laboratory room.

Interview 3/11/11 at 3:15 p.m. with the nurse (ID# 48) on duty at St. Michaels Sugar Land revealed the autoclave is used to sterilize instruments for suturing. The nurse stated the center does not maintain logs of quality assurance testing for the autoclave.

Record review of a hospital policy titled "Infection Control for Sterile Processing" dated 12/2009 stated "Sterilizer logs, chart / chemical / biological tests, and spore test shall be maintained as required......Recording charts and gauges: shall be examined by the sterilizer operator at the beginning and end of each cycle (temperature and pressure). Records shall be maintained per hospital / regulatory requirements."

The Infection Control nurse (ID# 61) at the hospital stated she has never been to any of the out-patient emergency centers and was not aware the centers were using autoclaves to sterilize instruments.

Record review of a policy titled "Surveillance" dated 1/12/2009 stated "Surveillance requires a constant flow of information to the Infection Control Practitioner. Information is usually acquired by: Rounds also ensure that environmental and engineering controls are in place and properly utilized."

VIOLATION: OUTPATIENT SERVICES

Based on interview and record review the Hospital failed to appropriately admit 4 of 4 sampled indigent patients with a diagnoses of appendicitis from out-patient emergency centers. (Patient ID#'s 10, 15, 19, and 35) The hospital also failed to ensure that 4 employees at Bellaire out-patient emergency center received hospital orientation. (Staff ID#'s 150, 151, 152, 153)

Findings include:

Four indigent out-patient emergency room patients were inappropriately transferred to other hospitals for higher level of care. (Patient ID#'s 10, 15, 19, 35).

Record review of emergency room patient transfers for patient ID#'s 10, 15, 35 and 41 revealed each patient was seen in out-patient provider based emergency departments and each was diagnosed with appendicitis. Each patient was indigent with no insurance and all were transferred to other hospitals for higher level of care / surgical intervention. In each case, the hospital had the capability and the capacity to care for these patients but the out-patient emergency centers did not consult with the hospital prior to the transfers.

Record review of a policy titled "Emergency Department Scope of Service" dated 12/09 stated "Emergency Department patients are evaluated for response to treatment and are either admitted, transferred for further treatment that requires a higher level of care or is not provided by First Street Hospital......"

Record review of a policy titled "Scope of Services" dated 07/2010 stated "Perioperative Services - Surgery: Surgical services include a full range of general surgical procedures as well as surgical specialties.......The primary focus of service is to provide surgical support for inpatients and out-patients."

Patient ID# 10: Record review revealed this patient was seen 10/22/10 at St. Michaels emergency room Westheimer. The face sheet stated the patient was unemployed with no insurance. The Memorandum of Transfer form stated the patient was transferred to Hospital #90 with a diagnoses of Appendicitis. The Memorandum of Transfer stated the patient was being transferred for "Medical necessity / Upgrade in care." The patient record failed to document if the emergency room contacted First Street Hospital prior to transferring the patient to another hospital.

First Street Hospital had the capability and the capacity to care for patient # 10. Record review of the surgery on-call schedule dated 10/22/10 revealed a general surgeon (ID# 57) was on-call at First Street Hospital. Review of the general surgeon's credential file revealed one of the approved delineation of privileges was "appendectomy." Record review of the daily Census on 10/22/10 revealed the hospital

had a census of 2 in-patients with a total capacity of 5 beds.

Patient ID# 15: Record review revealed this patient was seen on 12/26/10 at St. Michaels emergency room Woodlands. The face sheet stated the patient was uninsured. The Memorandum of Transfer form stated the patient was transferred to Hospital # 89 with a diagnoses of Appendicitis. The Memorandum of Transfer stated the patient was being transferred for "Medical necessity / Upgrade in care." The patient record failed to document if the emergency room contacted First Street Hospital prior to transferring the patient to another hospital.

First Street Hospital had the capability and the capacity to care for patient # 15. Record review of the surgery on-call schedule dated 12/26/10 revealed a general surgeon (ID# 54) was on-call at First Street Hospital. Interview 3/15/11 at 10 a.m. with the Chief Executive Officer (ID# 50) revealed the hospital had no in-patients on 12/26/10 and 19 beds available. The CEO stated the hospital completed construction on an expansion 12/20/10 and added 14 additional beds to the existing 5 beds for a total of 19 beds.

Patient ID# 19: Record review revealed this patient was seen on 12/13/10 at River Oaks Emergency Center. The face sheet stated the patient was uninsured. The Memorandum of Transfer form stated the patient was transferred to Hospital #87 with a diagnoses of "acute appendicitis." The Memorandum of Transfer form did not state the reason for the transfer. The patient record failed to document if the emergency room contacted First Street Hospital prior to transferring the patient to another hospital.

First Street Hospital had the capability and the capacity to care for patient # 19. Record review of the surgery on-call schedule dated 12/13/10 revealed a general surgeon (ID# 57) was on-call at First Street Hospital. Record review of the daily Census on 12/13/10 revealed the hospital had a census of 4 in-patients with a total capacity of 5 beds. The patient record failed to document if the emergency room contacted First Street Hospital prior to transferring the patient to another hospital.

Patient ID# 35: Record review revealed this patient was seen on 9/23/10 at Bellaire Emergency Center. The face sheet stated the patient was uninsured. The Memorandum of Transfer form stated the patient was transferred to the County Hospital (ID# 88) for "Medical" Necessity / Upgrade in care and Patient Request."

Interview 3/16/11 at 3 p.m. with patient ID# 35 revealed the patient did not request to be transferred to the County hospital, that the emergency room made all the arrangements.

The patient record failed to document if the emergency room contacted First Street Hospital prior to transferring the patient to the County hospital.

First Street Hospital had the capability and the capacity to care for patient ID# 35. Record review of the surgery on-call schedule dated 9/23/10 revealed a general surgeon (ID# 57) was on-call at First Street Hospital. Record review of the daily census on 9/23/10 revealed the hospital had a census of

4 in-patients with one bed available.

Record review of a policy titled "Patient Transfer Policy" dated 8/29/06 stated "Introduction: The Governing Board of First Street Hospital, after consultation with the Medical Staff, has adopted the following policy according to rules adopted by the Texas Department of State Health Services regarding the evaluation, treatment, and transfer of patients from this hospital to another hospital in a medically appropriate manner.....The transfer of a patient may not be predicated upon arbitrary, capricious, or unreasonable discrimination based upon race, religion, national origin, age, gender, physical condition or economic status." The policy further stated "Administrative Protocols: If a patient has an emergency condition which has not been stabilized or when stabilization of the patient's vital signs is not possible because the hospital or emergency department does not have the appropriate equipment or personnel to correct the underlying process, evaluation and treatment shall be performed and transfer shall be carried out as quickly as possible."

ORIENTATION:

Record review of nine full time employees at Bellaire out-patient emergency room revealed four staff members never received general hospital orientation. (Staff member ID#'s 150, 151, 152, 153)

The Human Resources Director (ID# 154) acknowledged 3/15/11 at 1 p.m. that staff member #'s 150, 151, 152, and 153 had not received general hospital orientation.

Record review of the employee files revealed the following:

Employee ID# 150 was hired 12/20/09 as a Registered Nurse

Employee ID# 151 was hired 8/1/2010 as a Registered Nurse Employee ID# 152 was hired 8/25/2009 as a Registered Nurse

Employee ID# 153 was hired 2/22/2010 as a Radiology Technician

Record review of a policy titled "General Orientation" dated 8/30/2006 stated "All employees will attend General Orientation for new hires within thirty days of employment."

Tag No: A0043

VIOLATION: GOVERNING BODY

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

FACTS: First Street Hospital has added seven out-patient emergency centers that are classified as Provider Based Entities (PBE) with

CMS. The seven centers are as follows: Bellaire: effective date of PBE 9/1/10

Memorial Heights: effective date of PBE 9/1/10 St Michaels Sugarland: effective date of PBE 9/1/10 St. Michaels Westheimer: effective date of PBE 9/1/10 St. Michaels Woodlands: effective date of PBE 9/1/10

Preferred: effective date of of PBE 1/3/11 River Oaks: effective date of PBE 10/18/10

Based on observation, interview, and record review the Governing Body failed to ensure that policies were adhered to per the policies and procedures established by the Governing Board:

- 1) Two emergency room Medical Directors mis-represented the out-patient emergency center / hospital as a "Free Standing Emergency Center" to other hospitals (Physician ID#'s 58 and 62)
- 2) One emergency room Medical Director was not forthright with another hospital when asked if he had a "Transfer agreement with any hospitals." (Physician ID# 58)
- 2) Four indigent emergency room patients were inappropriately transferred to other hospitals (Patient ID#'s 10, 15, 35, 41)
- 3) One of seven out-patient emergency room laboratories failed to meet Federal Laboratory requirements (no CLIA certificate: Clinical Laboratory Improvement Amendments at the Bellaire Emergency Center)
- 4) The Governing Body failed to obtain a laboratory contract between Bellaire Emergency Center and hospital ID# 90.
- 5) Infection control activities at 3 out-patient emergency room s were not integrated with the hospital. Three locations were using autoclaves to sterilize instruments without implementing quality controls. (St Michael's Sugar Land, Westheimer, and the Woodlands)

Findings include:

Record review of a policy titled "Performance Improvement Plan" dated 4/2009 stated "Governing Board: The Governing Board has the ultimate responsibility for establishing policy, maintaining safe qaultiy patient care, and providing for the management, planning, and maintenance of the Performance Improvement Plan. The Board is responsible for the Hospital and its Medical Staff providing quality medical care that meets the needs of the community."

(HOSPITAL MIS-REPRESENTATION)

Two emergency room Medical Directors mis-represented the out-patient emergency center / hospital as a "Free Standing Emergency Center" to other hospitals (Physician ID#'s 58 and 62). Medical Director ID# 58 also told a County Hospital that Bellaire emergency room was not contracted with any hospital to receive patients.

Patient ID# 1

Record review of a Memorandum of Transfer form for patient ID# 1 dated 2/5/11 stated the patient was transferred to the County Hospital (ID# 88). The Memorandum of Transfer form stated River Oaks Emergency Center was a "Free Standing Emergency Medical Care Facility." The form did not reflect the fact that the emergency room is an out-patient department of First Street Hospital.

Review of hospital transfer tapes from the County Hospital (ID# 88) revealed the following conversation between the Medical Director (ID# 62) of River Oaks Emergency Center and the hospital transfer center regarding patient ID# 1:

The Medical Director (ID# 62) told the County hospital "This is River Oaks Emergency Center free standing emergency room ." The transfer center then asks "and what is the nature of the transfer?" The Medical Director stated "Patient with severe dehydration." The transfer center proceeds to ask "And you are transferring for? and the Medical Director stated "Higher level of care and patient request."

Record review of a contract titled "emergency room Department Management Agreement" stated "This emergency room Department Management Agreement is dated October 1, 2010 and is between River Oaks Emergency Management and First Street Hospital.......Manager is engaged in the business of providing certain administrative and management services to hospital-based off-campus emergency room departments." The management contract was signed by the Medical Director of River Oaks emergency center (ID# 62) and dated 8/5/10. The same Medical Director told the County Hospital transfer center the facility was a "Freestanding emergency room ."

Patient ID# 19

Record review revealed this patient was seen on 12/13/10 at River Oaks Emergency Center. The Memorandum of Transfer form stated River Oaks Emergency Center was a "Free Standing Emergency Medical Care Facility." The Memorandum of Transfer form stated the patient was transferred to Hospital #88 with a diagnoses of "acute appendicitis."

Review of hospital transfer tapes from Hospital ID# 87 revealed the following conversation between the ER Medical Director (ID# 62) of River Oaks Emergency Center and the hospital transfer center regarding patient ID# 19:

The Medical Director told the transfer center surgeon "I am one the emergency room doctors at River Oaks Emergency free standing emergency department. I have a patient for you with appendicitis."

Patient ID# 35

Record review of a Memorandum of Transfer form for patient ID# 35 dated 9/23/10 stated the patient was transferred to the County Hospital (ID# 88).

Review of hospital transfer tapes from the County Hospital (ID# 88) revealed the following conversation between the Medical Director (ID# 58) of Bellaire Emergency Center and the hospital transfer center regarding patient ID# 35:

The Medical Director (ID# 58) told the transfer center "I am trying to initiate a transfer, we are a free standing emergency room and I have a patient with appendicitis." The transfer center then asks "you are a freestanding, what is the name of your hospital?" The Medical Director replied "Bellaire Emergency Center." The transfer center then asks "are you contracted with any hospital to receive patients from you all? and the Medical Director replied "We are not officially contracted with any hospital." The surgeon (ID# 86) at the County Hospital then gets on the line and the Medical Director tells him "I am at one of the free standing emergency room s in Bellaire." The surgeon then ask "you are a free standing emergency room there?" The Medical Director replied "Yea, Yea, So, I will get the ambulance and we will transfer him to the emergency room there."

The Physician Chairman (ID# 59) of the hospital acknowledged 3/14/11 at 8 a.m. the out-patient emergency departments were previously functioning as unlicensed emergency room s and he thought the physicians at the centers were in the habit of identifying themselves as "Free Standing Emergency Centers."

Record review of a contract titled "emergency room Department Management Agreement" stated "This emergency room Department Management Agreement is dated June 7th, 2010 and is between Bellaire Emergency Center and First Street Hospital.......Manager is engaged in the business of providing certain administrative and management services to hospital-based off-campus emergency room departments." The management contract was signed by the Medical Director of Bellaire emergency center (ID# 58) and dated 6/9/10. The same Medical Director told the County hospital "We are not officially contracted with any hospital."

(INAPPROPRIATE PATIENT TRANSFERS)

Four indigent emergency room patients were inappropriately transferred to other hospitals for higher level of care. (Patient ID#'s 10, 15, 19, 35).

Record review of a policy titled "Emergency Medical Treatment and Active Labor Act (EMTALA) dated 5/2010 stated "Screening within the off-campus locations sahll be within the location's capabilities and available personnel. If the patient's condition is outside the scope of services available, the off-campus location shall arrange patient transportation.......Patients shall be routinely shall be routinely transferred to facilities where transfer agreements have been established, or the patient's choice."

Record review of emergency room patient transfers for patient ID#'s 10, 15, 35 and 41 revealed each patient was seen in out-patient provider based emergency departments and each was diagnosed with appendicitis. Each patient was indigent with no insurance and all were transferred to other hospitals for higher level of care / surgical intervention. In each case, the hospital had the capability and the capacity to care for these patients but the out-patient emergency centers did not consult with the hospital prior to the transfers.

The Chief Executive Officer (CEO) acknowledged 3/11/11 at 4:30 p.m. that it is sometimes in the best interest of the patients to be transferred to the closest hospital in the area of town. The CEO stated the hospital has never received a patient admission from any of the seven out-patient emergency room s.

The CEO provided documentation that 536 emergency room patients had been transferred to other hospitals from September 2010 to February 2011.

Record review of a policy titled "Emergency Department Scope of Service" dated 12/09 stated "Emergency Department patients are evaluated for response to treatment and are either admitted, transferred for further treatment that requires a higher level of care or is not provided by First Street Hospital......"

Record review of a policy titled "Scope of Services" dated 07/2010 stated "Perioperative Services - Surgery: Surgical services include a full range of general surgical procedures as well as surgical specialties.......The primary focus of service is to provide surgical support for inpatients and out-patients."

Patient ID# 10: Record review revealed this patient was seen 10/22/10 at St. Michaels emergency room Westheimer. The face sheet stated the patient was unemployed with no insurance. The Memorandum of Transfer form stated the patient was transferred to Hospital #90 with a diagnoses of Appendicitis. The Memorandum of Transfer stated the patient was being transferred for "Medical necessity / Upgrade in care." The patient record failed to document if the emergency room contacted First Street Hospital prior to transferring the patient to another hospital.

First Street Hospital had the capability and the capacity to care for patient # 10. Record review of the surgery on-call schedule dated 10/22/10 revealed a general surgeon (ID# 57) was on-call at First Street Hospital. Review of the general surgeon's credential file revealed one of the approved delineation of privileges was "appendectomy." Record review of the daily Census on 10/22/10 revealed the hospital had a census of 2 in-patients with a total capacity of 5 beds.

Patient ID# 15: Record review revealed this patient was seen on 12/26/10 at St. Michaels emergency room Woodlands. The face sheet stated the patient was uninsured. The Memorandum of Transfer form stated the patient was transferred to Hospital # 89 with a diagnoses of Appendicitis. The Memorandum of Transfer stated the patient was being transferred for "Medical necessity / Upgrade in care." The patient record failed to document if the emergency room contacted First Street Hospital prior to transferring the patient to another hospital.

First Street Hospital had the capability and the capacity to care for patient # 15. Record review of the surgery on-call schedule dated 12/26/10 revealed a general surgeon (ID# 54) was on-call at First Street Hospital. Interview 3/15/11 at 10 a.m. with the Chief Executive Officer (ID# 50) revealed the hospital had no in-patients on 12/26/10 and 19 beds available. The CEO stated the hospital completed construction on an expansion 12/20/10 and added 14 additional beds to the existing 5 beds for a total of 19 beds.

Record review of a "Patient Transfer Agreement" between Hospital ID# 89 and St. Michael's emergency room Woodlands dated 11/10/10 stated "Woodlands Freestanding Emergency Center doing business as St. Michael's emergency room is a Texas free-standing emergency center." The transfer agreement was signed by the Medical Director (ID# 81) of St. Michael's Emergency Centers and not by an administrative representative from First Street Hospital.

Interview 3/11/11 at 3 p.m. with the Transfer Coordinator / Director of Trauma Services at Hospital ID# 89 revealed the hospital was not aware that St. Michael's emergency room was an out-patient emergency department of First Street Hospital. The Transfer Coordinator stated that St. Michael's Emergency Center presented themselves to the hospital as a "Free Standing emergency room ."

Patient ID# 19: Record review revealed this patient was seen on 12/13/10 at River Oaks Emergency Center. The face sheet stated the patient was uninsured. The Memorandum of Transfer form stated River Oaks Emergency Center was a "Free Standing Emergency Medical Care Facility." The Memorandum of Transfer form stated the patient was transferred to Hospital #87 with a diagnoses of "acute appendicitis." The Memorandum of Transfer form did not state the reason for the transfer. The patient record failed to document if the emergency room contacted First Street Hospital prior to transferring the patient to another hospital.

First Street Hospital had the capability and the capacity to care for patient # 19. Record review of the surgery on-call schedule dated 12/13/10 revealed a general surgeon (ID# 57) was on-call at First Street Hospital. Record review of the daily Census on 12/13/10 revealed the hospital had a census of 4 in-patients with a total capacity of 5 beds. The patient record failed to document if the emergency room contacted First Street Hospital prior to transferring the patient to another hospital.

Patient ID# 35: Record review revealed this patient was seen on 9/23/10 at Bellaire Emergency Center. The face sheet stated the patient was uninsured. The Memorandum of Transfer form stated the patient was transferred to the County Hospital (ID# 88) for "Medical Necessity / Upgrade in care and Patient Request."

Per telephone interview 3/16/11 at 3 p.m. with patient ID# 35 revealed the patient did not request to be transferred to the county hospital, that the emergency room made all the arrangements.

Review of the transfer tapes from the county hospital for patient ID# 35 revealed the Medical Director (ID# 58) of Bellaire emergency room telling the County hospital transfer center "I am trying to initiate a transfer, we are a free standing emergency room and I have a patient with appendicitis." The transfer center then asks "what is the name of your hospital?" and the Medical Director replies "Bellaire Emergency Center." The transfer center then asks if the Medical Director contacted any other hospital and the Medical Director stated "no, you are the first one." The transfer center then asks "are you contracted with any hospital to receive patients from you all?" The Medical Director replies "We are not officially contracted with any hospital." The patient record failed to document if the emergency room contacted First Street Hospital prior to transferring the patient to the County hospital.

First Street Hospital had the capability and the capacity to care for patient ID# 35. Record review of the surgery on-call schedule dated 9/23/10 revealed a general surgeon (ID# 57) was on-call at First Street Hospital. Record review of the daily census on 9/23/10 revealed the hospital had a census of

4 in-patients with one bed available.

Record review of a policy titled "Patient Transfer Policy" dated 8/29/06 stated "Introduction: The Governing Board of First Street Hospital, after consultation with the Medical Staff, has adopted the following policy according to rules adopted by the Texas Department of State Health Services regarding the evaluation, treatment, and transfer of patients from this hospital to another hospital in a medically appropriate manner......The transfer of a patient may not be predicated upon arbitrary, capricious, or unreasonable discrimination based upon race, religion, national origin, age, gender, physical condition or economic status." The policy further stated "Administrative Protocols: If a patient has an emergency condition which has not been stabilized or when stabilization of the patient's vital signs is not possible because the hospital or emergency department does not have the appropriate equipment or personnel to correct the underlying process, evaluation and treatment shall be performed and transfer shall be carried out as quickly as possible."

The hospital had previously performed an appendectomy. Record review of the medical record revealed Patient ID# 41 was admitted to the hospital on 1/25/11. A general surgeon's (ID# 57) operative note dated 1/27/11 stated a laparoscopic appendectomy was performed.

(FEDERAL LABORATORY REQUIREMENTS)

Observation 3/10/11 at 3 p.m. at Bellaire Emergency Center revealed a laboratory with testing equipment. No CLIA certificate was posted. (Clinical Laboratory Improvement Amendments)

The Medical Director (ID# 58) of Bellaire Emergency center acknowledged 3/11/11 at 8:50 a.m. the center did not have a CLIA certificate. The Medical Director stated that the center performs laboratory work onsite for "Internal reasons only." The Medical Director further stated that all laboratory studies are sent out to Hospital ID# 90.

The Chief Executive Officer (CEO) acknowledged 3/10/11 at 3 p.m. the hospital just realized two weeks ago that Bellaire emergency room did not have a CLIA certificate. The CEO could not locate a contract with Hospital ID# 90 to perform laboratory studies for Bellaire

emergency center.

Interview 3/11/11 at 9 a.m. with the Medical Laboratory Director (ID# 82) revealed he was aware that Bellaire emergency center did not have a CLIA certificate. The Laboratory Director stated he was not really aware of the arrangements between the out-patient emergency room s and the hospital because he primarily oversees the Hospital laboratory.

Record review of a policy titled "Clinical Laboratory Scope of Services" dated 11/30/06 stated "The responsibilities of the Medical Laboratory Director will include: assuring compliance with the applicable regulations."

The Centers for medicare and Medicaid web page regarding "Clinical Laboratory Improvement Amendments (CLIA)" stated "CLIA requires all entities that perform even one test, including waived tests......to meet certain Federal requirements. If an entity performs tests for these purposes, it is considered under CLIA to be a laboratory and must register with the CLIA program."

