

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

PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2011
NAME OF PROVIDER OR SUPPLIER GIFFORD MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 44 SOUTH MAIN STREET RANDOLPH, VT 05060	
(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
C 000	INITIAL COMMENTS	C 000	C271 – 485.635(a) Patient Care Policies Care not provided in accordance with facility policy Concerns Identified: 1. Patient vital signs not monitored after medication administration 2. Patient vital signs not monitored prior to discharge 3. Patient with abnormal vital signs on admission not reassessed Corrective Action: 1. Revision of Emergency Department Standards of Care Policy to include clarification for parameters for recheck of vital signs (II. H.2.3.4) 2. Mandatory education of ED nursing and physician staff to revision of policy and expectations for vital signs monitoring. Power point presentation and post test for all ED nursing staff. 3. Parameters for vital signs posted in ED nursing station. 4. Nursing staff to discharge patients to ensure pre discharge vital signs taken and recorded per policy. Monitoring: 1. ED staff to concurrently review X 6 months their ED records prior to shift end to ensure vitals signs documented per policy. 2. ED nurse manager will monitor compliance to VS documentation by random audit of 30 closed ED records/month X 6 months. 3. Concurrent review & monitoring to continue until compliance 100%, then sample 30 records per quarter X 12 months to ensure continued compliance to policy. 4. Findings will be reported in ED Committee meetings as well as individual feedback to staff. Completion Date: 1. Policy revision completed March 9, 2011 2. Staff notified of changes and expectations by March 11, 2011 3. Monitoring to start by the week of March 21, 2011	
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on record review and staff interview nursing staff failed to provide health care services in accordance with facility policies during the provision of care in the Emergency Department for 2 of 21 records reviewed. (Patients #3 and #14). Findings include: 1. Per review on 2/14/11, Patient #3 was treated in the Emergency Department (ED) on 11/10/10 for an allergic reaction. The patient's vital signs were recorded at 2220 when triaged. At 2300 the patient was examined by the ED physician who prescribed Pepcid 20 mg. IVP (intravenously push); Solu-Medrol 125 mg. IVP and Benadryl 50 mg. IVP for symptoms that included ".....a wheal and flare reaction particularly on the forearms and the anterior chest where h/she has been scratching". Over the course of the 2 hours the patient received treatment, nursing staff failed to monitor the patients vital signs especially after medication administration or prior to discharge. Per review of the "Emergency Department Nursing Standards of Care", effective 07/06/2010, states "All patients will be re-assessed prior to discharge (including vital signs). No vital signs	C 271		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susaw R. Peterson TITLE: Director of Quality Mgmt (X6) DATE: 3-10-2011

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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C 271	<p>Continued From page 1 were recorded prior to discharge of this patient.</p> <p>2. Per record review Patient #14 presented to the ED on the evening of 1/1/11 complaining of "severe" dental pain. The patient's vital signs were documented at 11:40 PM, during triage assessment, and revealed an elevated BP reading of 152/97 as well as elevated pulse rate of 109. Although the patient was discharged just 30 minutes later, at 12:10 AM on 1/2/11, nursing staff failed to reassess the vital signs prior to discharge, in accordance with the facility's policy, "Emergency Department Nursing Standards of Care". The policy states: "H. Documentation will include; 3. Patients with abnormal vital signs on admission to the ED will have vital signs repeated prior to being discharged, admitted or transferred." During interview, at 1:01 PM on 2/14/11, the VP of Hospital Services confirmed the lack of reassessment of the patient's vital signs prior to discharge.</p>	C 271	<p>3/24/11 C-271- POC Accepted J. J. Intosh, RN</p>	
C 276	<p>485.635(a)(3)(iv) PATIENT CARE POLICIES</p> <p>[The policies include the following:]</p> <p>rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.</p> <p>This STANDARD is not met as evidenced by:</p>	C 276		

