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Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

St. Francis Regional Medical Center
1455 St. Francis Avenue
Shakopee, Minnesota
Scott County

Report # H0104006

Date: March 23, 2009

Date of Visit: 1/30/09; 2/2/09
Time of Visit: 8:15 A.M.; 8:00 A.M.

By: Pat FitzGibbon, R.N.
Special Investigator

Nature of Visit:

An unannounced visit was made at St. Francis Regional Medical Center in order to investigate an alleged violation of the Conditions of Participation for accredited hospitals participating in Medicare, specifically 42 CFR 482.12 regarding the Governing Body, 42 CFR 482.22 regarding Medical Staff and 42 CFR 482.51 regarding Surgical Services.

The allegation is: Patient #1 was not adequately evaluated when he was seen in the hospital emergency department (ED) on April 21, 2008. As a result, he had to return to the ED later that day and it was determined that he required an appendectomy. Surgery was performed in the early morning of April 22, 2008. Although the patient was experiencing severe pain and a "racing" heart, he was discharged to home at 3:00 P.M. on April 22, 2008. The patient continued to have severe pain and contacted the hospital ED on April 23, 2008 and reported he observed blood in his urine. The ED nurse told the patient he was "probably dehydrated" and that he would be fine. On April 24, 2008, the patient developed a temperature and again contacted the ED. The ED nurse agreed to page the surgeon. When the physician called the patient at home, he indicated that lab results showed that his appendix had not actually been removed in surgery and that he would require additional surgery. By the time the patient had the second surgery, his appendix had ruptured and more extensive surgery was needed. As a result, the patient's recovery has been delayed.

Investigative Findings:

All employees and persons were interviewed in private as desired and given the Tennessen Statement.

During the course of the investigation, medical records, Governing Body and Medical Staff bylaws/rules/regulations, meeting minutes, and policies/procedures were reviewed. In addition, physician credentialing files and Surgical Services policies/procedures were reviewed. Also, interviews were conducted and the hospital surgical service area was toured.

Regarding the events of April 21, 2008 and April 22, 2008:

Patient #1's medical record was reviewed and indicated that:

The patient presented to the hospital emergency department (ED) at approximately 12:42 P.M. on April 21, 2008 and reported he was experiencing abdominal pain or "pressure".

Physician (J) saw the patient and documented that "given his lack of focality and his abdominal exam" the patient could be discharged to home. Documentation indicated that observation at home versus testing at the hospital was discussed and agreed to by the patient.

The patient was instructed to return to the ED or call the MD if his symptoms worsened or if he had any questions.

The patient was discharged at 1:39 P.M. on April 21, 2008.

The patient returned to the ED at 8:26 P.M. on April 21, 2008 and reported that his abdominal pain had worsened. Laboratory tests and a CT scan were completed and demonstrated an elevated white blood count and evidence of acute appendicitis.

The patient was admitted to the hospital and physician/surgeon (M) assumed his care.

The patient had an appendectomy performed by physician/surgeon (M) on April 22, 2008 and was discharged to home the same day.

An operative report regarding the April 22, 2008 procedure was not completed by physician/surgeon (M). This was verified by administrative employee (B).

Physician (J) was interviewed by phone on 2/2/09 indicated that:

When patient #1 presented to the ED on April 21, 2008 at approximately 12:42 P.M., no focal abdominal tenderness was noted during his physical exam and the patient had non-specific complaints about his symptoms.

A CT scan would have been necessary to diagnose acute appendicitis and that was not warranted based on the patient's symptoms during his first visit to the ED on April 21, 2008.

The patient agreed to be discharged to home with a plan to return to the ED and/or call the physician if his symptoms worsened or if he had any questions.

The patient phoned physician (J) in the ED at approximately 4:00 P.M. on April 21, 2008 (not documented in the patient's medical record) and reported he was not feeling well so he was told to return to the ED.

Employees (F, H, I)/RNs were interviewed in person on January 30, 2009 and stated that:

ED nursing staff do not give any medical advice over the phone to patients who call the ED.

Patients who call the ED would be advised to call their primary physician or to come to the ED for an evaluation.

All patients who are discharged from the ED are given discharge instructions to return to the ED or call their physician if their condition worsens.

Regarding the events of April 24, 2008:

Patient #1's medical record was reviewed and indicated that:

The patient returned to the ED on April 24, 2008 at 8:37 P.M and reported that he had received a phone call from physician/surgeon (M) who indicated his appendix had not been removed during the April 22, 2008 surgery but rather a "piece of fat" was removed.