Record review of patient ID# 48 revealed he was treated at Bellaire emergency room on [DATE]. The record revealed laboratory studies were performed at Bellaire emergency center without a CLIA certificate. Laboratory studies included Comprehensive Metabolic panel, complete blood count, and a urinalysis.

INFECTION CONTROL

Infection control activities at 3 out-patient emergency room s were not integrated with the hospital. Three locations were using autoclaves without implementing quality controls. (St Michael's Sugar Land, St. Michaels Westheimer, and St. Michaels Woodlands)

Observation 3/11/11 at 11:55 a.m. at St. Michaels Emergency center Woodlands revealed an autoclave in the laboratory room.

Interview 3/11/11 at noon with the emergency room technician (ID# 49) revealed the autoclave is used to sterilize surgical instruments for suturing. The technician stated the center does not maintain logs of quality assurance testing for the autoclave and the center did not have a policy for operational standards, such as temperature monitoring or monthly spore testing.

Observation 3/15/11 at 10:30 a.m. at St. Michaels Emergency center Westheimer revealed an autoclave in a storage room.

Interview 3/15/11 at 10:35 a.m. with an emergency room technician (ID# 84) revealed the autoclave is used to sterilize surgical instruments for suturing. The technician stated the center does not maintain logs of quality assurance testing for the autoclave and the center did not have a policy for operational standards, such as temperature monitoring or monthly spore testing.

Observation 3/11/11 at 3:00 p.m. at St. Michaels Emergency center Sugar Land revealed an autoclave in the laboratory room.

Interview 3/11/11 at 3:15 p.m. with the nurse (ID# 48) on duty at St. Michaels Sugar Land revealed the autoclave is used to sterilize instruments for suturing. The nurse stated the center does not maintain logs of quality assurance testing for the autoclave.

Record review of a hospital policy titled "Infection Control for Sterile Processing" dated 12/2009 stated "Sterilizer logs, chart / chemical / biological tests, and spore test shall be maintained as required......Recording charts and gauges: shall be examined by the sterilizer operator at the beginning and end of each cycle (temperature and pressure). Records shall be maintained per hospital / regulatory requirements."

The Infection Control nurse (ID# 61) at the hospital stated she has never been to any of the out-patient emergency centers and was not aware the centers were using autoclaves to sterilize instruments.

Record review of a policy titled "Surveillance" dated 1/12/2009 stated "Surveillance requires a constant flow of information to the Infection Control Practitioner. Information is usually acquired by: Rounds also ensure that environmental and engineering controls are in place and properly utilized."

VIOLATION: QAPI Tag No: A0263

Based on observation, interview, and record review the Hospital failed to ensure seven out-patient emergency departments were monitored by the performance improvement program. (Bellaire Emergency Center, Memorial Heights Emergency Center, St. Michaels emergency room Sugar Land,

St. Michaels emergency room Westheimer, St. Michaels emergency room Woodlands, Preferred emergency room , and River Oaks Emergency Center.

Findings include:

Interview 3/9/11 at 11:15 a.m. with the Chief Executive Officer (CEO) revealed the hospital has seven out-patient emergency room s that are provider based. The CEO stated the hospital has established contracts / leases with each emergency room and the emergency room s are operated by a contract management agreement with contract Medical Directors at each location.

Interview 3/14/11 at 11 a.m. with the Medical Director of emergency room Services (ID# 53) revealed he does not supervise the seven out-patient emergency room locations but does attend Medical Executive Committee meetings to provide over-sight regarding emergency services.

Record review the hospitals "Performance Improvement Plan" dated 4/2009 stated "Policy: the scope of the Performance Improvement Plan encompasses all services provided at First Street Hospital. The hospital-wide program will monitor the performance of Medical Staff and hospital departments compliance with regulatory and accreditation requirements."

Record review of Governing Board / Quality Assurance meetings dated 9/22/10, 12/8/10, 2/23/11 revealed the hospital was tracking transfers to a higher level of care, patients that left against medical advise, and the total volume of emergency room patients. The hospital

documented that all transfers to a higher level of care were appropriate.

Interview 3/14/11 at 10:40 a.m. with the Director of Quality Assurance revealed the hospital does not have a specific policy establishing quality indicators for the emergency departments.

Problems identified:

Four out-patient emergency room indigent patients were inappropriately transferred to other hospitals (Patient ID#'s 10, 15, 35, 41) Performance Improvement Reviews completed by the contract management company revealed the transfers to a higher level of care was appropriate for each patient
***Refer to CMS tag A0043 Governing Body

Two Contract emergency room Medical Directors mis-represented the out-patient emergency center / hospital as a "Free Standing Emergency Center" to other hospitals (Physician ID#'s 58 and 62) ***Refer to CMS tag A0043 Governing Body

One emergency room Contract Medical Director was not forthright with another hospital when asked if he had a "Transfer agreement with any hospitals." (Physician ID# 58)
***Refer to CMS tag A0043 Governing Body

One of seven out-patient emergency room laboratories failed to meet Federal Laboratory requirements (no CLIA certificate: Clinical Laboratory Improvement Amendments at the Bellaire Emergency Center)
***Refer to CMS tag 576 Laboratory Services

The Governing Body failed to obtain a laboratory contract between Bellaire Emergency Center and hospital ID# 90. ***Refer to CMS tag A0043 Governing Body

Infection control activities at 3 out-patient emergency room s were not integrated with the hospital. Three locations were using autoclaves without implementing quality controls. (St Michael's Sugar Land, Westheimer, and the Woodlands)
***Refer to CMS tag 747 Infection Control



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4801 BISSONNET BLVD BELLAIRE, TX 77401 | Proprietary

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Report date Number of violations

March 15, 20115 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department.

Incomplete reports

Number of incomplete reports Number of violations Report date March 15, 20111

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EAST TEXAS MEDICAL CENTER ->

Report No. 1485

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

EAST TEXAS MEDICAL CENTER

1000 SOUTH BECKHAM STREET TYLER, TX 75701

March 14, 2011

Tag No: A0142

VIOLATION: PATIENT RIGHTS: PRIVACY AND SAFETY

Based on document review and interview the facility failed to insure the safety of the patient as evidenced by 1 of 1 patient fall with injury.

On 3/14/2011 at 9:30 AM a review of the medical record (MR) revealed: On 10/21/2010 the patient was found at home by her spouse on the bathroom floor. After Transfer to the Emergency Department she was evaluated with acute changes in level of consciousness. The initial CT revealed a very large right middle cerebral artery occlusion. She was admitted to the hospital for further medical management. Her Morse fall Risk assessment was 85 (45 or higher requires intervention for fall risk).

On 3/14/2011 at 9:00 AM a review of the spouse's statement revealed: 10/23/2010 the he left to get something to eat around 5:30 requesting the staff "keep an eye on my wife" upon his return approximately 6:00 PM the spouse found the patient in the floor near the bed side. Note: ALL pt rooms are visible from the nurses station.

On 3/14/2011 at 10:00 AM in the conference room Pt #1 MR revealed nursing documentation records the following entry. 1810 hours; Medical staff called to the pt's room by the pt's husband. Pt was found on the floor, pt was transported back into bed, pt assessed for injuries, hematoma to Left side of head, small abrasion to pt's bottom lip, bruising noted to pt's left shoulder, VS stable. family at bedside Dr notified of pt's condition, new orders given, bed alarm in place, will continue to monitor pt.

There was no documentation of nursing intervention for the patient after the fall to relieve the swelling to the head. There was no documented effort to provide comfort for the patient or the family after the fall. There was documentation the pt left the floor for the CT at 2100 hours, 3 hours after the fall.. There was no documentation of Neuro checks status posts fall with closed head injury. There was no education documented for the family. There was no follow up documentation reflecting a change in the care plan secondary to a fall. There was no documentation at all after the fall for two (2) hours. The documentation begins again at 2000 hours with every 2 hour vital signs, however there was no documentation that reflected a recent fall with injury. There was no reassessment documented of the patient injuries after 1810 hours. There was no description of color,or size of bruising. There was no follow up documentation for injuries resulting from the fall.

A review of the Quality Improvement Complaint Record (completed 11/10/2010) confirms the spouse returned and found the patient on the floor at 1800 hours (6:00 PM).

On 3/14/2011 at 9:30 AM the Neurology consult dated 10/24/2011 revealed: The patient was alone in her room, unrestrained, the husband returned and found her on the ground. Bruising to the left forehead, lips and arm. CT of head showed new critical contusions Left frontal, left temporal & parietal lobes in the setting of evolving stroke.

On 3/14/2011 at 10:30 AM in the conference room an interview with the Director of Neuro/Critical care confirmed the bed alarm was not engaged. When asked if the bed alarm had been inspected and found to be damaged or otherwise not in working order, the reply was "no". The bed was not inspected because the alarm was found to be in working order. Further inquiry confirmed the bed alarm had not been properly engaged by the nursing staff. The staff failed to insure the safety of the patient.

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on documentation and interview the facility failed to provide patient care in a safe setting based on one patient fall with injury.

Tag No: A0144

Tag No: A0154

On 3/14/2011 at 9:30 AM a review of the patient record revealed a fall was documented on 10/23/2010. The nursing documentation reveals the following at 1610 hours *pt report received, pt resting in bed with family at the bedside, will continue to monitor* at 1810 hours *medical staff called to the pt's room by the pt's husband, pt was found on the floor, pt was transported back into bed, pt assessed for injuries, hematoma to Lt side of head, small abrasion to pt's bottom lip, bruising noted to pt's Lt shoulder. VS (Vital Signs) stable, family at bedside, Dr. notified of pt's condition, new orders given, bed alarm in place, will continue to monitor the pt.* A physician order dated 10/23/2011 reflects *CT of head Now* The next Nursing documentation occurs at 2000 hrs * Report received from off going nurse. Pt awake, breathing regular & unlabored. Denies pain, no complaints at this time. Husband at bedside, being transferred to private room, awaiting transport to X-ray for CT of head*. The nurses documentation reveal the patient was not transferred to CT until 2100 hours. 3 hours after the documented fall. It was also revealed that the documentation for *Bed Alarm activated* was *yes* beginning 10/21/2010 at 1445 hours through 11/3/2010 1200 hours. The nursing documentation records the bed rails (3) were noted as up for the same time period.

On 3/14/2011 at 11:00 AM in the conference room a review of the facility policy for assessment/reassessment found in the Administrative manual reveals, under Purpose: # 3 We define assessment as analysis of the data collected for the formulation of a plan of care which will be evaluated and reassessed based in the patient diagnosis, area in which care is delivered, patient willingness to participate in his/her care and response(s) to previous care.

Further review of this policy page #16 Scope of Assessment-Nursing A. The patient will be assessed on admission to determine nursing care needs. The assessment will include the Patient Admission Assessment, Functional Health Assessment, Risk Assessment Screen and the Assessment of the Patient Care record. C.1. The RN will be responsible for prioritizing the patient's care needs and developing a plan of care utilizing information gathered from the patient, family members/significant others, physician, licensed staff, non licensed staff and other disciplines as appropriate.

There was no documentation of nursing intervention prior to the fall even though the patient's Morse fall scale was 85. (A score of 45 indicates intervention.) There was no documentation that nurses recognized the needs of a patient with altered neurological functioning. There was no on-going documentation of nursing assessment, Vital signs or intervention involving the patient's injuries after the fall (No ice to head for swelling). There was no on-going documented patient/family teaching to reduce future injury. There was no alteration in the patient care plan to reflect nursing interventions to reduce future falls.

Further review of documentation in the Quality review process revealed a Quality Improvement Complaint (QCI) Record which revealed the spouse had complained regarding his wife's fall. The document reflects the events surrounding the fall. The complaint identifies* Staff response* as the issue. The only intervention documented was*spoke of this incident with staff involved & stressed watching pt's carefully and fall prevention*. The QCI record reflects a recommended delay in the mandatory letter of response by one week as a personal conversation resolved the issue. There was no documentation of further Quality review process. There was no documentation of specific staff education. There was no documentation of staff discipline for policy violation. There was no documented plan to monitor staff documentation. There was no documentation of investigation into the 3 hour delay for CT services after a patient fall with visible injury to the head (Large hematoma to Lt forehead).

On 3/14/2011 at 10:30 AM in the conference room an interview with the Director of Neuro/Critical care confirmed the bed alarm was not engaged. When asked if the bed alarm had been inspected and found to be damaged or otherwise not in working order, the reply was "no". The bed was not inspected because the alarm was found to be in working order. Further inquiry confirmed the bed alarm had not been properly engaged by the nursing staff. This presented an unsafe setting for a mentally confused patient with left sided weakness who fell, with bed rails up x 3 sustaining bruising and contusions to the left forehead, lips and left shoulder as documented in the nursing notes.

An interview on 3/14/2011 at 1:00 PM in the conference room ,with the Director of Nursing Quality of care revealed no system was in place to insure the Nursing Department incident reports were reviewed, consistently by the Nursing Department. Incident reports are routinely sent to the Risk Management then to Quality/RN reviews then back to Risk Management. Risk Management tracks and trends the information and gives the information back to units. The specific Incident Reports may never be seen by the unit in which the incident occurred. There was no documentation the facility had acted on the information identifying this fall as a safety issue, there was no documentation environmental factors had been considered relating to this fall. There was no documentation that delayed services after the fall (CT-X-ray) had been questioned. The lack of vital signs and neuro checks for the 2 hours after the patient fell was not identified as a significant nursing issue. The discrepancy in nursing documentation and Director of Critical Care/Neuro services findings was not addressed.

VIOLATION: USE OF RESTRAINT OR SECLUSION

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on document review and interview the facility failed to assess for restraint as evidenced by on of one patients.

On 3/14/2011 at 1:00 PM in the conference room the medical record (MR) was reviewed for Patient # 1. The MR record revealed after the patient fell on [DATE] the Neurologist documented a recommendation to the spouse to begin using restraint.

Further review of MR revealed physician's telephone order for bilateral wrist restraint, vest restraint, bed rails X 4 and bed alarm. There was no nursing documentation assessing for least restrictive restraint. There was no physician documentation for daily assessment of restraint. There was no care plan reflecting the need for restraint or reassessment of restraint.

Interview with the Director of Critical Care services confirmed that the rails were pulled up and bed alarm engaged after the fall.

There is a physician's order for vest restraint however there is no nursing documentation that the vest restraint was applied. There is no documentation that an assessment for a vest restraint was completed.

The wrist restraints were consistently documented on at least a daily basis in the nurses notes. There is documentation they were applied to the patient's wrist on 10/25/2010 at 7:30 but they are not tied to the bed.



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COZBY-GERMANY HOSPITAL ->

Report No. 1513

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

COZBY-GERMANY HOSPITAL 707 N WALDRIP GRAND SALINE, TX 75140

March 7, 2011

VIOLATION: MEDICAL STAFF - ACCOUNTABILITY

Tag No: A0049

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based upon record review and interview, the governing body failed to ensure 1 of 3 physicians (Staff #1) provided quality care to 2 of 2 (#1, #2) patients reviewed. Patient #1 had a change in condition and there was no physician available to evaluate patient and direct care. Patient #2 was admitted to the services of staff #1 but patient was not seen by staff #1 for 5 days.

Review of medical record for patient #2 revealed patient was admitted to the service of staff #1 on 2/23/11 with Cervical Spinal Fracture from a fall. Patient was in a hard plastic cervical collar and was requiring pain medication for pain control. The emergency room physician, Staff #2 requested transfer to a higher level of care at 2 acute care facilities but unable to negotiate the transfer so staff #2 admitted the patient to the services of staff #1. Further review of the medical record revealed physician progress notes written by Staff #2 on 2/24/11 and 2/25/11. On 2/26/11 and 2/27/11, patient #2 was seen by the Physician Assistant that was working in the emergency department. A progress note was written by the Physician Assistant only on 2/26/11. The Physician Assistant was not appointed by the medical staff, did not have a collaborative agreement with a supervising physician in this facility, and the physician listed on the Texas Medical Board Website as his supervising physician practices 180 miles from this facility. Review of nurses notes for 2/28/11 revealed patient was seen by staff #1. New telephone orders were written by the charge nurse for staff #1 but no physician progress notes were written by staff #1. The patient was hospitalized for 5 days before being transferred to another facility and staff #1, who was her attending physician, did not visit the patient until the 5th day.

Review of medical record #1 revealed patient was admitted to the facility on [DATE] with a diagnosis of acute exacerbation of chronic obstructive pumonary disease. Admitting orders were for Oxygen per nasal cannula at 3 liters/minute, hand held nebulizer treatments every 8 hours, and antibiotics. On 2/10/11, patient began responding to treatment. Patient was exhausted with minimal activity. On 2/11/11 at 1:30 am, patient was requesting water pitcher to be filled. At 3:30 am, patient again requested water pitcher to be filled and breathing treatment given. At 5:30 am, patient wasnistructed he was drinking too much. At 7:30 am, patient was sitting up in bed, alert and oriented, patient conversing, no complaints. Patient was seen by PA and physician (staff #3) approximately 8am on 2/11/11. Orders were written for additional labs and an EKG to be done in am (2/12/11), and to change IV fluids to 3% Normal Saline, 500 cc @ 100 cc/hour then Normal Saline @ keep vein open rate.

A telephone interview was conducted with the patient's wife on 3/1/11 at 1:30 pm. The patient's wife reported on 2/10/11 she was at the hospital that evening and her husband had a good day and was responding to treatment and he told her to go home and get a good night's sleep because he would probably be coming home the next day and she would have to care for him. The wife went home and returned at approximately 9:45 am. The wife reported when she walked in the room her husband was breathing very shallow and rapid and was unresponsive to verbal stimuli and she tried shaking him to arouse him without success. The wife reported she went to the nurse's station and asked what had happened to her husband and the nurse told her he was alright earlier that morning but the night nurses told that he had a very bad night. The wife reported she asked the nurses to call staff #3 (physician) but they did not call him. The wife reported she went to the emergency room and requested staff #2 to go evaluate her husband but he did not. The wife reported that approximately 12:30 pm, Staff #3 came to the patient's room and informed the patient's family that he had been relieved of his duties and

he suggested that the family have the patient transferred to another facility. The wife reported at that time she asked staff #3 to evaluate the patient but staff #3 told the wife he was not allowed. The wife then went back to the emergency room and begged staff #2 (emergency room physician) to evaluate her husband. The wife reported he came to the room and stuck his head in the door and looked at the patient but did not evaluate him and turned and walked away. The wife further reported that approximately3:00 pm, staff #1 arrived and evaluated the patient. Staff #1 told the wife that the patient was too critical to move and discussed the patient's living will and advanced directives. Wife reported family agreed to honor patient's living will and not utilize any heroic measures. Staff #1 ordered arterial blood gases and increased hand held nebulizer treatments to every 2 hours.

Review of nurse notes for patient #1on 2/11/11 at 9:55 am revealed "patient given xanax as ordered per wife's request. Review of nurse notes on 2/11/11 at 1200 noon revealed "patient sleeping soundly but arousable (night shift reported patient awake most of night). 12:30 pm - Dr (staff #3) in to see patient and family and notified them of his dismissal.. Family has requested transfer to another facility, initial contact made and staff #2 notified. Patient not verbally responding at present; family anxious and concerned. 1:30 pm - Spoke with staff #1 regarding taking over care of patient per the administrator's instructions. 2:40pm - Staff #1 in to see patient; new orders written. 15:00 -Blood gases obtained and patient placed on BIPAP set @ 18/5 per respiratory therapy.

Review of physician's orders revealed blood gases were ordered and change in IV fluids but there was no written order for BIPAP. Review of respiratory therapy progress notes dated 2/11/11 at 3:30 pm. revealed "Patient placed on BIPAP @ 16/5 with oxygen bleed-in @5 L/min."

Review of physician's progress notes revealed the final progress note written by staff #3 (physician) on 2/11/11: "Having been removed from medical staff by administrator, further orders will be from whomever he designates effective immediately per administrator." Staff #1 did not write any progress notes from 2/11/11-2/13/11.

VIOLATION: PATIENT RIGHTS

Based upon record review and interview, the facility failed to ensure that nursing assessed 2 of 2 (#1, #2) patients when they experienced a change in condition. Nursing failed to notify the physician of the change of condition of 2 of 2 (#1, #2) patients. Nursing also failed to ensure a physician's order was obtained for interventions initiated with a change of condition for 2 of 2 (#1,#2) patients reviewed. Physician #1 failed to provide evaluation and direction for care for 1 of 2 (#2) patients reviewed.

Tag No: A0115

REFER TO TAG A144

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based upon record review and interview, the facility failed to ensure that nursing assessed 2 of 2 (#1, #2) patients when they experienced a change in condition. Nursing failed to notify the physician of the change of condition of 2 of 2 (#1, #2) patients. Nursing also failed to ensure a physician's order was obtained for interventions initiated with a change of condition for 2 of 2 (#1,#2) patients reviewed. Physician #1 failed to provide evaluation and direct care for 1 of 2 (#2) patients reviewed.

A telephone interview was conducted with the wife of patient #1on 3/1/11 at 1:30 pm. The patient's wife reported on 2/10/11 she was at the hospital that evening and her husband had a good day and was responding to treatment and he told her to go home and get a good night's sleep because he would probably be coming home the next day and she would have to care for him. The wife went home and returned at approximately 9:45 am. The wife reported when she walked in the room her husband was breathing very shallow and rapid and was unresponsive to verbal stimuli and she tried shaking him to arouse him without success. The wife reported she went to the nurse's station and asked what had happened to her husband and the nurse told her he was alright earlier that morning but the night nurses told that he had a very bad night. The wife reported she asked the nurses to call staff #3 (physician) but they did not call him. The wife reported she went to the emergency room and requested staff #2 to go evaluate her husband but he did not. The wife reported that approximately 12:30 pm, Staff #3 came to the patient's room and informed the patient's family that he had been relieved of his duties and he suggested that the family have the patient transferred to another facility. The wife reported at that time she asked staff #3 to evaluate the patient but staff #3 told the wife he was not allowed. The wife then went back to the emergency room and begged staff #2 (emergency room physician) to evaluate her husband. The wife reported he came to the room and stuck his head in the door and looked at the patient but did not evaluate him and turned and walked away. The wife further reported that approximately3:00 pm, staff #1 arrived and evaluated the patient. Staff #1 told the wife that the patient was too critical to move and discussed the patient's living will and advanced directives. Wife reported family agreed to honor patient's living will and not utilize any heroic measures. Staff #1 ordered arterial blood gases and increased hand held nebulizer treatments to every 2 hours.