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C 276	<p>Continued From page 2</p> <p>Based on staff interviews and record review Pharmacy failed to develop an effective process for assuring timely dispensation and administration of all physician ordered medications for patient use. Findings include:</p> <p>Per review of medical records, for 2 separate inpatient stays from 11/22/10-11/24/10 and from 12/14/10-12/17/10, Patient #26 did not receive a physician ordered daily medication during either of the respective hospital stays. The patient who was admitted to the facility on 11/22/10, had a physician order, dated 11/22/10, that directed nursing staff to administer Namenda 10 mg PO (by mouth) daily. Review of the patient's MARs (Medication Administration Records) for 11/23/10 and 11/24/10 revealed that the medication had been omitted on each of those days. Staff had documented the reason for omission of the med as: "med not here" and "need to get from....." The patient was discharged on 11/24/10, and did not receive the physician ordered daily dose of Namenda during the 2 days of hospitalization.</p> <p>Patient #26 was re-admitted to the facility on 12/14/10 and had a physician order, dated 12/14/10, that stated to administer Namenda 10 mg PO BID (twice a day). Review of the patient's MARs for 12/15/10, 12/16/10 and 12/17/10 revealed that each dose of the medication had, again, been omitted for the following documented reasons; "med not available", and "absent from unit". The patient was discharged back to the nursing facility on 12/17/10 and had not received the physician ordered medication for the 3 days of hospitalization. There was no evidence, during either inpatient stay, that nursing staff had contacted the physician to inform him/her that the medication had not been administered.</p>	C 276	<p>C276 –485-635 (a)(3)(iv) – Patient Care Policies (3 records)</p> <p>Concerns Identified:</p> <ol style="list-style-type: none"> 1. Pharmacy failed to develop an effective process for assuring timely dispensation and administration of physician ordered medications. 2. Patient discharged and did not receive the physician ordered daily dose of medications – no documentation as to reason. 3. Patient readmitted and did not receive physician ordered medication. No formal process for pharmacy or nursing to identify physician or what is expectation when medication not available. <p>Corrective Action:</p> <ol style="list-style-type: none"> 1. Nonformulary medications and Patient's Own Medications policy revised to clarify process. 2. Formulary additions/deletions Policy revised to clarify process. 3. Education of nurses, providers and pharmacists. (Providers and pharmacists received e-mail. Nursing staff will sign signature page signifying that the policy was reviewed) <p>Monitoring:</p> <ol style="list-style-type: none"> 1. Daily concurrent review by pharmacy of administration for any non-formulary medication ordered 2. Random chart auditing by nursing of 30 charts per quarter until 100% compliance with policy maintained X 6 months. 3. Audit results reported to Hospital Division meeting and Nursing staff meetings. <p>Completion Date:</p> <ol style="list-style-type: none"> 1. Education of nurses, providers and pharmacist by March 15, 2011. 2. Monitoring to start by the week of March 21, 2011. 	

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C 276	Continued From page 3 The Director of Pharmacy services stated, during interview at 1:50 PM on 2/7/11, that when a drug is not available for patient use in the facility's pharmacy the drug is obtained through 3 possible routes including; samples obtained from an affiliated physician office, from a local pharmacy or use of a patient's own medication brought in from home. The Pharmacy Director further stated that, if a patient's own medication is to be used the family will bring the medication to the hospital where it is appropriately identified and labeled by the hospital's pharmacy and then made available for patient use. The pharmacist stated they "Do not have good process for follow up when patients bring in own meds to assure meds are available and given." S/he stated that although there is a process within the pharmacy for assuring timely delivery of non-formulary medications for patient use, it is not a formal process, is not included in any policy and not all pharmacists are aware of it. The Clinical Nurse Manager confirmed, during interview at 3:00 PM on 2/7/11, that it appeared the medication had never been administered to Patient #26 during either of the aforementioned hospital stays. S/he further confirmed the lack of evidence that the physician had been notified that the medication had not been administered. The VP of Hospital Services stated, during the same interview, that the expectation for nursing staff is to notify the physician if a medication is not available within 24 hours of the order.	C 276	C- 3/24/11 C-276 POC Accepted A. Deet to SM	
C 297	485.635(d)(3) NURSING SERVICES All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or where permitted by	C 297		

