

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0000	<p>This visit was for the investigation of one (1) State complaint.</p> <p>Complaint number: IN00107655 Substantiated: deficiency related to allegation cited.</p> <p>Date of survey: 08-15-12</p> <p>Facility number: 005087</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 08/24/12</p>	S0000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S1510	<p>410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following: (A) Provision for the care of the disturbed patient. (B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care. (C) Provision for transfer of patients when care is needed which cannot be provided.</p> <p>Based on document review and staff interview, the facility failed to ensure patients were triaged in a timely fashion according to facility policy for 1 of 5 patients (patient #2).</p> <p>Findings include:</p> <p>1. Facility policy titled "Triage of Emergency Department Patients" last reviewed/revised 1/10 states under policy on page 1: "Patients who present to the ED will be taken to a triage area by a medically qualified staff member (RN, LPN, Paramedic), or directly to a room</p>	S1510	The responsible party for making sure this plan of correction is fully implemented is Betty Sease, Manager of Emergency Department and Respiratory Therapy, with oversight provided by Dana Muntz, Chief Nursing Officer. A list of Triage nurse duties was developed by Betty Sease, Manager of Emergency Department. This list of duties was shared with all ED associate that perform triage duties. Hospital policy, competencies, and evaluations were in place, but staff needed to be re-educated on proper procedures. The ED Manager also educated	08/24/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>for a medical screening exam." Page 2 states under procedure: "A. 1. Registration will notify the Emergency Department Nurse that there is a patient to be triaged. 2. The patient will be taken to the triage area, where a triage assessment will be performed in a timely manner...."</p> <p>2. Review of patient #2 medical record indicated the following: (A) ER Registration Short Form" was completed and indicated the patient arrived at facility at 2046 with complaint of possible strep throat. (B) The patient was not triaged until 2245.</p> <p>3. Review of ED log indicated a patient had not been triaged since 2058, therefore the triage nurse was not triaging other patients during this timeframe.</p> <p>4. Staff member #1 indicated the following in interview beginning at 10:30 a.m. on 8/15/12: (A) A patient presents to the registration desk and completes the "half form". The registration clerk gets a triage nurse who takes the patient to triage or to a bed if a bed is available. (B) Triage is completed immediately and a patient is not sent to the waiting room without being seen. (C) From 10 a.m.-10 p.m. a specific</p>		<p>associates on proper protocols if ED staff are all busy with other patients: 1. Get assistance from Respiratory Therapy, 2. Get nurse from Surgery or Inpatient unit if they are available, 3. Call in Manager or another nurse. All triage trained associates were educated by 8/24/2012. Monthly spot checks are done from the Emergency Department Log book, to see if any patients were not provided with an "immediate assessment". This data is reported to the monthly ED committee meeting for review.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151314	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>person is assigned to triage.</p> <p>(D) He/she verified that patient #2 should have been triaged prior to 2245 as indicated in the record.</p> <p>5. Staff member #4 indicated the following in interview beginning at 12:05 p.m. on 8/15/12: (A) Triage is an immediate process when the patient arrives and occurs within 10 minutes.</p> <p>6. RN #2 indicated the following in phone interview beginning at 9:55 a.m. on 8/22/12: (A) Patients get triaged as soon as nursing staff is made aware the patient is there. The "half sheet" is laid on the nurse station by the registration clerk.</p>				