Review of nurse notes on 2/11/11 at 7:30 am revealed "Received patient sitting up in bed, awake, alert and oriented. Oxygen at 3L/min via nasal cannula. Leg bag in place, Left forearm IV without redness or swelling. Patient conversing, no complaints. Review of nurse notes on 2/11/11 at 9:55 am revealed "patient given xanax as ordered per wife's request." Patient's vital signs documented at 10:00 am were 97.8, pulse-55, respirations-22, blood pressure-119/55. There was no assessment documented for the patient's change of condition reported by the wife. Review of nurse notes on 2/11/11 at 1200 noon revealed "patient sleeping soundly but arousable (night shift reported patient awake most of night). 12:30 pm - Dr (staff #3) in to see patient and family and notified them of his dismissal. Family has requested transfer to another facility, initial contact made and staff #2 notified. Patient not verbally responding at present; family anaxious and concerned. There was no desumentation of pursing assessment when patient #1 experienced this change of condition. There was no concerned. There was no documentation of nursing assessment when patient #1 experienced this change of condition. There was no documentation of the physician (staff #1) being notified of change of condition.

Review of the medical record of patient #2 revealed patient was hosptalized on [DATE] due to a fractured cervical vertebrae. Patient was placed in a hard plastic cervical collar and was admitted to stabilize blood pressure and pain management.

Review of nurses' notes dated 2/25/11 at 8:00 am revealed initial shift assessment that "patient was alert and oriented. Respirations even and non-labored, lungs clear to auscultation. O2(oxygen) at 3 L/min. Abdomen soft and NTND (non-tender non-distended) with BS (bowel sounds) present in 4 quadrants. Hard C-collar in place. Denies needs."

At 1:30 pm, "Patient vomiting at this time. Given Zofran 4 mg. IV." At 7:00 pm on 2/25/11, patient assessment revealed vital signs were 97.4, pulse-51, respirations-20, blood pressure-170/71. Respirations were regular and lung sounds were diminished in right and left lungs, patient voiced no complaints, resting quietly, c-collar in place. On 2/26/11 at 7:30 am, the initial assessment revealed vital signs-temperature 97.7, pulse-50, respirations-18, blood pressure-157/71. Respirations were regular, lung sounds were clear on the right and upper left lobe with crackles in the left lower lobe, heart rate was 48 beats per minute with bradycardic rhythm. Further review of nurses notes, physician progress notes, and physician orders revealed physician was not notified of the change in lung sounds on assessment. Notification of physician would be warranted due to the patient having a vomiting episode the day before. Review of the nursing assessment done at 8:40 pm for the 7pm-7am shift revealed patient now had wheezes in the right lung and crackles in the left lung. Vital signs were temperature-98, pulse-46, respirations-18, blood pressure-166/70. No notification of physician due to change in lung sounds was done. Review of physician progress note revealed patient was seen by the Physician Assistant at 4:30 pm and documented lungs were clear to auscultation. Review of summary of nursing shift assessment on 227/11 at 7:30 am revealed patient "Awake, oriented to time, place, and name. Hard of hearing. Follows simple verbal commands. Lungs clear to auscultation. Respirations unlabored. O2 at 3 L/min in use. Heart rate irregular, no edema, TED hose on, c-collar in place.

Review of nurses' notes dated 2/27/11at 8:00 am that stated "Having difficulty swallowing secondary to hard C-collar (cervical collar). Suction placed at bedside to use prn." There was no documentation in nurses' notes, physician progress notes or physician orders that physician had been notified and no physician orders were found to suction the patient. At 9:30 pm. "Meds crushed and given in pudding, patient took well." There was no physician order found in medical record to crush patient's medication The next nursing documentation related to difficulty swallowing and suctioning was on 2/28/11 at 6:00 am and the entry stated "Suctioned NT(?) with return thick white secretions and orally thick frothy secretions. 6:30 am Orally suctioned with large amount thich tenacious secretions. 8:00am - Patient awake alert and oriented to self. Respiration even and nonlabored. Required frequent suctioning secondary to increase of secretions." Further review of shift assessment flowsheet timed 8:00 am revealed patient had crackles in both right and left lungs, patient only oriented to person.11:20 am Patient continues to be suctioned periodically as needed. 2:15 pm Patient continues to be suctioned. 4:15 pm Patient unable to take meds by mouth due to increased secretions and difficulty swallowing. 5:40 pm Patient suctioned at this time. 9:30 pm Patient transferred to another facility via ambulance." Review of medication administration record revealed on 2/28/11, patient only received IV medications. Review of nursing intake and output records revealed patient had no oral intake on 2/28/11.

Review of Dietary Consultant notes dated 2/28/11 revealed the following: "Regular diet and IV fluids 60 cc/hr. Wearing large plastic neck collar. Spoke with family member that haws assisted at meals, who told that patient had choking episode yesterday (2/27/11). Staff report no problems with meals until yesterday, and ate little from then on. Staff also report resident is sitting up for all meals, and has no developed secretions and is being suctioned. Chest x-ray done to rule out aspiration, results pending. Nursing told me they are trying to treanfer patient to hospital that can better meet needs. Patient may not be safe to eat or drink. Recommend to MD add 10 meq Potassium to IV fluids every day, Speech therapy screen prior further intake by mouth, and increase IV rate to 75cc/hr if no oral fluids for more than 24 hours." There was a form titled "Communication between Dietary Consultant and attending Physician that listed these recommendations with an area for the physician to sign and agree or disagree with the recommendations and order the recommendations. Physician (Staff #1) did not complete or sign the form to order the recommendations.

Review of physician's orders revealed no order written for suctioning of patient, crushing medications, and no orders written for recommendation by Dietician. Review of physician's progress notes revealed no documented notes related to patient having difficulty swallowing or increased secretions. Further review of the medical record revealed patient #2 was not seen by Physician #1, attending physician, from the time of admission until the day of her discharge (5 days).

VIOLATION: MEDICAL STAFF

Based upon record review and interview, the medical staff failed to ensure 1 of 3 physicians (Staff #1) provided quality care to 2 of 2 (#1, #2) patients reviewed. Patient #1 had a change in condition and there was no physician available to evaluate patient and direct care. Patient #2 was admitted to the services of staff #1 but patient was not seen by staff #1 for 5 days. The medical staff failed to ensure the medical staff bylaws, rules and regulations, included provision for the utilization and appointment of 1 of 1 physician assistants. The facility utilized a physician assistant in the emergency department on weekends who had not been appointed by the medical staff and did not have a supervising physician that was appointed to the facility's medical staff.

REFER TO TAGS - A338, A347

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Tag No: A0338

Based upon record review and interview, the medical staff failed to ensure the medical staff bylaws, rules and regulations, included provision for the utilization and appointment of 1 of 1 physician assistants. The facility utilized a physician assistant in the emergency department on weekends who had not been appointed by the medical staff and did not have a supervising physician that was appointed to the facility's medical staff.

Review of the Medical Staff Bylaws, Rules and Regulations revealed the section in the Rules and Regulations titled "Specified Professional Personnel or Medical Affiliates." The section contained the following information: "Specified professional personnel or medical affiliates shall be individually authorized and assigned to carry out their professional activities under the supervision of the appropriate attending staff member assigned this responsibility, and shall be subject to the approved policies and procedures of the medical staff and hospital. Specified professional personnel in this facility include CRNA's."

Review of facility policy titled "Mid-Level Practitioners" with adoption date of 4/14/98 revealed the following: "Active medical staff physicians may designate another person or persons to perform for, or on their behalf, certain lawful acts as a mid-level practitioner (MLP) of said physician. Said acts are to be considered as the lawful acts of the physician and said physician shall be directly responsible for the acts of the mid-level practitioner. For purpose of these rules and regulations, mid-level practitioners shall include only Advanced Practice Registered Nurse (ARNP) and Physician Assistant (PA). Further review of policy revealed: Section III Rules and Regulations for MLP: 1. Each MLP will have one specifically designated responsible primary physician, even though they may perform duties under the direction of more than one physician. 2. In no instance will a MLP be assigned or allowed to perform tasks where no competently trained physician is available, even though the MLP may be trained to do those tasks. SECTON IV - Levels of Assignment- 3. Procedures which may be performed by the MLP in an emergency situation, pending the immediate availability of a physician, include: a. Managing cardiac and/or

respiratory arrest, including CPR (cardiopulmonary resuscitation); b. Major trauma; c. Initiating electro-defibrillation; d. Intubating; e. ordering and administering blood. SECTION V - "Delineation of Responsibilities"- 1. The medical staff shall be responsible for the following: development of guidelines for the utilization of MLP which will be consistent and compliment the Medical Staff Bylaws and Rules and Regulation . 2. The responsible primary physician shall be responsible for the following: a. Assumes responsibility for the medical care of his/her patients, and shall supervise the MLP in the care of the patients. b. Assumes all responsibility for and countersigns all entries in medical records as documented by the MLP.

Review of the facility's credentialing or personnel file for the Physician Assistant (PA) contained the following expired documents: PA license, Cardiopulmonary Resuscitation (CPR) Expired 9/2010, Advanced Cardiac Life Support (ACLS) expired 9/2010, Pediatric Advanced Life Support (PALS) expired 1/2011. There was no DPS or DEA registration. There was no appointment as a "medical associate" to the medical staff. There was no document indicating who the supervising physician was and no collaborative agreement between a physician and the PA.

Review of "Public Verification/Physician Profile" obtained from the Texas Medical Board Website revealed the PA's primary practice address as a facility in Cameron, Texas and the active supervising physician is on the medical staff at the facility in Cameron, Texas which is located 180 miles from this facility.

An interview was conducted with staff #5 on 3/7/11 at 1:30 pm. Staff #5 reviewed credentialing file for the PA and confirmed the license, CPS, ACLS, and PALS were all expired. Staff #5 also reported Staff #2 was the supervising physician for the PA but staff #5 confirmed there were no documents acknowledging staff #2 as the supervising physician and there was no collaborative agreement between staff #2 and the PA.

An interview was conducted with staff #2 on 3/7/11 at 1:00 pm in the ER. Staff #2 reported he remembered completing a form as supervising physician but he had no idea what happened to it when he completed it. Staff #2 also confirmed there was no collaborative agreement with the PA.

Tag No: A0347

VIOLATION: MEDICAL STAFF ACCOUNTABILITY

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based upon record review and interview, the medical staff failed to ensure 1 of 3 physicians (Staff #1) provided quality care to 2 of 2 (#1, #2) patients reviewed. Patient #1 had a change in condition and there was no physician available to evaluate patient and direct care. Patient #2 was admitted to the services of staff #1 but patient was not seen by staff #1 for 5 days.

Review of medical record for patient #2 revealed patient was admitted to the service of staff #1 on 2/23/11 with Cervical Spinal Fracture from a fall. Patient was in a hard plastic cervical collar and was requiring pain medication for pain control. The emergency room physician, Staff #2 requested transfer to a higher level of care at 2 acute care facilities but unable to negotiate the transfer so staff #2 admitted the patient to the services of staff #1. Further review of the medical record revealed physician progress notes written by Staff #2 on 2/24/11 and 2/25/11. On 2/26/11 and 2/27/11, patient #2 was seen by the Physician Assistant that was working in the emergency department. A progress note was written by the Physician Assistant only on 2/26/11. The Physician Assistant was not appointed by the medical staff, did not have a collaborative agreement with a supervising physician in this facility, and the physician listed on the Texas Medical Board Website as his supervising physician practices 180 miles from this facility. Review of nurses notes for 2/28/11 revealed patient was seen by staff #1. New telephone orders were written by the charge nurse for staff #1 but no physician progress notes were written by staff #1. The patient was hospitalized for 5 days before being transferred to another facility and staff #1, who was her attending physician, did not visit the patient until the 5th day.

Review of medical record #1 revealed patient was admitted to the facility on [DATE] with a diagnosis of acute exacerbation of chronic obstructive pumonary disease. Admitting orders were for Oxygen per nasal cannula at 3 liters/minute, hand held nebulizer treatments every 8 hours, and antibiotics. On 2/10/11, patient began responding to treatment. Patient was exhausted with minimal activity. On 2/11/11 at 1:30 am, patient was requesting water pitcher to be filled. At 3:30 am, patient again requested water pitcher to be filled and breathing treatment given. At 5:30 am, patient wanted water pitcher filled and patient was instructed he was drinking too much. At 7:30 am, patient was sitting up in bed, alert and oriented, patient conversing, no complaints. Patient was seen by PA and physician (staff #3) approximately 8am on 2/11/11. Orders were written for additional labs and an EKG to be done in am (2/12/11), and to change IV fluids to 3% Normal Saline, 500 cc @ 100 cc/hour then Normal Saline @ keep vein open rate.

A telephone interview was conducted with the patient's wife on 3/1/11 at 1:30 pm. The patient's wife reported on 2/10/11 she was at the hospital that evening and her husband had a good day and was responding to treatment and he told her to go home and get a good night's sleep because he would probably be coming home the next day and she would have to care for him. The wife went home and returned at approximately 9:45 am. The wife reported when she walked in the room her husband was breathing very shallow and rapid and was unresponsive to verbal stimuli and she tried shaking him to arouse him without success. The wife reported she went to the nurse's station and asked what had happened to her husband and the nurse told her he was alright earlier that morning but the night nurses told that he had a very bad night. The wife reported she asked the nurses to call staff #3 (physician) but they did not call him. The wife reported she went to the emergency room and requested staff #2 to go evaluate her husband but he did not. The wife reported that approximately 12:30 pm, Staff #3 came to the patient's room and informed the patient's family that he had been relieved of his duties and he suggested that the family have the patient transferred to another facility. The wife reported at that time she asked staff #3 to evaluate the patient but staff #3 told the wife he was not allowed. The wife then went back to the emergency room and begged staff #2 (emergency room physician) to evaluate her husband. The wife reported he came to the room and stuck his head in the door and looked at the patient but did not evaluate him and turned and walked away. The wife further reported that approximately3:00 pm, staff #1 arrived and evaluated the patient. Staff #1 told the wife that the patient was too critical to move and discussed the patient's living will and advanced directives. Wife reported family agreed to honor patient's living will and not utilize any heroic measures. Staff #1 ordered arterial blood gases and increased hand held

Review of nurse notes for patient #1on 2/11/11 at 9:55 am revealed "patient given xanax as ordered per wife's request. Review of nurse notes on 2/11/11 at 1200 noon revealed "patient sleeping soundly but arousable (night shift reported patient awake most of night). 12:30 pm - Dr (staff #3) in to see patient and family and notified them of his dismissal.. Family has requested transfer to another facility, initial contact made and staff #2 notified. Patient not verbally responding at present; family anxious and concerned. 1:30 pm - Spoke with staff #1 regarding taking over care of patient per the administrator's instructions. 2:40pm - Staff #1 in to see patient; new orders written. 15:00 -

Blood gases obtained and patient placed on BIPAP set @ 18/5 per respiratory therapy.

Review of physician's orders revealed blood gases were ordered and change in IV fluids but there was no written order for BIPAP. Review of respiratory therapy progress notes dated 2/11/11 at 3:30 pm. revealed "Patient placed on BIPAP @ 16/5 with oxygen bleed-in @5 L/min."

Review of physician's progress notes revealed the final progress note written by staff #3 (physician) on 2/11/11: "Having been removed from medical staff by administrator, further orders will be from whomever he designates effective immediately per administrator." Staff #1 did not write any progress notes from 2/11/11-2/13/11.

VIOLATION: MEDICAL STAFF RESPONSIBILITIES

Tag No: A0358

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based upon record review and interview, the facility failed to ensure the history and physical examination was completed and on the medical record within 24 hours on 2 of 2 patient medical records reviewed.

Review of medical record #2 revealed patient was admitted on [DATE] by emergency room Physician to the services of staff #1(physician). A hand written history and physical examination was found in the physician progress notes dated 2/23/11 completed by staff #2.. Also found in the medical record was a typed document titled History and Physical that was completed by staff #1. The date of dictation was 2/28/11 (date of transfer) and the transcription date was 3/1/11.

Further review of the typed History and Physical revealed statements that clearly indicated the History and Physical was not completed within 24 hours of admission. The Statements were as follows:

"Urinalysis showed bacteria." Review of physician orders revealed the only time a urinalysis was ordered was on 2/26/11.

"I have discussed this with "physician #2" at the time of admission. The plan was discussed with me and I agreed to watch her while she is being treated with Levaquin, blood pressure and pain control, C-Collar, fluids and oxygen." Review of physician orders revealed the Levaquin was ordered on [DATE] (day before discharge) for urinary tract infection.

"ASSESSMENT - 1. Status post fall; 2. Cervical fracture; 3. Possible Aspiration Pnuemonia; Urinary Tract Infection." Review of medical record revealed Urinalysis was obtained on 2/27/11 and antibiotics started for Urinary Tract Infection on 2/27/11. Patient record revealed patient began having difficulty swallowing on 2/28/11 (date of discharge) and orders were given for nebulizer treatments and chest x-ray.

During an interview with staff #5 on 3/7/11, the medical record was reviewed. Staff #5 confirmed the typed history and physical examination contained events that occurred during the hospitalization and was not completed within 24 hours of admission.

Review of medical record #1 revealed patient was admitted to the facility on [DATE]. Review of the history and physical report revealed the report was dictated on 2/10/11 but was transcribed on 2/19/11which was nine days after admission.

VIOLATION: USE OF VERBAL ORDERS

Tag No: A0407

Tag No: A0450

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based upon record review and interview, the facility failed to ensure physicans gave verbal orders infrequently on 2 of 2 (#1, #2) patient records reviewed.

Review of medical record #1revealed patient was hospitalized from [DATE] - 2/13/11. On 2/11/11 at approximately 2:30 pm, physician #1 assumed care for patient #1 after the dismissal of physician #3. Review of physician's orders revealed 6 telephone or verbal orders written by nursing staff and 1 physician written order from 2/11/11 - 2/13/11.

Review of medical record #2 revealed patient was hospitalized from [DATE]-2/28/11. Review of physician's orders revealed 7 verbal or telephone orders and 4 physician written orders during the 6 day hospitalization.

An interview was conducted with staff #5 on 3/7/11. Staff #5 reported the problem had been identified but it had not been addressed with the physicians.

VIOLATION: MEDICAL RECORD SERVICES

and authenticated by the responsible staff or physician.

Based upon record review and interview, the facility failed to ensure entries in the medical records of 2 of 2 patients (#1, #2) were timed

Review of patient #1 revealed 12 of 15 physician's orders that were not timed and 3 of 3 physician progress notes that were not timed. In addition, 12 of 15 physician orders were signed off and dated by the nurse but no time was noted.

Review of patient #2 revealed 3 of 4 progress notes and 5 of 11 physician's orders that were not timed. In addition, 7 of 11 physician's orders were signed off and dated by the nurse but no time was noted.

During an interview with staff #5 on 3/7/11 at 11:30 am, staff #5 confirmed the orders and progress notes were not timed.

VIOLATION: ORDERS DATED AND SIGNED

Based upon record review and interview, the facility failed to ensure physician orders were dated, timed, and authenticated by the physician who gave the orders on 2 of 2 patient medical records reviewed.

Review of medical record of patient #1 revealed 12 sets of physician orders. Further review revealed 6 of the 12 sets were not dated or timed and 2 of 12 were not timed.

Tag No: A0454

Tag No: A0457

Tag No: A1163

Review of medical record of patient #2 revealed 11 sets of physician orders. Further review revealed 6 of 11 sets were not dated, timed, and authenticated by the ordering physician, 2 of 11 sets were not dated and timed, and 1 of 11 sets were not dated.

An interview was conducted with staff #5 on 3/7/11 at 11:30 am. Staff #5 confirmed the orders were not dated, timed, or signed and reported that was an ongoing problem that was being addressed.

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

Based upon record review and interview, the facility failed to ensure physicians authenticated all verbal orders on 1 of 2 (#2) patient medical records.

Review of patient medical record #2 revealed 6 of 11 verbal or telephone orders that were not authenticated by the physician who wrote the orders.

An interview was conducted with staff #5 on 3/7/11 at 11:30 am. Staff #5 reported being aware of problem with physicians not signing off on verbal and telephone orders.

VIOLATION: CONTENT OF RECORD Tag No: A0458

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based upon record review and interview, the facility failed to ensure the history and physical examination was completed and on the medical record within 24 hours on 2 of 2 patient medical records reviewed.

Review of medical record #2 revealed patient was admitted on [DATE] by emergency room Physician to the services of staff #1(physician). A hand written history and physical examination was found in the physician progress notes dated 2/23/11 completed by staff #2.. Also found in the medical record was a typed document titled History and Physical that was completed by staff #1. The date of dictation was 2/28/11 (date of transfer) and the transcription date was 3/1/11.

Further review of the typed History and Physical revealed statements that clearly indicated the History and Physical was not completed within 24 hours of admission. The Statements were as follows:

"Urinalysis showed bacteria." Review of physician orders revealed the only time a urinalysis was ordered was on 2/26/11.

"I have discussed this with "physician #2" at the time of admission. The plan was discussed with me and I agreed to watch her while she is being treated with Levaquin, blood pressure and pain control, C-Collar, fluids and oxygen." Review of physician orders revealed the Levaquin was ordered on [DATE] (day before discharge) for urinary tract infection.

"ASSESSMENT - 1. Status post fall; 2. Cervical fracture; 3. Possible Aspiration Pnuemonia; Urinary Tract Infection." Review of medical record revealed Urinalysis was obtained on 2/27/11 and antibiotics started for Urinary Tract Infection on 2/27/11. Patient record revealed patient began having difficulty swallowing on 2/28/11 (date of discharge) and orders were given for nebulizer treatments and chest x-ray.

During an interview with staff #5 on 3/7/11, the medical record was reviewed. Staff #5 confirmed the typed history and physical examination contained events that occurred during the hospitalization and was not completed within 24 hours of admission.

Review of medical record #1 revealed patient was admitted to the facility on [DATE]. Review of the history and physical report revealed the report was dictated on 2/10/11 but was transcribed on 2/19/11which was nine days after admission.

VIOLATION: RESPIRATORY SERVICES

Based upon record review, nursing failed to ensure a physician's order was obtained for providing suctioning to clear the airway and crushing medications in pudding of 1 of 2 (#2) patients reviewed. Nursing also failed to ensure a physician's order was obtained for oxygen therapy via BIPAP for 1 of 2 (#1) patients reviewed.

Review of nurse notes for patient #1on 2/11/11 at 9:55 am revealed "patient given xanax as ordered per wife's request. Review of nurse notes on 2/11/11 at 1200 noon revealed "patient sleeping soundly but arousable (night shift reported patient awake most of night). 12:30 pm - Dr (staff #1) in to see patient and family and notified them of his dismissal.. Family has requested transfer to another facility, initial contact made and staff #2 notified. Patient not verbally responding at present; family anxious and concerned. 1:30 pm - Spoke with staff #1 regarding taking over care of patient per the administrator's instructions. 2:40pm - Staff #1 in to see patient; new orders written. 15:00 - Blood gases obtained and patient placed on BIPAP set @ 18/5 per respiratory therapy.

