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March 15, 2011 (read report)	WAGONER COMMUNITY HOSPITAL	WAGONER	OK	5
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(read report)				
Jan. 5, 2011 (read report)	ST JOHN MEDICAL CENTER, INC	TULSA	OK	3

HospitalInspections.org

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

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For AHCJ members

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Examples: abuse; "medication error";

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ST JOHN MEDICAL CENTER, INC ->
Report No. 1264

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 JOHN MEDICAL CENTER, INC 1923 SOUTH UTICA AVENUE TULSA, OK 74104 Nov. 14, 2012

VIOLATION: *PATIENT RIGHTS: RESTRAINT OR SECLUSION* **Tag No:** A0165

Based on clinical record review, policy and procedure review and staff interview, it was determined the hospital failed to ensure the type of restraints used were the least restrictive intervention available to maintain the patient's safety.

Findings:

1. Records #4 and 5 did not contain documentation less restrictive interventions had been tried or determined to be ineffective.

2. On the afternoon of 11/14/2012, Staff A, H and I told the surveyor that restraint reassessment and documentation of continued need for medical-use restraints would be documented at least every shift.

3. At 1500 on 11/14/2012, Staff A, H and I told the surveyor that the hospital had recently replaced preprinted restraint forms with all documentation being computerized. The computerized version had listed reasons for restraints, but no area for individualized text. Staff A and D told the surveyor that the " protocol " the hospital used for developing the computerized version was reviewed by CMS for input. According to the form, in addition to " Pulls at tubes, lines, dressing, etc. " , the approved reasons for restraints included: " Decreased level on consciousness, Can be aroused but unable to maintain wakefulness; exhibits confusion and/or disorientation; unable to remember instructions; (and) no understanding of therapies, equipment, risks. "

4. Staff A, H and I agreed that just because a patient had decreased level of consciousness, confusion, disorientation or was unable to remember instructions, it did not necessarily mean the patient needed restrained.

5. Restraint justification documented for Patient #4 did not contain evidence every shift that wrist restraints were the least restrictive intervention that could be utilized to protect the patient. Although the computerized entry checked at least once a day that the patient "pulls at tubes, lines, dressings, etc.", the checked documentation in the restraint portion the other times listed "decreased level of consciousness" and/or "no understanding of equipment, therapies and risks." Nursing narrative did not describe actions that would necessitate restraints. These findings were reviewed with Staff H at the time of review. She stated she remembered the patient and that although he would sleep, they were "constantly titrating" his sedation and he would immediately try to pull at his tubes/lines when he became slightly conscious.

6. Patient #5 - At the time of initiation of restraints on 11/01/2012 at 1900, the nurse documented,"decreased level of consciousness, arousable but unable to maintain wakefulness" as the reason for the restraint. The documentation did not support the need for restraint. The findings were reviewed with Staff H at the time of review of the afternoon of 11/14/2012.

VIOLATION: *PATIENT RIGHTS: RESTRAINT OR SECLUSION* **Tag No:** A0168

Based on review of hospital documents and medical records and interviews with hospital staff, the hospital failed to ensure restraints were used in accordance with physician's orders. This occurred for three of five patient records (Records #3, 4 and 5) reviewed.

Findings:

1. State Hospital Licensure Standards, Chapter 667, Subchapter 15-8, requires that a patient may be restrained only upon the order of a physician or licensed independent practitioner. "Orders for physical restraint shall include a statement of reason for the restraint and specify which approved facility methods and devices shall be used."

2. Record #3 - On 10/16/2012 at 1540, the nurse changed the patient's restraint from soft right arm restraint to a waist restraint without a physician's order.

3. The hospital's "Restraint and Seclusion" policy, approval 10/20/2012, required renewal or new order to be "issued no less often than once each calendar day." Patient #3 was restrained on 12/21/2012 without a physician's order.

Staff A and I told the surveyor that once an order was written, depending where the patient was located, the computer program generated an automatic prompt in the way of a nursing "order/flag" to the physician to write a continuation or discontinue of the restraint order.

4. The hospital's "Restraint and Seclusion" policy, approval 10/20/2012, documented for critical care units, "Continues use of restraint will require a renewal order every 7 days based on physicians (sic) evaluation."

a. Patient #4 - The patient was placed in soft wrist restraints on 09/24/2012 at 0330, at the time of oral intubation, and, according to documentation in the medical record, remained in restraints until 10/08/2012 at 1524, when they were removed. The chart did not contain an initial order or any order for renewal of the restraints.

Staff H told the surveyor on 11/14/2012 at 1350, that she remembered this patient and the physician ordered restraint at the time of the intubation.

b. Patient #5 - The patient was placed in soft wrist restraints on 11/01/2012 at 1900. and continued until 11/02/2012 after 0300 (last time restraint documentation occurred). The chart did not contain an order for restraints.

c. She stated I and J told the surveyor on the afternoon of 11/14/2012 that although the nurse may check the box notifying the physician of the need for an order for restraint, the computer did not register the order until the physician "hits the button" to generate an order and therefor none of the prompts for continued restraint orders are generated.

5. The above findings were reviewed and confirmed with staff during the chart reviews.

VIOLATION: *PATIENT RIGHTS: SECLUSION OR RESTRAINT*

Tag No: A0214

Based on review of patient medical records and hospital documents, the hospital failed to ensure the clinical record contained documentation of the date and time CMS (Centers for Medicare and Medicaid Services) was notified of the death of a patient during the use of restraints. This occurred for one of two deaths in restraints that should have been reported to CMS (Record #3 of Records #1 and 3).

Findings:

1. A hospital policy titled, "In Case of Death, Notification and Responsibility", documented staff were required to "Document the date and the time the death was reported to CMS in the patient's medical record.

2. Although hospital reports and the death in restrain log recorded CMS was notified of Patient #3's death, the medical record did not contain this information. This was confirmed with Staff D at the time of review on the afternoon of 11/14/2012.

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ST JOHN MEDICAL CENTER, INC
ST JOHN MEDICAL CENTER, INC
1923 SOUTH UTICA AVENUE TULSA, OK 74104 | Voluntary non-profit - Church

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Report date	Number of violations	
Nov. 14, 2012	3 (click for details)	Read full report
June 22, 2011	2 (click for details)	Read full report
March 1, 2011	1 (click for details)	Read full report
Jan. 5, 2011	3 (click for details)	Read full report

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Incomplete reports

Report date	Number of incomplete reports	Number of violations
July 17, 2012	1	4
July 17, 2012	1	7

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STROUD REGIONAL MEDICAL CENTER **2308 HIGHWAY 66 WEST STROUD, OK 74079** **July 18, 2012**

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on record review and interviews with hospital staff, the hospital does not ensure the consultant pharmacist evaluates the performance and competency of drug room personnel who provide pharmacy services when the consultant pharmacist is not on the premises and assures that all outdated, mislabeled or otherwise unusable drugs are not available for patient use. Two (D & E) of two drug room personnel files reviewed did not contain evidence of orientation to the drug room, performance evaluations, or job descriptions for the drug room. Expired drugs were observed on drug room shelves available for patient use.

Findings:

1. Two 5ml (milliliter) bottles of Bromonidine Tartrate 0.15% ophthalmic solution (Exp. 11/11), two bottles of carbamide proxide 6.5% ear drops (Exp. 10/11), one box plus several loose vials of Heparin 1000u/ml (Exp. 4/11) and Dexamethasone 4mg/ml one ml vials (Exp. 4/11) were expired.

2. Drug room staff D, who was working while the fulltime drug room person was on vacation stated on 07/18/12 that she had not been formally oriented to the drug room.

STROUD REGIONAL MEDICAL CENTER

2308 HIGHWAY 66 WEST STROUD, OK 74079 | Government - Federal

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Report date Number of violations
July 18, 20121 (click for details) Read full report

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Incomplete reports

No incomplete reports available.

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MERCY HEALTH CENTER, INC | **4300 WEST MEMORIAL ROAD OKLAHOMA CITY, OK 73120** | **July 3, 2012**

VIOLATION: *CONTENT OF RECORD - OTHER INFORMATION* **Tag No:** A0467

Based on a review of medical records and interviews with hospital staff, the hospital failed the ensure the medical records were complete and contained all pertinent information such as complete nursing assessments, reports of treatments, and documentation of care provided.

Findings:

1. On 7/2 and 7/3/2012 surveyors reviewed seven emergency room records. Seven of seven (Pt#1,2,3,4,5.6.7) records did not contain dated, timed, and authenticated physician orders. This finding was confirmed with staff E

2. Patient #1's medical record stipulated in the physician assistant documentation "(patient miscarried in WR bathroom and fetus sent to pathology)". There was no documentation of the incident by personnel assisting the patient. On the morning of 7/3/2012 Staff B confirmed this finding.

3. Patient #1 presented with a chief complaint of threatened miscarriage and vaginal bleeding. Documentation at the time of triage indicates "threatened miscarriage X (times) one day"; vaginal bleeding X 1 hour". There is no documentation to quantify the amount of bleeding. The initial nursing assessment indicates vaginal bleeding with characteristics "continuous; painful" and "pad count 'retired' with the number 3 and in parenthesis "number of pads saturated/hr). There is no other documentation in the medical record regarding amount or pad changes, quantifying the bleeding included in any nursing assessments or triage assessments.. On the morning of 7/3/2012 Staff B told surveyors there was no other documentation by nursing of amount of bleeding.
The ED (emergency department) provider note stipulates "large amount of tissue and clotting removed from the vaginal vault. Os slightly patent with bleeding coming from it." The provider note does not indicate the time of the assessment, the amount of tissue and clotting, and the amount of bleeding.

4. The above findings were reviewed at the exit conference 7/3/2012. No further documentation was provided.

VIOLATION: *QUALIFIED EMERGENCY SERVICES PERSONNEL* **Tag No:** A1112

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on medical record review and interviews with hospital staff, the hospital failed to ensure the emergency services department (ED) required staff to be trained to provide complete triage assessments for patients presenting to the ED with complaints of vaginal bleeding.
Findings:

1. Patients # 1 (MDS) dated [DATE] at 1705 with a complaint of vaginal bleeding and possible miscarriage. Triage documentation at 17:26 does not include vital signs to determine orthostatic hypotension, no documentation of the amount, type of bleeding, or frequency of pad changes. Triage assessment indicates the patients pain level was an "8" "threatened miscarriage X (times) one day"; vaginal bleeding X 1 hour". Triage documentation the patient was classified as "urgent".

According to interviews, hospital documents, and documents received at the Department, patient #1 had a miscarriage in the waiting room bathroom. There is no documentation of this event in the patient's medical record by personnel caring for the patient during the event. This finding was verified with Staff B on 7/3/2012

According to the next documentation in the record an initial nursing assessment was performed at 2000. At that time documentation reflected the patient's pain level was a "7". One set of supine vital signs are documented. There is no documentation of the amount or type of vaginal bleeding. A sanitary pad count indicated "3/retired". The assessment did not include any information regarding the miscarriage in the waiting room bathroom. At 2100 the nurse documents intravenous pain medication was given. Nursing documentation "note time 2118-patient informed of need for pelvic exam....assistance provided to physician." The provider note does not have a date and time the pelvic exam was performed.

2. On 7/2 and 7/3/2012 surveyors reviewed the emergency room log for January 2012. All patient's with a chief complaint of "vaginal bleeding were triaged level 3 "urgent". Staff B told surveyors triage classification was based on the number of resources (intravenous lines, lab, x-ray) utilized by the patients. There was no documentation, policy or procedure differentiating the type and amount of bleeding that indicates a patient has a "life threatening" amount of bleeding or should be triaged to a higher level. There was no policy, procedure or process indicating who or how frequent patient's would be checked on while waiting to be seen. There is no policy, procedure, or process in place to ensure triaged patient's who's conditions deteriorate or change while waiting are reassessed and the information documented to ensure continuity of care.

3. On 7/2/2012 surveyors reviewed the emergency room triage and assessment educational packet. According to Staff B any nursing personnel assigned to the triage position must go through this training. There was no documentation the amount, type, frequency of dressing/pad changes were included in the triage education. These findings were reviewed with administration at the time of the exit and no further documentation was provided.

VIOLATION: *FORM AND RETENTION OF RECORDS*

Tag No: A0438

Based on record reviews and interviews with hospital staff, the hospital does not ensure that medical records are complete, retained, and properly filed for prompt retrieval.

Findings:

1. On the morning of 7/2/2012, administrative staff told the surveyors that all patient medical records were maintained on computer/electronic medical records. In the afternoon, surveyors were provided hard copy closed medical records. Review of the medical records indicated the hard copy documents did not include physician orders for treatment, date and time of procedures, physician/mid-level authentication. On the afternoon of 7/2/2012 Staff E told surveyors the charts provided to surveyors in the morning were the same records that would be provided to patients requesting a copy of their complete medical record.

2. On the afternoon of 7/2/2012 and the morning of 7/3/2012, surveyors reviewed medical records policies. There was no policy indicating what a complete medical record included. On the morning of 7/3/2012 Staff E provided surveyors a hard copy "Training Workflow: Release of Information Printing Cheat Sheet", and stated the document was the policy on complete medical records. There document was not on the intranet with the other policies. There was no documentation this document is a policy. The policy does not match the form and content of the other policies. There is no header with policy name, date written, date revised, date reviewed and approved.

3. On the morning of 7/3/2012 surveyors reviewed medical records policy and procedures. According to Staff B and D the physician emergency documentation is completed in a separate electronic system and is merged into the patient emergency room record. There was no policies, procedures, or processes in the medical records policies stipulating the physician utilized a separate system and how the information could be retrieved. . The policy and procedures do not reflect all the current electronic medical records practice.

4. The facility did not have policy and procedures addressing all components of the electronic documentation in outpatient and inpatient medical records.

5. The above findings were reviewed with administration at the exit conference. No further documentation was provided.

MERCY HEALTH CENTER, INC

4300 WEST MEMORIAL ROAD OKLAHOMA CITY, OK 73120 | Voluntary non-profit - Church

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Report date Number of violations
July 3, 20123 (click for details) Read full report

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Incomplete reports

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OKLAHOMA HEART HOSPITAL	**4050 WEST MEMORIAL ROAD OKLAHOMA CITY, OK 73120**	**July 3, 2012**

VIOLATION: *COMPLIANCE WITH 489.24* **Tag No:** A2400

Based on review of hospital documents, review of clinical records and interviews with hospital staff, it was determined the hospital failed to follow it's policies and procedures to ensure compliance with the requirements of 42 CFR 489.24. The hospital failed to follow it's policies on medical screening examination and transfers.

Findings:

1. A hospital document, titled, Screening/Stabilizing/Transfer Policy, documented, "... Medical Screening Examination (MSE): An examination which is sufficiently detailed to determine within reasonable clinical confidence, whether the patient suffers from an emergency medical condition which includes a pregnant woman having contractions... The examination must include medically indicated screens, tests... and history and physical examination as indicated by the presenting signs and symptoms. Ancillary services available to other patients in the hospital must be utilized, as necessary..."

The emergency room record for patient #1 was reviewed for evidence of a medical screening exam. The history and physical examination completed by the physician documented, "... Chief Complaint: 'I think I'm having a miscarriage.'... Medical Decision-Making: The patient was evaluated in triage. A medical screening examination was performed. In light of no obstetric coverage, I will have the patient go to the [hospital name deleted] emergency department where they do have obstetric coverage... vital signs stable and she is to proceed there directly. She states understanding of this... Assessment:... Vaginal bleeding by history..."

