

PRINTED: 03/09/2006
FORM APPROVED

MA DPH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 06-0281		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 220031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2006
NAME OF PROVIDER OR SUPPLIER BOSTON MEDICAL CTR CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 1 BOSTON MEDICAL CTR PL BOSTON, MA 02118		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	INITIAL COMMENTS An On-Site Hospital Licensure survey was conducted in response to a complaint received by the Department of Public Health (reference # 06-0281) at: Boston Medical Center 830-840 Harrison Avenue Boston, MA	P 000		
P 009	130.200 Inc of Medicare Condi of Participation in Hos Each hospital shall meet all of the requirements of the Medicare Conditions of Participation for Hospitals, 42 C.F.R. 482.11 through 482.62 (hereinafter Conditions of Participation), as they may be amended from time to time, except the requirement for institutional plan and budget specified in 42 C.F.R. 482.12(d), for utilization review specified in 42 C.F.R. 482.30, the requirement for compliance with the Life Safety Code specified in 42 C.F.R. 482.41(b), and any requirement that conflicts with the supplementary standards in 105 CMR 130.000 Subparts C and D. This Requirement is not met as evidenced by: 1. Based on documentation review the Hospital was not in compliance with Standard A-0079 (In accordance with the order of a physician or other licensed independent practitioner permitted by the State and hospital to order seclusion or restraint.) of the Conditions of Participation of Patient's Rights (482.13) because it failed to ensure a physician's order was obtained to restrain a patient in one of one applicable patient	P 009	All Emergency Department physicians and nurses were instructed that any restraint requires a physician order and a face-to-face evaluation by the physician within one hour.	3/15/06

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

TITLE

(X6) DATE

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P 009	Continued From Page 1 record reviewed. Findings included: Review of nursing documentation indicated the ordered Ativan was administered at 10:39 PM. However, due to the Patient ' s uncooperative behavior four additional staff members were needed to restrain the Patient while the injection was administered. Review of nursing documentation indicated the ordered Haldol was administered at 10:39 PM. However, due to the Patient ' s continued uncooperative behavior four additional staff members were needed to restrain the Patient while the injection was administered. Further review of physician orders did not indicate there was an order to restrain the Patient while the medication injections were administered. II. Based on interview and documentation review the Hospital was not in compliance with Standard A-0082 (A Physician or other licensed independent practitioner must see and evaluate the need for restraint or seclusion within 1 hour after the initiation of this intervention.) of the Conditions of Participation of Patient's Rights (482.13) because it failed to ensure the need for both chemical and physical restraints were evaluated in one of one applicable patient record reviewed. Findings included: Review of 12/30/05 11:49 PM nursing documentation indicated the Patient ' s behavior had escalated . He was out of his ED room	P 009	All Emergency Department physicians and nurses were instructed that any restraint requires a physician order and a face-to-face evaluation by the physician within one hour.	3/15/06

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P 009	Continued From Page 2 verbally threatening staff and refusing attempts by staff to redirect him. Review of physician orders indicated an injection of 2 mg of Ativan was ordered administered at 10:35 PM. Review of nursing documentation indicated the Ativan was administered at 10:39 PM. However, due to the Patient ' s uncooperative behavior four additional staff members were needed to restrain the Patient while the injection was administered. Continued review of physician orders indicated an injection of 5 mg of Haldol was ordered administered at 10:36 PM. Review of nursing documentation indicated the Haldol was administered at 10:39 PM. However, due to the Patient ' s continued uncooperative behavior four additional staff members were needed to restrain the Patient while the injection was administered. Review of physician ' s progress notes also did not indicate a face to face comprehensive assessment of the Patient was performed to evaluate the need for the utilization of a chemical and/or physical restraint.	P 009	The Restraint Policy and Procedure is under revision to include physical hold and chemical restraint. The policy will go the April 13, Policy and Procedure Roundtable All Emergency Department physicians and nurses were instructed that physical hold requires a physician order, restraint documentation and a face-to-face evaluation by the physician within one hour.	<i>3/30/06</i> <i>4/13/06</i> <i>3/28/06</i>	