

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151309	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2013
NAME OF PROVIDER OR SUPPLIER ST VINCENT CLAY HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 E NATIONAL AVE BRAZIL, IN 47834		
(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	
S000000	<p>This visit was for the investigation of one (1) State complaint.</p> <p>Date of survey: 3/12/13</p> <p>Facility number: 005046</p> <p>Complaint number: IN00105656 Substantiated; Deficiency related to allegation cited.</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 03/19/13</p>	S000000			

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.

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S000946	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-7 (c)(4)</p> <p>(c) Drugs and biologicals shall be prepared for administration and administered as follows:</p> <p>(4) In accordance with the signed written orders of the practitioner or practitioners responsible for the patient's care. When verbal or telephone orders are used they shall be accepted only by personnel that are authorized to do so by the medical staff rules.</p> <p>Based on document review and staff interview, the facility failed to ensure the nursing staff followed physician orders for 1 of 5 patients. (patient #1)</p> <p>Findings include;</p> <p>1. Review of patient #1 medical record indicated the following:</p> <p>(A) He/she presented to the emergency department on 3/12/12 with chief complaint of nausea, vomiting, diarrhea, and aching "all over".</p> <p>(B) Admission orders were written by M.D. #1 at 6:25 a.m. on 3/12/12 which included, but was not limited to, an order for Zofran 4 mg every 4 hours prn (as needed) for nausea or vomiting.</p> <p>(C) Narrative nurses notes at 10:45 a.m. on 3/12/12 indicated the patient vomited approximately 300 cc. dark liquid. The</p>	S000946	<p>The CNO and Nurse Manager met with the RN caring for this particular patient on 03/14/13. The appropriate Disciplinary Action was taken. This RN and all other staff nurses will be re-educated on documentation and responsibility to follow the physician's orders unless there is reason to question harm to the patient. Nursing staff were re-educated on hospital policy NS2.27, "Receiving and Transcribing Physician Orders," as part of the Medical-Surgical Department Staff meetings on March 14 and 18, 2013. It will be discussed at the upcoming April meetings and "Read and Sign" on this policy was distributed on March 18, 2013. When the RN responsible for this patient's care was interviewed, she did not recall any reason why she did not administer the Zofran on 03/12/12. Her documentation</p>	04/24/2013			

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	<p>patient was not given Zofran for the vomiting.</p> <p>(D) Facility document titled "MEDICAL-SURGICAL FLOWSHEET" indicated that the patient had 1140 cc of emesis (vomiting) at 4:00 p.m. on 3/12/12. The patient was not given Zofran for the vomiting.</p> <p>2. Document titled "Therapy Description" from pharmacy verified that patient #1 did not receive Zofran for the nausea/vomiting that was documented at 10:45 a.m. or 4:00 p.m. on 3/12/12.</p> <p>3. Staff member #1 reviewed the medical record information for patient #1 at 1:45 p.m. on 3/12/13 verifying that patient #1 did not receive medication for nausea/vomiting that was documented at 10:45 a.m. and 4:00 p.m. on 3/12/13.</p>		<p>indicated at 10:45 a.m. on 03/12/12: "Patient has been up to bathroom per self. Vomited in bag approximately 300 cc dark liquid seen and poured down toilet. Quiet and does not speak." The responsible RN explained the "1140 cc" of emesis which was recorded on the "Medical-Surgical Flowsheet" at 16:00 hours was a 'grand total' for the period of 04:00 to 16:00 since that is when Intake and Output Records are retrieved and totalled. "1140 cc" emesis was recorded on the "Graphic Vital Signs Record," form #SVC068, as a total for that 12-hour period. Since this survey, the "Medical-Surgical Flowsheet" and "Graphic Vital Signs Record" have been revised to make the proper documentation of emesis clearer. Education of the revised forms will occur at the April 17, 23, and 24, 2013 departmental staff meetings. A monthly Performance Improvement initiative will begin to randomly monitor PRN medications, i.e. anti-emetic orders and the patient's receipt of such medication based on their c/o symptoms and signs observed by the nurse. The findings will be reported at the monthly Quality Council meeting.</p>		