The physical examination did not include documentation of a gynecological exam.

On 07/02/12 at 2:45 p.m., Staff F stated she assisted in the care of Patient #1 in the emergency department. She stated she did not see the physician perform a physical examination on the patient. She stated the patient did not receive a gynecological exam.

On 07/03/12 at 9:15 a.m., patient #1 was asked if she had received a physical examination by the physician. She stated the physician asked her questions about her symptoms and her medical history but did not perform an exam.

2. The Screening/Stabilizing/Transfer policy also documented, "... If, following the MSE, the patient is determined to have an EMC [emergency medical condition], the treating physician must determine if the patient is stable... A stable patient may be transferred, at the patient's request,... At a minimum, transfer of the stable patient must include the following elements:

1. Permission of the patient...
2. The receiving facility accepts the patient and has both the capability and the capacity to treat the condition; and
3. Adequate records reflecting the evaluation and treatment of the patient are sent to the receiving facility with the patient...

Hospital Personnel Duties:... 1. If a patient is transferring to another facility, the following forms will be completed as documentation of services rendered: Transfer Consent, Physician Certification and Transfer Information form... 2. Refusals for Examination/Treatment/Transfer: when a patient refuses examination, treatment, or transfer as suggested by the Physician, the staff will

assist the patient and physician in the completion of either the Refusal of Transfer to Another Medical Facility form or AMA Against Medical Advice form. Staff will document in the electronic medical record all interventions and/or efforts to provide services to the patient..."

There was no documentation the patient refused examination and treatment at the Oklahoma Heart Hospital or that the patient left against medical advice.

There was no documentation of the patient's request and consent for a transfer to another hospital emergency room .

There was no documentation the emergency department personnel followed the hospital policies and procedures regarding transfers.

VIOLATION: *MEDICAL SCREENING EXAM*

Tag No: A2406

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on clinical record review, policy and procedure review and staff/patient interviews, it was determined the hospital failed to provide an appropriate medical screening examination for one (#1) of twenty records reviewed for evidence of medical screening exams.

Findings:

1. A hospital document, titled, Screening/Stabilizing/Transfer Policy, documented, "... Medical Screening Examination (MSE): An examination which is sufficiently detailed to determine within reasonable clinical confidence, whether the patient suffers from an emergency medical condition which includes a pregnant woman having contractions... The examination must include medically indicated screens, tests... and history and physical examination as indicated by the presenting signs and symptoms. Ancillary services available to other patients in the hospital must be utilized, as necessary..."

2. The emergency room (ER) record for patient #1 was reviewed for evidence of a medical screening exam. The record documented the patient (MDS) dated [DATE] at 1639 with complaints of vaginal bleeding. The nurse and physician documented the physician went to the triage area to see the patient. (This is not in the examination rooms portion of the ER.) The nurse recorded the patient's vital signs as: pulse - 88 beats per minute; blood pressure - 108/99; respirations - 14 per minute; and oxygen saturation as 99%. She also documented, "To triage for complaints of a possible miscarriage, reports she was 3-4 months since last menstrual cycle and was told by her physician she was pregnant...complains today at work she has been having abd (abdominal) cramping similar to menstrual cramping. Complains of heavy bleeding."

The history and physical examination completed by the physician documented, "... Chief Complaint: 'I think I'm having a miscarriage.'... Medical Decision-Making: The patient was evaluated in triage. A medical screening examination was performed. In light of no obstetric coverage, I will have the patient go to the [hospital name deleted] emergency department where they do have obstetric coverage... vital signs stable and she is to proceed there directly. She states understanding of this... Assessment:... Vaginal bleeding by history..."

The physical examination was not complete. It did not include documentation of a gynecological exam.

3. On 07/02/2012, the Staff G confirmed he did not perform a vaginal examination on the patient, but stated he did use a stethoscope to examine the patient (See Finding #5 for refute.)

4. On 07/02/12 at 2:45 p.m., Staff F stated she assisted in the care of Patient #1 in the emergency department. She stated the physician accompanied her to the triage room. When asked, she told the surveyors that this was not a usual practice. She stated she did not see the physician perform a physical examination on the patient. She stated the patient did not receive a gynecological exam.

5. On 07/03/12 at 9:15 a.m., patient #1 was asked if she had received a physical examination by the physician. She stated the physician asked her questions about her symptoms and her medical history but did not perform an exam. She stated he did not touch her - did not even use a stethoscope.

6. Information from the other hospital documented, the patient arrived at 1705 and was triaged at 1734 with complaining of abdominal pain and vaginal bleeding; being 12 to 18 weeks pregnant with a possible miscarriage. Laboratory documentation in the chart reflects lab was ordered and drawn per the emergency room physician protocol for vaginal bleeding. Documentation stipulates the patient was taken to a room and assessed by the emergency room nurse at 2000. Nursing documentation also stipulates the patient was seen by the emergency room provider at 2118.

OKLAHOMA HEART HOSPITAL

4050 WEST MEMORIAL ROAD OKLAHOMA CITY, OK 73120 | Proprietary

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Report date Number of violations
July 3, 20122 (click for details) Read full report

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MERCY HOSPITAL LOGAN COUNTY	200 SOUTH ACADEMY ROAD GUTHRIE, OK 73044	April 23, 2012

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on observation, policy and procedure review, record review and interview, it was determined the facility failed to ensure medical equipment in need of repair was removed from service.
Findings:

1. According to the policy titled, Work Orders, documented, "... Upon receipt of notification of a situation, the Plant Operations Coordinator will issue a work order..."

On 04/23/12 at 3:00 p.m., the patient in room 116 was observed sitting in a recliner beside his bed. There was a pressure-relieving air mattress on the bed.The patient was asked if there were any mechanical problems with his room. He stated the air mattress on his bed did not work. He stated he reported the problem to the nursing staff a day or two ago and a maintenance person checked the mattress, but could not identify the problem. He was asked if the deflated mattress was uncomfortable. He stated he tried to stay out of his bed as much as possible because lying on the mattress felt like lying on a bare bed frame.

The patient also stated a blood pressure cuff on the wall did not work and staff had to bring in a portable machine to take his blood pressure. No work orders for the faulty air mattress and the blood pressure cuff were found.

2. On 4/23/2012 surveyors reviewed several months of work orders and preventive maintenance schedules. Included in this information was documentation regarding the hospital ' s operating room humidifiers. The humidifiers were listed as " out of service " . In an interview with Staff D and E, this problem initially started about the time the transition to new ownership. Staff E indicated to surveyors the previous Director had been waiting on parts. There was no documentation the problems had been identified and made known to administration. There was no documentation the operating rooms were in compliance with humidity.

3. When asked, Staff E told surveyors there had been issues with the call light remaining on and this had been corrected. There was no departmental documentation of the problem or the work order correcting the problem. Staff E also indicated problems (sparking) with an outlet when a piece of equipment was plugged in. Staff E stated this issue had been fixed. There were no documents, work order, meeting notes, or incident reports identifying this problem and the corrective steps taken.

4. The above information was provided at the exit conference on 4/23/2012. No further documentation was provided.

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on review of hospital documents, policies, and interviews with staff the hospital failed to provide a preventive maintenance program and oversight of environmental services that ensures a safe patient care environment.

Findings:

1. Review of work orders and continued maintenance over the last six months included information regarding the hospital ' s operating room humidifiers. The humidifiers were listed as " out of service " for several months. In an interview with plant operations staff, this problem initially started about the time the transition to new ownership. Staff E indicated to surveyors the previous Director had been waiting on parts. There was no documentation the problems had been identified and made known to administration. There was no documentation the operating rooms were in compliance with humidity.

2. On 4/23/2012 surveyors reviewed committee meeting minutes. There were no Safety Committee meetings and minutes after July 27, 2011. On the morning of 4/23/2012, Staff D told surveyors the committee had not been functioning since the transition of ownership but that Staff D would send out work orders, review scheduling, and coordinate activities for the plant operations as well as oversee housekeeping services. Staff D told surveyors Staff D reported to Staff B.

In a separate interview that afternoon, Staff C told surveyors prior to the transition the committee functions were the responsibility of the Plant Operations Director and the facility no longer had that position. Staff D's job description indicated Staff D coordinated Safety Committee Meetings, prepared agendas, and takes minutes. Staff C confirmed Staff D did not perform many of the duties of Plant Operations Director but coordinated activities and performed administrative duties for the Plant Operations Department. Staff C also confirmed Staff D did not have departmental training documented for either role.

3. There is no documentation preventive programs are in place and functioning. There is no documentation the hospital reviews facility preventive maintenance programs and/or issues with plant operations to ensure a safe environment for the patients and visitors.

VIOLATION: *UNSPECIFIED CATEGORY*

Tag No:

Based on record review and interviews with hospital staff, the governing body of the Critical Access Hospital (CAH) does not ensure that policies for the CAH are implemented and monitored to ensure quality health care is provided in a safe environment.

Findings:

1. There is no documentation variances occurring in the plant operations department and clinical equipment are being tracked, trended and analyzed to ensure a safe environment of care. When asked plant operations staff told surveyors of problems with the nurse call light, electrical system, and gaps around doors. There is no documentation these variances were reported through the incident reporting system or through the preventive maintenance schedule and log. There is no documentation of Safety Committee Meeting Minutes since July 2011.

2. Review of Governing Board Meeting minutes indicate many of the committees had not reported for the past eight months. There was no Safety Committee reporting in any of the Board Meeting Minutes for 2011-2012. There is no quality reporting from all departments/services in any of the governance meeting minutes for 2011-2012.

3. The hospital does not have quality assurance indicators and/or monitoring for all departments in the hospital. The hospital does not have a functioning quality assurance program to assure quality health care in a safe environment. Refer to Tag # 0222 and 0226

4. The hospital does not assure all personnel are trained, competent, and evaluated for their specific departmental duties. Job duties and reporting structures do not match current practice. See tag #0226.

5. The hospital does not have current policy and procedure reviewed, approved, and implemented for all departments. The plant operations policies do not match current practice. See tag #0222

6. The hospital does not have a contract or policy indicating what services/personnel will be provided by the partner hospital.

7. These findings were reviewed during the exit conference with administration. No further documentation was provided.

VIOLATION: *UNSPECIFIED CATEGORY*

Tag No:

Based on record review and interviews with hospital staff, the hospital does not ensure that the hospital has a contract defining the services to be provided by the partner hospital The hospital failed to have documentation stipulating what services are provided and no documentation of processes to how staff at the to assure the services rendered are monitored and care for hospital patients is adequately supervised by licensed personnel.

Findings:

1. The hospital does not have written agreements or contracts with the owners for the specific services that are provided. On 4/23/12 Staff B and C stated that some staff were provided by Mercy Oklahoma City. There were no shared services contracts provided for review that defined the services provided by each of the entities. There was no documentation of processes for sharing staff.

2. On 4/23/2012 surveyors were provided policies for facilities management. On 4/23/12 Staff D and E told surveyors they received plant operations support from Mercy Oklahoma City. Staff D and E said there was no formalized process but they would call the facilities personnel and Mercy Oklahoma City provided support if they could. The policies provided did not reflect these processes. Job descriptions for Staff D and E include reporting structure to employees/positions that were deleted during the transition.

3. The above findings were reviewed with administration at the exit conference. No further documentation was provided.

MERCY HOSPITAL LOGAN COUNTY

200 SOUTH ACADEMY ROAD GUTHRIE, OK 73044 | Government - Hospital District or Authority

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April 23, 20124 (click for details) Read full report

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Incomplete reports

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ATOKA COUNTY MEDICAL CENTER 1200 WEST LIBERTY ROAD ATOKA, OK 74525 April 13, 2012

VIOLATION: *USE OF RESTRAINT OR SECLUSION*

Tag No: A0154

Based on review of personnel files, medical records, hospital documents, and interviews, the hospital failed to verify personnel were licensed, trained, and competent.

Findings:

1. In an interview with Staff B on 4/13/12 the surveyor was told Staff B,F, I,J, L had been trained to perform pulmonary functions tests (PFTs). Review of Staff B, F, I, J, and L's personnel file does not include documentation each staff member was trained, evaluated, and found competent with the equipment.
On 4/13/2012 surveyors reviewed Patient record #1, Staff B performed pulmonary function testing. Staff B is a registered nurse. There is no documentation Staff B has the education, training, competency, license/certification, to perform PFTs.

2. On 4/12/12 surveyors reviewed personnel files. 4 of 4 (B,C,D,K) nursing personnel files reviewed did not have evidence of departmental orientation, training, and competencies specific to the duties performed in each department.

3. Three of three (C,D,K) emergency room personnel identified as providing respiratory treatments in the emergency room did not have current competency and evaluation of skills. There was no documentation a respiratory therapist reviewed and evaluated respiratory therapy treatments and tests.

4. On 4/12/12 Staff A told surveyors the facility did not have a respiratory therapist employee or contractor.

VIOLATION: *UNSPECIFIED CATEGORY*

Tag No:

Based on record review and interviews with hospital staff, the governing body of the Critical Access Hospital (CAH) does not ensure that bylaws, rules and regulations and policies for the CAH are implemented and monitored to ensure quality health care is provided in a safe environment.

Findings:

1. The facility does not have a full-time or contract respiratory therapist who oversees the respiratory services as required by State and Federal Law. See tag 0154
2. Respiratory and Nursing Policy and Procedures are not reviewed and approved annually. See tag 0271
3. Respiratory Policies indicate only employees of the respiratory department will perform pulmonary function tests on patients. The hospital is not following the respiratory policies and procedures reviewed and approved through the medical staff and governing body. See tag 0271, 0294
4. Nursing personnel providing care in the emergency room do not have documentation indicating they are trained, evaluated, and competent to provide emergency room care. See tag 0271, 0294

5. Nursing personnel providing respiratory care do not have documentation indicating they are trained, evaluated, and competent to provide respiratory treatments and tests. See tag 0294

VIOLATION: *UNSPECIFIED CATEGORY*

Tag No:

Based on review of hospital documents, policies and procedures, and interviews with staff the hospital failed to follow respiratory policies and procedures.

Findings:

1. On 4/12/2012 surveyors reviewed the policy and procedure manual for respiratory care. The last update indicated the manual was reviewed/revised in 2010. All policies provided to surveyors included a "scope" which stipulates "Members of Respiratory Therapy Department, as defined by job descriptions. Other policies have a stipulation, "Members of Respiratory Therapy Department, as defined by job descriptions, and nursing staff".

2. According to the respiratory policy "Pulmonary Function Tests" the scope of the policy includes "members of Respiratory Department as described by job description". On 4/12/12 Staff B told surveyors Staff B, F, I, J, L, went through an online education program on a pulmonary function test machine. Staff B showed the machine to the surveyors. Review of all personnel files did not include training documents for the pulmonary function test equipment. Review of Staff B's personnel file did not indicate Staff B was a certified respiratory therapist/registered respiratory therapist. Staff B's job description did not include provisions for providing pulmonary function tests.

3. On 4/12/12 surveyors reviewed two personnel files (Staff I and J). Staff I and J's personnel records indicated a disciplinary notice had been written for failure to provide pulmonary function testing to patients. Staff I and J's personnel records did not include any training materials, competencies, or return demonstration on use of the testing equipment.

4. The above findings were addressed in the exit conference 4/13/2012.

VIOLATION: *UNSPECIFIED CATEGORY*

Tag No:

Based on policy and procedure manual review and interview with the hospital staff, the hospital failed to ensure policies are reviewed at least annually.