The patient had mild shortness of breath, a distended abdomen, hypoactive bowel sounds, and pain and tenderness of the abdomen.

Physician/Surgeon (M) saw patient #1 in the ED and documented that the patient had a laparoscopic appendectomy on April 22, 2008 and was discharged to home and that the patient called physician (M) on April 24, 2008 to report a temperature of 102 degrees and persistent lower right quadrant abdominal pain.

On April 24, 2008, physician (M) was notified by the pathologist that the specimen removed during patient #1's April 22, 2008 surgery was not an appendix.

Patient #1 was admitted to the hospital.

A laparoscopic appendectomy was initially attempted by Physician/Surgeon (M) on April 24, 2008 but the physician changed to an open procedure due to visualization concerns. An "appendix epiploicum that was large, firm and inflamed and looked quite a bit like an appendix with appendicitis" was identified but with further dissection the "true appendix" was found and removed from the retrocecal area. The appendix was sent to pathology. The abdominal cavity was irrigated with saline and the abdominal wall was closed. However, the wound was left open.

After surgery, the patient was transferred to an intensive care unit in critical but stable condition.

Regarding patient #1's post-operative period from April 24, 2008 to May 5, 2008:

Patient #1's medical record was reviewed and indicated that:

On April 27, 2008, the patient verbalized concerns regarding his surgery and post-op care and requested that another physician (other than physician M) be assigned to his care. Therefore, an administrative staff and another physician met with the patient on April 27, 2008 to discuss his ongoing care at the hospital.

It was determined that the patient had a post-op paralytic ileus (a partial or complete blockage of the bowel that results in the failure of the intestinal contents to pass through). Therefore, on April 27, 2008, a naso-gastric tube was placed to decompress the intestine with suction and a "nothing by mouth" diet was ordered.

A May 1, 2008 nutrition note indicated the patient was started on a regular diet.

Nursing documentation indicated the patient received wet to dry abdominal wound dressings which required pre-medication with Morphine during his hospitalization from April 24, 2008 to May 5, 2008.

The patient was discharged to home on May 5, 2008 with orders for home care services for daily wound dressing changes.

Employees (B) and (E)/administrative staff were interviewed in person on January 30, 2009 and February 2, 2009 and indicated that:

The medical staff had procedures in place to review any concerns identified regarding the care provided by a member of the medical staff.

Administrative staff were aware of concerns regarding the care of patient #1.

Physician (M) had a provisional appointment to the medical staff approved by the hospital governing board. This provisional appointment ended in November 2008. A reappointment was not requested. Therefore, physician (M) is no longer a member of the hospital medical staff.

The complainant was not interviewed. A voice mail message was left for the complainant and a letter was sent by mail requesting a return phone call if the complainant had any additional information. No phone call was received.

Conclusion: It is recommended that the hospital be found in compliance with the Conditions of Participation 42 CFR 482.12 regarding the Governing Body, 42 CFR 482.22 regarding Medical Staff

and 42 CFR 482.51 regarding Surgical Services. Although, patient #1 had to have a second more invasive surgical procedure (after his appendix had ruptured) because physician/surgeon (M) failed to remove the patient's appendix during the patient's first appendectomy procedure on April 22, 2008 and that the second procedure necessitated an extended post-operative hospitalization and painful abdominal wound care, there was no specific evidence that any actions by the hospital caused this to occur. It was established through medical record review and interview that, when hospital administration became aware of concerns about the patient's surgery and ongoing medical care by physician (M), administrative staff met with the patient and arranged for a new physician and continued to monitor the patient's care until his discharge from the hospital. In addition, interview established that physician (M) is no longer a member of the hospital's medical staff since his reappointment was not requested.

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Medical Practice

06/07

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

PRINTED: 03/23/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 240104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/02/2009
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NAME OF PROVIDER OR SUPPLIER ST FRANCIS REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1455 ST FRANCIS AVE SHAKOPEE, MN 55379
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A 000	<p>INITIAL COMMENTS</p> <p>A substantial allegation survey was conducted to investigate an alleged violation of the conditions of participation for hospitals participating in Medicare, specifically the conditions of Surgical Services, Governing Body and Medical Staff, and in conjunction with H0104006. No violations were noted.</p>	A 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.