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C 297	<p>Continued From page 4</p> <p>State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review nursing staff failed to administer medications in accordance with physician orders for 2 patients. (Patients #23 and #26). Findings include:</p> <p>1. Per record review, on 2/7/11, Patient #23 was admitted to the hospital on 2/4/11 with multiple health issues including a psychiatric diagnosis for which s/he routinely received Depakote (used in the treatment of some mood disorders). Although there was a physician order, dated 2/4/11, that stated to administer Depakote 125 mg orally at HS (hour of sleep) the patient had only received the medication on one occasion as of 2/7/11. This was confirmed by the Clinical Nurse Manager during interview at 3:30 PM on 2/7/11. The nurse who had reconciled the physician orders had documented, in red ink, next to the Depakote order on the order sheet; "as a x 1 (ch)". The hospital pharmacist stated, during interview at 3:35 PM on 2/7/11, that the order form, which was then faxed to the pharmacy, did not differentiate colored ink and appeared to be a "one time only" order and therefore was only given one time.</p> <p>2. Per review of Patient #26's medical records, for 2 separate inpatient stays on 11/22/10-11/24/10 and 12/14/10-12/17/10, respectively, nursing failed to administer a physician ordered daily medication. The patient was admitted to the facility on 11/22/10, from a local nursing home, with a diagnosis of right</p>	C 297	<p>C297 – 485-635(d)(3) Nursing Services Concerns Identified:</p> <ol style="list-style-type: none"> 1. Nurse had not reconciled physician order – med given only once. 2. Nurse failed to administer a physician ordered daily medication. 3. Nursing failed to contact physician that medication was not given. <p>Corrective Action:</p> <ol style="list-style-type: none"> 1. Nursing Documentation policy revised to clarify process. Nurse to notify provider as soon as reasonably possible when a medication is omitted or refused and document the omission/refusal and provider notification. 2. Nonformulary medication and Patient's Own Medication policy revised to clarify process. 3. Nursing to make notations/clarifications on left side of provider orders in red ink. 4. Education of all nurses to updated policy. <p>Monitoring:</p> <ol style="list-style-type: none"> 1. Night shift will continue with daily 24 hour order checks with special attention to medication orders. 2. Night shift will use the Event Reporting system to flag notations made on orders outside of left side column. QM will track these events weekly X 3 months with feedback to nursing for remediation /intervention. 3. Unit Director or designee will concurrently audit 5 open records/wk X 3 months for medication reconciliation to orders and verification of administration. Auditing will continue X 6 months or until 100% compliance achieved with monthly reports to nursing staff. <p>Completion Date:</p> <ol style="list-style-type: none"> 1. Education of all nurses by April 4, 2011. 2. Chart audits to be started no later than week of April 11, 2011. 	
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C 297	<p>Continued From page 5</p> <p>Middle Lobe Pneumonia. A physician order, dated 11/22/10, directed nursing staff to administer Namenda 10 mg PO (by mouth) daily. Review of the patient's MARs for 11/23/10 and 11/24/10 revealed that the medication had been omitted on each of those days. Staff had documented the reason for omission as; "med not here" and "need to get from....." The patient was discharged on 11/24/10, back to the nursing facility, and did not receive the physician ordered daily dose of Namenda during the 2 days of hospitalization.</p> <p>Patient #26 was re-admitted to the facility on 12/14/10 with a diagnosis of; Change in Mental Status, Bronchitis and Prostate Enlargement. A physician order, dated 12/14/10, directed staff to administer Namenda 10 mg PO BID. Review of the patient's MARs for 12/15/10, 12/16/10 and 12/17/10 revealed that each dose of the medication had, again, been omitted for the following documented reasons; "med not available", and "absent from unit". The patient was discharged back to the nursing facility on 12/17/10 and had not received the physician ordered medication for the 3 days of hospitalization. There was no evidence that nursing staff had contacted the physician, during either inpatient stay, to inform him/her that the medication had not been administered.</p> <p>The Director of Pharmacy services stated, during interview at 1:50 PM on 2/7/11, that when a drug is not available for patient use in the facility's pharmacy the drug is obtained through 3 possible routes including; samples obtained from an affiliated physician office, from a local pharmacy or use of a patient's own medication brought in from home. The Pharmacy Director further stated</p>	C 297	<p>3/24/11 C-297- Accepted O. Olet, Jash RN</p>	