Review of physician's orders revealed blood gases were ordered and change in IV fluids but there was no written order for BIPAP. Review of respiratory therapy progress notes dated 2/11/11 at 3:30 pm. revealed "Patient placed on BIPAP @ 16/5 with oxygen bleed-in

@5 L/min." The BIPAP settings were different in the nurse's notes from what was written in the Respiratory Therapy progress notes.

Review of physician's progress notes revealed Staff #1 did not write any progress notes from 2/11/11-2/13/11 therefore no documentation by Staff #1of the use of oxygen therapy by BIPAP was found.

Review of the medical record of patient #2 revealed nurses' notes dated 2/27/11at 8:00 am that stated "Having difficulty swallowing secondary to hard C-collar (cervical collar). Suction placed at bedside to use prn." The next nursing documentation related to difficulty swallowing and suctioning was on 2/28/11 at 6:00 amand the entry stated "Suctioned NT(?) with return thick white secretions and orally thick frothy secretions. 6:30 am Orally suctioned with large amount thich tenacious secretions. 8:00am - Patient awake alert and oriented to self. Respiration even and nonlabored. Required frequent suctioning secondary to increase of secretions. 11:20 am Patient continues to be suctioned periodically as needed. 2:15 pm Patient continues to be suctioned. 4:15 pm Patient unable to take meds by mouth due to increased secretions and difficulty swallowing. 5:40 pm Patient suctioned at this time. 9:30 pm Patient transferred to another facility via ambulance."

Review of physician's orders revealed no order written for suctioning of patient. Review of physician's progress notes revealed no documented notes related to patient having difficulty swallowing or increased secretions.



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METHODIST CHARLTON MEDICAL CENTER ->

Report No. 1562

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

METHODIST CHARLTON MEDICAL CENTER

3500 W WHEATLAND ROAD DALLAS, TX March 7, 75237 2011

VIOLATION: COMPLIANCE WITH 489.24

Tag No: A2400

Based on review of records and interviews, the hospital failed to comply with 489.24 in that:

- 1) 1 of 1 patient (Patient #1) who presented to the Emergency Department for emergency medical treatment was improperly transferred to another facility for specialized psychiatric treatment which the transferring facility did not provide.
- 2) The hospital failed to enforce the Patient Transfer policy to ensure compliance with the requirements of 489.24.

Cross Reference: A2409

VIOLATION: APPROPRIATE TRANSFER

Tag No: A2409

Based on interview and record review, the hospital failed to provide an appropriate transfer to 1 of 1 patient (Patient #1) treated in the Emergency Department (ED) on 02/15/11 for overdose and attempted suicide. The patient was inappropriately transferred to Hospital A by PD. The hospital staff did not notify, request or obtain permission from the receiving hospital for the patient transfer, send copies of the medical record and required paperwork related to the emergency medical condition, or transport the patient with appropriate equipment and personnel.

Findings Included:

Patient #1, presented to Methodist Charlton MC Emergency Department on 02/15/11 at 5:28 A.M. with complaints of overdose (OD) and attempted suicide. The medical record revealed he was treated for the OD and received a psychiatric evaluation. The psychiatric evaluation, not timed revealed, "Recommend evaluation by a psychiatrist for possible inpatient care."

The Physician (Personnel #6) documented in the "Physician Notes" timed at 9:00 A.M. revealed, "[Hospital C] here evaluating and patient became agitated and states he wants to go home and "finish it off". We will do an APOWW [Peace Officer Application for Emergency Detention without warrant] to [Hospital A]."

At 9:05 A.M., the physician notes revealed, "Patient calm and resting. Aware of pending transfer to [Hospital A]."

The RN (Registered Nurse, Personnel #22) documented at 9:13 A.M. in the "Nursing Notes," "Medically cleared, patient left with [PD] to be transferred to [Hospital A]."

There was no discharge assessment, neurological assessment, discharge vital signs, self harm screening assessment, disposition, mode of discharge, discharge instructions or the required transfer paperwork documented or included in the nursing notes.

The "Physician Orders" did not show an order to discharge or transfer patient to Hospital A.

The Medical Record did not contain a copy of the Application for Court-Ordered Mental Health Services, Physician's Certificate for Medical Examination for Mental Illness, the Addendum, Memorandum of Transfer or a Single Portal Authority (SPA) letter to the Mental Illness Court to show acceptance of the patient to a facility.

There was no patient consent form in the medical record or documentation by the nurse or physician in the attempt to obtain consent from the patient for transfer to Hospital A.

Patient #1's medical record dated 02/15/11, timed at 9:50 A.M. from Hospital A ED revealed, "ED Admission Notes - [Patient #1] arrived under APOWW by the [PD] for Overdose, Acute Alcoholic Intoxication and Mood Disorder."

The medical record did not contain documentation showing a nurse or physician report, a copy of the Application for Court-Ordered Mental Health Services, Physician's Certificate for Medical Examination for Mental Illness, the Addendum, Memorandum of Transfer or a Single Portal Authority (SPA) letter to the Mental Illness Court to show acceptance of the patient to a facility from Methodist Charlton MC.

In an interview at 10:00 A.M. on 03/03/11, the physician (Personnel #6) was interviewed. She was asked to review the medical record of Patient #1. She was then asked if she was the ED physician that provided care to Patient #1. She stated, "Yes. The patient was brought in because he had threatened suicide and OD'd. He had been started on charcoal, and had vomited and was tachycardic (fast heart rate). The initial plan was to treat and send him home. I told [Hospital C] he was medically cleared. After he was evaluated by [Hospital C], he said we would APOWW him to [Hospital A] because [Patient #1] told him he was going to go home and finish it off." She was asked if the hospital policies and procedures were followed for appropriate patient transfer. She stated, "No."

In an interview at 9:15 AM on 03/07/11, the RN (Personnel #22) was interviewed. She was asked to review the medical record of Patient #1. She was then asked if she was assigned to take care of Patient #1. She stated, "Yes. He was there for intoxication and overdose. [PD] and his girlfriend was in the room. His treatment was finished except for the second liter of saline going in. [Hospital C] came in and saw the patient. When [Hospital C] was finished, he tried to give me report and I was on the phone. I asked him to give me a minute because I was giving report on another patient. He told me to discharge the patient. He was going to [Hospital A]. Shortly after [Hospital C] left, the [PD] had the patient up and dressed. I had them take off the handcuffs so I could take out the IV and have him sign the discharge paperwork. They put the cuffs back on and took him to [Hospital A]."

She was asked if the medical record contained a discharge or transfer order from the physician. She stated, "No." She was asked if she had followed hospital policies and procedures for an appropriate patient transfer. She stated, "No."

The Administrative Policy, "Psychiatric Care/Referral": dated 08/30/10 required, "Although ...does not have a Psychiatric Unit...will provide to patients...referral to appropriate facilities for serious psychiatric conditions...For any patient involuntarily transferred to a mental health facility the physician shall complete and the forms shall be notarized, as indicated: A. Physician Assessment Prior to Transfer, B. Memorandum of Transfer, C. Application for Court Ordered Mental Health Services - Temporary, D. Physician's Certification of Medical Examination for Mental Illness, E. Physician's Certification of Medical Examination for Mental Illness - Addendum, F. Physician's Order Form and Discharge Instructions...To arrange for transport the Social Worker or Charge Nurse will arrange an ambulance or ...as appropriate, once the patient is medically stable. The ...will accompany the transport if the ambulance staff would be at risk or for every APOWW...Involuntary Patients in the ED: Once the medical staff has determined the necessity of a psychiatric evaluation for the patient and the patient is deemed medically stable, the physician should refer to the Medical Management/Social Worker to initiate the psychiatric evaluation on-site by the mobile assessment team...once the team completes the assessment and determines the most appropriate care for the patient, ...staff will facilitate recommended plan of care for patient with assistance from ...as needed...If recommendation is OPC (Order of Protective Custody) then follow involuntary patient requirements...A copy of the Application for Court-Ordered Mental Health Services, Physician's Certificate for Medical Examination for Mental Illness, the Addendum, and History Sheet should be kept in the patient's medical record. The original and a second copy should be sent to the Mental Illness Court to show acceptance of the patient to a facility...Arrange transportation when all paperwork (the OPC document signed by the presiding Judge, the SPA letter assigning a bed, Me

The Administrative Policy, "Patient Transfers": dated 04/30/09 required, "The Board of Directors...adopted this policy to comply with state and federal laws regulating transfers of patients from ...to other hospitals...must be complied with whenever a patient is transferred...the charge nurse, Nursing Supervisor or Administrator on Call will have the authority to represent each ...hospital and the physician with regard to the transfer from or receipt of patients...The transfer of a patient may not be predicated upon arbitrary, capricious or unreasonable discrimination...the transfer of patients who require emergency services...as determined by a physician...the physician who authorized the transfer shall...assure the proper transfer procedures are used...and complete the form entitled Physician Assessment Prior to Transfer and sign the Memorandum of Transfer...shall determine and order the utilization of appropriate personnel and equipment for the transfer...will secure a receiving physician and a receiving hospital that are appropriate to the medical needs of the patient and that will accept responsibility for the patient's medical treatment and hospital care...A Memorandum of Transfer shall be completed on every transfer...Charge nurses, physician, social worker, nursing supervisor or administrator on call will contact accepting facility to confirm administrative approval, obtain room number and/or specific area that is receiving the patient and a telephone number to call report...will ensure that...qualified personnel are available and on duty to assist with arrangements for patient transfers and to provide accurate information...and written protocols or standing delegation orders are in place to guide hospital personnel when a patient requires transfer to another hospital...shall implement procedures for the hospitals medical staff to review appropriate records of patients transferred from the hospital to determine that the appropriate standard of care has been met...Medical Records: During a transfer...the hospital shall provide a copy of those portions of the patient's medical record...are relevant to the transfer and to the continuing care of the patient are forwarded to the receiving physician and hospital with the patient...The medical records shall contain at a minimum: A brief description of the patients medical history and physical examination, a working diagnosis...physical assessment of patients condition at the time of transfer...reason for transfer...results of all diagnostic tests...medication reconciliation...Memorandum of Transfer: ...will complete a MOT for every patient who is transferred...will be signed by transferring physician and must also be signed by a Nursing Supervisor, Charge Nurse, Social Worker, or administrative designee in compliance with hospital policy...administrative approval and approval of the accepting physician at the receiving facility must be completed prior to ... representative signing the form...Original MOT will accompany the patient being transferred...a copy of the MOT will be retained and filed separately from the medical record...compliance with this policy is mandatory...'

In an interview at 11:00 A.M. on 03/01/11, the CNO (Personnel #1) was interviewed. She was asked to review the medical record of Patient #1. She was then asked if the staff followed the hospital policies and procedures for patient transfers. She stated, "No."

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MEMORIAL HERMANN KATY HOSPITAL ->

Report No. 1578

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MEMORIAL HERMANN KATY HOSPITAL 23900 KATY FREEWAY KATY, TX 77494 March 3, 2011

VIOLATION: UNSPECIFIED CATEGORY Tag No:

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and review of 1 of 1 clinical record, the facility failed to inform the patient of a change in discharge plans resulting in a transfer of the patient to another hospital without notifying the patient. Findings:

Record review reflected a progress note entered described the patient, a [AGE] year old female presented to the emergency room of hospital #1 on 12/10/10 at 2:11pm. Chief complaint: "depression" The patient reported uncontrollable depression due to chronic pain over 20 years.

Plan: transfer to a psychiatric facility.
On 12/10/10 at 8:38pm it was noted "will be transferred for psych treatment and stabilization. Patient/ husband RN and MD agreed.

Present in the record was a form from hospital #2, a psychiatric hospital titled "Exclusionary Criteria: This form ,dated 12/10/10 at 7:55pm was faxed to the ER physician to attest that the patient was medically(to transfer to psychiatry) with the direction to fax back to hospital #2.

Per interview with the CEO at hospital #2 on 2/15/11 at 2:15pm, hospital #2 records show that hospital #1 contacted his hospital on [DATE] about 7:00pm requesting a female bed. He stated that, at that time his hospital had 3 female beds available. Acceptance was pending returning, via fax the signed exclusionary criteria form. He stated their records show this form was never faxed back.

Per interview with the patient on 3/3/11 at 2:10pm she was informed she would be transferred to hospital #2 and she agreed to this transfer only, but she ended up being transferred to hospital #3 the next day. She stated no one told and she did not agree to going to hospital #3 until she arrived at hospital #3.

Further record review reflected on 12/11/10 at 0718 the patient was transferred to hospital #3

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MEMORIAL HERMANN KATY HOSPITAL MEMORIAL HERMANN KATY HOSPITAL

23900 KATY FREEWAY KATY, TX 77494 | Voluntary non-profit - Private

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Report date Number of violations

March 3, 20111 (click for details) Read full report

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No incomplete reports available.



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Texas -> NORTH CENTRAL SURGICAL CENTER LLP ->

Report No. 1764

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NORTH CENTRAL SURGICAL CENTER LLP

9301 NORTH CENTRAL EXPRESSWAY SUITE 100 DALLAS, TX 75231

March 3, 2011

VIOLATION: INFECTION CONTROL OFFICER RESPONSIBILITIES

Tag No: A0749

Based on interview and record review, the Infection Control Preventionist did not implement and evaluate measures as required by the facility's policy for identifying, reporting, investigating, and controlling infection for 1 of 1 patient (Patient #1) who was readmitted on [DATE] for possible right shoulder infection.

Findings include:

Patient #1 was initially admitted and discharged on [DATE] for a scheduled "right shoulder arthroscopic repair of ...rotator cuff tear ..." The patient presented in the ER (emergency room) for right shoulder pain on 08/14/10. The physician's orders dated 08/18/10 at 12:00 PM included "admit to Physician #6, diagnosis: right shoulder infection S/P RTC repair...Plan to OR (operating room)...for I&D (Irrigation & Debridement) of right shoulder..." Samples were obtained for culture and sensitivity. The final laboratory test results on 08/25/10: "Subacromial bursa culture...aerobic=heavy growth of "Citrobacter Freundii Complex."

Computer data entry of Infection Control records: "HAI-POA Line List" (Hospital Acquired Infection - Present on Admission) dated August 2010 included that Patient #1's prior visit was on 06/17/10. The patient was readmitted on [DATE] for "re-injury" and not for a possible right shoulder infection.

In an interview on 03/03/11 at approximately 11:30 AM in the presence of Personnel #1, Personnel #5 was asked if the infection acquired by Patient #1 since being admitted on [DATE] was documented and tracked. She replied that it was not documented as an infection but a "re-admit due to re-injury." She was asked if she knew that part of the procedure performed on 08/18/10 was an "I&D" and that samples were obtain to rule out infection. She replied the infection was not documented and tracked. The CEO stated that "I&D's" was an indicator of infection.

Policies and Guidelines #2: "Infection Prevention & Control Plan" revised [DATE] page 1 required "The Infection Prevention & Control plan ...includes the following: 1. Patient population served by the facility ...5. Strategies to reduce risks ..." On page 2 "2010-2011 Infection...Program Goals...4. Surveillance of infection with physician follow-up."

Policies and Guidelines #11: "Surveillance" revised [DATE] required "Surveillance will be systematic and continuous process for the recognition, monitoring, and reporting of infections ...The Infection Preventionist and Quality personnel ...are responsible for data collection

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**



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NORTH CENTRAL SURGICAL CENTER LLP NORTH CENTRAL SURGICAL CENTER LLP

9301 NORTH CENTRAL EXPRESSWAY SUITE 100 DALLAS, TX 75231 | Voluntary non-profit - Other

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Report date Number of violations

March 3, 20111 (click for details) Read full report

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No incomplete reports available.

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Tag No: A0145

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UNIVERSITY MEDICAL CENTER ->

Report No. 1555

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UNIVERSITY MEDICAL CENTER 602 INDIANA AVENUE LUBBOCK, TX 79415 Feb. 28, 2011

VIOLATION: PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT

Based on review of patient's clinical records and interview with staff, the hospital failed to protect patient #1 from a physical assault committed by patient #2, on 2/26/11, in the Medical Intensive Care Unit.

Findings were:

On 2/26/11 patient #2 while in the Medical ICU at about 0800 waiting to be transferred to a regular room was walking around the ICU and staring into the room of patient #1. Staff redirected patient #2 not to walk by the room of patient #1 multiple times. Patient #2 was following his nurse into the room of patient #1, at approximately 1125, the nurse took him back to his room. His nurse then went to get the charge nurse who was approximately 100 feet away. As soon as his nurse turned around, patient #2 went into the room of patient #1 and proceeded to perpetrate a physical assault on patient #1. The hospital failed to take any action for over three hours to protect patient #1 from patient #2 who had been attempting entry into the room. The findings were confirmed in interview on 2/28/11 in the workroom.



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602 INDIANA AVENUE LUBBOCK, TX 79415 | Government - Hospital District or Authority

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Report date Number of violations

Feb. 28, 20111 (click for details) Read full report

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No incomplete reports available.

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PARKVIEW REGIONAL HOSPITAL ->

Report No. 1522

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PARKVIEW REGIONAL HOSPITAL 600 SOUTH BONHAM STREET MEXIA, TX 76667 Feb. 25, 2011

VIOLATION: PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES Tag No: A0122

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the hospital failed to respond to a patient grievance for 1 of 3 patients reviewed [Patient #1].

Findings Included:

[Patient #1] was admitted on [DATE] and discharged [DATE]. [Patient #1's] medical diagnosis was Pneumonia.

The Interdisciplinary patient needs database dated 12/31/10 timed at 00:15 AM. Patient standing in the hall and reports he wants to die. Complains of hurting all over. Valium 10 milligrams and Norco 10/325 pulled from pyxis ...patient would not believe that our Valium was the same as his. Patient got his own bottle out of a bag and compared the two. He then tried to take his Valium and our Valium. Abel to get four 5 milligram tablets from patient. The patient 's bottle was removed and taken to the nursing station, refused to take pain medication ...son contacted...reports he will be up in a few minutes ...patient found lying on floor pointing at fall sign and laughing ...patient assisted to bed ...able to move all extremities, no deformities observed ..."

On 02/25/11 at 11:07 AM Staff #1 was interviewed. Staff #1 was asked if [Patient #1] filed a complaint/grievance with the hospital regarding care he was provided in the hospital. Staff #1 stated [Patient #1] and his family member came into the hospital complaining about the care he received while inpatient. Staff #1 was asked to provide evidence of the complaint/grievance from [Patient #1]. Staff #1 stated she had no documentation which indicated [Patient #1's] complaint/grievance was investigated. Staff #1 stated she was not aware of any hospital response and/or follow-up made to [Patient #1] regarding his complaint/grievance.

The policy entitled, "Complaints and Grievances on Behalf of Patients with an effective date of 11/09 reflected, "It is policy of...to provide patients and/or their legal representative with a mechanism for submitting a complaint or grievance...hospital will respond in writing to all grievances within seven days...if the grievance is not fully resolved...the hospital's written response will provide an update on what has been learned from the investigation...all verbal or written compliant regarding patient care, abuse, neglect, patient harm...are grievances...a verbal complaint is a patient grievance if...requires investigation and/or requires further actions for resolution..."

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PARKVIEW REGIONAL HOSPITAL PARKVIEW REGIONAL HOSPITAL

600 SOUTH BONHAM STREET MEXIA, TX 76667 | Proprietary

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Report date Number of violations

Feb. 25, 20111 (click for details) Read full report

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No incomplete reports available.



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RED RIVER REGIONAL HOSPITAL ->

Report No. 1587

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

RED RIVER REGIONAL HOSPITAL 504 LIPSCOMB STREET BONHAM, TX 75418 Feb. 18, 2011

VIOLATION: UNSPECIFIED CATEGORY Tag No:

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

485.631 (b) Medical Staff Responsibilities

The CAH (Critical Access Hospital) must ensure that specific responsibilities of the Doctor of Medicine or Osteopathy requirements are met.

Based on review of records and interview, the Medical Staff failed to implement and enforce their own rules in that the physician's orders were not complete for 1 of 2 patients (Patient #1) who was in restraints and hospitalized between 01/11/11 and 02/18/11. This deficient practice presents a risk of potential harm to patients that may need to be restrained at the hospital in the future.

Findings included:

The "History and Physical" (01/12/11) of Patient #1, [AGE], noted that Patient #1 was admitted on [DATE] after a fall at a nursing home. Patient #1 "had a large hematoma over the left forehead and bruising and contusion around his left eye." History included Congestive Heart Failure, Diabetes, anxiety, and dementia with aggressive behavioral disorder. At 11:40 PM, Physician #4 ordered bilateral restraints to the upper and lower extremities of Patient #1.

The 01/13/11 10:00 AM "Protective/Restraint Need Assessment" noted, Patient #1 had attempted to pull out tubing and climb out of the bed or chair. On 01/13/11 at 10:00 AM, Physician #4 gave a verbal order for "4 point restraint for safety/behavior..." This order was signed by Physician #4 on 01/20/11 at 02:00 PM (approximately 7 days after the order was given).

The hospital's "Restraint Orders" form verbal order from Physician #4 was dated 01/13/11 at 10:00 AM by the nurse and was signed by Physician #4 on 01/14/11 at 11:00 AM (approximately 25 hours after the order was given). The order included wrist and ankle restraints with an order limitation of 24 hours.

The 01/14/11 10:00 AM "Restraint Orders" form documented wrist restraints limited to 24 hours. The "Alternatives tried and documented" and "Purpose of restraint" were not documented. This order was not complete.

The 01/15/11 (untimed with no nurse signature) "Restraint Orders" form was signed by Physician #4 on 01/17/11 at 08:30 AM (approximately 2 days after the order was dated). The 01/15/11 order did not contain the "Order limitation," "Alternatives tried and documented," and "Purpose of restraint." This order was not complete.

The 01/16/11 (untimed with no nurse signature) "Restraint "Orders" form was signed by Physician #4 on 01/17/11 at 08:30 AM. This order did not contain the "Alternatives tried and documented" and "Purpose of restraint." This order was not complete.

During an interview on 02/18/11 at approximately 02:00 PM, Physician #4 reviewed the physician's orders and physician's documentation

for Patient #1 with the nurse surveyor. Physician #4 agreed that the information was missing and the orders were not all signed within the 24 hour timeframe.

The physician's "Restraint Orders" form (undated) included the Policy: "Patients who need restraints will be re-assessed and alternatives considered every 24 hours. A new order will be written every 24 hours. Times must be consistent. Orders must be signed on an hourly basis. If order not signed and effective, restraint will be removed. Restraint policy applies to all nursing units..."

The "Authorized Entries in the Medical Record" policy revised February 2004 noted, "...All restraint orders will be authenticated, dated, and timed within 24 hours."

