

ASSOCIATION OF
HEALTH CARE JOURNALISTS
Improving public understanding of health and health care

[Home](#) -> [New Jersey](#) -> [KIMBALL MEDICAL CENTER](#) -> Report No. 3223

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](#).

KIMBALL MEDICAL CENTER	600 RIVER AVE LAKEWOOD, NJ 8701	Sept. 23, 2013
VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION		Tag No: A0173
<p>Based on review of two medical records of patients in medical restraints, it was determined that the facility failed to ensure that the Restraint/Seclusion policy was implemented.</p> <p>Findings include:</p> <p>Reference: Facility's "Restraint/Seclusion" policy states, "Policy: ... 10. Verbal orders, telephone orders, PRN [as needed] orders and standing orders for restraint and/or seclusion are not allowed.</p> <p>1. Medical Record #15 revealed that Patient #15 had been in soft hand mitten restraints since September 1, 2013 at 11:00 PM. On 9/4/13 at 13:53, a verbal order for soft hand mitten restraints was obtained. Verbal orders are not permitted, as per the above referenced policy.</p> <p>2. The above was confirmed with Staff #14.</p>		
VIOLATION: PATIENT RIGHTS: PARTICIPATION IN CARE PLANNING		Tag No: A0130
<p>Based on medical record review, staff interview, and review of facility policy and procedure, it was determined that the facility failed to include patients and or patient's families in the decision to include a Do Not Resuscitate (DNR) order in the patient's plan of care, in two of two medical records reviewed (Medical Records #12 and #13).</p>		

Findings include:

Reference: Facility policy # AP-R-01, titled "DO NOT RESUSCITATE (DNR)" states "... POLICY: It is the policy of -- [facility name]-- to recognize and respect the right of our patients to self-determination, including the withholding and/or withdrawing of life-sustaining measures. A "Do Not Resuscitate" ("DNR" or "No Code") order is primarily a medical, rather than a legal, decision which should be made by the patient and/or family or other legally responsible persons in conjunction with the attending physician. ... PROCEDURE: ... 3. ... The name of the patient and/or family members or significant other with whom the Do No Resuscitate order was discussed should be entered into the medical record, either on the order sheet, directly into the TDS system, in the Progress Notes or in the admitting history and physical report. 4. The physician should document in the Progress notes section of the medical record why the Do Not Resuscitate order was written, what the plan of care is and what the treatment goals are for the patient."

1. On 9/23/13, upon review of medical records for DNR orders, Medical Records #12 and #13 lacked evidence of documentation of a physician discussion with the patient/family for the DNR orders entered into the medical records. The following was reviewed in the presence of Staff #12 and Staff #14:

a. Medical Record #12 indicated, in the History and Physical dated 9/16/13, that the Patient has a living will at home. A physician telephone order on 9/20/13 at 19:52 indicated that two nurses obtained a telephone DNR order from the attending physician. There was no documented evidence by the physician in Medical Record #12 as to why the DNR was ordered, or the name of the patient and/or family members or significant other with whom the DNR was discussed, as per facility policy.

b. Medical Record #13 indicated a DNR order dated 9/12/13, the date of Patient #13's admission. The Advance Directive section of the History and Physical, dated 9/12/13 was blank. There was no documented evidence by the physician in Medical Record #13 as to why the DNR was ordered or the name of the patient and/or family members or significant other with whom the DNR was discussed as per facility policy.

2. The above was confirmed by Staff #12.

VIOLATION: *USE OF RESTRAINT OR SECLUSION*

Tag No: A0154

Based on review of facility QA data and staff interview, it was determined that the facility failed to aggregate restraint data to identify specific areas needed for improvement.

Findings include:

1. On 9/23/13 the QA for restraints was reviewed in the presence of Staff #1. The QA graph for restraints indicated the facility was reviewing the rates of restraint use. Per Staff #1, the facility also looks at other data for restraints.

2. A Restraint Data Collection Tool indicated the facility collects data on restraints, i.e. documentation of alternatives, completion of the physician one hour face to face evaluation, and care plan modification. There was no evidence that the data from the data collection tool is aggregated and trended.

3. Staff #1 confirmed on 9/23/13 at 3:10 PM, that the facility has QA for restraint rates only and that the collected data on the Restraint Data Collection tool is not aggregated.

4. Without aggregated data on the use of restraints in the facility, it cannot be determined what areas the facility may need to improve on, and what areas require interventions for improvement.

VIOLATION: PATIENT RIGHTS: RESTRAINT OR SECLUSION

Tag No: A0175

Based on review of two medical records of patients restrained for medical reasons, it was determined that the facility failed to ensure that the Restraint/Seclusion policy was implemented in one of two medical records reviewed (Medical Record #15).

Findings include:

Reference: Facility's "Restraint/Seclusion" policy stated, "... III. Orders for Restraint or Seclusion: ... 2. Inform physician to come evaluate the patient and write the order within 1 hour of application of restraint device. ... VI. Reassessment for the need to Continue Restraint or Seclusion: ... 2. Obtain a new order when need for continued restraint past the time when the time limited order expired by the physician or LIP [licensed independent practitioner] primarily responsible for the patient's ongoing care, or his/her designee, based on a face to face examination of the patient to determine if restraint use continues to be clinically justified. ... Medical Reasons: The physician or LIP must examine the patient before the order expires, document evaluation findings and write a new order to continue or discontinue the restraints. This evaluation must be done face to face. Orders may not exceed 24 hours."

1. Medical Record #15 revealed the following:

a. The ICU nurse's note of 9/1/13 at 11:00 PM indicated that Patient #15 was placed in bilateral mitts for medical reasons. The physician order was written on 9/1/13 at 23:53. There was no evidence in the medical record of a face to face evaluation at the time the order was written by the physician.

b. Orders were written by the physician for hand mitt restraints on 9/2/13 at 10:44, and on 9/3/13 at 10:23. There was no evidence in the medical record of a documented evaluation by the physician of Patient #15 to continue the restraints, as per facility policy.

2. The above was confirmed with Staff #14.

VIOLATION: ADMINISTRATION OF DRUGS

Tag No: A0405

Based on document review, it was determined that the facility failed to ensure that medication was administered in accordance with physician orders.

Findings include:

1. Medical Record #1 revealed that on 3/31/12 at 2330, verbal orders for Geodon 20 mg [milligrams] IM (intramuscularly) Stat (immediately), Ativan 2 mg IM Stat for severe agitation, Seroquel 50 mg PO (by mouth) q 4 circle (every 4 hours) PRN (as needed) psychosis, Ativan 2 mg PO q 4 circle PRN anxiety ..." were obtained.

2. A nurse's note dated 4/1/2012, at midnight, indicated that Patient #1 refused the IM medications, and agreed to take Ativan by mouth. The Medication Administration record indicated that at 12 midnight Ativan 2 mg by mouth for anxiety/agitation was administered to Patient #1.

a. There is no evidence that the physician was notified that the stat medications of Geodan IM and Ativan IM were not given as ordered because the patient refused them.