Findings:

1. On the morning of 4/12/12 surveyors were given copies of the Respiratory Department policy and procedure manual. On 4/12/12 Staff A and Staff B told surveyors the facility was updating all of their policies and not all policies and procedures were current. The Respiratory policy and procedure manual was dated 2010.

2. On the morning of 4/12/12 Nursing policies were provided to surveyors. The latest review and revision was dated 2010.

VIOLATION: *UNSPECIFIED CATEGORY*

Tag No:

Based on review of hospital documents and interviews with hospital staff, the hospital does not assure nursing staff are adequately trained to meet the needs of the patients. Four of four nursing personnel did not have departmental orientation, competency, and evaluation for the specialized areas where they worked.

Findings:

1. On the afternoon of 4/12/12 surveyors were provided personnel files. There was no documentation provided indicating Staff (C) had orientation to the hospital and specific departments. There was no documentation Staff C had respiratory treatment training and competencies. Staff C is not a registered nurse or respiratory therapist. There was no job description in the file indicating Staff C's scope of practice. Staff C administered respiratory treatments in the emergency room to patient's #6,7.

2. On the afternoon of 4/12/12 surveyors reviewed four registered nurse personnel files. Four of four registered nurse files did not contain emergency room departmental training. There was no documentation indicating Staff B, D,K, M were trained and competent to provide respiratory therapy treatments and procedures. Staff B performed a pulmonary function test on Patient #1. Staff D, K, M provided respiratory treatments and/or emergency room care for patients #2,3,4,5,6 and 7. The hospital did not provide documentation staff were properly trained and evaluated competent to work in the emergency room and provide respiratory treatments.

3. The above findings were reviewed at the exit conference. No further documentation was provided.

ATOKA COUNTY MEDICAL CENTER

1200 WEST LIBERTY ROAD ATOKA, OK 74525 | Government - Hospital District or Authority

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Report No. 1272

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ST JOHN SAPULPA **1004 EAST BRYAN SAPULPA, OK 74066** **April 5, 2012**

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on review of hospital documents, nursing policies and procedures, and interviews with staff the hospital failed to follow perioperative policies and procedures.

Findings:

1. On 4/4/2012 surveyors requested policy and procedure manuals surgery, anesthesia, and central sterile. Review of the surgery manual indicated policies had been reviewed and approved in 2012. The facility also provided the current Association of periOperative Registered Nurses (AORN) Standards and Recommended Practices. . According to the policy "Fire Safety" D. Is an ESU (electrosurgical unit), laser, or fiber-optic cord being used? Actions-fiber optic light cord use: Place the light source in standby mode or turn it off when the cable is not in active use (eg, used within 5 to 10 seconds). Inspect light cables before use and remove from service if broken light bundles are visible. Secure the working end (ie, the end that is inserted into the body) of the telescope or cord on a moist towel or away from any drapes, sponges, or other flammable

AORN Standards and Recommended Practices also stipulates in "Safe Environment of Care, Recommendation IX.b.4. The ends of an active fiber-optic light cable should not come in contact with surgical drapes. Fiber-optic light cables provide an ignition source if they are disconnected from the working element or light source and allowed to contact drapes, sponges, or other fuel sources. IX.b.5. Light cables should be connected before activating the light source. IX.b.6. The light source should be placed into a stand-by mode when not in use to prevent ignition. Backing into the light source or turning the fiberoptic light cable toward the body may cause surgical attire to ignite. IX.c. Personnel should move any equipment that emits smoke at any time, whether in use or not to a safe area. IX.d.7. Gowns and drapes should not be exposed to ignition sources."

2. According to hospital documents, the patient chart, and personnel interviews, at the conclusion of a shoulder arthroscopy case, Staff F a certified surgical technician (CST) noticed a burn hole in the drapes and blanket covering Patient #1, Staff F then checked the patient and noted a small reddened area less than a centimeter in size with a pin point brownish center. Further documentation indicates Dr. N was notified and instructed the nurse to apply "Bacitracin and a bandaid". Discharge instructions stipulate "antibiotic ointment and bandaid R (right upper thigh burn). Keep clean and dry. In an interview with Staff D the circulator present during the case, the light handle of the arthroscopy equipment had been placed on the drape covering the patient. Staff Dalso told surveyors Staff K was instructed to remove the equipment from use and send to be checked out.

3. According to the policy entitled "Documentation of Intraoperative Nursing Care" page 8 "Discharge Assessment"1. The condition of thepatient's skin on discharge is described. The drawing of the human form on the back of the first page of the record may be used to indicate the location of any change in the skin condition, i.e. abrasions, ecchymosis, lacerations, skin disorders, etc. There was no documentation of the "small reddened area" on the intraoperative documents.

4. The above findings were addressed in the exit conference 4/5/2012.

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MCCURTAIN MEMORIAL HOSPITAL 1301 LINCOLN ROAD IDABEL, OK 74745 March 15, 2012

VIOLATION: *PATIENT RIGHTS: RESTRAINT OR SECLUSION* **Tag No:** A0196

Based on review of hospital policies and procedures, staffing schedules and personnel files, and interviews with hospital staff, the hospital failed to ensure staff, working on the mental health/psychiatric (psych) unit, were trained and kept current in the safe implementation in CPI (Crisis Prevention Intervention by Crisis Prevention Institute), the facility's approved method to hold/restrain patients, identify behaviors/circumstances that might trigger the use restraints, and deter the necessity to utilize restraints and seclusion, before patient care was assigned. This occurred for six of eleven (Staff # F, H, J, K, L, and N of Staff #D, E, F, G, H, I, J, K, L, M, and N) personnel files reviewed for CPI competency.

Findings:

1. On the morning of 03/15/2012, Staff B told the surveyors that the hospital used CPI as the hospital's approved method for identifying and managing potential aggressive situations, including methods to physically hold/restrain patients. This was confirmed by policy review and personnel file review.

2. State Licensure Chapter 667 Hospital Standards, Subchapter 33, 310:667-33-2(b)(2), stipulates, "All staff providing active treatment or monitoring patients shall be trained in facility methods approved to physically hold or restrain patients before patient care responsibilities are assigned. These staff members shall be reoriented regarding these policies annually or when policies are revised."

3. Six of the eleven personnel file reviewed did not have CPI training. All six staff who did not have CPI training had worked on the psych unit within the last month. This was verified with Staff B at the time of review on the afternoon of 03/15/2012.

VIOLATION: *MAINTENANCE OF PHYSICAL PLANT* **Tag No:** A0701

Based on surveyors observation and review of hospital documents and policies, the hospital failed to maintain the environment on the New Directions Unit (the hospital's geriatric psychiatric unit) to ensure the safety and well-being of the patients are assured.

Findings:

1. The hospital has a 14-bed geriatric psychiatric unit. Patient rooms are private and semi-private rooms.

2. During the tour on the morning of 03/15/2012, Staff D told the surveyors that patient population on the unit was generally 70 years and older adults, but that in special cases they accepted younger patients with physician review. The admission criteria provided to the surveyors for review recorded admission age of 65 years or older unless physician approval occurred.

3. During the tour, the surveyors noted one individual using a walker. The patient had a slow, hesitant gait and staff accompanied the patient with a hand partially outstretched.

4. All patient room doors swung inward and had frame mounts that prevented the doors from swinging out into the hall.

5. Patient room doors for rooms 304, 306 and 307 did not have access panels in the door or any other mechanism to access a patient/individual should they fall against the door and be unable to move to allow access to others.

6. The doors that had access panels to patient room had been painted. For one of two of these doors, that staff and surveyors tried to unlock, the access panel would not open to allow entrance should the need arise.

7. The hospital did not have a plan/procedure on what would be done if a patient/individual fell against the door or barricaded themselves in the room and the door/room did not have a functioning access panel opening outward to allow entrance. With the age and fragility of the patient population on the unit, if staff tried to force the door open upon a fallen patient, it could cause injury/further harm to the patient.

MCCURTAIN MEMORIAL HOSPITAL

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JANE PHILLIPS MEDICAL CENTER	**3500 EAST FRANK PHILLIPS BOULEVARD BARTLESVILLE, OK 74006**	**Nov. 1, 2011**

VIOLATION: *PATIENT RIGHTS: GRIEVANCES*

Tag No: A0118

Based on review of hospital policies and the grievance and complaint log, selected grievances and complaints, and interviews with hospital staff, the hospital failed to ensure the hospital's established grievance process was implemented.

Findings:

1. The hospital's grievance policy, entitled "Patient Grievance ," with an issue date of June 30, 2011, defined a grievance as "a formal or informal written or verbal complaint that is made to the (hospital) (when the complaint is not resolved at the time of the complaint by staff present), abuse or neglect, issues related to the hospital compliance with CMS Hospital Conditions of Participation or a Medicare beneficiary billing complaint related to right and limitations." Although the hospital's policy correctly defines a grievance, the hospital failed to educate, train staff and implement the policy.

2. The hospital failed to identify grievances: The surveyors reviewed the grievance log for 2011. Three grievances (2,3,4) did not have a letter written to the complainant with all required elements. In an interview on the afternoon of 11/1/2011 Staff B told surveyors at times complaints/grievances are provided through several avenues. Two complaints provided by Staff C were identified as complaints although they required an investigation. In an interview on the afternoon of 11/1/2011, Staff B told surveyors that all of the grievances and complaints were not always provided to the patient liaison and/or risk manager and were not always logged correctly Staff F stated if the grievance went to governing board first they were not always acted on by the Patient Relations department and followed the grievance process.

3. The data provided to the surveyors did not demonstrate the hospital investigated all the grievances. The grievance log provided to surveyors did not contain all grievances received by the hospital in 2011. There was no documentation of investigation and required elements on the grievances that were forwarded to the Patient liaison. There was no documentation of investigations of all personnel involved and actions taken on behalf of the patient in several of the grievances.

4. The hospital does not ensure the written response to the complainant contains all of the required elements. All of the grievances listed on the log were reviewed by surveyors. Not all of the complainants received letters. Not all of the letters to the complainants included what was done to investigate or what actions were taken to resolve the grievance.

5. The hospital does not ensure grievance data is incorporated in the hospital's Quality Assessment and Performance Improvement (QAPI) Program with analysis of the data and implementation of processes to improve patient care:
In an interview on 11/1/11 Staff A told surveyors the quality department reviewed all grievances. Staff A told surveyors the meetings did not have minutes but staff in the department discussed grievances routinely. There was no evidence that grievance and complaint data was reviewed, trended and analyzed with implementation of corrective and/or process changes to improve patient care. There was no evidence the Governing Body reviewed, trended, and analyzed grievance and complaint data.

VIOLATION: *PATIENT RIGHTS: REVIEW OF GRIEVANCES*

Tag No: A0119

Based on review of records, interviews with staff, and review of policies, the hospital does not ensure that all patient grievances are reviewed, resolved, and a written response sent in the hospital's grievance process. Six (1,2,3,4,5,6,) of nine (Patient #1,2,3,4,5,6,7,8,9) complaint/grievances did not follow the grievance process or include all required elements.
Findings:

1. On 11/1/2011 surveyors reviewed the grievance log from January 2011 to present. Grievances #2,3,4 indicated allegations had been reviewed but there was no written response sent to the complainant.

2. Grievance #1 (the patient mentioned in the complaint) included a response letter. Hospital documents provided to surveyors did not indicate all of the practitioners involved had been interviewed and appropriate personnel action documented. Staff A told surveyors on the afternoon of 11/1/2011 she had given the information to Staff F administration (also mentioned in the grievance) but she did not know what actions had been taken on behalf of the patient with regard to Staff E the practitioner involved in the grievance. The investigation does not stipulate Staff E had been interviewed by Staff F and any actions deemed necessary taken.

3. According to the policy "Patient Grievance, IV.I Following the investigation and review of the patient's complaint/grievance, a formal review of corrective or preventive action is conducted under the supervision of the Compliance Office and will include, as necessary a meeting with involved associates, the patient and patient Advocate." The policy does not stipulate Staff F had been delegated the responsibility of corrective/preventive action. None of the documents provided to surveyors indicate Staff F had been given the responsibility of the grievance process or oversight.

3. On 11/1/2011 surveyors reviewed incident logs from March, April, and May of 2011. Two (#5,6) of seven incidents reviewed were incorrectly noted as complaints. Both incidents involved patient care issues and required investigation. There was no information provided to surveyors the grievance process was followed.

4. On 11/1/2011 Staff A told surveyors information from grievance investigations was provided to administration but Staff A did not attend Board Meetings and could not tell surveyors how or if grievances were reviewed through governance. According to the policy "Patient Grievance"IV.I "data from grievances is also used in formal Performance Improvement efforts under direction of the Director of Quality and/or Quality manager." There is no documentation the Governing Body reviews grievance data. The policy does not stipulate the governing body delegated the responsibility of the grievance process to the Quality Department.

VIOLATION: *PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION*

Tag No: A0123

Based on review of the hospitals grievance policy, log and individual grievances, the hospital failed to provide a written response to the complainant with 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. This occurred for three of three patients/patients' representatives who filed grievances (Grievance #3,4,5) and the complaint was not resolved at the time of the complaint by staff present or immediately available.

Findings:

1. The hospital's grievance policy, provided to the surveyors on the morning of 11/1/2011 and identified by the Quality Administrator as the current policy, stipulated that grievances would be investigated and the complainant would be provided a written response with the required information within 7 days. The policy stated that if the investigation was not completed within the 7 days, a written response would be sent to the complainant stating the hospital was still investigating and then another written response, with the required information, would be sent when the investigation was complete.

2. From the grievance/concern log, five grievances (Grievances #1 through 5) were selected and the surveyor requested all documentation the hospital had concerning the grievance, including investigation and any written correspondence. Three of the grievances were not resolved at the time of the grievance/concern. The material supplied did not contain documentation a written response had been provided to the complainant as required. The surveyor again asked Staff A if the hospital had any additional documentation. None was provided.

VIOLATION: *UNSPECIFIED CATEGORY*

Tag No:

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of medical records, interviews with staff and hospital documents the hospital failed to supervise the development of a discharge plan.

Findings:

1. According to the policy "Initial Transition/Discharge Planning Process" the "RN and Social Worker Case Managers are jointly accountable for assessing the patient and determining the needs and interventions. The assessments consists of a personal interview with the patient and/or family, a modified physical and/or psychosocial assessment and review of Medical Record.
Another policy "Case Management Process" 8. Facilitate and coordinate discharge process by identifying patient's readiness based on pre-determined discharge goals. Confirm date and final discharge plan with physician, patient, and family. 9. Ensure all discharge/transfer activities are completed effectively for follow up care or post discharge services with necessary paperwork completed."
2. Pt#1's medical record indicates the patient had been hospitalized for [DIAGNOSES REDACTED]. According to hospital documents, Pt#1 was told by Staff E she was to be discharged the following day and if the patient had not selected a hospice prior to discharge, Patient #1 would be discharged without hospice care. Documents also indicate Staff E returned to Patient #1's room the next morning and told the patient she would need to pick out a hospice by 1100 AM or be discharged without hospice services. Staff E is credentialed and privileged as a hospitalist nurse practitioner. Staff E was not listed on the hospital's case management/discharge planner roster. There

was no documentation Staff E contacted case management/discharge planning. In an interview on the morning of 11/1/11 Staff A told surveyors she was not aware of any policies stipulating the patient had to be out of the hospital by 11:00 AM.