The Medical Staff Rules and Regulations (07/23/10) noted that all physician's orders "should be recorded on the patient's chart, timed, dated and signed by the staff member in charge of the case ...orders dictated over the telephone shall be signed by the person to whom dictated with the name of the physician giving the order and countersigned by the person recording the dictation ...The record is not complete until such an order is signed personally by the physician issuing the order."

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record reviews, the Critical Access Hospital failed to maintain complete medical records in that the medical records of 1 of 2 patients (Patient #1) who was in restraints and hospitalized between 01/11/11 and 02/18/11 contained medical record entries that were not complete, dated, timed, and authenticated as required by 25 Texas Administrative Code (TAC) 133.41 (j)(5) and their own policy. This deficient practice presents a risk of potential harm to patients that may need to be restrained at the hospital in the future.

25 TAC 133.41 (j)(5): Medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

Findings included:

The "History and Physical" (01/12/11) of Patient #1, [AGE], noted that Patient #1 was admitted on [DATE] after a fall at a nursing home. Patient #1 "had a large hematoma over the left forehead and bruising and contusion around his left eye." History included Congestive Heart Failure, Diabetes, anxiety, and dementia with aggressive behavioral disorder. At 11:40 PM, Physician #4 ordered bilateral restraints to the upper and lower extremities of Patient #1.

The 01/13/11 10:00 AM "Protective/Restraint Need Assessment" noted, Patient #1 had attempted to pull out tubing and climb out of the bed or chair. On 01/13/11 at 10:00 AM, Physician #4 gave a verbal order for "4 point restraint for safety/behavior..." This order was signed by Physician #4 on 01/20/11 at 02:00 PM (approximately 7 days after the order was given).

The hospital's "Restraint Orders" form verbal order from Physician #4 was dated 01/13/11 at 10:00 AM by the nurse and was signed by Physician #4 on 01/14/11 at 11:00 AM (approximately 25 hours after the order was given). The order included wrist and ankle restraints with an order limitation of 24 hours.

The 01/14/11 10:00 AM "Restraint Orders" form documented wrist restraints limited to 24 hours. The "Alternatives tried and documented" and "Purpose of restraint" were not documented. This order was not complete.

The 01/15/11 (untimed with no nurse signature) "Restraint Orders" form was signed by Physician #4 on 01/17/11 at 08:30 AM (approximately 2 days after the order was dated). The 01/15/11 order did not contain the "Order limitation," "Alternatives tried and documented," and "Purpose of restraint." This order was not complete.

The 01/16/11 (untimed with no nurse signature) "Restraint "Orders" form was signed by Physician #4 on 01/17/11 at 08:30 AM. This order did not contain the "Alternatives tried and documented" and "Purpose of restraint." This order was not complete.

During an interview on 02/18/11 at approximately 02:00 PM, Physician #4 reviewed the physician's orders and physician's documentation for Patient #1 with the nurse surveyor. Physician #4 agreed that the information was missing and the orders were not all signed within the 24 hour timeframe.

The physician's "Restraint Orders" form (undated) included the Policy: "Patients who need restraints will be re-assessed and alternatives considered every 24 hours. A new order will be written every 24 hours. Times must be consistent. Orders must be signed on an hourly basis. If order not signed and effective, restraint will be removed. Restraint policy applies to all nursing units..."

The "Authorized Entries in the Medical Record" policy revised February 2004 noted, "...All restraint orders will be authenticated, dated, and timed within 24 hours."

The Medical Staff Rules and Regulations (07/23/10) noted that all physician's orders "should be recorded on the patient's chart, timed, dated and signed by the staff member in charge of the case ...orders dictated over the telephone shall be signed by the person to whom dictated with the name of the physician giving the order and countersigned by the person recording the dictation ...The record is not complete until such an order is signed personally by the physician issuing the order."

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of records and interview, a registered nurse did not provide or assign to other nursing personnel the care of Patient #1,

who was restrained during his January 2011 hospitalization, in accordance with Patient #1's needs and the specialized qualifications and competence of the staff available, in that 4 of 8 nurses (Nurses #6, #7, #8, and #9) did not receive the Critical Access Hospital's required restraint training before being assigned to care for Patient #1. This deficient practice presents a risk of potential harm to patients that may be restrained during their hospitalization.

Findings included:

The "History and Physical" (01/12/11) of Patient #1, [AGE], noted that Patient #1 was admitted on [DATE] after a fall at a nursing home. Patient #1 "had a large hematoma over the left forehead and bruising and contusion around his left eye." History included Congestive Heart Failure, Diabetes, anxiety, and dementia with aggressive behavioral disorder. At 11:40 PM, Physician #4 ordered bilateral restraints to the upper and lower extremities of Patient #1. The 01/13/11 10:00 AM "Protective/Restraint Need Assessment" noted, Patient #1 had attempted to pull out tubing and climb out of the bed or chair.

The 01/13/11 "Restraint Flow Chart" indicated Nurse #8 (LVN) cared for Patient #1, who was in restraints, from approximately 08:00 PM through 10:00 PM.

The 01/14/11 "Restraint Flow Chart" indicated Nurse #8 (LVN) cared for Patient #1, who was in restraints, from approximately 12:00 Midnight through 06:00 AM.

The 01/15/11 "Restraint Flow Chart" indicated Nurse #9 (RN) cared for Patient #1, who was in restraints, from approximately 08:00 AM through 12:00 Noon.

The 01/16/11 "Restraint Flow Chart" indicated Nurse #6 (RN) cared for Patient #1, who was in restraints, at approximately 08:00 AM.

The 01/17/11 "Restraint Flow Chart" indicated Nurse #7 (RN) cared for Patient #1, who was in restraints, from 08:00 AM through 06:00 PM.

The Critical Access Hospital's current training information through 02/18/11 and/or personnel files of Nurses #6, #7, #8, and #9 did not include documentation of the required restraint competency training.

During an interview on 02/18/11 at approximately 05:00 PM, the Chief Nursing Officer (Personnel #2) reviewed the training documentation of Nurses #6, #7, #8, and #9 with the surveyor. The Chief Nursing Officer (Personnel #2) agreed that Nurses #6, #7, #8, and #9 did not appear to have the required restraint training before being assigned to care for Patient #1 and could not produce documentation that reflected the training.

The "Orientation Plan-Medical/Surgical" policy effective June 2002 noted, "A one-two week orientation will be conducted for each category of nursing personnel to their assigned unit...Day Two...Competencies: Review with the nurse on duty...Restraints...Day Three...Complete Competencies...Care for 1-3 patients with nurse preceptor..."

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RED RIVER REGIONAL HOSPITAL RED RIVER REGIONAL HOSPITAL

504 LIPSCOMB STREET BONHAM, TX 75418 | Proprietary

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Report date Number of violations

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TEXAS INSTITUTE FOR SURGERY AT PRESBYTERIAN HOSPIT ->

Report No. 1583

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TEXAS INSTITUTE FOR SURGERY AT PRESBYTERIAN HOSPIT

7115 GREENVILLE AVENUE SUITE 100 DALLAS, TX 75231

Feb. 16, 2011

VIOLATION: PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES

Tag No: A0122

Based on interview and record review, the facility did not provide a written response to 1 of 1 patient (Patient #1) who lodged a complaint to Personnel #2 on January 9, 2010 as required by their policy.

Findings included:

In an interview on 02/16/11 at 1:15 PM, Personnel #2 was asked if he received a complaint from Patient #1. Personnel #2 replied that he did on "January 8th or 9th." Personnel #2 stated he informed the patient that her complaint will be referred to the clinical director since this was a "clinical" matter as well as administrative. Personnel #2 was asked if there was a record of this complaint and if they followed their "Complaint Resolution" process. He replied that he did not document this complaint and that there was no written response provided to Patient #1.

The "Hospital...Manual Complaint Resolution" revised 08/2006 required "The Administrator or their designee will...provide follow-up to the patient within seven days..."

VIOLATION: FORM AND RETENTION OF RECORDS

Tag No: A0438

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the facility did not accurately record the time of the "Time Out" procedure conducted in the OR (operating room) for 2 of 3 patients (Patient #1, #2, & #3) who underwent pain management procedures for the month of November 2010.

(Note: "Time Out" is a method of "verifying the patient, procedure, site & consent with the team" prior to start of procedure.)

Findings included:

Patient #1 was admitted on [DATE] for "Cervical epidural steroid injection Right C6-7 and Thoracic facet injection Left T6-7, T7-8." The "start time" of the procedure was recorded at 3:09 PM. The "Time Out" was conducted at 3:11 PM, 2 minutes after the procedure started.

Patient #2 was admitted on [DATE] for "Cervical epidural steroid injection midline C4-5 and Cervical facet injection bilateral C4-5, C5-6, C6-7." The "start time" of the procedure was recorded at 10:50 AM. The "Time Out" was conducted at 10:52 AM, 2 minutes after the procedure started.

In an interview on 02/16/11 at 10:25 AM, Personnel #3 was asked why the " time-out " was performed 2 minutes after the procedure started. She explained that they perform electronic documentation in the OR. " The nurse has to open 2 programs to document the time-out and it takes about 2 minutes to complete it. "

The "Clinical Manual Universal Protocol" revised 02/2011 required "Time-out is conducted prior to starting the procedure..."

The "...Health Information Management Documentation and Flow of the Medical Record" revised 06/2009 required "The medical record will provide adequate and accurate documentation..."



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TEXAS INSTITUTE FOR SURGERY AT PRESBYTERIAN HOSPIT TEXAS INSTITUTE FOR SURGERY AT PRESBYTERIAN HOSPIT

7115 GREENVILLE AVENUE SUITE 100 DALLAS, TX 75231 | Proprietary

View hospital's federal Hospital Compare record

Report date Number of violations

Feb. 16, 20112 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. **Incomplete reports**

No incomplete reports available.

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TEXAS HEALTH HARRIS METHODIST HURST-EULESS-BEDFORD ->

Report No. 1537

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

TEXAS HEALTH HARRIS METHODIST HURST-EULESS-BEDFORD

1600 HOSPITAL PARKWAY BEDFORD, TX 76022 Feb. 11, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

Based on interview and review of records, the hospital did not ensure that 1 of 1 patient (Patient #1) received care in a safe setting in that A) Patient #1 was tasered by a hospital employed off-duty Police Officer (Personnel #6) who did not have training mandated by the hospital's own policies, and B) the "Code White" Team Leader did not have "Code White" certification that included non-aggressive approaches to patient management. These practices could affect all patients and present a risk of potential harm to the hospital's patients and staff.

Findings included:

The 12/08/10 08:59 AM physician's "History and Physical" noted that Patient #1, [AGE], was admitted on [DATE] with osteoarthritis of the right knee. History included osteoarthritis, diabetes, psychiatric problem/depression, liver disease with transplant, and hypertension. Patient #1 was alert with normal muscle strength and normal speech. He had pain and swelling in both his knees and his skin was intact.

The 12/08/10 10:31 AM physician's "Operative Report" noted that on 12/08/10 Patient #1 had a "right total knee arthroplasty...under good spinal anesthesia supplemented with IV (intravenous) sedation..." with no complications.

The 12/14/10 05:30 AM nurse's "Progress Notes" indicated that Patient #1 "looks confused, agitated, and violent behavior, code white initiated..." At 06:30 AM, Patient #1 was "yelling, showing violent behavior...security personnel are at bedside..."

The 12/20/10 12:30 PM nurse's "Progress Notes" indicated that Patient #1 did not recall the "Code White" and did not know that he had displayed combative behavior. Patient #1 was informed that an off-duty Police Officer had utilized his stun device "to the patient's abdomen for approximately 3-5 seconds in order to give the code white respondents sufficient time to apply the soft restraints which had been ordered by the physician ...to provide for patient and staff safety...expressed remorse that he had injured staff..."

- A) During a telephone interview with Police Officer #6 on 02/10/11 at 10:30 AM, the following questions were asked by the surveyor:
- 1) Police Officer #6 was asked who was in the room during Patient #1's taser incident on 12/14/10. Police Officer #6 said that he was in the room with other staff members that included the Administrative Supervisor.
- 2) Police Officer #6 was asked who gave the order for the taser on 12/14/10. He said nobody. It was the Police Officer's decision. Police Officer #6 said that he was employed by the hospital as a Police Officer to enforce the law.
- 3) Police Officer #6 was asked if he was "CPI" (Nonviolent Crisis Intervention) certified by the hospital or had a certification in "Code White"

^{**}NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

before the 12/14/10 taser incident. He said "no" and that he was not certified now.

- 4) Police Officer #6 was asked who the "Code White" team leader was on 12/14/10. He said that he did not know who was in charge.
- 5) Police Officer #6 was asked if he was trained in patient rights at orientation. He said that he "didn't recall."
- 6) Police Officer #6 was asked if he was trained in "Code White" at orientation. He said that he was given an explanation of what the codes were, but would not go that far as to say he had training in the individual codes.
- B) During a telephone interview on 02/10/11 at approximately 11:30 AM, the Administrative Supervisor (Personnel #35) was asked if she had "Code White" certification or "CPI" training/certification before Patient #1's "Code White" on 12/14/10. Personnel #35 said "no," but that she would have functioned as Team Leader in the "Code White" since she was the Nursing Administrative Supervisor. Personnel #35 said that she was working on the computer with her back to the Police Officer and Patient #1 when she heard the Police Officer say, "If you don't calm down I'll tase you again..." She did not see the taser applied and was not told that Patient #1 would be tasered.

The hospital's "Patient Rights/Responsibilities" policy THHEB-002 issued August 2009 noted, "Each employee is responsible for providing for the rights of patient..." to receive considerate care that respects the patient's personal values and belief systems.

The "Orientation and Training" policy revised 05/20/09 noted, "New Employee Orientation, or an equivalent which supports the strategic plan and meets applicable regulatory requirements ...must be completed by each employee prior to the employee reporting for work at his or her respective unit or department ...must complete the initial competencies as designated for the position before being assigned to work independently ..."

The "Code White" policy THHEB-044 revised January 2009 noted the following: "Code White- is an emergency procedure primarily implemented, as needed, to mobilize adequate numbers of clinicians, nurses, security, and/or other hospital staff to the location of behavioral emergencies within the hospital. Code White team members shall include a Code White team leader who has Code White certification ...All hospital security officers must hold Code White certification ...All hospital Administrative Supervisors must hold Code White Certification ...Staff with Code White certification may respond to any Code White; staff who are not Code White certified may respond, but will function and initiate interventions at the specific directions of the Team Leader ...balance the patient's rights as defined in regulations and accreditation standards with the hospital's responsibility to maintain safety...responsibility of all responders to follow the directions and instructions of the Code White team leader..."

The "Emergency Action Record" Attachment B of "Code White" policy THHEB-044 revised January 2009, Publication THHEB-048 Code White noted, "Code White leader is clearly identified to the team members, along with an alternative leader ...code leader gives clear instructions to the Code Team prior to intervention with the patient ...Only staff certified in non-aggressive approaches to patient management will lead in the Code White ...the patient will be restrained without injury..."

The "Nonviolent Crisis Intervention, a CPI specialized offering" participant workbook 2005 (reprinted 2010) noted, " ...trained through the Nonviolent Crisis Intervention program to provide for the Care, Welfare, Safety, and Security of everyone involved in a crisis situation...include human service providers in fields such as health care...security, law enforcement... "

The hospital representatives were given an opportunity to provide evidence of compliance with those requirements of which non-compliance was found. No further evidence was provided to the surveyor prior to exit on 02/11/11.

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and review of records, the hospital did not ensure that 2 of 5 staff members (Police Officer #6 and Administrative Supervisor #35) who were in attendance during an emergency "Code White" on 12/14/10 had the appropriate hospital training to choose the least restrictive intervention based on an individualized assessment of Patient #1's medical, or behavioral status or condition.

Patient #1 was tasered by Police Officer #6 during the 12/14/10 "Code White" and Administrative Supervisor #35 functioned as the "Code White" Team Leader. These practices could affect all patients and present a risk of potential harm to the hospital's patients and staff.

Findings included:

The 12/08/10 08:59 AM physician's "History and Physical" noted that Patient #1, [AGE], was admitted on [DATE] with osteoarthritis of the right knee. History included osteoarthritis, diabetes, psychiatric problem/depression, liver disease with transplant, and hypertension. Patient #1 was alert with normal muscle strength and normal speech. He had pain and swelling in both his knees and his skin was intact.

The 12/08/10 10:31 AM physician's "Operative Report" noted that on 12/08/10 Patient #1 had a "right total knee arthroplasty...under good spinal anesthesia supplemented with IV (intravenous) sedation..." with no complications.

The 12/14/10 05:30 AM nurse's "Progress Notes" indicated that Patient #1 "looks confused, agitated, and violent behavior, code white initiated..." At 06:30 AM, Patient #1 was "yelling, showing violent behavior...security personnel are at bedside..." Patient #1 was in restraints.

The 12/20/10 12:30 PM nurse's "Progress Notes" indicated that Patient #1 did not recall the "Code White" and did not know that he had displayed combative behavior. Patient #1 was informed that an off-duty Police Officer had utilized his stun device "to the patient's abdomen for approximately 3-5 seconds in order to give the code white respondents sufficient time to apply the soft restraints which had been ordered by the physician ...to provide for patient and staff safety...expressed remorse that he had injured staff..."

- A) During a telephone interview with Police Officer #6 on 02/10/11 at 10:30 AM, the following questions were asked by the surveyor:
- 1) Police Officer #6 was asked who was in the room during Patient #1's taser incident on 12/14/10. Police Officer #6 said that he was in the room with other staff members that included the Administrative Supervisor.

- 2) Police Officer #6 was asked if he was "CPI" (Nonviolent Crisis Intervention) certified by the hospital or had a certification in "Code White" before the 12/14/10 taser incident. He said "no" and that he was not certified now.
- 3) Police Officer #6 was asked if he was trained in patient rights at orientation. He said that he "didn't recall."
- 4) Police Officer #6 was asked if he was trained in "Code White" at orientation. He said that he was given an explanation of what the codes were, but would not go that far as to say had training in the individual codes.
- B) During a telephone interview on 02/10/11 at approximately 11:30 AM, the Administrative Supervisor (Personnel #35) was asked if she had "Code White" certification or "CPI" training/certification before Patient #1's "Code White" on 12/14/10. Personnel #35 said "no," but that she would have functioned as Team Leader in the "Code White" since she was the Nursing Administrative Supervisor.

The hospital's "Patient Rights/Responsibilities" policy THHEB-002 issued August 2009 noted, "Each employee is responsible for providing for the rights of patient ..." to receive considerate care that respects the patient's personal values and belief systems.

The "Orientation and Training" policy revised 05/20/09 noted, "New Employee Orientation, or an equivalent which supports the strategic plan and meets applicable regulatory requirements ...must be completed by each employee prior to the employee reporting for work at his or her respective unit or department ...must complete the initial competencies as designated for the position before being assigned to work independently ..."

The "Code White" policy THHEB-044 revised January 2009 noted the following: "Code White- is an emergency procedure primarily implemented, as needed, to mobilize adequate numbers of clinicians, nurses, security, and/or other hospital staff to the location of behavioral emergencies within the hospital. Code White team members shall include a Code White team leader who has Code White certification ...All hospital security officers must hold Code White certification ...All hospital Administrative Supervisors must hold Code White Certification ...Staff with Code White certification may respond to any Code White; staff who are not Code White certified may respond, but will function and initiate interventions at the specific directions of the Team Leader ...balance the patient's rights as defined in regulations and accreditation standards with the hospital's responsibility to maintain safety...responsibility of all responders to follow the directions and instructions of the Code White team leader..."

The "Emergency Action Record" Attachment B of "Code White" policy THHEB-044 revised January 2009, Publication THHEB-048 Code White noted, "Code White leader is clearly identified to the team members, along with an alternative leader ...code leader gives clear instructions to the Code Team prior to intervention with the patient ...Only staff certified in non-aggressive approaches to patient management will lead in the Code White ...the patient will be restrained without injury..."

The "Nonviolent Crisis Intervention, a CPI specialized offering "participant workbook 2005 (reprinted 2010) noted, "...trained through the Nonviolent Crisis Intervention program to provide for the Care, Welfare, Safety, and Security of everyone involved in a crisis situation...include human service providers in fields such as health care ...security, law enforcement ... "

The hospital representatives were given an opportunity to provide evidence of compliance with those requirements of which non-compliance was found. No further evidence was provided to the surveyor prior to exit on 02/11/11.

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WESTBURY COMMUNITY HOSPITAL, LLC ->

Report No. 1777

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

WESTBURY COMMUNITY HOSPITAL, LLC 5556 GASMER HOUSTON, TX 77035 Feb. 11, 2011

VIOLATION: NURSING SERVICES Tag No: A0385

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, review of written statements and review of 1 of 3 clinical records, there was a failure to monitor and supervise nursing services resulting in the death of a patient. Findings:

Citing patient #3, a [AGE] year old male. Review of the psychiatric evaluation reflected the patient was mentally retarded and psychotic. he resided at a personal care home where it was reported the patient was not eating, not acting the same and lying on the floor with tremors. it was noted the patient was admitted on [DATE] at 4:52pm with physician orders from the personnel dated 1/27/2011 for "Diet: Soft, chopped meat texture, dime size pieces."

Admission physician orders included the following: 1:1 (staffing)
Fall precautions
Mechanical soft diet

Review of nursing progress notes reflected on 2/3/2011 at 4:50pm the patient was observed in his wheelchair at the table in the activity room choking and another patient performed the Heimlich procedure on him. The patient was observed holding his mouth wide open with eyes bulging and hands beating on the table. Psychiatric Technician #52 attempted to lift the patient from the wheelchair to a standing position. Heimlich procedure not successful. There was a call for additional staff. Code Blue called and CPR began. patient had stopped breathing and became a bluish/gray color.

At 5:54pm the patient was transferred to an outside hospital emergency room .

Review of the menu for food served to the patient for 2/3/2011 reflected the patient was served a roast beef sandwich and chips for the dinner meal.

Although the patient was ordered to be on 1:1 staffing, In arms length at all times, there was no staff with the patient at the time and as nursing notes indicated, another patient in the room was the one to initiate the Heimlich maneuver.

Review of the Code Blue sheet reflected the code was called at 1700.hrs However the ER physician did not arrive until 1713 hrs and ordered staff call 911. Paramedics arrived at 1722 hrs and took over, the patient was transferred to an outside ER at 1750 hrs.