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C 297	Continued From page 6 that, if a patient's own medication is to be used the family will bring the medication to the hospital where it is appropriately identified and labeled by the hospital's pharmacy and then made available for patient use. The pharmacist stated they "Do not have good process for follow up when patients bring in own meds to assure meds are available and given." S/he stated that although there is a process within the pharmacy for assuring timely delivery of non-formulary medications for patient use, it is not a formal process, is not included in any policy and not all pharmacists are aware of it. The Clinical Nurse Manager confirmed, during interview at 3:00 PM on 2/7/11, that it appeared the medication had never been administered to Patient #26 during either of the aforementioned hospital stays. S/he further confirmed the lack of evidence that the physician had been notified that the medication had not been administered. The VP of Hospital Services stated, during the same interview, that the expectation for nursing staff is to notify the physician if a medication is not available within 24 hours of the order.	C 297		
C 302	485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to ensure complete and accurate documentation of the medical record for 3 applicable patients (Patients # 9, 16, 23) Findings include: 1. Per record review, on 2/7/11, Patient #23 was admitted to the hospital on 2/4/11 with multiple	C 302	C302 – 485-638(a)(2) Records Systems Concerns Identified 1. Nurse had not reconciled physician order – med given only once 2. The results of consultative screening by Clara Martin screener were not included in the record x2.	

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C 302	<p>Continued From page 7</p> <p>health issues including a psychiatric diagnosis for which s/he routinely received Depakote (used in the treatment of some mood disorders). Although there was a physician order, dated 2/4/11, that stated to administer Depakote 125 mg orally at HS (hour of sleep) the patient had only received the medication on one occasion as of 2/7/11. This was confirmed by the Clinical Nurse Manager during interview at 3:30 PM on 2/7/11. The nurse who had reconciled the physician orders had documented, in red ink, next to the Depakote order on the order sheet; "as a x 1 (ch)". The hospital pharmacist stated, during interview at 3:35 PM on 2/7/11, that the order form, which was then faxed to the pharmacy, did not differentiate colored ink and appeared to be a "one time only" order and therefore was only given one time.</p> <p>2. Per record review on 2/14/11, Patient #9 presented to the Emergency Department (ED) on 1/10/11 expressing suicidal ideation with a plan to hang his/herself.. A request was made by the ED physician to have a psychiatric counselor come to the ED to evaluate and screen Patient #9 for admission to an inpatient psychiatric facility. A psychiatric <i>social worker</i> from a mental health agency came to the ED, evaluated Patient #9 and recommended the patient be transferred to an inpatient psychiatric unit. Arrangements were made and a transfer was facilitated. The results of the consultative screening, to reflect the decision to transfer the patient, was not found in the patient's record.</p> <p>3. Per review, conducted on the morning of 2/14/11, the medical record for Patient #16 lacked documentation of the results of a mental health screening evaluation conducted in the ED (Emergency Department) on 2/7/11. The patient</p>	C 302	<p>Corrective Action:</p> <ol style="list-style-type: none"> 1. Nursing Documentation policy revised to clarify process. 2. Nursing to make notations/clarifications of provider orders on left side of provider orders in red ink, see revised order form. 3. Revision of Emergency Department Physician Order Sheet to include "<input type="checkbox"/> Clara Martin Consult". 4. ED provider to sign, date and time the written consult when it is completed by the Clara Martin screener at the ED visit. 5. Process flow charted to establish and communicate clear expectations for consistent process of consult documentation. 6. Education of ED nursing and physician staff of ED Physician Order Sheet and process revision. <p>Monitoring:</p> <ol style="list-style-type: none"> 1. Unit Director or designee will concurrently audit 5 open records/wk X 3 months for medication reconciliation to orders and verification of administration. Auditing will continue with reports monthly until 100% compliance achieved X 6 months. 2. Process has identified two points of ED monitoring: a) % consults documented in record at time of ED discharge and b) % consults needing intervention of VP of Hospital Division or AOC to obtain documentation for the record. 3. Medical Records will also track the % of Clara Martin consultations in the record when the record is processed in their area. <p>Completion Date:</p> <ol style="list-style-type: none"> 1. Medication documentation education for all nurses by April 4, 2011. 2. Medication administration chart audits to be started no later than week of April 11, 2011. 3. ED data collection for Clara Martin consult documentation to start no later than week of March 21, 2011 	