After the initial contact with Staff E, Patient #1 spoke with the physician in charge of her care and requested Staff E not return to her room. Documents stipulate Pt#1 was told by the physician she needed another x-ray before she could be discharged and Pt#1 would not be leaving the next morning. He also indicated he would "handle" the situation with Staff E. There was no documentation the physician contacted case management/discharge planning to delay the discharge or expedite arrangements for hospice.

Although an initial discharge planning evaluation had been completed, documents provided to surveyors did not indicate a case manager or discharge planner had been contacted to expedite an effective discharge. According to documents at the hospital, the patient was so upset after the second interaction with Staff E the patient was discharged without hospice arrangements procured. The patient was discharged on a holiday weekend. The hospital failed to ensure appropriately qualified staff oversaw discharge for effective and safe coordination of post hospital care.

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Report No. 1263

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ST JOHN MEDICAL CENTER, INC 1923 SOUTH UTICA AVENUE TULSA, OK 74104 June 22, 2011

VIOLATION: *UNSPECIFIED CATEGORY*

Tag No:

Based on record review and interviews with hospital staff, the hospital does not ensure that adverse patient events are investigated and analyzed to assess processes of care and to ensure quality of patient care.

Findings:

1. Patient #4 received burns from equipment used in a procedure.

2. The hospital did not have any evidence that the occurrence had been investigated, analyzed and measures taken to prevent a reoccurrence.

3. Staff A stated on 06/22/11 in the afternoon that there was no documentation of what the hospital did to investigate the incident. Staff A said that according to the radiology department the equipment was sent to the manufacturer, but did not have any documentation of the manufacturer's evaluation. There was also no investigation of whether there were other reasons this incident might have occurred.

4. The occurrence report stated that the radiology department would do a quality assurance (QA) investigation of the incident. Review of QA meeting minutes for 2009 which was when the incident occurred did not have any evidence of a review of this incident.

VIOLATION: *PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION*

Tag No: A0123

Based on review of the hospital's grievance/complaint policy, grievance log and seven grievances and interviews with hospital staff, the hospital failed to provide a written notice to the complainant with 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. This occurred for three of six patients/patients' representatives who filed grievances (Grievance #1 through 6 of Grievances #1 through 7) when the complaint was not resolved at the time of the complaint by staff present or immediately available.

Findings:
1. The hospital's grievance policy, entitled "Patient Complaint/Grievance Resolution," with an issue date of February 2008, on pages 2 and 3, appropriately stipulated that a written response would be provided to the complainant with the "steps taken on behalf of the patient to investigate the grievance; findings of the investigation; results of the grievance process (corrective measures initiated, if any); date of completion of the process; name of the hospital contact person"and this process should be completed within 45 days from the date of receipt of the complaint.

2. The surveyors selected six concerns/complaints/grievances from the complaint, grievance and claim log for September 2009, and March and April 2011. Upon review of the data supplied by the hospital, five of the concerns listed were grievances. The problems/concerns identified by complainants could not be resolved at the time of the complaint and required investigation. This finding was reviewed and verified with hospital administrative staff # A throughout the survey.

3. During the review of the incident reports selected from the incident log for the time period listed in Finding #2, in two of the incidents, the patient/patient representative had also voiced a grievance. For one of these grievances voiced (Patient #3), the hospital could not produce evidence it had investigated and responded to the complainant. For the other one, voiced by Patient #1, the hospital investigated the complaint, but it was not channeled through the grievance process, but was identified as a claim.

5. Three of six grievances/complaints reviewed, not resolved at the time the complaint was issued, did not contain a written response to the complainant with the required information. On the afternoon of 06/22/2011, the surveyors confirmed with administrative staff #A that no additional written response had been provided to the complainants.

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.

OKLAHOMA SURGICAL HOSPITAL, LLC	**2408 EAST 81ST STREET, SUITE 300 TULSA, OK 74137**	**March 31, 2011**

VIOLATION: *PATIENT RIGHTS: GRIEVANCES* **Tag No:** A0118

Based on review of hospital documents and interviews with staff, the hospital failed to ensure that all grievances/complaints not resolved at the time of the complaint by staff present are included in the hospital's grievance process. Three of four complaints/grievances on the grievance log reviewed during the investigation were not included in the hospital's grievance process.

Findings:

1. One grievance which was entered into the system was not included in the grievance process because it was not considered a grievance. The grievance log described the grievance as a "billing issue", but the patient's issues also concerned patient care issues. No investigation was conducted and no letter was sent to the complainant.

2. The second grievance concerned a complaint of pain and care issues. These issues required an investigation, but staff stated that they did not consider this a grievance and did not treat it as such.

3. The third grievance was listed as one complaint, but was really two different incidences on two separate days. The first incident did not have an investigation and the second incident did not have an investigation that interviewed all parties involved.

5. The hospital's definition in their grievance policy of a complaint does not agree with CMS's definition. Any complaint/grievance that cannot be resolved at the time by staff present is considered a grievance and should be treated as such. The hospital says if it can be resolved within 24 hours and involves staff present while the patient is actively receiving care then it considered a complaint and is not considered a grievance and is not treated as such.

VIOLATION: *PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT* **Tag No:** A0145

Based on the review of abuse and neglect policies and procedures, a written letter from a hospital staff member, patient complaints/grievances and interviews with hospital staff, the hospital does not have mechanisms/methods defined in a policy that clearly describes the procedures to follow when a patient alleges abuse by a hospital employee.

Findings:

1. The hospital's policy, Reporting of Abuse, Neglect and Exploitation with an effective date of 05/1/2001, stipulates all employees of Oklahoma Surgical Hospital, particularly those responsible for patient care, are required to report instances of abuse, neglect or exploitation. The policy defines abuse/neglect as any intentional harmful or offensive conduct. This includes: assault battery; sexual assault; unreasonable physical constraint; prolonged deprivation of food and water; the use of prolonged or unnecessary physical or chemical restraints; any acts or procedures used as means of punishment; and verbal abuse. In the section "accountability: 3. If an employee is suspected of abusing or harassing a patient, the immediate supervisor of the employee should be notified. The supervisor

should then contact Human Resources for further direction. Surveyors also reviewed the policy "Employee conduct /Disciplinary Process". None of the policies clearly define the steps to be followed when a patient alleges abuse or neglect by a hospital employee or contract worker or contain the components to prevent, screen, identify, train, and report/respond to allegations of abuse/neglect .

2. On the afternoon of 3/31/11, Staff C told surveyors Patient #1 called the hospital the day after an outpatient procedure and alleged sexual misconduct by a hospital staff member (Staff E). Staff C told surveyors the hospital staff member (Staff E) was not on duty the day the allegation was made. Staff C stated staff E had been removed from patient care duties during the investigation. Staff C also told surveyors Human Resources had not been contacted for further direction. In an interview later in the afternoon Human Resources confirmed they had not been involved in the investigation.

3. On the morning of 3/31/11, surveyors reviewed the Patient #1's grievance, the hospital's investigation, and a written statement by Staff E. The written statement alleged that Staff E had been grabbed in the groin by the complainant and sexual comments were made by the complainant at that time. On 3/31/11, Staff C told surveyors she was not aware this occurred until Staff E provided a written statement four days after the complaint. Staff C told surveyors Staff E told a supervisor but did not complete a incident report or report the alleged misconduct to anyone else. Staff C told surveyors the supervisor did not complete an incident report or notify Risk Manager about the occurrence.

4. On the morning of 3/31/11, surveyors reviewed the abuse and neglect training for hospital employees. There was no documentation that hospital staff were trained regarding abuse of patient's by hospital employees.

OKLAHOMA SURGICAL HOSPITAL, LLC

2408 EAST 81ST STREET, SUITE 300 TULSA, OK 74137 | Proprietary

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March 31, 20112 (click for details) Read full report

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Incomplete reports

No incomplete reports available.

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WAGONER COMMUNITY HOSPITAL	**1200 WEST CHEROKEE STREET WAGONER, OK 74467**	**March 15, 2011**

VIOLATION: *PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT* **Tag No:** A0145

Based on the review of abuse and neglect policies and procedures, patient complaints/grievances, medical records and interviews with hospital staff, the hospital does not have mechanisms/methods defined in a policy that clearly describes the procedures to follow when a patient alleges abuse by a hospital employee.

Findings:

1. On the morning of 3/14/2011, the hospital provided policies for review. The policy "patient rights: to be free from abuse, neglect, or harassment from staff, other patient, and/or visitors-dated 5/09" stipulates if there is a circumstance where there is suspected abuse, neglect , or harassment by hospital staff, other patients, and/or visitors, measures will be immediately instituted to secure the patient and investigate the allegations. The policy stipulates all staff shall have criminal background checks prior to hire. The policy also stipulates identifying events as "unexplained fearfulness of people where there had not been prior complaints and aggressive behaviors (threats, insults). The policy stipulates education will occur during initial orientation and annually thereafter. The policy indicates "for the protection of the patient in question and patients in general, the staff member will be placed on suspension without pay pending investigation.
A policy entitled "occurrence/incident reporting" stipulates an occurrence/incident is "any happening out of the ordinary which results in a potential for or actual injury to a patient, visitor or employee, or damage to facility, property or reputation will be reported through completion of occurrence/incident report." The policy also stipulates "if the occurrence pertains to a fall/other injury of a patient, examine the patient for injury, vital signs, take a subjective statement if possible and notify the physician.

2. On 3/14/2011 surveyors received mental health unit grievances from October 2010 to February 2011. Of the nine grievances filed on the Mental Health Unit only two grievances(Pt 1 and 8) were reviewed by the Staff B designated by the hospital as the grievance coordinator. Seven of nine mental health unit grievances alleged staff physical or verbal abuse. Eight (Pt's 1,4,5,6,7,9,10,11) of nine (Pt's 1, 4,5,6,7,8,9,10,11) specifically stated staff names, shifts, or physical descriptions of the alleged abuser. Of the eight grievances alleging abuse by staff, the hospital failed to follow the abuse policy. None of the staff were relieved of duty pending investigation into the allegation.

Patient # 5 filed a grievance on 10/26/11 alleging at bedtime Staff F "grabs and snatches me up so hard from behind my shirt came open. I also have a bad back from two surgeries. Patient # 5's medical record documentation during the time of the incident stipulates at 0155 "pt (patient) is in bed resting with eyes closed. Resp. (respirations) even and unlabored. No gestures self harm. Pt delusional and paranoid believes staff members are out to get her called 911 to report she was being asaulted. Pt did calm down without medication and went to bed and slep soundly. No further incident."

On the morning of 3/15/11, Staff C told surveyors an investigation had taken place but there was no documentation. Staff C told surveyors the treatment team discussed the grievance but there had been no review of the documentation of the 911 call regarding abusive treatment. There was no documentation on the grievance indicating there had been investigation into the allegations. There was no incident report filed on the 911 call. Staff C stated the patient was seeking attention and was very familiar to the unit. Staff C indicated the patient was placed in a CAPE (creating a positive environment) hold during the incident. There was no documentation in the restraint and seclusion log or the medical record the patient had been restrained. Staff C told surveyors the medical record had not been reviewed. Staff

C did not indicate personnel working the night of the alleged incident had been interviewed.

Patient #4 filed a grievance on 10/26/11 alleging staff were verbally abusive. Pt #4 documented "Sunday night and Monday night will curse and yell and people and (sic) be rude and hateful . Didn't happen to me but seen it happen to a lot of people." Staff C told surveyors she had interviewed Patient #1. Documentation on the grievance stipulates "spoke with patient. She states there was a "blonde female" that acted like she owned the place. Monday night was an Indian guy (sic) was screaming - another tech was yelling and screaming at patients - was cussing at patients stated "shut the fuck up, get this damn dayroom cleaned up or you're not going out to fucking smoke!" Staff C documented follow up conversations with the staff alleged involved. No other staff listed as working the night of the incident were interviewed. The investigation of the grievance did not follow the hospital policies.

Patient #6 filed a grievance on 2/3/11. Patient #6 documented "against (name withheld) for making me take off my clean scrubbs (sp) with little diapers on to try and put on my jeans and t-shirt that I was told to hol on to and not let go off (sp) while other people were left alone with there (sp) scrubs left on. Patient #6 also documented on another grievance report "jumpin on me when they should be jumpin (sp) on some one else-don't know there (sp) names".

Staff C documented "patient iillogical and paranoid". There was no investigation of the complaint documented. Later on 3/15/11 Staff C told surveyors the treatment team reviewed allegations but there was no documentation of the meeting. The investigation of the grievance did not follow the hospital policies.

Patient #10 filed a grievance on 1/3/11. Pt #10 alleged staff had asked patient's to remind staff when they needed or wanted medications but when patients asked for their medications they were accused of being drug seekers. Patient also stated in the grievance "please don't hold this against me". There was no investigation documented on the grievance. There was no indication the patient's allegation had been reviewed.

3. Hospital staff (Staff C and D) the morning of 3/14/11, told surveyors various ways they would handle an allegation of abuse or neglect of a patient or witnessed abuse and neglect. These staff could not identify exactly and verbalize what to do if they witnessed an incident of abuse or neglect of a patient by a staff member.

4. On 3/14/11 surveyors reviewed staff meeting minutes dated 1/26/11. Items reviewed in the staff meeting include "12. There have been many complaints made about staff attitudes., i.e. talking rudely to the patients and lack of compassion. 13. In appropriate force used to take the patients in cape holds, etc. Not trying verbal intervention, prns, and etc. first. 16. All cape holds have to have the same paperwork pulled and completed by the nurses. The debriefment must be signed by all witnesses. Make sure that the care plan is put in the chart.

5. Surveyors toured the mental health unit 3/14/11. During the tour, surveyors were were shown where patient's could submit written grievances. The "inbox" (basket stipulated for grievances) was out on the unit and a open wire basket. The grievance inbox was not locked and could be accessed by all patients and staff. Later Staff C told surveyors patient's could put grievances under the door of the manager's office if the patients wanted.

VIOLATION: *PATIENT RIGHTS: RESTRAINT OR SECLUSION* **Tag No:** A0196

Based on review of hospital policies and procedures, staffing schedules and personnel files, and interviews with hospital staff, the hospital failed to ensure staff, working on the mental health/psychiatric (psych) unit, were trained and kept current in the safe implementation in CAPE (Creating a Positive Environment), the facility's approved method to hold/restrain patients, and application of restraints before patient care were assigned. This occurred for nine of nineteen (Staff # F, K, L, N, O, P, Q, R, and T of Staff #C, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U and V) personnel files reviewed for CAPE competency.

Findings:

1. State Licensure Chapter 667 Hospital Standards, Subchapter 33, 310:667-33-2(b)(2), stipulates, "All staff providing active treatment or monitoring patients shall be trained in facility methods approved to physically hold or restrain patients before patient care responsibilities are assigned. These staff members shall be reoriented regarding these policies annually or when policies are revised."

2. On the morning of 03/14/2011, staff told the surveyor that CAPE was the approved method to physically hold/restrain patients. This was confirmed by policy review and personnel file review.

3. On 03/14/2011 at 1100, Staff C and D told surveyors that Security was often on the unit every day and did participate in CAPE holds and restraints.

