Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	670031	10/29/2015
Name of Provider or Supplier	**Street Address, City, State**	
St Luke's Patients Medical Center	4600 East Sam Houston Parkway South, Pasadena, TX	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide care in a safe setting for one (1) of ten sampled patients (Patient # 7). The facility failed to: a. Fully investigate a reported allegation of verbal and possible physical abuse by a Registered Nurse (RN) staff member. b. Establish and implement a written procedure to ensure timely investigation of alleged abuse or mistreatment. Findings include: TX 00223716 1. Review of complaint intake # TX 00223716 revealed allegations by a staff RN # 13 that he witnessed another staff RN # 9 get " right in the face and yelled and cursed at the patient...he then aggressively put the oxygen nasal cannula on the patient..." Complainant alleged this RN had been abusive to other patients. RN # 13 documented he informed a nursing supervisor of the incident he witnessed and said "nothing had been done; RN # 9 was still providing care to patients." Record review of facility document titled "EP Call Center... Primary Issue : Patient Abuse, dated 08-12-15" (transcript of 'hotline call' by RN # 13) read: On 08-10-15...RN # 9 requested his assistance with an ICU patient who was combative and bedound. RN # 13 said the patient moved his leg and was attempting to get out of bed. "RN # 9 aggressively put his face near the patient and rudely stated "'(expletive) you will not get out of this bed or else....RN # 13 said the patient became startled and said 'Don't hurt me.'... RN # 9 then "whipped the oxygen tube and forced it into the patients nose.." RN # 13 documented he reported the incident immediately to the charge nurse and he also spoke with the director of nursing the following day. Review of RN # 9's personal file revealed written documentation by DON # 14, dated 09-03-15, regarding a complaint by an ICU

	patient's family member about RN #9's "aggressive and abrasive behavior." This same documentation read: " leadership has received complaints from staff members advising that RN # 9 has been aggressive, disrespectful, and bullying.." (documented witnessed abuse by RN # 9 over 3 weeks prior) Interview on 10-29-15 at with Director of Nursing (DON) # 14, she stated there were 2 reported incidents involving RN #9's behavior very close together and they were dealt with together. DON had a few handwritten notes regarding the allegations made on 08-10-15 ; there was no official documentation of an investigation of the allegations made by RN # 13. Interview on 10-29-15 at 3:45 p.m. with Director of Quality Improvement # 3, he stated the process (at the time of incident) was a PSN (Patient Safety Net /variance report) form was to be completed after calls received over the " EP call center" hot line." This "PSN" triggered the investigation process, and was the mechanism to document the investigation. The QI Director said a PSN was not completed after RN # 13 alleged witnessed patient abuse by RN # 9. 2. Review of facility policy titled "Patient Rights (System)," dated January 2013, read: "...8. Abuse and Harassment: The patient has the right to be free from all forms of abuse, neglect.. from the workforce, other patients, or visitors...a. The hospital shall establish procedures or processes to protect patients from abuse, neglect and harassment:..b. Effective abuse protection includes the following components;..v. Protection: protect patients from abuse during investigation of alleged abuse..vi. Investigation: establish a written procedure to ensure a timely , thorough and objective investigation of alleged abuse, neglect or mistreatment... Interview on 10-29-15 at 4:15 p.m. with facility Chief Nursing Officer (CNO) # 2, she staled the facility did not have an established policy/process specific to investigation of abuse, neglect or mistreatment, as referenced in the "Patient Rights" policy . She went on to say the facility was in the process of revising & integrating their policies with the large Catholic healthcare network that recently acquired facility ownership.