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C 302	Continued From page 8 presented to the ED, on that date, with a chief complaint of, "vomiting'.....drank half gallon of rum over past 12 hours." The patient who had an elevated blood alcohol level of 231 mg/dL at that time, had a final diagnosis of Acute and Chronic Alcoholism. During the course of treatment a nurse's note at 2:20 PM identified that "from Clara Martin here to talk with patient.." (the area's mental health agency). The patient was subsequently discharged to home, however there was no documentation of the evaluation by the mental health provider to reflect the decision for disposition at discharge. Per interview on the afternoon of 2/14/11 the VP of the Hospital Division confirmed the documentation was not found in the records for Patients #9 and #16 and acknowledged that although this issue has been identified in the past, the mental health agency continues not to provide the consultative screening information and the hospital has been inconsistent with requesting the information at the time of the consultation	C 302			
C 305	485.638(a)(4)(ii) RECORDS SYSTEMS [For each patient receiving health care services, the CAH maintains a record that includes, as applicable--] reports of physical examinations, diagnostic and laboratory test results, including clinical laboratory services, and consultative findings; This STANDARD is not met as evidenced by: Based on record review and confirmed by staff interview, the hospital failed to include in the medical record the results of consultative	C 305			

C. 302
3/24/11
J. DeTosh
POC Accepted

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C 305	<p>Continued From page 9</p> <p>screening for 2 of 2 applicable patients. (Patients # 9 and #16) Findings include:</p> <p>1. Per record review on 2/14/11, Patient #9 presented to the Emergency Department (ED) on 1/10/11 expressing suicidal ideation with a plan to hang his/herself. A request was made by the ED physician to have a psychiatric counselor come to the ED to evaluate and screen Patient #9 for admission to an inpatient psychiatric facility. A psychiatric social worker from a mental health agency came to the ED, evaluated Patient #9 and recommended the patient be transferred to an inpatient psychiatric unit. Arrangements were made and a transfer was facilitated. The results of the consultative screening, to reflect the decision to transfer the patient, was not found in the patient's record.</p> <p>2. Per review, conducted on the morning of 2/14/11, the medical record for Patient #16 lacked documentation of the results of a mental health screening evaluation conducted in the ED (Emergency Department) on 2/7/11. The patient presented to the ED, on that date, with a chief complaint of, "vomiting'.....drank half gallon of rum over past 12 hours." The patient who had an elevated blood alcohol level of 231 mg/dL at that time, had a final diagnosis of Acute and Chronic Alcoholism. During the course of treatment a nurse's note at 2:20 PM identified that "from Clara Martin here to talk with patient.." (the area's mental health agency). The patient was subsequently discharged to home, however there was no documentation of the evaluation by the mental health provider to reflect the decision for disposition at discharge.</p> <p>Per interview on the afternoon of 2/14/11 the VP</p>	C 305	<p>C305 – Records Systems – 485-638(a)(4) Concerns Identified:</p> <p>1. The results of consultative screening by Clara Martin screener were not included in the record x2.</p> <p>Corrective Action:</p> <p>1. Revision of Emergency Department Physician Order Sheet to include "<input type="checkbox"/> Clara Martin Consult".</p> <p>2. Process flow-charted to establish and communicate clear expectations for consistent process.</p> <p>3. ED provider to sign, date and time the written consult when it is completed by the Clara Martin screener at the ED visit.</p> <p>4. Education of ED nursing and physician staff of ED Physician Order Sheet and process revision.</p> <p>Monitoring:</p> <p>1. Process has identified two points of ED monitoring: a) % consults documented in record at time of ED discharge and b) % consults needing intervention of VP of Hospital Division or AOC to obtain documentation for the record.</p> <p>2. Medical Records will also track the % of Clara Martin consultations in the record when the record is processed in their area.</p> <p>Completion Date:</p> <p>1. Education of ED nursing and physician staff – by March 14, 2011.</p> <p>2. Chart audits to be started no later than week of March 21, 2011</p> <p><i>- 3/24/11 PAC - Accepted J. [Signature]</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2011