4. Four of five psych unit staff (Staff # F, L, R and T of Staff # F, L, R, T and V), hired within the last year and whose personnel files were reviewed, did not have CAPE training before working on the psych unit.
a. Staff F - date of hire was 05/12/2010; CAPE training was 06/25/2010.
b. Staff L - date of hire was 07/09/2010; CAPE training was 08/16/2010; schedule review confirmed worked on unit before CAPE.
c. Staff R - date of hire was 07/15/2010; CAPE training was 08/16/2010; schedule review confirmed worked on unit before CAPE.
d. Staff T - date of hire was 10/05/2010; CAPE training was 12/28/2010; schedule review confirmed worked on unit before CAPE.

5. Three of three Security staff (Staff #O, P and Q), hired within the last year and whose personnel files were reviewed, did not have CAPE training before helping on the psych unit.
a. Staff O - date of hire was 08/12/2010; CAPE training was 09/09/2010; schedule reviewed confirmed worked and was available to help on the unit before CAPE.
b. Staff P - date of hire was 02/25/2011; has not had CAPE training; seen on unit with patients on 03/15/2011.
c. Staff Q - date of hire was 01/14/2010; CAPE training was 09/25/2010; schedule review confirmed worked and was available to help on the unit before CAPE.

6. Security Staff N did not have current CAPE training. Security Staff N's last CAPE training was 12/10/2003.

7. Staff K did not have current CAPE training. Staff K's last CAPE training was 12/__/2009.

8. These findings were reviewed with administrative staff on the afternoon of 03/15/2011.

VIOLATION: *PATIENT RIGHTS: GRIEVANCES*

Tag No: A0118

Based on record review and interviews with hospital the hospital does not ensure patient grievances are investigated and the hospital's grievance process is implemented. Seven (#'s 2,3,4,5,6,7 & 9) of nine patient grievances filed on the hospital's mental health unit were not investigated and the hospital's grievance process was not implemented.

Findings:

1. Seven of the nine grievances reviewed from the hospital's mental health unit during the months October 2010 through February 2011 did not have review by the hospital's grievance coordinator as required by the hospital's grievance policy. The hospital's grievance policy states "The individual receiving the grievance will initiate a written Grievance Management form, completing as much information as is available. The person who initiated the grievance will be advised that the grievance will be directed to the hospital's COO or designee for prompt resolution."

2. Mental health unit staff keep a separate grievance log and this log is not integrated into the hospital's grievance process. This was verified on 03/14/11 in the morning by Staff C and A.

3. On 03/15/11 Staff A stated that Staff B was responsible for the grievance process and was the only person reviewing the grievances. Mental health unit grievances are not "usually" investigated by Staff B according to both Staff A & B. Most of the grievances filed in the mental health unit are reviewed and investigated by the mental health unit staff not by the hospital's designated grievance individual. Documentation provided to the surveyors did not contain evidence the grievances had been investigated.

VIOLATION: *PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION*

Tag No: A0123

Based on review of the hospital's grievance policy, selected grievances from the mental health (paych) unit and interviews with hospital staff, the hospital failed to provide a written response to the complainant with the required information. This occurred for nine of nine grievances reviewed filed for the psych unit patients (Patients #1, 4, 5, 6, 7, 8, 9, 10 and 11).

Findings:

1. Patient #1 - On 03/15/2011 at 1030, Staff B stated she investigated the complaint filed by the patient's representative, but did not send a written response, with all the required information, to the complainant.

2. Patient #8 - On 03/15/2011 at 1035, Staff B stated she investigated the complaint referred by another source. Documentation provided did not show a written response was provided to the actual complainant, but a written response was provided to the referral source. Staff stated she responded to the referral source because that was the person who had contacted her about the problem.

3. Documentation for complaints/grievances filed for Patients #2, 3, 4, 5, 9, 10 and 11) did not demonstrate a written response, with the required information, was provided to the complainants. Staff B stated she did not investigate these complaints. Staff A stated that psych complaints were handled on the unit. Staff C stated they were "handled" in Treatment Team and that a written response was not provided to the complainant.

VIOLATION: *PATIENT RIGHTS: CARE IN SAFE SETTING*

Tag No: A0144

Based on surveyor observations, review of hospital documents, and interviews with hospital staff, the hospital failed to provide a safe environment and care in a safe setting.

Findings:

1. Upon tour of the mental health unit on the morning of 03/14/2011, they surveyors observed one patient using a Styrofoam cup scooping out ice from a bowl on a cart in the hallway. The patient had not sanitized his hand before obtaining the ice. The cart did not have a designated scoop. The bowl was uncovered and not monitored to ensure sanitary access.

2. On 03/14/2011 at 1105, Staff C and D stated that patients could get their own ice from the bowl and that staff did not monitor the ice bowl to ensure patients used safe aseptic practices when obtaining their ice.

3. Seven of nine grievances reviewed alleged staff abuse, mental and/or physical. Documentation provided and interviews did not demonstrate the hospital had followed its policy to provide care in a safe setting while investigating the allegations. (Refer to Tag A-145 for details.)

WAGONER COMMUNITY HOSPITAL

1200 WEST CHEROKEE STREET WAGONER, OK 74467 | Government - Hospital District or Authority

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March 15, 20115 (click for details) Read full report

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Incomplete reports

No incomplete reports available.

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HILLCREST HOSPITAL SOUTH **8801 SOUTH 101ST EAST AVENUE TULSA, OK 74133** **March 2, 2011**

VIOLATION: *PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT* **Tag No:** A0145

Based on the review of abuse and neglect policies and procedures and various policies from the human relations department and interviews with hospital staff, the hospital does not have mechanisms/methods defined in a policy that clearly describes the procedures to follow when a patient alleges abuse by a hospital employee.

Findings:

1. The hospital provided policies for review. The policies concerned child abuse, elder abuse, sexual abuse and spousal/domestic abuse concerning patients who present to the hospital. The policies did not clearly define the steps to be followed when a patient alleges abuse or neglect by a hospital employee or contract worker or contain the components to prevent, screen, identify, train, and report/respond to allegations of abuse/neglect .

2. Interviews with hospital staff on 03/02/10 in the afternoon verified that the hospital does not have a written policy that includes the required elements for effective abuse protection.

VIOLATION: *PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION* **Tag No:** A0123

Based on a review of policies and procedures, complaint/grievance reports, and a staff interview, the hospital failed to ensure a written notice of the patients' grievance resolutions containing 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 were provided to the complainants. One (#1) of three grievances reviewed did not contain a written response to the complainant containing the required elements. Two (#'s 2 & 3) of three grievances did not have any written response.

Findings:

1. These three grievances were marked resolved on the grievance log, but two did not have a written response to the complainant and the one with a written response did not contain the required elements. The hospital classified grievances as either formal or informal.

2. Hospital Staff C stated on 03/02/10 in the afternoon that the hospital believed grievances/complaints that were classified as formal needed a written response and the informal did not. Staff C also verified these three complaints required an investigation and were not resolved at the time of the complaint by staff present.

HILLCREST HOSPITAL SOUTH

8801 SOUTH 101ST EAST AVENUE TULSA, OK 74133 | Proprietary

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March 2, 20112	(click for details)	Read full report

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Incomplete reports

Report date	Number of incomplete reports	Number of violations
Sept. 18, 20121		6

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ST JOHN MEDICAL CENTER, INC 1923 SOUTH UTICA AVENUE TULSA, OK 74104 March 1, 2011

VIOLATION: *INTEGRATION OF OUTPATIENT SERVICES* **Tag No:** A1077

Based on a review of policies and procedures, quality assurance/performance (QAPI) improvement meeting minutes and staff interviews, the facility failed to ensure the QAPI reviews were implemented into the housewide QAPI program.

Findings:

1. In the review of the QAPI meeting minutes for the last six months there was no evidence the Department (The Breast Care Center) participated in the hospital"s (St. John Medical Center) house wide QAPI, process, or findings.

2. During an interview with the Radiology Director on 03/01/11 at approximately 1125, the director confirmed that the Breast Care Center is not included in the hospital's QAPI process.

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NORMAN REGIONAL HEALTH SYSTEM 901 NORTH PORTER NORMAN, OK 73070 Feb. 23, 2011

VIOLATION: *PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT* **Tag No:** A0145

Based on review of policies and procedures, hospital documents and medical records, and interviews with hospital staff, the hospital failed to follow its policy to ensure abuse did not occur. For one of one patient (Patient #3), the hospital staff did not follow the hospital's procedure when allegations of abuse by staff occurred.

Findings:

1. The hospital's policy, PCM #200, Abuse/Neglect (Child, Domestic, Dependent Adult/Elderly, Sexual) with an effective date of 06/23/2010, stipulates all cases of reported abuse would be investigated. The policy documents that the patient's nurse is to notify her immediate supervisor, the Case Management department and the unit Manager.

2. The Progressive Care Unit Manager told the surveyors on the morning of 02/23/2011 that she had not had any reports of allegations of patient abuse by staff.

3. Staff I told the surveyors on 02/23/2011 at 1055 that Patient #3 and Patient #3's representative reported that the patient had been "hit" by an aide and the aide had "been rough with (the patient)." When asked what she did about this, she replied she reported it to the charge nurse on the unit. She did not report that she examined the patient for any evidence of injury to the patient.

4. Staff J told the surveyors on 02/23/2011 at 1325 that Staff I had reported the allegation of patient abuse by Staff K to her. She stated that since Staff I stated she had been with the aide and did not witness abuse; and since the patient was confused at times, she did not report the allegation to anyone else. She stated she talked with the family and it was decided to reassign the aide. She did not report that she examined the patient for any evidence of injury to the patient.

5. Review of incident/occurrence reports, the grievance log, and Patient #3's medical record did not contain documentation that an allegation of abuse had occurred or that the patient was assessed for physical harm. Staff I and J told the surveyors on 02/23/2011 that they had not completed an incident report.

VIOLATION: *INFECTION CONTROL OFFICER RESPONSIBILITIES* **Tag No:** A0749

Based on review of the hospital's documents and interviews with staff, the hospital failed to ensure the infection control practitioner developed and implemented an ongoing infection control program based on nationally recognized infection control guidelines and designed to identify, prevent, control and investigate infections and communicable diseases of patients and personnel.

Findings:

1. On the morning of 2/21/11 surveyors reviewed the hospital's infection control log. Patient #5 was listed on the log. The documentation for patient #5 indicated "HAI" (hospital acquired infection) was written on the log with a line drawn through and above HAI was written

"POA" (present on admission). On the afternoon of 2/21/11 surveyors spoke with staff E the infection prevention specialist. Staff E told surveyors Patient #5's infection was initially identified as a HAI but when Staff E went to investigate the infection, a physician caring for the patient told Staff E the infection was POA. There was no documentation in the chart by this physician indicating the infection was present on admission. Staff E told surveyors there was no further review of care and no review of the information regarding Patient #5 in the infection control meeting.

2. On the afternoon of 2/22/11, Staff E told surveyors Patient #5's infection was determined to be POA because the patient had a bowel surgery and later developed a blood stream infection of VRE (vancomycin resistant enterococci). Staff E told surveyors the growth of VRE indicated the patient was colonized with the infection prior to admission. Patient #5's chart did not indicate any cultures had been performed on the patient prior to arrival to establish the patient had been colonized with VRE. There was no documentation in the chart which reflected the patient had an infection or microbial colonization prior to admission. There was no documentation in the history and physical the patient had been treated for this infection or was currently being treated for this infection at the time of admission.

3. These findings were reviewed with administration during the exit conference on 2/23/2011. No further documentation was provided.

NORMAN REGIONAL HEALTH SYSTEM

901 NORTH PORTER NORMAN, OK 73070 | Government - Local

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Feb. 23, 20112 (click for details) Read full report

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EPIC MEDICAL CENTER **1 HOSPITAL DRIVE EUFAULA, OK 74432** **Feb. 15, 2011**

VIOLATION: *CRITERIA FOR MEDICAL STAFF PRIVILEGING* **Tag No:** A0363

Based in record review and interviews with facility staff, the hospital does not ensure that all practitioners are working within their scope of privileges while providing patient care. One of one (Staff A) physician assistant working in the emergency room , and whose credential file was reviewed, did not have current privileges granted for the tasks performed. The physician assistant terminated advanced cardiac life support measures and pronounced patient's dead without consultation with a supervising physician (Pt's 1,2,3,4).

Findings:

1. On 2/15/2011 surveyors were provided copies of Medical Staff Bylaws, rules and regulations. Section 3.4-2 stipulates: "Physician assistants are responsible to their supervising physician who remains ultimately responsible for the patient's care. It is the responsibility of the PA-C to discuss their findings with the attending physician upon completion of their examinations. Part 11-Hospital Deaths and Autopsies 11.1 Death Pronouncement: Only the physician may pronounce death in situations of brain death prior to removal of artifical respiratory or circulatory support." Five of five patient records (Pt's 1,2,3,4,5) reviewed did not contain documentation the physician assistant Staff A consulted with a supervising physician prior to termination of advanced cardiac life support measures, prior to transferring patients, or prior to pronouncing a patient dead.

2. On 2/15/2011 surveyors reviewed privileges for a physician assistant, Staff A. Staff A did not have privileges to pronounce patient's dead.

3. On 2/15/2011 surveyors reviewed Medical Staff Meeting Minutes 2010-2011 and Quality Improvement Committee Meeting Minutes 2010-2011. There was no documentation the Medical Staff reviewed or evaluated care provided by the physician assistants. This finding was confirmed with Staff B in an interview the afternoon of 2/15/11. This finding was reviewed with administration on 2/15/11. No further documentation was provided.

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on review of hospital documents and interviews with hospital staff, the hospital failed to include, analyze and track adverse patient events as part of the quality process to improve patient care and hospital services.

Findings:

1. Review of the Quality Improvement (QI) meeting minutes for 2010-2011, Medical Staff meeting minutes and Governing Body meeting minutes did not demonstrate all adverse patient events were part of the quality improvement program with analysis to improve hospital practices. Four of four records (Pt's 1,2,3,4) documented adverse patient events. There was no documentation in any of the QI or Governing Body Meeting Minutes demonstrating the adverse events had been reviewed, analyzed, or tracked.

2. In an interview on 2/15/11 Staff B told surveyors reviews of the adverse events were done by Staff B, Staff C and Staff D. Staff B told

surveyors the adverse events were reviewed with nursing personnel but there had not been any reporting to committees. Staff B told surveyors if the adverse event involved personnel other than nursing, there had not been any other review or review by committees.

3. These findings were reviewed with administration during the exit conference. No further documentation was provided.

VIOLATION: *EMERGENCY SERVICES POLICIES*

Tag No: A1104

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of emergency room (ER) policies and procedures manual, hospital documents and medical records and interviews with hospital staff, the hospital failed to ensure medical staff developed, revised, and enforced the ER policies governing medical care provided in the ER. The physician assistant (PA) provided medical care to ER patients without direction or input from the supervising physician. This occurred in five of five (Records 1,2,3,4,5) of ER medical records reviewed in which Staff A provided care.

Findings:

1. On the morning of 2/15/2011 surveyors were provided the medical staff bylaws, rules and regulations, "section 11 Hospital Deaths and autopsies 11.1 Death pronouncement. Only the physician may pronounce death in situations of brain death prior to removal of artificial respiratory or circulatory support". In five of five medical records (#1,2,3,4,5) in which patient's arrived to the emergency room in cardiac or respiratory arrest with cardiopulmonary resuscitation (CPR) and advanced cardiac life support (ACLS) measures being performed, Staff A pronounced the patient's dead without documentation of consultation with a supervising physician. Credentialing files for Staff A did not indicate Staff A was privileged to perform this duty.