Review of the rounds sheet for documentation of every 15 minute observation on 2/3/2011 appeared to have been falsified as follows:

All 15 minute observations from the time the code was called to the time the patient was transferred to an outside ER noted the following:

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1700

Location: activity room Visual appearance: calm Behavior: composed

1715

Location: activity room Visual appearance: calm Behavior: composed

1730

Location: activity room Visual appearance: calm Behavior: composed

1745

Location: activity room Visual appearance: calm Behavior: composed

1800

Location: activity room Visual appearance: calm Behavior: composed

VIOLATION: PATIENT RIGHTS Tag No: A0115

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview, review of written statements and review of 1 of 3 clinical records, there was a failure to protect patient's right to receive care in a safe setting resulting in the death of a patient. Findings:

Citing patient #3, a [AGE] year old male. Review of the psychiatric evaluation reflected the patient was mentally retarded and psychotic. he resided at a personal care home where it was reported the patient was not eating, not acting the same and lying on the floor with tremors. it was noted the patient was admitted on [DATE] at 4:52pm with physician orders from the personnel dated 1/27/2011 for "Diet: Soft, chopped meat texture, dime size pieces."

Admission physician orders included the following: 1:1 (staffing)
Fall precautions
Mechanical soft diet

Review of nursing progress notes reflected on 2/3/2011 at 4:50pm the patient was observed in his wheelchair at the table in the activity room choking and another patient performed the Heimlich procedure on him. The patient was observed holding his mouth wide open with eyes bulging and hands beating on the table. Psychiatric Technician #52 attempted to lift the patient from the wheelchair to a standing position. Heimlich procedure not successful. There was a call for additional staff. Code Blue called and CPR began. patient had stopped breathing and became a bluish/gray color.

At 5:54pm the patient was transferred to an outside hospital emergency room .

Review of the menu for food served to the patient for 2/3/2011 reflected the patient was served a roast beef sandwich and chips for the dinner meal.

Although the patient was ordered to be on 1:1 staffing, In arms length at all times, there was no staff with the patient at the time and as nursing notes indicated, another patient in the room was the one to initiate the Heimlich maneuver.

Review of the Code Blue sheet reflected the code was called at 1700.hrs However the ER physician did not arrive until 1713 hrs and ordered staff call 911. Paramedics arrived at 1722 hrs and took over. the patient was transferred to an outside ER at 1750 hrs.

Review of the rounds sheet for documentation of every 15 minute observation on 2/3/2011 appeared to have been falsified as follows:

All 15 minute observations from the time the code was called to the time the patient was transferred to an outside ER noted the following:

1700

Location: activity room Visual appearance: calm Behavior: composed

1715

Location: activity room Visual appearance: calm Behavior: composed

1730

Location: activity room Visual appearance: calm Behavior: composed 1745

Location: activity room Visual appearance: calm Behavior: composed

1800 Location: activity room Visual appearance: calm Behavior: composed



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TRUSTPOINT HOSPITAL ->

Report No. 1765

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

TRUSTPOINT HOSPITAL

4302 PRINCETON LUBBOCK, TX 79415

Feb. 9, 2011

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

Tag No: A0457

Based on review of records and interview with staff, the facility failed to ensure that verbal orders were authenticated within 48 hours for 1 of 1 patient whose record was reviewed.

Findings were:

Review of the medical record for Patient #1 was conducted during the survey, 2/9/2011. Included in the record were telephonic physician orders given by the admitting physician's physician assistant (PA) on 10/1/10 and 10/2/10. These orders were not authenticated until 12/6/2010. These findings were confirmed by the facility Chief Nursing Officer during an interview conducted the afternoon of 2/9/2010.



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LIMESTONE MEDICAL CENTER ->

Report No. 1585

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

LIMESTONE MEDICAL CENTER 701 MCCLINTIC DRIVE GROESBECK, TX 76642 Feb. 8, 2011

VIOLATION: UNSPECIFIED CATEGORY Tag No:

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review the facility's governing body had not monitored policies governing the Critical Access Hospital's (CAH's) total operation, in that, their Adverse Drug Reaction Reporting policy, and their quality assurance (QA) policy, had not been implemented when a quality health care issue occurred for 1 of 1 patients (Patient # 1).

Findings included:

Medical Record review of the medication administration record (MAR) for Patient # 1, showed that she had received Phenergan 25 mg. IVP (IV push) at 3:50 PM on 07/31/10. Nurse's notes recorded at 5:10 PM that "redness noted around IV site. Positive blood return. IV site dc'd (discontinued) with catheter intact."

In an interview at 9:30 AM on 02/08/11 with the RN (Personnel # 4), she confirmed that during an Emergency Department (ED) visit on 07/31/10 she had noticed there was redness around the intravenous (IV) site of Patient #1, 1 hour and 20 minutes after she had given Phenergan by IV push. She stated that she had informed the physician and received an order to discontinue the IV at that time. When asked if she had completed an incident report or reported the redness at the IV site to anyone other than the ED physician, she said "no."

In an interview at 10:30 AM on 02/08/11 with the Director of Nurses (DON), (Personnel # 3), he said that Patient #1 had returned to the hospital on [DATE], and voiced her complaints that her left hand was red and swollen after receiving IV Phenergan in the ED on 07/31/10. The DON stated that her left hand had "looked like an IV infiltrate, but it wasn't bad." He was asked if this identified issue had been sent to the Pharmacy as a possible adverse drug reaction, or through the quality assurance (QA) process from the ED, and he said "no."

The facility's "Adverse Drug Reaction Reporting" policy, effective date 03/28/03, noted the following:

- -"As part of (the facility's) overall medication management program, all significant adverse drug reactions (ADR's) will be reviewed by the Pharmacy and Therapeutic (P&T) Committee."
- -"(The facility's) ADR monitoring and reporting process will include a concurrent surveillance system: Based on the reporting of suspected adverse drug reaction by pharmacists, physicians, nurses or patients..."
- -"All concurrently reported potential adverse drug reaction reports will be investigated by a pharmacist" and "can be submitted by telephone...or in writing..."
- -"The pharmacist will assign a severity rating to each adverse drug reaction report according to a scale" including as "Significant: An adverse drug reaction which results in hospital admission, increases length of stay, requires medical treatment or requires discontinuation of therapy."

In a later telephone interview at 2:30 PM on 02/10/11 with the Chief Operating Officer (CEO), (Personnel # 1), she verified that this identified issue of a suspected adverse drug reaction had not been reported to the Pharmacy, and had not gone through the facility's

Pharmacy & Therapeutics (P&T) Committee. She confirmed that the facility had not followed their policy & procedure for reporting adverse drug reactions for Patient # 1.

The facility's "Quality Assurance Reporting" policy, last reviewed 03/01/05, noted that "each department of the facility is required to report to the Quality Assurance Committee every other month"...and "these departmental reports will be submitted to the Governing Board every other month."

In an interview at 2:30 PM on 02/08/11 with the Quality Assurance Coordinator (Personnel # 7), she was asked if Patient # 1's quality of care issue related to an IV infiltrate, causing redness and swelling, and further medical treatment after discharge, had been identified and gone through the facility's QA process, and she said "no." She provided QA meeting minutes for 2010, and verified that this issue was not discussed or documented in their records, and therefore, had not been reported to the governing board.

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Tag No: A0297

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the facility had not followed their policy and procedure for reporting adverse drug reactions, in that, the facility had no documentation of the suspected adverse drug reaction for 1 of 1 patients (Patient #1), who required follow-up medical treatment after receiving intravenous (IV) Phenergan in the Emergency Department (ED) on 07/31/10.

Findings included:

Medical Record review of the medication administration record (MAR) for Patient # 1, showed that she had received Phenergan 25 mg. IVP (IV push) at 3:50 PM on 07/31/10. Nurse's notes recorded at 5:10 PM that "redness noted around IV site. Positive blood return. IV site dc'd (discontinued) with catheter intact."

In an interview at 9:30 AM on 02/08/11 with the RN (Personnel # 4), she confirmed that she had diluted the 25 mg. of Phenergan in 6 cc's of diluent, as this was her usual routine when giving it by IVP. She said she had noticed there was redness around the IV site, only after she had given Ativan by IVP at 5:10 PM, which was 1 hour and 20 minutes after she had given the IV Phenergan. She stated that she had informed the physician and received an order to discontinue the IV at that time. When asked if she had completed an incident report or reported the redness at the IV site to anyone other than the ED physician, she said "no."

In an interview at 10:30 AM on 02/08/11 with the Director of Nurses (DON), (Personnel # 3), he was asked when he became aware of Patient #1's complaint that her left hand was red and swollen after her ED visit on 07/31/10. He said that Patient #1 had returned to the hospital on [DATE], and voiced her complaints that her left hand was red and swollen after receiving IV Phenergan in the ED on 07/31/10. The DON stated that her left hand had "looked like an IV infiltrate, but it wasn't bad," and he had taken the patient back to the ED for evaluation and assessment by the physician. He was asked if this identified issue had been sent to the Pharmacy as a possible adverse drug reaction, and he said "no."

Medical Record review of a return visit to the ED by Patient #1 on 08/02/10, documented an X-ray of left hand and wrist, with a chief complaint of "swelling and redness to left hand," with physician progress notes stating "history of ED visit and subsequent pain and swelling back of left hand and forearm...(back of hand)-phlebitis (inflammation of the vein)," ED physician had spoken to clinic physician (FMC Personnel #1), who had placed Patient #1 on oral antibiotics, given an IM (intramuscular) shot, ordered rest and elevation of left arm which had been placed in a sling. The patient was discharged with a diagnosis of "Cellulitis," and instructed to elevate left arm, apply ice, and to return to ED if concerned.

The facility's "Adverse Drug Reaction Reporting" policy, effective date 03/28/03, noted the following:

- -"As part of (the facility's) overall medication management program, all significant adverse drug reactions (ADR's) will be reviewed by the Pharmacy and Therapeutic (P&T) Committee."
- -"(The facility's) ADR monitoring and reporting process will include a concurrent surveillance system: Based on the reporting of suspected adverse drug reaction by pharmacists, physicians, nurses or patients..."
- -"All concurrently reported potential adverse drug reaction reports will be investigated by a pharmacist" and "can be submitted by telephone...or in writing..."
- -"The pharmacist will assign a severity rating to each adverse drug reaction report according to a scale" including as "Significant: An adverse drug reaction which results in hospital admission, increases length of stay, requires medical treatment or requires discontinuation of therapy."

In a later telephone interview at 2:30 PM on 02/10/11 with the Chief Operating Officer (CEO), (Personnel #1), she verified that this identified issue of a suspected adverse drug reaction had not been reported to the Pharmacy, and had not gone through the facility's Pharmacy & Therapeutics (P&T) Committee. She confirmed that the facility had not followed their policy & procedure for reporting adverse drug reactions for Patient #1.

VIOLATION: QAPI PERFORMANCE IMPROVEMENT PROJECTS

Based on interview and record review, the registered nurse (RN),((Personnel # 4) had not followed the facility's reference used as a standard of practice for diluting a medication, in that, Phenergan 25 milligrams (mg.) was diluted in 6 cc's (cubic centimeters), instead of the 9 cc's of diluent as recommended, before administering it to 1 of 1 patients (Patient #1), by intravenous (IV) push injection.

Findings included:

Medical Record review of the medication administration record (MAR) for Patient # 1, showed that she had received Phenergan 25 mg. IVP (IV push) at 3:50 PM on 07/31/10. Nurse's notes recorded at 5:10 PM that "redness noted around IV site. Positive blood return. IV site dc' d (discontinued) with catheter intact."

In an interview at 9:00 AM on 02/08/11, with the RN (Personnel #4), who had administered IV Phenergan to Patient #1, she was asked how she had mixed this medication to give as an IV push injection. She stated that she always drew up Phenergan and mixed it with IV fluid in a 6 cc syringe, before giving it slow IV push. When asked what drug book was used as a reference for the Emergency Department's (ED) standard of practice for administering IV medications, she said they had a Mosby's drug book at the nurse's desk in the ED. When asked what the standard of practice was for administering IV Phenergan, she said that she thought the standard was to give no more than 25 mg. IV push.

Review of Mosby's Drug book, dated 2007, noted the process to administer Phenergan by IV route as "after diluting each 25-50 mg/9 ml (milliliters) of NaCl (Sodium Chloride) for injection; give 25 mg. or less/2 minutes." Cubic centimeters (cc's) are equal to milliliters (ml's).

In an interview at 9:30 AM on 02/08/11 with the RN (Personnel #4), she confirmed that she had diluted the 25 mg. of Phenergan in 6 cc's of diluent, as this was her usual routine, and had thought this met practice standards. When asked if she had completed an incident report or reported the redness at the IV site to anyone other than the ED physician, she said "no."

VIOLATION: UNSPECIFIED CATEGORY

Tag No:

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the facility had not ensured they had an effective quality assurance (QA) program that evaluated all patient care services, in that, they had no documentation of an adverse patient outcome affecting an Emergency Department (ED) patient's health, for 1 of 1 patients (Patient # 1).

Findings included:

Medical Record review of the medication administration record (MAR) for Patient # 1, showed that she had received Phenergan 25 mg. IVP (IV push) at 3:50 PM on 07/31/10. Nurse's notes recorded at 5:10 PM that "redness noted around IV site."

In an interview at 9:30 AM on 02/08/11 with the RN (Personnel #4), she confirmed that she had diluted the 25 mg. of Phenergan in 6 cc's of diluent, as this was her usual routine when giving it by IVP. She said she had noticed there was redness around the IV site, only after she had given Ativan by IVP at 5:10 PM, which was 1 hour and 20 minutes after she had given the IV Phenergan. She stated that she had informed the physician and received an order to discontinue the IV at that time. When asked if she had completed an incident report or reported the redness at the IV site to anyone other than the ED physician, she said "no."

In an interview at 10:30 AM on 02/08/11 with the Director of Nurses (DON), (Personnel # 3), he was asked when he became aware of Patient #1's complaint that her left hand was red and swollen after her ED visit on 07/31/10. He said that Patient #1 had returned to the hospital on [DATE], and voiced her complaints that her left hand was red and swollen after receiving IV Phenergan in the ED on 07/31/10. The DON stated that her left hand had "looked like an IV infiltrate, but it wasn't bad," and he had taken the patient back to the ED for evaluation and assessment by the physician. He was asked if this identified quality of care issue had been reported through the QA process from the Emergency Department, and he said "no."

Medical Record review of a return visit to the ED by Patient #1 on 08/02/10, documented an X-ray of left hand and wrist, with a chief complaint of "swelling and redness to left hand," with physician progress notes stating "history of ED visit and subsequent pain and swelling back of left hand and forearm...(back of hand)-phlebitis (inflammation of the vein)," ED physician had spoken to clinic physician (FMC Personnel #1), who had placed Patient #1 on oral antibiotics, given an IM (intramuscular) shot, ordered rest and elevation of left arm which had been placed in a sling. The patient was discharged with a diagnosis of "Cellulitis," and instructed to elevate left arm, apply ice, and to return to ED if concerned.

In an interview at 2:30 PM on 02/08/11 with the Quality Assurance Coordinator (Personnel # 7), she was asked if Patient #1's quality of care issue related to an IV infiltrate, causing redness and swelling, and further medical treatment after discharge, had been identified and gone through the facility's QA process, and she said "no." She provided QA meeting minutes for 2010, and verified that this issue was not discussed or documented in their records.

The facility's "Quality Assurance Reporting" policy, last reviewed 03/01/05, noted that "each department of the facility is required to report to the Quality Assurance Committee every other month"...and "these departmental reports will be submitted to the Governing Board every other month."



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Feb. 8, 20114 (click for details) Read full report

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UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE ->

Report No. 1494

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UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE

601 E 15TH STREET AUSTIN, TX 78701

Feb. 2, 2011

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

Tag No: A0457

Tag No: A0144

Based on review of documentation and interviews with facility staff the facility failed to authenticate verbal orders based on Federal and State law which requires that verbal orders must be authenticated within 48 hours.

The findings were:

Review of the medical record of patient #1 revealed that 9 out of 17 telephone orders were not authenticated within 48 hours. This finding was confirmed by the facility chief nursing officer in an interview on 2/1/11.

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Based on review of documentation and interviews with facility staff, the facility failed to provide a safe setting for the patient to receive care as an order for a Foley urinary catheter was not carried out in a timely manner.

The findings were:

Review of the medical record of patient #1 revealed that on the "Post-Operative Laninectomy/Discectomy/Fusion Orders" the order for "Foley if no void by____" was checked. The order sheet was signed by the physician 's assistant on 8/25/10 at 1219 hours. The order sheet was noted by the "CA" at 2000 hours on 8/25/10 and by the nurse at 1000 hours on 8/26/10. The patient was discharged from the post anesthesia care unit (PACU) at 1800 hours on 8/25/10. The patient complaint stated that when the patient was admitted to the floor, his bladder was distended, he was experiencing discomfort, and was unable to urinate. A telephone order was obtained by the nurse at 1915 hours 8/25/10 to insert Foley catheter now. It was documented in the medical record that a urinary catheter was inserted on 8/25/10 at 1845 hours. These findings were confirmed by the chief nursing officer in an interview on 2/1/11.

Additional findings determined that the facility failed to provide a safe setting for the patient to receive care as effective pain management was not provided patient #1 as evidenced by:

Medical records indicate that patient #1 had unmanaged pain during his hospitalization. The hospital uses a pain scale of 0-10 with 0 being no pain and 10 being maximum, severe pain.

Review of medical records of patient #1 shows that the patient rarely achieved an acceptable pain intensity level of 4/10 as defined in the Pain Assessment document.

(8-25-10) Pre and Post Operative Progress Notes: "Pt with very difficult pain control in PACU"; "Pain 9-10/10"

(8-26-10) Progress Notes: "Lots of incisional pain, slow to mobilize. Pain control a big issue." Orthotic Note - "Patient expressed feeling pain the minute we walked in." "aching, sharp, shooting", "Security was called to the patient's room because he was in pain and yelling at staff.", "Pain 5-6-7-8-9-10/10"

(8-27-10) Progress Notes: "Pain remains severe." Medication Response Summary: "still in pain, pt states that he is unable to become

comfortable". "pt complaining of sharp, shooting, tingling pain from back down left leg", Critical Response Team was called because patient was in crisis: hyperventillating and diaphoretic because of pain. "Pain 4-5-7-8-9/10" (8-28-10) Medication Response Summary: "feels like it's getting worse", "Still hurts", "MD aware of pt's unrelieved pain", "pt still has ridiculous amounts of pain despite all his pain meds. MDs aware. Pt has not slept in days and can get ambien tonight. Pt had revision of his fusion today but still with tingling/shooting pain to leg." "Give PRN pain meds when he can have them, instead of waiting for him to request them" "Pain 5-6-7-8/10"

(8-29-10)Patient Information: "Pt requesting to see physician to address nerve pain." "Pain and anxiety" "Pain 5-6-7-8/10" (8-30-10) "Pain, anxiety", "Shooting pain in LLE from hip to foot", "Aching, radiating", "Pain 4-5-7-8-10/10" (8-31-10) "Have prn pain and anxiety meds ready when he can have them.", "Sharp, shooting pain in left leg from hip to foot", "Pain chronic", "Pain 5-6-7-8/10"

(9-1-10)"Pt states that pain radiates from back to left lower posterior leg down to foot", "He has continued to have significant pain, although he was a chronic pain patient, and we have consulted with Dr. Thai multiple times who is his pain management physician on an outpatient basis. He is currently complaining of mild incision pain with the exception of with movement, increases to moderate pain, and he has intermittent left leg pain, more so with movement. He continues to have slight numbness and tingling in the left leg.", "Pain 4-6/10"

VIOLATION: MEDICAL RECORD SERVICES

Based on review of documentation and interviews with facility staff, the facility failed to assure that all patient medical record entries were legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided as a number of forms in the medical record of patient #1 were incomplete or unauthenticated.

Tag No: A0450

The findings were:

Review of the medical record of patient #1 revealed the following forms were incomplete or unauthenticated.

- 1. Adult Patient Profile-Part A, Patient History Information; not signed. The form has a signature block for the express admit nurse and stated "for nursing must be signature of RN" and there was no RN signature.

 2. Adult Patient Profile-Part B. Patient Screening; form not completed and not signed. The form has a signature block for "RN Signature"
- and there was no RN signature.
- 3. Pre and Post Operative Progress Notes dated 8/25/10 and dated 8/28/10; The section to document that "There are no changes or discrepancies from the attached H&P OR The attached H&P is valid with the following changes." was not completed and signed by the
- 4. Preoperative Checklist dated 8/28/20 was incomplete, vital signs and physical assessment not done.

These findings were confirmed by the facility chief nursing officer in an interview on 2/1/11.



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View hospital's federal Hospital Compare record

Report date Number of violations

Feb. 2, 20113 (click for details) Read full report Feb. 1, 20114 (click for details) Read full report

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Report No. 1493

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UNIVERSITY MEDICAL CENTER AT BRACKENRIDGE

601 E 15TH STREET AUSTIN, TX

Feb. 1, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

Tag No: A0144

The patient has the right to receive care in a safe setting.

Based on review of documentation and interview, it was determined that the facility failed to respond in a timely manner to Patient # 1's rapidly deteriorating condition.

Findings were:

Facility policy entitled "Physician/Nurse Chain of Command for Issues of Clinical Concern " stated "The purpose of the Chain of Command policy is to identify the process for a timely resolution of clinical issues of concern when the physician is not available in the needed time frame or if the nurse and physician have conflicting approaches to the issue that they cannot resolve. "...the same policy continued, " If upon assessment, an RN has a concern regarding a change of the patient 's status to clinically unstable, the RN contacts the CRT and the patient 's appropriate physician(s). If the RN is unable to reach the patient 's physician in the needed time frame, then the RN contacts the Charge Nurse. The Charge Nurse assesses the issue and, as appropriate to specific department and/or site protocol contacts the CRT, house supervisor and the following:

Attending physician, other physician designated as in charge of patient or call partner. If the attending/other designated physician/call partner physician is contacted but cannot be at the bedside in the needed timeframe, then the attending/designated physician/call employee, contractor partner will contact the Facility Medical Director and ask him to facilitate finding a physician to attend to the patient. "

Nurse 's note dated 9/18/10 20:51 for Patient # 1:

Preceding Events: Acute abdominal pain, Change in LOC, Change in vital signs, Respiratory distress

Event Type: Respiratory event

Medical Status Change Event description: Abd pain began worsening approx 1400, starting as epigastric and gradually lower in abd. Pt complaining of being unable to have BM by 1600. Calls to Staff Member # 10 (resident physician) and Staff Member # 11 (resident physician) advising that they would be up multiple times. Checked pt at 1845, respirations at 20. Called Staff Member # 10, he will get with Staff Member # 11 and she or they would be up soon. Hung potassium approx 1910-1915. Checked on pt at approx 1915, respires in low 30 's, bp 93/48, O2 was 43% on RA, HR 137. Called RT. Started O2 per NC at 4L. Had Staff Member # 11 paged overhead, advised her that I was going to call a CRT or Code to get someone to look after pt. Called CRT approx 1920. CRT arrived within 5 minutes. Staff Member # 12 and RT also arrived sometime thereafter. Gave Ativan 2mg per Staff Member # 12 approx 1940 to assist RT in taking AGBs. Staff Member # 11 arrived sometime there after. Started IV NS bolus at 999 mls/hr per Staff Member # 11. Per Staff Member # 13 onc on call is stopped Cytarabing with 201 left to give per IV pump setting; made admin note of same RV this time RT and CRT were arranging to call) stopped Cytarabine with 201 left to give per IV pump setting; made admin note of same. By this time, RT and CRT were arranging to take PT to ICU. RT had started O2 per nonbreather mask at 15L.