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C 305	Continued From page 10 of the Hospital Division confirmed the documentation was not found in the records for Patients #9 and #16 and acknowledged that although this issue has been identified in the past, the mental health agency continues not to provide the consultative screening information and the hospital has been inconsistent with requesting the information at the time of the consultation.	C 305		
C 336	<p>485.641(b) QUALITY ASSURANCE</p> <p>The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that --</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to identify and implement measures to improve quality and correct a previously identified deficient practice regarding documentation of consultative findings for patients presenting in the ED. Findings include:</p> <p>Per review of medical records conducted on 2/9/11, 2/10/11 and 2/14/11 the medical records for 2 patients lacked documentation of consultative screenings conducted as part of the ED treatment and decision for discharge disposition for each of the respective patients. The following information was obtained:</p> <p>1. Per record review on 2/14/11, Patient #9 presented to the Emergency Department (ED) on 1/10/11 expressing suicidal ideation with a plan to hang themselves. A request was made by the ED physician to have a psychiatric counselor come to</p>	C 336	<p>C336 – 485.641(b) Quality Assurance Concerns Identified:</p> <ol style="list-style-type: none"> 1. Failure to monitor previously identified deficient practice of documentation for Clara Martin consultative findings for patients in the ED. 2. Inconsistent process in place to ensure consultative screening by Clara Martin is documented in the patient record at the time of the visit <p>Corrective Action:</p> <ol style="list-style-type: none"> 1. Process flow charted to establish and communicate clear expectations for consistent practice, posted in ED. 2. ED provider to sign, date and time the written consult when it is completed by the Clara Martin screener at the ED visit. 3. Process has identified two points of ED checks & monitoring: a) % consults documented in record at time of ED discharge and b) % consults needing intervention of VP of Hospital Division or AOC to obtain documentation for the record. <p>Monitoring:</p> <ol style="list-style-type: none"> 1. See #3 above. 2. Medical Records will also track the % of Clara Martin consultations in the record when the record is processed in their area. <p>Completion Date:</p> <ol style="list-style-type: none"> 1. Monitoring to start by the week of March 21, 2011. 	

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C 336	<p>Continued From page 11</p> <p>the ED to evaluate and screen Patient #9 for admission to an inpatient psychiatric facility. A psychiatric social worker from a mental health agency came to the ED, evaluated Patient #9 and recommended the patient be transferred to an inpatient psychiatric unit. Arrangements were made and a transfer was facilitated. The results of the consultative screening, to reflect the decision to transfer the patient, was not found in the patient's record.</p> <p>2. Per review, conducted on the morning of 2/14/11, the medical record for Patient #16 lacked documentation of the results of a mental health screening evaluation conducted in the ED (Emergency Department) on 2/7/11. The patient presented to the ED, on that date, with a chief complaint of, "vomiting".....drank half gallon of rum over past 12 hours." The patient who had an elevated blood alcohol level of 231 mg/dL at that time, had a final diagnosis of Acute and Chronic Alcoholism. During the course of treatment a nurse's note at 2:20 PM identified that "from Clara Martin here to talk with patient.." (the area's mental health agency). The patient was subsequently discharged to home, however there was no documentation of the evaluation by the mental health provider to reflect the decision for disposition at discharge.</p> <p>Per interview on the afternoon of 2/14/11 the VP of the Hospital Division confirmed the documentation was not found in the records for Patients #9 and #16 and acknowledged that, although this issue had been identified by surveyors during the survey on 7/28/10, the mental health agency continues not to provide the consultative screening information and the hospital has been inconsistent with requesting the</p>	C 336	<p>3/24/11 C-336 P.O.C Accepted <i>[Signature]</i></p>	

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C 336	Continued From page 12 information at the time of the consultation	C 336		