2. On the morning of 2/15/2011 surveyors were provided copies of the emergency room policy "emergency room Subject: Code Blue" The policy stipulates "emergency room personnel will perform cardio pulmonary resuscitation according to ACLS guidelines. Responsible Party: A. RN, LPN, MD: 1. Place on monitor. 2. Initiate appropriate drug therapy for appropriate heart rhythm. See algorhythms (sic) and drug protocols. 3. Defibrillate as per procedure. 4. Arterial blood gases as soon as possible when indicated. According to the American Heart Association 2010 American Heart Association Guidelines for cardiopulmonary resuscitation-Adult Cardiac Arrest algorithm "Asystole/PEA, cardiopulmonary resuscitation is performed for 2 minutes followed by a rhythm check. If the cardiac rhythm is asystole/PEA, asystole is best determined in 2 separate cardiac leads. CPR is continued and treat reversible causes. Reversible causes to be considered are: hypovolemia, hypoxia, acidosis, hypo/hyperkalemia, hypothermia, tension pneumothorax, cardiac tamponade, toxins, pulmonary or coronary thrombosis. If the cardiac rhythm is ventricular fibrillation (VF) or pulseless [DIAGNOSES REDACTED] (VT) monophasic defibrillation should be attempted at 360 joules."

On the morning of 2/15/2011, Staff C told surveyors defibrillators at the hospital were monophasic. Staff C also told surveyors when pads are used the cardiac monitor lead initially reads in Lead II. Staff C told surveyors emergency personnel would have to change lead settings to have the pads read alternative leads.

On the afternoon of 02/15/2011, Staff B told surveyors the hospital did not have the equipment to run arterial blood gases. Staff B told surveyors asystole should be verified by two or three different cardiac monitor leads. Staff B also stated typically patients would have anterior posterior pads placed along with three cardiac leads. The hospital ' s ER policies and procedures did not contain a policy that provided this direction. Nine of nine medical records reviewed of patients pronounced dead did not contain evidence that asystole was verified by at least two different leads. Staff B told the surveyors that if a patient was in PEA (pulseless electrical activity), documentation should show a Doppler reading had occurred. The ER policy manual did not contain a policy or protocol directing this should occur. ER policies and procedures did not specify who could pronounce patient death.

3. Record #1- The patient (MDS) dated [DATE] in cardiac arrest, intubated, with intravenous fluids infusing and ambulance personnel performing CPR. Staff A documented in the "emergency medical physician assessment and progress record -chief complaint as "cardiac arrest" and in the section "exam abnormalities" documented non responsive, skin cool, color dusky on arrival, eyes fixed, pupils~2 mm equal unresponsive, good air entry with assistant ventilator, v-fib (ventricular fibrillation) on arrival, epi (epinephrine) x (times) 3, Atropine x (times) 2, Shock x (times) _____ (section was blank). Staff A documented "pronounced deceased at 2001". Staff A documented "this patient was pronounced dead at 2001 found spontaneous resp, HR (heart rate) pink color 2120 Oxygen sat (saturation) to 99 with ET (endotracheal) tube, skin warm, pedal pulse 2/4, R = L (right equal left), radial pulse 2/4 R= L cheyne stoke resp (respiration)." Further documentation by Staff A indicated in the diagnosis and treatment plan section of emergency room form "MI-resp assist" and "found 2120 with spontaneous resp, heart rate, color pink cheyne stoke resp, oxygen saturation 75-95 with oxygen". Staff A did not document there had been an assessment of the patient prior to life support measures being removed. Staff A did not document consultation with the supervising physician prior to removal of life support, pronouncement of death, or when treatment was resumed after patient was found breathing and with pulses.

Nursing documentation stipulated the patient was defibrillated at 1954 with 120 joules, 1956 with 150 joules, 1958 with 200 joules, and 1959 with 200 joules. Epinephrine administration times were documented by Staff E as 1951, 1955, and 1959. Atropine was documented by Staff E as given at 1952 and 1957. Cardiac rhythm strips were documented by Staff E prior to first defibrillation as "v-fib" (ventricular fibrillation) and after "fourth shock and monitor rechecked, pt in PEA (pulseless electrical activity)". Staff E documented 2001"code called at 2001 by PA. patient with no respirations, no palpital (sic) pulse, no heartbeat heard, no respirations heard by ausculation." Documentation in the chart did not indicate the patient had been checked by doppler for pulses. Staff E documented pt moved to room 101 to await ME (medical examiner). Staff E documented at 2120 "nurse takes wife to rm (room) to view pt (patient) before leaving. Resp. (respirations) heard at door x (times) 3. Wife taken back to waiting rm. Assistance called to rm. Pt with spontaneous resp. O2 (Oxygen) saturations 76%, radial pulses bilateral at 85. Cardiac monitor reapplied with afib (atrial fibrillation) noted. EKG (electrocardiogram) completed. Staff A ventilating patient with increase in oxygen saturation to 98%". The patient was transferred to another hospital at 2242.

4. Record #2 - The patient presented to the ER [DATE] at 1800 in cardiac arrest, intubated, with CPR in progress by ambulance personnel. Staff A documented in the emergency medical physician assessment progress record at 1800 chief complaint "cardiac arrest/code blue". In the pain assessment portion Staff A documented "35 y/o (year old) female arrest at home - Checotah EMS". In the portion stipulated exam abnormalities Staff A documented "see note". Staff A documented under the "medications ordered" section- "exam/note (circled) 1800 intubated #9 tube taped at 19 cm BS (breath sounds) equal. No spontaneous resp/no heart rate skin cool mottled asystole intubated 1822 Oxygen saturation 0, HR (heart rate) 0, resp (respiration), expired 1824". Further documentation by Staff A stipulates in the diagnosis section "cardiac/resp arrest. There is no documentation by Staff A there was a consultation with the

supervising physician prior to removal of life support. There was no documentation throughout the record indicating the cardiac rhythm asystole was checked in two leads.

Nursing documentation by Staff H indicated "chief complaint as "arrived x (times) with EMS code blue CPR in progress. There was no nursing assessment documented. Staff H documented in the "code blue cardiopulmonary report - epi 1 amp (epinephrine) was given at 1812, 1815, and 1818. Atropine 1 amp was given at 1812. Staff H also indicated the patient was placed on the monitor at 1810 and expired at 1824. Staff H documented CPR was started at 1722 per ambulance personnel. Documentation on the ambulance run sheet indicated CPR was initiated at 1740. Cardiac rhythm strips indicate the monitor was tracing through "pads" setting. No other lead was documented.

5. Record #3 - The patient presented to the ER 1/6/11 at 1540 in cardiac arrest, intubated, CPR and ACLS in progress. Staff A documented in emergency medical physician assessment progress record at 1540, patient arrived in full arrest, thready pulse, no spontaneous respirations. Staff A documented the patient was "unresponsive/see nurses notes, pupils unresponsive, no spontaneous respirations, no pulse or very weak, abdomen distended/ no BS (bowel sounds), pt mottled/cyanotic on arrival, unresponsive, skin cool, unresponsive. Staff A circled "alert, stable, oriented, judgement, and checked no cyanosis, lips/gums no lesions" the physical exam portion. Staff A documented "patient arrive in full code x 30 minutes- no response time of death 1559". At 1600 nursing documentation stipulates a pulse was felt by staff. There is no documentation by Staff A there was a consultation with the supervising physician prior to removal of life support.

On the code blue recording sheet, Staff H documented "time of code blue team arrival as 1540 and time code called as 1559. At 1547 defibrillation was documented at 200 joules and the cardiac rhythm documented by Staff H was course v-fib (ventricular fibrillation). At the bottom of the code sheet was " asystole verified in 3 leads: Y N". Y was circled. No cardiac monitor strips were posted in any lead other than "pads". Staff H documented "1600 (name withheld) feels a pulse." The next entry is at 1605 "no pulse, no respirations code called. There was no documentation in the patient record indicating any further treatment was provided after 1600. Staff A did not document this event and there was no consultation with the supervising physician regarding this event.

6. Record #4 - The patient presented to the ER 1/27/11 at 2005 in cardiac arrest, Combi-tube in place, CPR in progress. Staff A documented in the emergency medical physician assessment progress record at 2005 chief complaint: Code Blue Checotah EMS. Staff A documented the patient was non responsive, pupils fixed, dilated, no response to light, skin warm abrasion lt (left) face where he fell . Staff A documented in the critical care services provided section "EMS arrived 2005, compressions 2006, Epi given 2012, Atropine 2014, Epi repeat, 2017, compression stopped 2018. Staff A documented in diagnosis section "cardiac arrest-resuscitation halted 2018". Staff A did not document time of death or consultation with the supervising physician prior to removal of life support.

Staff I documented in the emergency room nursing assessment heart rate "asystole". Cardiac strips posted on the record indicated after epinephrine and atropine dosing cardiac electrical activity was present. Staff I documented "2007 cardiac monitor applied - asystole on monitor- 0 (no) B/P (blood pressure) - 0 pulse - 0 respirations - CPR continued and ventilation via ambu bag sustained. 2011- asystole on monitor. 2012- Epinephrine 1 amp given IV- 0(no) response. 2014-Atropine 1 amp given IV - 0 response. 2017 Epinephrine 1 amp given 0 response. 2018 0 BP - 0 spont (spontaneous) resp (respiration) + 0 pulse. 2018 Code called - asystole remains on monitor." All cardiac monitor strips posted on record #4 were in Lead II. Nursing documentation did not indicate the electrical activity of the heart was viewed in any other lead prior to resuscitation efforts being stopped.

EPIC MEDICAL CENTER

1 HOSPITAL DRIVE EUFAULA, OK 74432 | Proprietary

View hospital's federal Hospital Compare record

Read complete reports

Report date Number of violations
Feb. 15, 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

No incomplete reports available.

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.

DEACONESS HOSPITAL	**5501 NORTH PORTLAND AVENUE OKLAHOMA CITY, OK 73112**	**Jan. 25, 2011**

VIOLATION: *UNSPECIFIED CATEGORY* **Tag No:**

Based on review of hospital documents and interviews with hospital staff, the hospital failed to include, analyze and track grievances as part of the quality process to improve patient care and hospital services.

Findings:

Review of the quality council and patient safety meeting minutes for 2010 did not demonstrate grievances, complaints, and incidents were part of the quality improvement program with analysis to improve hospital practices. Staff B told surveyors on the morning of January 24, 2011, grievances and complaints were reviewed in a separate greivance committee. Staff B stated there were no minutes taken at these meetings. Staff B also told surveyors the grievances/complaints are reviewed individually and there is no analysis and trending to identify potential performance improvement areas. Surveyors reviewed patient safety committee minutes for 2010. The data presented reflected volumes of complaints/grievances per department and did not have any other trending or analysis. This information was presented to administration and no further documentation was provided.

VIOLATION: *DISCHARGE PLAN* **Tag No:** A0817

Based on record review and interviews with hospital staff, the hospital does not ensure the hospital's Mental Health discharge criteria requirements are met. Three (#'s 1, 2 & 5) of nine (#'s 1 through 9) patients' records who were discharged from Deaconess-Bethany did not meet the hospital's Mental Health discharge criteria requirements.

Findings:

1. The hospital's mental health discharge criteria as documented in Nursing Guideline # MH-025 states the following:
A. Assess patients to determine if the following criteria are met for discharge as indicated:
a. No longer present as danger to self/others
b. Compliance with mediations and treatment
c. Special treatment modalities in the hospital resolved/stabilized
d. Achieved a safe medical detox
5. Demonstrates improved mood stability
6. Demonstrates increased ability to care for basic needs
7. Functions at highest level in least restrictive environment

2. Patient #1's record documented the patient was continuing to exhibit anxiety and agitation on the morning of the patient's discharge at approximately 10 AM. The previous day early in the morning the patient was observed having oral sex with another hospital patient. The patient was noncompliant with staff directions after being ordered by staff multiple times to exit the room.

3. Patient #1 was given an antipsychotic medication injection at 10:20 AM on the day of discharge because of behavioral symptoms and was discharged at 1200 PM.

4. Patient #2's discharge plan was to return home where she lives alone. According to documentation in the chart, the patient lived alone and her only means of transportation was her ex-mother-in-law. Patient #2's medical record documented on 11/02 and 03/2010, the patient expressed anxiety and concern about returning home alone -a disagreement with the discharge plans. The medical record did not reflect anyone addressed this concern/problem with the patient.

5. Documentation in Patient #5's chart 11/22/2010 indicated at "0805 the pateint was agitated with other patients and confrontational", at 1000 was "excited, intrusive and upset". There was no documentation the patient was ready for discharge. Documentation at 1535 indicates "patient's family here to pick up, personal belongings already packed up". The medical record did not reflect anyone addressed behaviors.

VIOLATION: *PATIENT RIGHTS: CARE IN SAFE SETTING*

Tag No: A0144

1. On the afternoon of 1/23/11, October and November 2010 incident reports were reviewed by surveyors. The incident reports provided indicated two instances of sexual encounters between residents and a altercation/fall that were not investigated. Incident One: Patient #1 was reported having oral sex with an unnamed female patient in a group meeting area. The incident report did not indicate any physical exam or follow up evaluation of the unnamed female patient. There was no documentation the encounter had been reported to the unnamed female patient's physician. Incident Two: Another incident occurred in a patient room. The incident form indicated Staff E found Patient #6 and Patient #10 in bed having intercourse. The incident report did not indicate any physical exam or follow up evaluation of Patient #10. There was no indication in the incident report the patient's physician had been notified. Incident Three: Patient #2 (one of the patient's mentioned in the complaint) was reported in an altercation with a staff member in which she received a bloody nose. Patient #2 alleged a she was "assaulted and hit her nose on the floor and it began to bleed heavily". The incident report completed by the Mental Health Tech involved indicated the patient had a "slight bloody nose". There was no further assessment of Patient #2 documented in the incident report or in Patient #2's chart. There was no indication the physician was notified.

2. On 1/23/11 Patient # 5's chart was reviewed. The documentation in the chart indicated the patient complained to staff about a male peer. The documentation stipulated "he has violated every woman in here, I don't want him to touch me". Physician and nursing documentation did not indicate Patient #5 was hallucinating or delusional at the time of the complaint. Further in the documentation Patient #5 was threatening to commit suicide if the male peer was not removed from the patient's side of the unit. There were no incidents, complaints, or grievances listed in any of the logs for the complaint or for patient #5. There was no evidence to indicate the complaint/incident had been investigated.

3. Review of the quality council and patient safety meeting minutes for 2010 did not demonstrate grievances, complaints, and incidents were part of the quality improvement program with analysis to improve hospital practices. Staff B told surveyors on the morning of January 24, 2011, grievances and complaints were reviewed in a separate greivance committee. Staff B stated there were no minutes taken at these meetings. Staff B also told surveyors the grievances/complaints are reviewed individually and there is no analysis and trending to identify potential performance improvement areas. Surveyors reviewed patient safety committee minutes for 2010. The data presented reflected volumes of complaints/grievances per department and did not have any other trending or analysis.

VIOLATION: *CRITERIA FOR DISCHARGE EVALUATIONS*

Tag No: A0800

Based on record review and interviews with hospital staff, the hospital does not ensure that patients receive adequate discharge planning. 3 of 3 (Pt#s 1,2,5) patients did not have evidence that post hospital needs were identified and implemented and the patients were provided with adequate assistance to assure the patients have appropriate continuing care.