Page Report 9th Floor UMCB 9/18/10 indicated that Staff Member 14 (RN) attempted to page the medical staff 7 times between the hours of 3 and 8 PM.

On 9/18/10, Patient # 1's condition deteriorated rapidly. His nurse (Staff Member # 14) attempted to call for medical assistance 7 times between 3 and 8 PM. A doctor did not arrive at the patient's bedside until the Critical Response Team appeared at approximatly 7:25 PM. In an interview with the Director of Risk Managment and with Patient # 1's attending MD on 2/1/11, it was acknowledged that medical staff did not respond in a timely manner in response to Patient # 1's deteroriating condition.

VIOLATION: VERBAL ORDERS AUTHENTICATED BASED ON LAW

All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hour

Tag No: A0457

Tag No: A0749

Based on Review of documentation, it was determined that the facility's medical staff failed to authenticate verbal orders within 48 hours.

Findings were:

The following verbal orders for Patient # 1 were not authenticated by the prescribing MD within 48 hours:

- ? Order written at 608 AM 9/16/10 was not authenticated until 10/11/10 at 3 PM
- ? Order written at 828 PM 9/16/11 was not authenticated until 10/11/10 at 3 PM
- ? Order written at 331 PM 9/18/11 was not authenticated until 10/12/10 at 1 PM
- ? Order written at 726 PM 9/18/11 was not authenticated until 10/12/10 at 1 PM
- ? Order written at 730 PM 9/18/11 was not authenticated until 10/12/10 at 5 PM
- ? Order written at 8 PM 9/18/11 was not authenticated until 10/12/10 with no noted time
- ? Order written 9/18/11 with no noted time was not authenticated until 10/20/10 at 12 PM
- ? Order written at 12:30 AM 9/19/11 was not authenticated until 10/20/10 at 12 PM
- ? Order written at 12:30 AM 9/19/11 was not authenticated until 10/07/10 at 12 PM

In an interview with the Director of Risk Management and the Director of Nurses on 2/1/11, the above delinquent authentication of Doctor's Orders was acknowledged.

VIOLATION: PATIENT SAFETY Tag No: A0286

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of documentation and interview, it was determined that the facility failed to track adverse events in its Performance Improvement Activities.

Findings were:

Facility policy entitled "Significant Event Management and Response" stated "Seton personnel will report all occurrences that have the potential to be considered Significant Events in accordance with this policy. This policy also applies to any occurrence arising from services provided by persons who, at the time of providing services, are employed or under contract by Seton, regardless of the location at which those services are provided. ...A 'major permanent loss of function 'means sensory, motor, physiological or intellectual impairment not present on admission, which requires or will require continued treatment or lifestyle change.

A Seton employee, contractor, medical staff member, allied health professional or other affiliated person who witnesses or has knowledge of an occurrence that may constitute a Significant Event or a Near Miss shall immediately report the occurrence to his/her supervisor and the Medical Director for the facility in which the occurrence took place if the person who witnesses or has knowledge of the occurrence is a Seton medical staff member or allied health professional. "

Patient # 1 died at University Medical Center at Brackenridge on 9/19/10 from acute hemorrhagic [DIAGNOSES REDACTED] related to the clostridium perfringens bacterium. There was no evidence of this unexpected death in Performance Improvment review.

In an interview with the Director of Risk Managment and the Director of Nurses on 2/1/11, the above findings were confirmed.

VIOLATION: INFECTION CONTROL OFFICER RESPONSIBILITIES

Based on review of documentation and interview, it was determined that the facility did not effectivelly track infections in all of its patients.

Findings were:

Epidemiology Report 9/01/10-10/15/10 revealed only one case of Clostridium Perfringens reported at University Medical Center at Brackenridge: Patient # 1

The Director of Infection Control spoke with the survey team on 2/1/11. She was not aware that Patient # 1 had died as a result of clostridium perfringens. When asked why she was unaware of a death related to food poisoning in the hospital, she stated, " A part time staff member was reviewing the lab cases when that report came through. She did not recognize the bacteria and didn't inform anyone of the problem. Nobody was aware of it."

In an interview with the Risk Manager and the Director of Nurses on 2/1/11, it was confirmed that the Infection Control officer was unaware of the death of Patient #1 as a result of infection with clostridium perfringens.

http://www.hospitalinspections.org/report/1493[3/26/2013 12:17:28 PM]



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Report No. 1527

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ETMC HENDERSON 300 WILS

300 WILSON STREET HENDERSON, TX 75652

Feb. 1, 2011

Tag No: A1104

Tag No: A0123

VIOLATION: EMERGENCY SERVICES POLICIES

Based on record review and interview, the facility failed to have current Emergency Department (ED) policies readily available to staff.

Findings include:

During a tour of the ED on 2/1/11 at 1000, no ED policy and procedure manual could be found. The trauma specific policy and procedure manual was available.

In an interview in the ED break room on 2/1/11 at 1010, the Chief Clinical Officer (CCO) reported that when the last ED Director left, the ED policy and procedure manual could not be found in either printed or computer file form. The CCO reported that the previous ED director left in June 2010 and that the current ED director (staff#3), hired January 2011, was currently creating a new policy and procedure manual.

In an interview in the ED break room on 2/1/11 at 1010, staff #3 confirmed the CCO's report.

VIOLATION: PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION

Based on document review and interview the facility failed to act on a patient complaint/grievance in one of one grievances identified.

On 2/11/2011 at 10:00 AM a review of facility policy titled: Patient Complaint/Grievance Resolution Process revealed the following: Section I GENERAL STATEMENT: The facility provides a process to assure the rights of the patient and their family to register complaints or grievances and that identified issues or concerns are communicated in a timely manner....

Section II POLICY A. Definitions: 1. Complaint. * Expressed displeasure with a process or person. * An expression of dissatisfaction with some aspect of care or service, * An issue resolved by staff present or within the same day, or by the Patient Service Representative. 2. Grievance * A formal or informal, written or verbal complaint, made to the hospital by a patient, or patient's representative.... A written complaint is ALWAYS considered a grievance.

Section II POLICY A .3.* Information obtained with a patient satisfaction survey does not usually meet the definition of a grievance UNLESS an identified patient attaches a separate letter to the survey. (The patient's daughter attached a three (3) page letter of complaint to the satisfaction survey)

Section II POLICY C. Process, 2. b). For all grievances, investigation will begin and an initial contact letter will be sent to the complainantwithin 7 days. 2. c). The Administrator or designee will log the grievance. 2. e). A response letter.... provided to the person issuing the grievance out lining steps that were taken to investigate the grievance, results of the investigation and the date of completion....

On 2/1/2011 at 10:15 AM a review of the patient's Emergency Department record revealed the nurses note narrative recorded the following: "2200 hrs Pt's daughter angry wants patient bathed. Wants patient transferred..." There is no documentation addressing the requested bath.

On 2/1/2011 at 10:30 AM an interview with staff # 2 revealed the following: 1) no documentation a 7 day initial contact letter had been sent. Staff # 2 indicated the satisfaction survey had been received approximately 2 weeks earlier. 2) The complaint had not been logged. 3) There was no documentation that any aspect of the grievance had been addressed. There was no documentation that a response letter had been provided outlining the steps that were taken to investigate the grievance, results of the grievance process and date of completion.

Staff #2 had forwarded the letter to the ED Director and the Director of Admissions. Staff #2 indicated the investigating was still on going.

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PARKLAND HEALTH AND HOSPITAL SYSTEM ->

Report No. 1457

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PARKLAND HEALTH AND HOSPITAL SYSTEM

5201 HARRY HINES BLVD DALLAS, TX 75235

Jan. 21, 2011

VIOLATION: MEDICAL STAFF - ACCOUNTABILITY

Tag No: A0049

Based on interview and record review, it was determined the medical staff failed to be accountable to the governing body for the provision of services for 1 of 1 Patient [Patient #1] by Resident Physician and Supervising Physician, which resulted in Patient #1 requiring a Left Below the Knee Amputation on 12/23/09.

Findings Included:

The operative report dated [DATE] reflected, "Left Total Knee Arthroplasty...complications none...patient is a [AGE]-year-old female with chronic history of left knee pain and degenerative joint disease which failed conservative treatment...Surgeon [Resident Physician, Staff #7] and Supervising M.D. #11] present for all important portions of case..."[signed by Supervising Physician Staff #11].

The general care flowsheet dated 08/29/08 timed at 11:30 AM reflected, "received patient from RR [Recovery Room]...at 12:30 PM notified MD [Medical Doctor] about patient c/o [complaining of] pain and burning sensation to left leg..."

The staff progress note [documented by Medical Student #10] dated 08/30/08 timed at 8:31 AM reflected, "Patient has diffuse numbness of L [Left] LE [Lower Extremity]. Unable to wiggle toes or dorsiflex ankle...toes warm...good cap refill....monitor for end of nerve block and resumption of motor sensory activity of LLE [Left Lower Extremity]..."

The Staff progress note [documented by Resident Physician, Staff #7] dated 08/30/08 timed at 11:00 AM reflected, "agree with above...monitor nerve function for return..."

The general care flowsheet dated 08/30/08 timed at 4:00 PM reflected, "Toes warm to touch patient unable to wiggle toes, MD aware...patient complains of pain, medicated...at 21:15 feels tingling in left foot continue to monitor..."

The Staff progress note [documented by Medical Student #10] dated 08/31/08 timed at 8:36 [unknown time whether AM or PM] reflected, "Patient states that her foot has a burning sensation on medial plantar surface and that she is still unable to move toes or ankle...monitor for resumption of LLE motor function..."

The Staff progress note [documented by Resident Physician, Staff #7] dated 08/31/08 untimed reflected, "Agree..."

The Staff progress note dated 08/31/08 timed at 2:45 PM documented by a nurse reflected, "Noted decreased sensation to toes. Positive sensation to heel through mid foot...MD aware of decrease sensation and pain..."

The Staff progress note dated 09/01/08 timed at 1:00 PM [documented by Resident Physician, Staff #7] called to evaluate patient with

^{**}NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

persistent LLE pain...LLE positive for swelling, tight compressible compartments...concern for [DIAGNOSES REDACTED]...to OR [Operating Room].

No documentation was found from 08/29/08 to 08/31/08 indicting the supervising physician assessed Patient #1's condition and/or the resident physician's medical record entries.

The Intra-operative report dated [DATE] timed at 01:15 AM reflected, "Left Leg Compartment...procedure Fasciotomy left leg...at 02:14 PT [Patient] admitted to OR #18 as emergent case secondary to [DIAGNOSES REDACTED]..."

The first operative report dated [DATE] reflected, "Compartment of the left leg...findings...a deep posterior compartment with patchy necrosis, no posterior tibial pulse by Doppler...status post total knee arthroplasty approximately 2 days...following the procedure, the patient was unable to dorsiflex or plantarflex her ankle or her toes...the patient had new onset paresthesias in sural saphenous distribution...patient taken to operating room for compartment ...the posterior tibial artery was identified and there was no pulse palpable...all 4 sites were taken both proximally and distally...at this point there was concern the patient had a vascular injury as we could not obtain posterior tibial, dorsalis pedis or posterior pulses..."

The 09/01/08 general care flowsheet timed at 8:00 AM reflected, "Toes cold/vascular resident at bedside dopplering pulses unable to hear...patient has consented for OR...at 08:15 NPO [Nothing by mouth] for OR...at 9:30 AM off floor to OR..."

A second operative report dated [DATE] reflected, "High grade Left Popliteal Artery Injury...operation performed...left lower extremity arteriogram and left femoral artery to posterior tibial artery with vein....left lower extremity arteriogram demonstrated acute and abrupt cutoff height demonstrating high-grade injury of the left popliteal artery behind the knee with no identifiable run off on the angiogram....there was a weak monophasic signal in the posterior tibial artery at the end of the case...disposition....poor prognosis for bypass as well as limb salvage due to late grade of ischemia..."

The 09/01/08 nurses note timed at 8:00 PM reflected, "Pulse on LLE [Left Lower Extremity] not palpable. Foot warm...at 2400 ...no change in pulse...on 09/2/08 at 06:00 AM doctor...at bedside with vascular. Stated vascular may just wash out versus AKA [Above Knee Amputation]...No other changes."

The 09/02/08 Operative Report reflected, "Irrigation and debridement of left lower leg...vascular surgery was consulted..."

The 09/05/08 Operative Report reflected, "Debridement and irrigation and application of VAC [vacuum] wound dressing..."

The 09/08/08 Operative Report reflected, "Irrigation and debridement of the left leg and application of vacuum dressing to the left leg..."

The 09/12/08 Operative report reflected, "closure of the lateral wound, split-thickness skin graft to the medial wound and application of vacuum-assisted closure dressing to the medial wound..."

The Discharge Summary dated 09/19/08 reflected, "Patient continued to work with physical therapy and subsequently cleared physical therapy. The VAC [vacuum] dressing was taken down on 09/17/08 and there was evidence of good healing of the skin graft, which appeared to have taken well...the lateral site continued to perform well without [DIAGNOSES REDACTED], induration, or exudate...patient was discharged home on 09/19/08..."

The 12/23/09 Operative Report reflected, "Postoperative left total knee arthroplasty infection...operation performed amputation of lower extremity...this [AGE] year old female has had a very long and complicated course in regards to her left total knee arthroplasty...her last procedure consisted of a free flap to cover her total knee arthroplasty that was performed by plastics and was doing well up until 3 days ago when the patient was taken back to OR by plastic service and an infection was noted....recommendation was an amputation...."

On 12/10/10 at 9:25 AM, [M.D. #18] was interviewed. [M.D. #18] stated the hospital did not recognize Patient #1's case as a concern until the article in the local newspaper appeared in 2010. [M.D. #18] stated Patient #1's case was being reviewed and the peer review process was in progress. [M.D. #18] stated the hospital failed to identify the connection between the multiple surgeries Patient #1 underwent and the initial surgery performed 08/29/08.

On 12/30/10 at 1:00 PM [Staff #4] stated this event was missed by the hospital.

On 12/31/10 at 10:45 AM [Staff #1] was interviewed. Staff #1 stated communication and policy revisions on resident supervision had been done over the last two years. [Staff #1] stated the event was not identified after the surgical event and the surgical complications Patient #1 sustained.

On 12/31/10 at 1:15 PM [Resident Physician, Staff #7] was interviewed. [Resident Physician, Staff #7] stated he notified the supervising physician of Patient #1's medical changes but did not document it.

On 01/26/11 at approximately 4:30 PM [Staff #1] was asked to provide Resident Physician supervision policy for 2008. A hand written faxed response dated 01/26/11 timed at 19:22 PM reflected, "No formal policy and procedure for Resident Supervision in 2008 for...hospital..."

The public verification/physician profile for [Resident Physician, Staff #7] reflected, "Physician in Training Permit begin date 07/01/08 to 06/30/12."

The Texas Occupations Code Section 155.105. entitled, "Physician in Training Permit" (b) A physician-in training permit does not authorize the performance of a medical act by permit holder unless act is performed: 1) as a part of graduate medical education training program; and 2) under supervision of a physician.

Tag No: A0266

VIOLATION: QAPI MEDICAL ERRORS

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, it was determined the hospital failed to identify a medical error which occurred when 1 of 1 Patient [Patient #1] had a Left Total Knee Replacement on 08/29/08. Patient #1 sustained a Popliteal Artery Injury. The injury required Patient #1 to endure multiple surgical procedures and/or complications related to the surgery which resulted in a Left Below the Knee Amputation on 12/23/09.

Findings Included:

The operative report dated [DATE] reflected, "Left Total Knee Arthroplasty...complications none...patient is a [AGE]-year-old female with chronic history of left knee pain and degenerative joint disease which failed conservative treatment...Surgeon [Resident Physician, Staff #7] and [Supervising M.D. #11] present for all important portions of case..."

The general care flowsheet dated 08/29/08 timed at 11:30 AM reflected, "received patient from RR [Recovery Room]...at 12:30 PM notified MD [Medical Doctor] about patient c/o [complaining of] pain and burning sensation to left leg..."

The staff progress note [documented by Medical Student #10] dated 08/30/08 timed at 8:31 AM reflected, "Patient has diffuse numbness of L [Left] LE [Lower Extremity]. Unable to wiggle toes or dorsiflex ankle...toes warm...good cap refill....monitor for end of nerve block and resumption of motor sensory activity of LLE [Left Lower Extremity]..."

The Staff progress note [documented by Resident Physician, Staff #7] dated 08/30/08 timed at 11:00 AM reflected, "agree with above...monitor nerve function for return..."

The general care flowsheet dated 08/30/08 timed at 4:00 PM reflected, "Toes warm to touch patient unable to wiggle toes, MD aware...patient complains of pain, medicated...at 21:15 feels tingling in left foot continue to monitor..."

The Staff progress note [documented by Medical Student #10] dated 08/31/08 timed at 8:36 [unknown time whether AM or PM] reflected, "Patient states that her foot has a burning sensation on medial plantar surface and that she is still unable to move toes or ankle...monitor for resumption of LLE motor function..."

The Staff progress note [documented by Resident Physician, Staff #7] dated 08/31/08 untimed reflected, "Agree..."

The Staff progress note dated 08/31/08 timed at 2:45 PM documented by a nurse reflected, "Noted decreased sensation to toes. Positive sensation to heel through mid foot...MD aware of decrease sensation and pain..."

The Staff progress note dated 09/01/08 timed at 1:00 PM [documented by Resident Physician, Staff #7] called to evaluate patient with persistent LLE pain...LLE positive for swelling, tight compressible compartments...concern for [DIAGNOSES REDACTED]...to OR [Operating Room].

No documentation was found from 08/29/08 to 08/31/08 indicting the supervising physician assessed Patient #1's condition and/or the resident physician's medical record entries.

The Intra-operative report dated [DATE] timed at 01:15 AM reflected, "Left Leg Compartment...procedure Fasciotomy left leg...at 02:14 PT [Patient] admitted to OR #18 as emergent case secondary to [DIAGNOSES REDACTED]..."

The first operative report dated [DATE] reflected, "Compartment of the left leg...findings...a deep posterior compartment with patchy necrosis, no posterior tibial pulse by Doppler...status post total knee arthroplasty approximately 2 days...following the procedure, the patient was unable to dorsiflex or plantarflex her ankle or her toes...the patient had new onset paresthesias in sural saphenous distribution...patient taken to operating room for compartment ...the posterior tibial artery was identified and there was no pulse palpable...all 4 sites were taken both proximally and distally...at this point there was concern the patient had a vascular injury as we could not obtain posterior tibial, dorsalis pedis or posterior pulses..."

The 09/01/08 general care flowsheet timed at 8:00 AM reflected, "Toes cold/vascular resident at bedside dopplering pulses unable to hear...patient has consented for OR...at 08:15 NPO [Nothing by mouth] for OR...at 9:30 AM off floor to OR..."

A second operative report dated [DATE] reflected, "High grade Left Popliteal Artery Injury...operation performed...left lower extremity arteriogram and left femoral artery to posterior tibial artery with vein....left lower extremity arteriogram demonstrated acute and abrupt cutoff height demonstrating high-grade injury of the left popliteal artery behind the knee with no identifiable run off on the angiogram....there was a weak monophasic signal in the posterior tibial artery at the end of the case...disposition....poor prognosis for bypass as well as limb salvage due to late grade of ischemia..."

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The 09/12/08 Operative report reflected, "closure of the lateral wound, split-thickness skin graft to the medial wound and application of vacuum-assisted closure dressing to the medial wound..."

The Discharge Summary dated 09/19/08 reflected, "Patient continued to work with physical therapy and subsequently cleared physical therapy. The VAC [vacuum] dressing was taken down on 09/17/08 and there was evidence of good healing of the skin graft, which appeared to have taken well...the lateral site continued to perform well without [DIAGNOSES REDACTED], induration, or exudate...patient was discharged home on 09/19/08..."

The 12/23/09 Operative Report reflected, "Postoperative left total knee arthroplasty infection...operation performed amputation of lower extremity...this [AGE] year old female has had a very long and complicated course in regards to her left total knee arthroplasty...her last procedure consisted of a free flap to cover her total knee arthroplasty that was performed by plastics and was doing well up until 3 days

ago when the patient was taken back to OR by plastic service and an infection was noted....recommendation was an amputation...."

On 12/10/10 at 9:25 AM, [M.D. #18] was interviewed. [M.D. #18] stated the hospital did not recognize Patient #1's case as a concern until the article in the local newspaper appeared in 2010. [M.D. #18] stated Patient #1's case was being reviewed and the peer review process was in progress. [M.D. #18] stated the hospital failed to identify the connection between the multiple surgeries Patient #1 underwent and the initial surgery performed 08/29/08.

On 12/30/10 at 1:00 PM [Staff #4] stated this event was missed by the hospital.

On 12/31/10 at 10:45 AM [Staff #1] was interviewed. [Staff #1] stated communication and policy revisions on resident supervision had been done over the last two years. [Staff #1] stated the event was not identified after the surgical event and the surgical complications Patient #1 sustained.

On 12/31/10 at 1:15 PM [Resident Physician, Staff #7] was interviewed. [Resident Physician, Staff #7] stated he notified the supervising physician of Patient #1's medical changes but did not document it.

On 01/26/11 at approximately 4:30 PM [Staff #1] was asked to provide Resident Physician supervision policy for 2008. A hand written faxed response dated 01/26/11 timed at 19:22 PM reflected, "No formal policy and procedure for Resident Supervision in 2008 for...hospital..."

The Hospital Bylaws with a revision date of 03/25/08 reflected under section 7 entitled, "Quality and Risk Management Committee" the following: "The Quality and Risk Management Committee shall consist of a Chairman and two other Board members. Administration will provide...reports on performance improvement and quality and risk management activities...these reports will address such issues as clinical safety, compliance, regulatory and accreditation activities..." Noted the hospital was unaware of Patient #1's case until if was brought to the hospitals attention through the media.