Findings:

1. Patient #1 was involuntarily admitted to the hospital. Patient #1's medical record did not have evidence that the patient had a safe place to return after discharge. The record stated on admission, 11/1/10, that the patient lived with his girlfriend and would be returning there. An address was listed on the face sheet, but was not identified who's address it was. There was no evidence that the girlfriend had been contacted to verify that was where the patient would be returning. The admission sheet stated that they were unable to get much information from the patient due to his manic condition. No evidence in the medical record showed further evaluation of the patients living arrangements.

2. Patient #1's medical record stated on the day of discharge, 11/01/10, that the patient was discharged by taxi. It did not document where the taxi was taking the patient.

3. Patient #1 had been a patient at an outpatient mental health clinic prior to admission to the hospital. The medical record progress note stated "followup care with "clinic name", but no times or appointments were documented.

4. Patient #1 medical record documented the patient was discharged with prescriptions, but there was no information evaluating the patient's ability to pay for or obtain the medication.

5. Patient #2's discharge plan was to return home where she lives alone. According to documentation in the chart, the patient lived alone and her only means of transportation was her ex-mother-in-law. Patient #2's medical record documented on 11/02 and 03/2010, the patient expressed anxiety and concern about returning home alone -a disagreement with the discharge plans. The medical record did not reflect anyone addressed this concern/problem with the patient.

6. Documentation in Patient #5's chart 11/22/2010 indicated at "0805 the pateint was agitated with other patients and confrontational", at 1000 was "excited, intrusive and upset". The medical record did not reflect anyone addressed the agitation and confrontational behaviors. Documentation at 1535 indicates "patient's family here to pick up, personal belongings already packed up". There was no documentation the patient was ready for discharge. The documentation did not reflect the pateint was functioning at the highest level or the patient's mood had been stabilized.

VIOLATION: *PATIENT RIGHTS: REVIEW OF GRIEVANCES* **Tag No:** A0119

Based on review of records, interviews with staff, and review of policies, the hospital does not ensure that all patient grievances are reviewed, resolved, and a written response sent in the hospital's grievance process. One of one (Patient Record #5) complaint, documented in the medical record had not been identified, reviewed and resolved.

Findings:

1. On 1/23/11 Patient # 5's chart was reviewed. The documentation in the chart indicated the patient complained to staff about a male peer. The documentation stipulated "he has violated every woman in here, I don't want him to touch me". Physician and nursing documentation did not indicate Patient #5 was hallucinating or delusional at the time of the complaint. Further in the documentation Patient #5 was threatening to commit suicide if the male peer was not removed from the patient's side of the unit. There was no evidence to indicate the complaint/incident had been investigated or action taken at the time, or after, the complaint was voiced. There were no Event/occurrence reports for this complaint/incident.

2. The grievance log did not contain the complaint/grievance voiced by Patient #5, voiced to staff about another patient ' s behavior toward peers and requests to be separated from the patient.

3. When the surveyors asked about the complaint, Staff B stated he had not heard about the complaint. Staff A, B, C, and D stated they would have to do more education with staff on the complaint/grievance process.

DEACONESS HOSPITAL

5501 NORTH PORTLAND AVENUE OKLAHOMA CITY, OK 73112 | Proprietary

View hospital's federal Hospital Compare record

Read complete reports

Report date Number of violations
Jan. 25, 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.

MUSKOGEE COMMUNITY HOSPITAL

2900 NORTH MAIN STREET MUSKOGEE, OK 74402 | Proprietary

View hospital's federal Hospital Compare record

Read complete reports

Report date	Number of violations	
Jan. 13, 201111	(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 reports	Number of violations
Oct. 13, 20111		15

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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

CORETOPICS
Essential coverage areas for health journalists

COVERING HEALTH
An AHCJ blog

Award winners share their tips for reporting significant stories #ahcj13
How does one report a story that has real impact? Ten of the first-place winners of this year's Awards for Excellence in Health Care Journalism ...

Snapshots from #ahcj13 | Constance Alexander
Constance Alexander, independent journalist, Murray, Kentucky: What do you do? I teach humanities at Murray State University and work in the College ...

How to cover nursing homes with more depth and data #ahcj13
It was worth the wait to attend one of the last sessions on the last day of Health Journalism 2013. Data mining is one of those topics that can make ...

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 ...

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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

Photo by afagen via Flickr

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 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. DeNoon

Tips on covering medical studies on a deadline

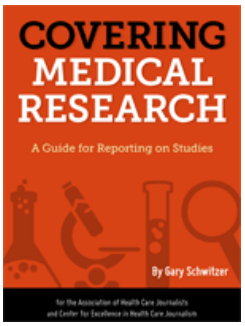
Deadline in a few hours? "Don't panic" is bad advice. It's not even possible when deadline looms and nobody has called you back. Managing that hot little ball of panic is key. Think of it as a controlled nuclear reaction from which you can draw energy.

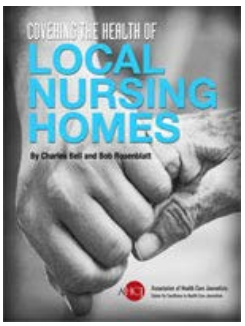
Award-winning health reporter Daniel J. DeNoon shares his straightforward strategy for reporting and writing a news story about a journal article while on deadline.

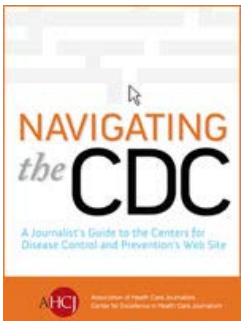
He has tips about what parts of the study to read first, how to find experts to comment, how many people to interview and how to convey the importance of your deadline to your sources.

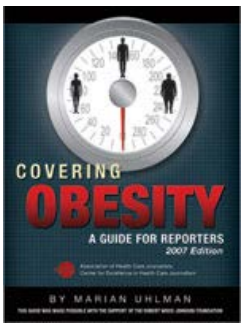
New resource will help reporters cover medical research

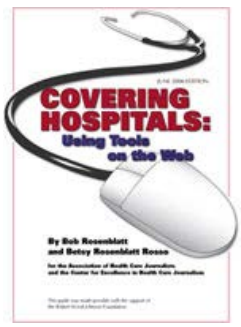
AHCJ has rolled out another Core Curriculum topic on its website. "Covering Medical

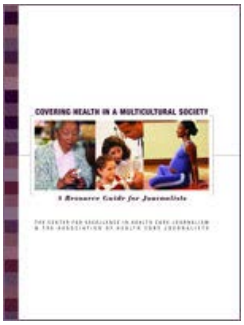


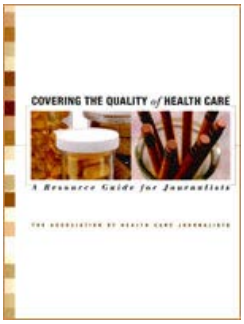












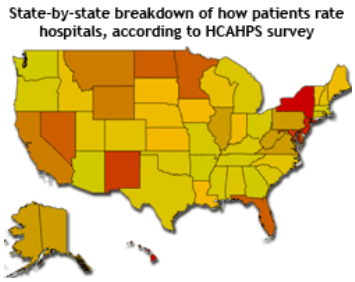
Studies" is the fourth in a series of core topic subject areas making up the curriculum. It is one of at least a dozen key subject areas the organization believes today's health journalists will need to master to cover the beat well.

"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 area.



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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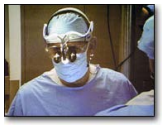
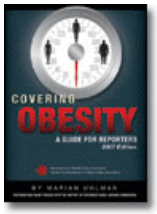
'Downsized' members can take advantage of transition-assistance program

AHCJ makes Nursing Home Compare data easier to analyze



Find stories with ready-to-use Hospital Compare data

Reporting Guides



- 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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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 care.

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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Editor	Group SJR	Full-time	New York, NY	03/05/13
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
Medical editor	Audio-Digest Foundation		Glendale, CA	01/17/13
Health Research Institute Director	PricewaterhouseCoopers LLP	Full-time	Dallas, TX	01/14/13

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.

MUSKOGEE COMMUNITY HOSPITAL	2900 NORTH MAIN STREET MUSKOGEE, OK 74402	Jan. 13, 2011

VIOLATION: *CONTRACTED SERVICES* **Tag No:** A0083

Based on review of personnel files and interviews with hospital staff, the hospital failed to ensure contract personnel are oriented, trained and evaluated specific to the facility.

Findings:

1. On 1/11/11 surveyors requested contract personnel files (EE,FF, GG, HH, II, JJ, KK, LL, MM, NN,) . Ten (10) of ten (10) (EE,FF,GG, HH,II JJ,KK,LL MM,NN) contract personnel files did not contain facility specific orientation, training, and evaluation. On the afternoon of 1/12/11 Staff B confirmed the above findings .

2. These findings were reviewed with administration during the exit interview on 1/12/11. No further documentation was provided.

VIOLATION: *CONTRACTED SERVICES* **Tag No:** A0084

Based on record review and interviews with hospital staff, the governing body does not ensure that all services performed under contract are provided in a safe and effective manner. Services provided to the hospital by contract are not monitored and evaluated by the hospital's quality assessment and performance improvement (QAPI) program to ensure that they are provided in a safe and effective manner. The governing body does not ensure contract services are provided in a safe and effective manner.

1. On the morning of 1/12/11 surveyors reviewed orientation and training documents for contracted services. This occurred for 10 of 10 (EE,FF,GG,HH,II,JJ,KK,LL,MM,NN,OO) contract personnel whose files were requested for review. This finding was reviewed at the exit conference and no further documentation was provided.

2. According to the policy "Performance Improvement Plan -2010" there were no contracted services indicators included in the plan. This was reviewed with Staff H on the afternoon of 1/12/2010. This finding was also reviewed with administration at the exit interview. No further documentation was provided.

3. On 1/12/2011 surveyors reviewed governing body meeting minutes for 2010. There were no meeting minutes where contracted services were discussed. This finding was reviewed with administration at the exit interview. No further documentation was provided.

VIOLATION: *PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION* **Tag No:** A0123

Based on review of the hospital documents and interviews with hospital staff, the hospital failed, after investigation and resolution of the grievance, to provide a written notice to the complainant with the steps taken on behalf of the patient to investigate the grievance, the

results of the grievance process, and the date of completion. All of the grievances listed on the grievance log were reviewed. None of the written responses contained all of the required information to the complainant once the hospital had finished its investigation. On the afternoon of 1/12/2010, surveyors reviewed this finding with Staff F. This finding was reviewed with hospital administration at the exit interview on 01/12/2011.

VIOLATION: *UNSPECIFIED CATEGORY*

Tag No:

Based on review of hospital documents and interviews with hospital staff, the hospital failed to include, analyze and track grievances as part of the quality process to improve patient care and hospital services.

Findings:

1. Review of grievances taken from the grievance log, did not show all the grievances had been investigated and resolved with written response provided to the complainant within the hospital's specified time period. On 1/12/11 Staff F stated not all grievances were reported to the Grievance Coordinator. Staff F stated if the grievance is received into administration first, the grievance doesn't always get forwarded on. This finding was reviewed with administration at the exit interview.

2. Review of the performance improvement meeting minutes for 2010 did not demonstrate grievances were part of the quality improvement program with analysis to improve hospital practices. Staff F stated that there had only been a request to review grievances once. Staff F told surveyors there had been no requests for information to be sent to Governing Body or Performance Improvement for quite some time.

VIOLATION: *PATIENT RIGHTS: GRIEVANCES*

Tag No: A0118

Based on review of hospital policies and grievance and complaint log, selected grievances and complaints, and interviews with hospital staff, the hospital failed to ensure the hospital's established grievance process was implemented.

Findings:

1. The hospital's grievance policy, entitled "Patient Complaint/Grievances Procedure," with an issue date of March 2009, appropriately defined the difference between complaints and grievances; provided time frames for investigation and resolution of grievances; stipulated that a written response with the required information would be provided to the complainant; and stipulated the Grievance Coordinator will present the finding of the review to the Performance Improvement Committee which acts as the Grievance Committee and reports finding to the Medical Staff Committee. The policy also states patient satisfaction as well as patient grievances will be submitted to the Board of Governors through the Performance Improvement Committee, which also acts as the grievance committee quarterly or more frequently as indicated. The hospital failed to follow policy.

2. The hospital failed to identify grievances: The surveyors reviewed the grievance log for 2010. There were no grievances listed on the log after July 2010. A review of Governing Board Minutes indicated a review of two written grievances which were not listed on the log. In an interview on the afternoon of 1/12/2011, Staff F told surveyors that all of the grievances and complaints were not provided to the Grievance Coordinator and were not logged. Staff F stated if the grievance went to governing board first they were not always forwarded to the Grievance Coordinator.

3. The data provided to the surveyors did not demonstrate the hospital investigated all the grievances. The grievance log provided to surveyors did not contain all grievances received by the hospital in 2010. There was no documentation of investigation and required elements on the grievances that were not forwarded to the Coordinator. This finding was confirmed with Staff F on the afternoon of 1/12/11.

4. The hospital does not ensure the written response to the complainant contains all of the required elements. All of the grievances listed on the log were reviewed by surveyors. Letters to the complainants did not stipulate what was done to investigate or what actions were taken to resolve the grievance.

5. The hospital does not ensure grievance data is incorporated in the hospital's Quality Assessment and Performance Improvement (QAPI) Program with analysis of the data and implementation of processes to improve patient care:
In an interview on the afternoon of 1/12/11 Staff F told surveyors there had not been a performance improvement committee meeting for over six months. Surveyors requested performance improvement committee meeting minutes on the morning of 1/11/11. Staff B told surveyors performance improvement was done through performance improvement committee, safety committee, and clinical practice committee. Review of the minutes provided from these committees did not demonstrate that grievance and complaint data was reviewed, trended and analyzed with implementation of corrective and/or process changes to improve patient care. This finding was reviewed with administrative staff on the afternoon of 1/12/2011.

VIOLATION: *SUPERVISION OF CONTRACT STAFF*

Tag No: A0398

Based on review of personnel files and interviews with hospital staff, the hospital failed to ensure the Director of Nursing, or designee, provided orientation and evaluation of agency nursing personnel. This occurred for one of one nursing agency personnel requested for review.

Findings:

1. The surveyors requested one agency personnel record (Staff II). The records provided to surveyors the afternoon of 1/12/2011 contained information from the agency. There was no documentation provided in the agency personnel record the hospital had oriented, trained, or evaluated care provided by the agency staff. None of the documentation indicated the hospital verified current licensure. Later in the afternoon of 1/12/11, Staff B brought other information from contract agency. None of the information reviewed indicated the facility oriented, trained, or evaluated the care provided by the agency nursing staff. On the afternoon of 1/12/2011, Staff (D) told surveyors there had not been a orientation program for the agency nursing personnel. In an interview on the afternoon of 1/12/2011 this finding was verified with Staff B.

2. This finding was reviewed with administration on the afternoon of 1/12/2011. No further information was provided.

VIOLATION: *PATIENT RIGHTS: CARE IN SAFE SETTING*

Tag No: A0144

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of files at the Department, hospital documents and interviews with hospital staff, the hospital failed to provide care in a safe setting to four of four patients (Pt's 11,12,13,14) whose medical records were reviewed.

Findings:

1. According to documents filed with the Department, the hospital is licensed for 45 medical/surgical beds and does not have any specialty units. Three beds on the fourth floor have been converted for post partum cesarean-section patients and certain staff were trained to take care of post partum patients and infants.