Tag No: A0450

VIOLATION: MEDICAL RECORD SERVICES

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, the hospital failed to maintain complete medical records for 1 of 1 patients [Patient #1] treated and discharged after 09/19/08. The medical record entries were not complete, dated, timed, and/or authenticated according to hospital policy.

Findings Included:

1) Patient #1's surgery procedure notes dated 08/29/08 to 09/12/08 reflected the following:

The 08/29/08 note reflected, "Diagnosis: Arthritis Left Knee." The note documented no entry time.

The 09/01/08 note reflected, "Diagnosis: [DIAGNOSES REDACTED] Left Leg." The note documented no entry time. A second 09/01/08 note reflected, "diagnosis is [DIAGNOSES REDACTED]] Total Knee Replacement." No entry time was documented.

The 09/08/08 note reflected, "Diagnosis: Complex wounds L [Left] leg secondary to Fasciotomies and Vascular repair." The note documented no entry time.

The 09/12/08 note reflected, "Diagnosis: Wounds of L [Left] leg S/P [Status Post] Fasciotomy. The note documented no entry time.

- 2) The 09/01/08 Intensive Care Unit Progress note under the section entitled, "Resident Documentation" reflected a time of "22:00." The Resident documentation reflected, "51 year old F [Female] S/P [Status Post] TKA [Total Knee Arthroplasty] 08/29/08 for Osteoarthritis, complicated by [DIAGNOSES REDACTED]] [DIAGNOSES REDACTED] S/P [Status Post] L [Left] LE [Lower Extremity] 09/01/08...patient lost left lower extremity pulse..." The section of the document entitled, "Attending Documentation" reflected no documentation.
- 3) The Operative Reports dated 08/29/08 to 09/12/08 reflected the following:

The operative report dated [DATE] was dictated by [Resident Physician #7] at "09:16:40." [Supervising Physician #11] signed the dictated report. No date and time was documented.

The operative report dated [DATE] was dictated by [Resident Physician #14] at "03:36:25." [Supervising Physician #13] signed the dictated report. No date and time was documented.

The operative report dated [DATE] was dictated by [Resident Physician #16] at "18:19:21." [Supervising Physician #15] signed the dictated report. No date and time was documented.

The operative report dated [DATE] was dictated by [Resident Physician #17] at "19:27:59." [Supervising Physician #15] signed the dictated report. No date and time was documented.

The operative report dated [DATE] was dictated by [Resident Physician #14] at "22:50:15." [Supervising Physician #11] signed the dictated report. No date and time was documented.

The operative report dated [DATE] was signed by [Supervising Physician #15] but no date and time was documented.

- 4) The Discharge Summary dated 09/19/08 was dictated by [Resident Physician #17] at "11:01:00." [Supervising Physician #11] signed the report but did not date and time the entry.
- 5) The "Physician" order signature was not timed and dated for the following dates:

The 09/3/08 verbal order timed at 7:00 AM and the 09/03/08 verbal order timed at 10:20 AM.

6) The "Physicians Orders" were not dated, timed and authenticated by the nurse for the following dates:

09/01/08 timed at 3:30 PM order, the 09/04/08 order timed at 7:00 AM, and the 09/04/08 order timed at 10:00 AM.

7) The surgical consent dated 08/24/08 timed at 11:00 AM reflected, [Resident Physician, Staff #7] signed the consent along with Patient #1. After the surgery was performed on 08/29/08 the consent form reflected, no signature of "surgeon of record [to be signed after procedure]..."

On 12/30/10 at approximately 3:30 PM [Staff #2] verified the above medical record entries did not have dates, times and written authentication.

The Hospital Health and Hospital System Rules and Regulations with a revision date of 08/22/06 reflected under section two, "All entries in the medical record shall be authenticated, dated, and timed by the individual who is responsible for ordering, providing, or evaluating the services furnished..."

The policy entitled, "Transcription of Provider Orders" with a revision date of 11/08 reflected, "All orders must be verified and signed by a registered nurse...the nurse shall verify each set of physician's/other provider's orders shall have full signature, title and ID # of the nurse who checked them, as well as the date and time.



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HARRIS HEALTH SYSTEM ->

Report No. 1515

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

HARRIS HEALTH SYSTEM

2525 HOLLY HALL HOUSTON, TX 77054

Jan. 21, 2011

Tag No: A0386

VIOLATION: ORGANIZATION OF NURSING SERVICES

Based on review of nurse staffing rosters, review of personnel/training files and review of hospital policy the Director failed to ensure 8 of 9 nursing personnel assigned to the rehabilitation unit were provided with eight hours annual training on the identification of patient abuse and neglect and unethical/unprofessional conduct as required by hospital policy.

Findings:

Review of the staffing roster for the rehabilitation unit for the 7 am - 7pm shift on 10/14/2010 reflected the assignment of 4 RN's, 4 Certified Nurses Aids(CNA) and one unit secretary. In review of corresponding personnel/training files, 8 of the 9 personnel had no evidence of 8 hours annual training in the identification of patient abuse and neglect that is required by hospital policy.. (Personnel # 1,2,3,5,6,7,8,9)



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2525 HOLLY HALL HOUSTON, TX 77054 | Government - Hospital District or Authority

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Report date Number of violations

Jan. 21, 20111 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. **Incomplete reports**

No incomplete reports available.



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Tag No: A0144

Tag No: A0395

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COVENANT MEDICAL CENTER ->

Report No. 1470

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

COVENANT MEDICAL CENTER 3615 19TH STREET LUBBOCK, TX 79410 Jan. 13, 2011

VIOLATION: PATIENT RIGHTS: CARE IN SAFE SETTING

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on the review of two separate records for patient #1, he suffered skin breakdown on both feet and his coccyx between 12/25/10 and 12/27/10, while hospitalized for pylonephritis. He was discharged on ,d+[DATE] at 1500 with his caregivers. On his second admission at 1710 on 12/28 in an ED assessment there were wounds present on the left heel, back of right thigh and bilateral buttocks, as well as bilateral 4+ edema to both hands and feet. It could not be determined that the patient was safely cared for during his hospitalization .

Findings were:

Based on review of the two admission for patient #1 he was admitted on [DATE] and his skin assessment was documented as clear. He was ambulatory with his walker and toileted independently. On 12/27 the R.N. documented stage I skin breakdown on the patients coccyx, right and left feet. On 12/25 the skin assessment was blank except for "none" written indicating clear skin. On 12/26 the skin assessment for both shifts indicated "none" for skin breakdown. On 12/27 the first shift indicated no skin breakdown, however, the second shift indicated three wounds described as "unstageable". The first was on the coccyx, with slough, granulation and epithelialization. The left and right feet were described with slough, eschar, granulation and epithelialization. On the 28th the area for wounds/incision/breakdown was marked as "none". He was discharged on ,d+[DATE] at 1500 to caregivers.

At 1710 on 12/28 this patient was brought back to the hospital via ambulance to the emergency department. He had a temperature of 102 degrees and was very weak being unable to walk or stand. On admission to the floor on 12/29 his wounds were documented. Also on the 29 and 30th his scrotum and penile area were noted as red and swollen with no further documentation. No documentation of physician notification.

He was documented as bedridden and transfer with assist times 4 throughout his stay.

The patient was incontinent of urine and stool, and required cleaning by nursing staff.

No bathing was documented on 12/31, 1/1, 1/3 1/4, 1/6 and he refused on 1/5.

Although this patient was independent in a group home, after his hospital stay, he required placement in a nursing facility for rehabilitation as he was now a total care patient.

This was confirmed in interview on 1/13 with the quality management staff at the hospital.

VIOLATION: RN SUPERVISION OF NURSING CARE

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

The hospital failed to ensure that the nursing care for patient #1 was supervised or evaluated by a registered nurse as this patient was admitted to the hospital on 12/25/10 with clear skin; at discharge on 12/28 the caregivers saw wounds on the patient's feet and coccyx when he was brought to the group home. After the second admission, on 12/28 to 1/6/11, the patient was no longer able to walk or stand.

Findings were:

1. Patient #1 was admitted on [DATE] and his skin assessment was documented as clear. He was ambulatory with his walker. On 12/25 the skin assessment was blank except for "none" written indicating clear skin. On 12/26 the skin assessment for both shifts indicated "none" for skin breakdown. On 12/27 the first shift indicated no skin breakdown, however, the second shift indicated three wounds described as "unstageable". The first was on the coccyx, with slough, granulation and epithelialization. The left and right feet were described with slough, eschar, granulation and epithelialization. On the 28th the area for wounds/incision/breakdown was marked as "none". He was discharged on ,d+[DATE] at 1500 to caregivers.

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VIOLATION: UNSPECIFIED CATEGORY

Tag No:

Tag No: A0622

Based on review of the medical record for patient #1, there was no evidence of any discharge planning. Patient #1 was hospitalized between 12/25 and 12/28. The initial discharge planning space was blank on admission nursing assessment; there were no notes from a discharge planner or a social worker.

Findings were:

Patient #1 was hospitalized between 12/25 and 12/28. There was not a case management discharge plan of care. The initial assessment for discharge planning on the admission nursing notes was blank. There was no evaluation if the patient could continue to be cared for in the same living situation prior to hospitalization. This was confirmed in interview on 1/13/11 with the quality management staff.

VIOLATION: COMPETENT DIETARY STAFF

Based on review of the clinical record from 12/28 through 1/6 for patient #1 and interview with staff, the clinical nutrition staff failed to follow a physician order for a dietary consult as the patient required the skin care protocols, to be initiated for the patient's open wounds

Findings were:

Although the skin care protocols were ordered to be followed as patient #1 had four open wounds (left foot, left thigh and bilateral buttocks) there was no documentation to indicate that the order for the Dietary consult was completed during the hospitalization. This was confirmed through interview on 1/13 with the quality management staff.



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Report date Number of violations

Jan. 13, 20114 (click for details) Read full report

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No incomplete reports available.



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WISE REGIONAL HEALTH SYSTEM WISE REGIONAL HEALTH SYSTEM

609 MEDICAL CENTER DRIVE DECATUR, TX 76234 | Government - Hospital District or Authority

View hospital's federal Hospital Compare record

Report date Number of violations

Jan. 13, 20112 (click for details) Read full report

Some state health departments and regional offices of the Centers for Medicare and Medicaid Services sometimes did not upload their inspection reports into a central computer system that could then be shared by us. In such cases, CMS identified the dates of the missing inspections and the number of deficiencies identified. You can request the actual reports from CMS or your state health department. **Incomplete reports**

No incomplete reports available.



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Report No. 1510

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WISE REGIONAL HEALTH SYSTEM

609 MEDICAL CENTER DRIVE DECATUR, TX 76234

Jan. 13, 2011

VIOLATION: PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES

Tag No: A0122

Tag No: A0123

Based on interviews and record review, the hospital grievance process did not include a time frame for the provision of a written response.

In an interview at 10:15 AM on 01/12/11 with the Director of Customer Service (Personnel # 4), she was asked what time frames the hospital used to A: review a grievance, and B: provide a written response. She said that they review and and attempt to resolve a grievance within 7 days, but they do not have a time frame for the provision of a written response regarding the hospital's final determination of the grievance.

The hospital's "Complaints" policy, last revised 05/04/06, noted the following regarding:

A: the time frame for review of a grievance:

-"The hospital will review, investigate and attempt to resolve each patient's grievance within a reasonable time frame, usually seven (7) days."

B: the provision of a written response:

- -"If the grievance will not be resolved, or if the investigation is not or will not be completed within seven (7) days, the patient or the patient's representative will be advised of when to expect a response."
- -"A written response of the hospitals determination regarding the grievance will be provided to the patient or the patient's representative."

In an interview at 3:25 PM on 01/13/11 with the Vice President of Quality/Physician Relations (Personnel # 2), she agreed that the hospital's "Complaints" policy and their grievance process did not include a time frame for providing a written response to the patient with the hospital's final determination of the grievance.

VIOLATION: PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION

NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interviews and record review, the hospital had not followed their grievance process, nor regulatory requirements, in that, they had not provided the patient (Patient # 1), with an initial response within their 7 day timeframe, nor had they provided a written notice of its decision that contained the following components: A. the steps taken to investigate the grievance, B. the name of the hospital contact person, C. the results of the grievance process, or D. the date of completion.

In an interview at 10:15 AM on 01/12/11 with the Director of Customer Service (Personnel # 4), she was asked to describe their grievance process. She said that her job is to take in all complaints and grievances, to complete a "Complaint Information Form," and to refer those

complaints to department managers, who are responsible for following and providing written responses from their own areas. When asked if the complainant (Patient # 1), had filed a complaint or grievance while she was hospitalized from [DATE] to 03/07/09, she said "no," but that she had received a telephone call from her on 08/10/09, and she had completed a Complaint Information Form, #304, which she had referred out to the department manager (Personnel #8) and to the Director of Security (Personnel #5) for their review and follow-up. Personnel #4 said that she does not keep a complaint log, and even though she had spoken to the complainant several times by telephone, that she had not documented the dates and times of those interactions. She said that the department managers are responsible for sending written responses to the complainants, and in this case, she had helped to coordinate different areas associated with this one complaint.

Review of the hospital's written letter from Personnel # 4 to the complainant (Patient # 1), dated 08/20/09, stated that "this letter is in response to the concerns that you shared with me, on August 10, 2009, regarding your care provided here..., on March 6, 2009. The information you provided was immediately reported, an investigation was conducted, and all information was reviewed for process improvement opportunities. I want to thank you for sharing your concerns with..."

Personnel # 4 verified that she had sent the above written response letter to Patient # 1 dated 08/20/09, after receiving the initial telephone grievance on 08/10/09, 10 days earlier. She said that this was the hospital's first response, and agreed that it had not been sent within their policy time frame of 7 days. She also agreed that this letter had not included: A. the steps taken to investigate the grievance, B. the name of the hospital contact person, C. the results of the grievance process, or D. the date of completion. She stated that, although this letter said to call her for any additional questions, that she was not the designated hospital contact person for this complainant, as that would be the role of the department manager.

The hospital "Complaints" policy, last revised 05/04/06, noted the following process to resolve patient grievances:

- 1. "The hospital will review, investigate and attempt to resolve each patient's grievance within a reasonable time frame, usually seven (7)
- days."
 2. "If the grievance will not be resolved, or if the investigation is not or will not be completed within seven (7) days, the patient or the patient's representative will be advised of when to expect a response."
- 3."A written response of the hospitals determination regarding the grievance will be provided to the patient or the patient's representative. The written response should contain the name of a 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. Department managers are responsible for providing the written response for grievances received which pertain to their areas."

In an interview at 1:10 PM on 01/13/11 with the Medical/Surgical department manager (Personnel # 8), when asked if she had known about this grievance at the time it had happened on 03/07/09, she said "no," that it had not been reported to her at that time, even though Patient # 1's verbal complaints to the nurse and two house supervisors rose to the level of a grievance on that date. When asked for a record of her department's Grievance Log, she provided the log for March 2009, which did not contain this grievance. She verified that she had not sent a final written response to the complainant, as required by hospital policy...

In an interview at 10:45 AM on 01/13/11 with the Director of Security (Personnel # 5), he confirmed that he had sent a letter to Patient # 1 in response to her request for a copy of the video taken outside of the emergency department the evening of 03/07/09, in which he stated that "the videos are the property of the hospital, and can only be acquired if ...subpoenaed by a Magistrate." Personnel # 5 confirmed that his written response to Patient # 1 did not include: A. the steps taken to investigate the grievance, B. the name of the hospital contact person, C. the results of the grievance process, or D. the date of completion.

In an interview at 3:25 PM on 01/13/11 with the Vice President of Quality/Physician Relations (Personnel # 2), she agreed that the grievance process noted in the hospital's "Complaints" policy, and the regulatory requirements for a written response for Patient # 1 had not included: A. the steps taken to investigate the grievance, B. the name of the hospital contact person, C. the results of the grievance process, or D. the date of completion.

Training

Resources

Tag No: A0167

Johs

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Report No. 1484

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

EAST TEXAS MEDICAL CENTER 1000 SOUTH BECKHAM STREET TYLER, TX 75701 Jan. 5, 2011

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on record review, the facility failed to follow their own policy and procedure for obtaining time limited orders for restraints from the physician for one of one patients (#1). Restraint and Seclusion of Patients.

Review of policy #1600.112, titled "Behavioral Health Center /Restraint and Seclusion of Patients, Statements 25,26, 28, and 30 revealed

the following:

#25. If criteria for release has not been met by the time limit on mechanical restraint or seclusion, the RN calls the physician and receives a telephone or verbal order to continue the seclusion or restraint for up to: 1hour (child 8 or under), 2 hours (9-17), 4 hours (18 and older). Physical restraints may never be continued. If the patient still does not meet behavioral criteria for release after the time frame for the continuation, calls the physician and obtains a new order. 26. The Physician comes back to the facility, assesses the patient, documents findings and authenticates the verbal order. 28. The RN releases the patient from seclusion or restraint as soon as: Behavioral criteria are met, the patient falls asleep, and returns patient 's belongings that were removed. 30. The RN assists the patient to reintegrate back into the community milieu for 30 minutes after release and documents the interventions used and the patient 's response in the progress notes.

Review of Multidisciplinary Progress Notes (MDPN) by Registered Nurse (RN) #6 for 12/09/2011, timed 10:30 revealed the patient attacked a staff member and was placed in restraints and seclusion. Review of second entry in the MDPN by RN #6, timed 11:35 revealed patient continues to be aggressive, agitated and threatening. Patient remains in restraint and seclusion. Review of third entry in the MDPN by RN #6, timed 11:35 revealed patient continues to be aggressive, agitated and threatening. Patient remains in restraint and seclusion. Review of third entry in the MDPN by RN #6, timed 13:45 (1:35PM) revealed patient continues to be upset, yelling, cursing and unwilling to cooperate with treatment. Review of fourth entry in the MDPN by RN #6 had no time. Entry revealed " Patient still in seclusion and Behavioral still the same, yelling, cursing to self and at staff " . Review of fifth entry of the MDPN by RN #6, timed, 16:00 (4:00PM) revealed " Patient transferred to RSH (Rusk State Hospital) per physician 's order " .

Review of the Restraint/Seclusion Monitoring Log (log) (a form with check offs used by staff to monitor patient and restraints every fifteen minutes) was initiated by staff #6 at 10:50 AM and revealed a RN assessment was done and a physician assessment was done. No other entries were made by staff #6. An entry on the log at 14:30 (2:30PM) revealed a physician assessment was done. No documentation was found in the medical record of the physician 's findings for the assessment.

Review of " Physician 's Orders for Restraint/ Seclusion " by physician #7 revealed restraint and seclusion for up to 4 hours beginning at 10:30AM and ending by 14:30 (2:30PM), type of restraint, physical hold to body net (holding the patient with force and applying a net type of restraint that restricts patient 's movement). The order dated 12/09/2011and timed 10:45 AM. No other orders to continue restraint were documented in the patient 's chart. Reviewed order written by #7 at 3:45PM revealed " (1) Transfer to RSH. (2) Change to observation status " .

Further review of the patient 's chart revealed no order was obtained to continue the restraints after the first four hours. RN #6 failed to call for a verbal order to continue the restraints and physical restraints were continued. Order was received at 3:45PM, change to observation status. No evidence of documentation of an RN assessment or documentation of a change in the patient 's behavioral status. No evidence of an attempt to reintegrate the patient into the social environment.

During an interview at 3:00pm in the Administration Conference room Staff #1 confirmed there was no physician 's order to continue the restraint and seclusion of the patient.

Tag No: A0168

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Based on record review and interview the facility failed to follow their own policy and procedure on Restraint and Seclusion of Patients. The facility failed to obtain a physician 's order for the continuation of restraint and seclusion of 1 of 1 patients reviewed.

Review of policy 1600.112, titled "Behavioral Health Center /Restraint and Seclusion of Patients, Statements 25,26,28,and 30 revealed

the following:

" 25. If criteria for release has not been met by the time limit on mechanical restraint or seclusion, calls the physician and receives a telephone or verbal order to continue the seclusion or restraint for up to: 1 hour (child 8 or under), 2 hours (9-17), 4 hours (18 and older). Physical restraints may never be continued. If the patient still does not meet behavioral criteria for release after the time frame for the continuation, calls the physician and obtains a new order. 26. The physician comes back to the facility, assesses the patient, documents findings and authenticates the verbal order. 28. The RN releases the patient from seclusion or restraint as soon as: Behavioral criteria are met, the patient falls asleep, and returns patient 's belongings that were removed. 30. The RN assists the patient to reintegrate back into the community milieu for 30 minutes after release and documents the interventions used and the patient 's response in the progress notes. "

Review of Multidisciplinary Progress Notes (MDPN) by Registered Nurse (RN) #6 for 12/09/2011, timed 10:30 revealed the patient attacked a staff member and was placed in restraints and seclusion. Note ends with "See Restraint Packet paper work". Review of second entry in the MDPN by RN #6, timed 11:35 revealed patient continues to be aggressive, agitated and threatening. Patient remains in restraint and seclusion. Note reads "See Restraint/ incident paper work" Review of third entry in the MDPN by RN #6, timed 13:45 (1:35PM) revealed patient continues to be upset, yelling, cursing and unwilling to cooperate with treatment. Review of fourth entry in the MDPN by RN #6 has no time. Entry revealed "Patient still in seclusion and Behavioral still the same, yelling, cursing to self and at staff". Review of fifth entry of the MDPN by RN #6, timed, 16:00 (4:00PM) revealed "Patient transferred to RSH (Rusk State Hospital) per physician, so order." physician 's order

Review of the Restraint/Seclusion Monitoring Log (log) (a form with check offs used by staff to monitor patient and restraints every fifteen minutes) was initiated by staff #6 at 10:50 AM and revealed a RN assessment was done and a MD assessment was done. No other entries were made by staff #6. An entry on the log at 14:30 (2:30PM) revealed a physician assessment was done. No documentation was found in the medical record of the physician 's findings for the assessment.

Review of "Physician's Orders for Restraint/ Seclusion" by physician #7 revealed restraint and seclusion for up to 4 hours beginning at 10:30AM and ending by 14:30 (2:30PM), type of restraint, physical hold to body net (holding the patient with force and applying a net type of restraint that restricts patient's movement). The order dated 12/09/2011and timed 10:45. No other orders to continue restraint were documented in the patient 's chart. Reviewed order written by #7 at 3:45PM revealed (1) Transfer to RSH. (2) Change to observation status.

Further review of the patient 's chart revealed no order was obtained to continue the restraints after the first four hours. RN #6 failed to call for a verbal order to continue the restraints and physical restraints were continued. Order was received at 3:45PM, change to observation status. No evidence of documentation of an RN assessment or documentation of a change in the patient 's behavioral status.

During an interview at 3:00pm in the Administration Conference room Staff #1 confirmed there was no physician 's order to continue the restraint and seclusion of the patient.