2. On 1/12/11 surveyors reviewed four medical records (Pt's 11,12,13, 14) of patients requiring specialty services of critical cardiac intravenous IV drips, telemetry monitoring and or ventilators. From the medical record surveyors selected nursing personnel assigned to care for these patients (Staff). Review of the nursing personnel files, for staff assigned to these patients, and interviews with hospital staff, did not demonstrate the nurses had been trained to provide care for patients requiring the specialized treatments.

3. On 1/11/11 surveyors were given job descriptions for registered nurses (RN) and licensed practical nurses (LPN). The job descriptions stipulated that all nurses will have current certifications in BLS (basic life support), ACLS (advanced cardiac life support), PALS (pediatric advanced life support), and TNCC (trauma nurse core competency within 180 days of employment. Review of the nursing files did not demonstrate staff had completed the requirements either before the 180-day requirement or before being assigned to care for patients requiring competency in this area.

4. On 1/12/11 staff B told surveyors that the hospital did not have any dedicated monitor tech's. Staff B told surveyors that when patients were on telemetry, all nursing staff watched the monitors when they were at the desk. Patient rooms are single occupancy. Review of the staffing sheets for 8/17/2010 indicated Staff B was assigned to care for two patients (room 213 and 211) both patients were on telemetry. The rooms were not next to each other. The nurse could not monitor both patients at the same time. The staffing sheets did not have staff assigned to monitor the telemetry tracings.

5. On 1/12/11 Staff D told surveyors the emergency department had an orientation/competency training document that was to be completed on every nurse working the emergency room . Review of staffing sheets for 8/4,5,6/2010 indicated Staff U was scheduled to work the emergency room . Staff U did not have documentation showing previous experience in the care of emergency patients. Staff U did not have orientation or competency in the emergency room documented in the personnel file. Staff D and Staff G told surveyors there was no documentation

6. Review of three emergency room medical records (Pt# 6,7, and 8) from 8/4/2010 did not show the patients were assessed by a registered nurse. Assessments performed on Pt's 6, 7, and 8 were completed by a paramedic.

7. On 1/12/2010 surveyors were provided staffing sheets for 8/15/2010. According to the documentation Staff V was pulled to work the emergency room on [DATE]. Review of Staff V's personnel file did not indicate Staff V had been oriented to the emergency room and had the training required by the facility to care for patient's in the emergency room . Staff V was the only registered nurse assigned to work in the emergency room on [DATE]. This finding was verified with Staff D and Staff G on 1/12/2010.

8. On 1/12/2010 surveyors reviewed Pt #12's chart. According to the staffing documentation Staff Z was the only nurse assigned to care for Pt #12 who was on a cardizem drip. Staff Z was in orientation. Review of Staff Z's personnel file did not indicate Staff Z had been oriented to the unit and had critical care training required by the facility to care for patients on intravenous cardiac drips.

9. On 1/12/11 incident reports were reviewed by surveyors. The incident reports provided indicated repeated problems were found with orders being entered into the hospital computer charting program. There was no evidence the incident reports were reviewed, trended, analyzed, and acted on through the performance improvement program.

10. The hospital does not ensure incident reports, grievance data, and infection control data are incorporated in the hospital's Quality Assessment and Performance Improvement (QAPI) Program with analysis of the data and implementation of processes to improve patient care: Surveyors requested performance improvement committee meeting minutes on the morning of 1/11/11. In an interview on the afternoon of 1/12/11 Staff F told surveyors there had not been a performance improvement committee meeting for over six months. On 1/11/11, Staff H told surveyors she was new to the performance improvement and infection control role. Staff H told surveyors the facility was in the process of changing performance improvement indicators and infection control processes. Staff B told surveyors performance improvement and infection control was done through performance improvement committee, safety committee, and clinical practice committee. Review of the minutes provided from these committees did not demonstrate that grievance and complaint data was reviewed, trended and analyzed with implementation of corrective and/or process changes to improve patient care. Review of the minutes provided from these committees did not demonstrate an active infection control surveillance program was in place for the facility. This finding was reviewed with administrative staff on the afternoon of 1/12/2011.

VIOLATION: *CHIEF EXECUTIVE OFFICER*

Tag No: A0057

Based on review of governing body bylaws, meeting minutes the hospital failed to appoint a Chief Executive Officer who is responsible for the management of the entire hospital.

Findings:
1. On 1/12/11 surveyors received a copy of the hospital's governing body bylaws. The governing body bylaws stipulate "the governing board of directors may delegate the day to day management and conduct of the company's activities and affairs to any person or persons,

management company or committee however composed, provided that no such delegation of authority by the governing board of directors precludes the governing board from exercising the authority required to fulfill its responsibility to manage, supervise, and control the corporations activities and affairs." At the time the hospital opened, documents indicate the hospital had a chief executive officer and a chief operating officer. Surveyors requested a copy of the governing board minutes in which the current chief operations officer was named as the chief executive officer. Staff A told surveyors there were no written minutes indicating he had been named chief executive officer but there was a tape recording of the board meeting in which the appointment was made. On 1/12/11 a surveyor listened to a recording dated 8/19/09. The recording did not indicate a vote had occurred and the governing board appointed Staff A to chief executive officer. This finding was reviewed with administration at the exit conference.
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VIOLATION: *PATIENT CARE ASSIGMENTS*

Tag No: A0397

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on review of medical records, hospital documents and personnel files, and interviews with hospital staff, the hospital failed to ensure that the nursing care of each patient is assigned to nursing personnel who are trained, qualified and competent to care for patients with specialized needs. This occurred for nine of fifteen licensed staff whose personnel files were reviewed.

Findings:

1. The hospital's job description for registered nurse (RN) and licensed practical nurse (LPN) stipulated that all nurses would have current certifications in BLS (basic life support), ACLS (advanced cardiac life support), PALS (pediatric advanced life support) and TNCC (trauma nurse core competency) within 180 days of employment. At the time of review on 01/12/2011, none of the fifteen licensed staff, whose personnel files were reviewed, had TNCC training.

2. Staff #U did not have orientation, training and competency for the emergency room before working there on 08/04/, 5, and 6/2010.

3. Review of three emergency room medical records (Pt# 6,7, and 8) from 8/4/2010 did not show the patients were assessed by a registered nurse. Assessments performed on Pt's 6, 7, and 8 were completed by a paramedic.

4. On 1/12/2010 surveyors were provided staffing sheets for 8/15/2010. According to the documentation Staff V was pulled to work the emergency room on [DATE]. Staff V did not have orientation and training to work in the emergency room . Staff V was the only registered nurse assigned to work in the emergency room on [DATE]. This finding was verified with Staff D and Staff G on 1/12/2010.

8. On 1/12/2010 surveyors reviewed Pt #12's chart. According to the staffing documentation Staff Z was the only nurse assigned to care for Pt #12 and was in orientation. Review of Staff Z's personnel file did not indicate Staff Z had been oriented to the unit and critical care training required by the facility to care for patients on intravenous cardiac drips.

VIOLATION: *PATIENT RIGHTS: NOTICE OF RIGHTS*

Tag No: A0117

Based on record review and interviews with hospital staff, the hospital does not ensure that each patient or their representative is informed of their rights in advance of providing or stopping care.

Findings:

1. On the morning of 1/11/11 surveyors received the patient rights policy and the patient rights handout. The policy "patient rights and responsibilities" stipulated all patients will be informed in writing of their rights upon admission. The written patient rights hand outs provided to surveyors on the morning of 1/11/11 did not contain information about filing complaints with the Oklahoma State Department of Health.

2. Later in the morning, Staff B brought surveyors a notebook entitled "Patient Handbook" and stated "these are all over the hospital and this is how we inform patients of their rights". The notebook did contain information on how to file a complaint with the Department. Staff B also told surveyors patients could view their patient rights via the television in their rooms. On the afternoon of 1/11/11 during a tour of the nursing unit, surveyors asked Patient #16 about accessing patient rights information. Patient #16 did not know where to find patient rights.

3. The policy "patient rights and responsibilities" stipulates "all staff are educated upon hire and on an ongoing basis concerning patient rights, and are informed of the processes in place to support ethical decision making". Sixteen of sixteen personnel files (B, K,L, O,Q,R,S,T,U,V,W,Z,Y,X, AA,BB) did not contain current education regarding patient rights processes. Ten of ten (EE,FF,GG,HH,II, JJ,KK,LL, MM, NN) contract files did not contain education regarding patient rights processes. This finding was confirmed with Staff D and Staff F the afternoon of 1/12/11 and with administration in the exit interview. No further documentation was provided.

VIOLATION: *UNSPECIFIED CATEGORY*

Tag No:

Based on review of governing body meeting minutes, performance improvement meeting minutes, medical staff meeting minutes, performance improvement plan 2010, and staff interviews. The hospital 's governing body failed to ensure a performance improvement activities were reported, documented, analyzed, implemented, and evaluated.

Findings:

1. The performance improvement (PI) plan 2010 provided to surveyors indicates indicators will be provided from the following areas of the hospital: "all clinical departments, human resources, nursing pain management, business office/medical records, preop/POEM, SPD, case management, social work, environment of care, laboratory, post anesthesia recovery, pharmacy, radiology, surgery, endoscopy,

respiratory services, facilities, environmental services, emergency department services, information technology, security/communications, food services, along with SCIP (surgical care improvement project) and heart failure". The (PI) plan also stipulates "patient safety goals to be monitored on an ongoing basis in all clinical areas". The PI plan stipulates all data is collected monthly and reported via department scorecards to the Performance Improvement Committee. Opportunities for improvement are assessed and acted upon in accordance with the PI program.

2. On 1/11/11 surveyors were also provided a document entitled "Muskogee Community Hospital - 2010 Scorecard". Later in the morning on 1/11/11 Staff B told surveyors performance improvement monitors were reported on the score card. The indicators listed in the PI plan and the indicators listed on the score card did not match. The score card did not contain analysis incidents, grievances, and infection control.

3. On 1/12/11 surveyors reviewed sixteen governing body meeting minutes from 2010. Ten of sixteen meeting minutes indicated "quality and safety reported in medical staff". No medical staff meeting minutes were provided for the corresponding months. Surveyors were provided medical staff meeting minutes via e-mail from Staff B on 1/13/11. The meeting minutes were labeled "Medical Staff October 19, 2010". The indicators listed in the PI plan and the indicators listed on the score card were not reviewed in the meeting minutes.

4. On 1/11/11 Staff H told surveyors she was new to the Performance Improvement Coordinator position and had not used the performance improvement plan when reporting performance improvement activities. Staff H told surveyors reporting took place in several committees but there was no committee all of the indicators were reviewed, analyzed, trended, and acted upon.

5. On 1/11/11 Staff B told surveyors the performance improvement activities were conducted in multiple meetings: performance improvement, clinical practice, infection control, medical staff, and governing body. Review of each of these committee's meeting minutes indicated none of the data was analyzed, trended, and acted upon with submission to the governance for oversight.

6. On 1/12/11 Staff F told surveyors there had not been a performance improvement committee meeting for over six months.

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 JOHN MEDICAL CENTER, INC 1923 SOUTH UTICA AVENUE TULSA, OK 74104 Jan. 5, 2011

VIOLATION: *PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION*

Tag No: A0123

Based on review of the hospital's grievance/complaint policy, grievance log and five grievances and interviews with hospital staff, the hospital failed to provide a written notice to the complainant with 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. This occurred for seventeen of seventeen patients/patients' representatives who filed grievances (Grievance #1 through 12, 15, and 18 through 21) and the complaint was not resolved at the time of the complaint by staff present or immediately available.

Findings:

1. The hospital's grievance policy, entitled "Patient Complaint/Grievance Resolution," with an issue date of February 2008, on pages 2 and 3, appropriately stipulated that a written response would be provided to the complainant with the "steps taken on behalf of the patient to investigate the grievance; findings of the investigation; results of the grievance process (corrective measures initiated, if any); date of completion of the process; name of the hospital contact person"and this process should be completed within 45 days from the date of receipt of the complaint.

2. The surveyors selected 16 complaints and 2 grievances from the complaint and grievance log for August and September 2009, and July and August 2010. Upon review of the data supplied by the hospital, fifteen of the concerns listed as complaints were actually grievances. The problems/concerns identified by complainants could not be resolved at the time of the complaint and required investigation. This finding was reviewed and verified with hospital administrative staff # C and G at the time of review on the afternoon of 01/04/2011 and the morning of 01/05/2011.

3. Seventeen of the seventeen grievances reviewed did not contain a written response to the complainant with the required information. On the morning of 01/05/2011, the surveyors confirmed with administrative staff #C, G and K that no additional written response had been provided to the complainants.

VIOLATION: *OPERATING ROOM REGISTER*

Tag No: A0958

Based on review of the hospital records, the hospital failed to maintain a complete operating room log.

Findings:

Oklahoma State Hospital Standards subchapter 25 requires the facility to maintain a complete and up to date operating room log. The log must include: patient's name, medical record number, name of surgeon, name of assistant(s), type of anesthetic, person administering , circulating nurse, scrub nurse, procedures performed, time surgery began and ended, other persons present. On the morning of 1/5/2010, Staff A and Staff B told surveyors the facility did not record "other persons present".

VIOLATION: *PATIENT RIGHTS: GRIEVANCES* **Tag No:** A0118

Based on review of hospital policies and grievance and complaint log, selected grievances and complaints, and interviews with hospital staff, the hospital failed to ensure the hospital's established grievance process was implemented.

Findings:

1. The hospital's grievance policy, entitled "Patient Complaint/Grievance Resolution," with an issue date of February 2008, appropriately defined the difference between complaints and grievances; provided time frames for investigation and resolution of grievances; stipulated that a written response with the required information would be provided to the complainant; and stipulated data collected from complaints and grievances would be "trended and analyzed for opportunities to improve care and incorporated into the hospital's performance improvement program."

2. The hospital failed to identify grievances: The surveyors selected 16 complaints and 2 grievances from the complaint and grievance log. Upon review of the data supplied by the hospital, fifteen of the concerns listed as complaints were actually grievances. The problems/concerns identified by complainants could not be resolved at the time of the complaint and required investigation. This finding was reviewed and verified with hospital administrative staff # C and G at the time of review on the afternoon of 01/04/2011 and the morning of 01/05/2011.

3. The data provided to the surveyors did not demonstrate the hospital investigated the grievances: For seventeen of the seventeen grievances reviewed, the hospital could not provide data to show the hospital had investigated the all problems/concerns listed by the complainants. This finding was reviewed and verified with hospital administrative staff # C and G at the time of review on the afternoon of 01/04/2011 and the morning of 01/05/2011.

4. The hospital does not ensure all grievances are resolved within the time frames. Seventeen of seventeen grievances reviewed did not contain a date that the grievance was completed/date of resolution. The data supplied to the surveyors did not contain the date the hospital resolved the grievance or evidence the hospital had supplied a written response to the complainant with all the required data, including the date the hospital considered the grievance resolved.

4. The hospital does not ensures grievance data is incorporated in the hospital's Quality Assessment and Performance Improvement (QAPI) Program with analysis of the data and implementation of processes to improve patient care:
a. According to the the complaint and grievance log, six of eighteen complaints and grievances listed for August 2010 concerned Unit 10-West.
b. Staff #F showed the surveyors that she had instituted training and corrective actions for the unit.
c. Review of quality data did not demonstrate that grievance and complaint data was reviewed, trended and analyzed with implementation of corrective and/or process changes to improve patient care. This finding was reviewed with administrative staff on the morning of 01/05/2010.