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.

HIGHLAND RIDGE HOSPITAL	**7309 SOUTH 180 WEST MIDVALE, UT**	**March 12, 2015**
VIOLATION: *PATIENT RIGHTS: INFORMED CONSENT*		**Tag No:** A0131

Based on observation, interview, medical record review and policy review it was determined that the hospital did not inform the patients that there is no physician in the hospital 24 hours per day, 7 days per week.

Findings Include:

On 3/11/15 an abbreviated survey was conducted and 10 patient records were examined. It was noted that for 10 of 10 records the patients had not been informed that the physician was not present in the hospital 24 hours per day, 7 days a week. This issue was corrected on 3/12/15 by 8:30 AM. A statement was inserted into the authorization for treatment that states "I have been advised the physicians at Highland Ridge Hospital are available onsite at the hospital during day time hours through the week and weekends, and are on-call at night for consultation or any emergency situations."

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HIGHLAND RIDGE HOSPITAL	**7309 SOUTH 180 WEST MIDVALE, UT**	**June 12, 2013**
VIOLATION: *TRANSFER OR REFERRAL*		**Tag No:** A0837

Based on interview and record review, it was determined that the facility did not ensure that all discharged patients' medical records contained discharge summaries which were accurate and authenticated by the physician responsible for the patient during his/her hospital stay for 2 out of 11 sampled patients. (Patient identifiers: 3 and 5)

Findings include:

1. Eleven patient records were chosen for review, which included 8 discharged patients and 3 active patients.

2. One of the 8 patient records for patients who had been discharged from the facility did not contain a discharge summary. (Patient identifier: 3)

3. One of the 8 discharged patient records contained a discharge summary which contained inaccurate information. (Patient 5)

Review of Patient 5's medical record revealed the following:

On 5/04/13, patient 5 was voluntarily admitted to the facility's inpatient rehab with a diagnosis of alcohol dependence. Patient 5 transitioned to the hospital's residential treatment program on 3/20/13.

Patient 5's "Multidisciplinary Treatment Plan Updated" dated 3/25/13 revealed that patient 5 was scheduled to be

discharged from the hospital to a chemical dependency program on 3/26/13, with a discharge plan that included outpatient therapy.

Patient 5's initial hospital discharge summary sent to the outpatient therapist contained information that was incorrectly taken from a different patient's medical record, including history of present illness, past medical/surgical history, drug allergies, family history, and social history.

On 6/12/13, the surveyor asked the administrator (AD) if he was aware that the wrong information was sent to the outpatient psychiatrist regarding patient 5. The AD stated that sometime during the 2nd week of May 2013, he had received several frantic telephone messages from patient 5 who was concerned about the information contained in the records sent to her private therapist. The AD stated that patient 5 felt that the records listed her age and parent information wrong, in addition to other information. The AD stated that he had researched patient 5's record and discovered that the discharge summary provided to the therapist did contain inaccurate information. The AD stated that he had hospital medical records personnel pull the inaccurate information from patient 5's discharge summary and correct the information. The AD stated that he had not had an opportunity to follow up with patient 5 regarding this matter, but that, "if the records release was still current, he would send a corrected copy of the discharge summary to the therapist." The AD stated that he would also call patient 5's therapist to explain what had happened.

On May 12, 2013, an interview was held with the medical records director (MRD) regarding patient 5's incorrect discharge summary that was sent to patient 5's therapist. The MRD stated that she was asked to review patient 5's discharge summary, so she compared the information provided on patient 5's original history and physical form (history of present illness, past medical/surgical history, drug allergies, family history, and social history) to the information listed on the discharge summary and noted that it was incorrect. The MRD stated that the transcription company had apparently copied the wrong patient's history and physical (H&P) information into the discharge summary for patient 5. To correct the error, the MRD accessed the transcription company's website and copied and pasted the correct information from patient 5's original H&P into the discharge summary, printed it, and put it in patient 5's medical record. The MRD stated that she did not document anywhere that it was a corrected discharge summary, but just replaced the original discharge summary.

The surveyor asked the MRD to explain how the hospital discharge summaries were formulated. The MRD stated that the physician dictated the discharge summary, and that a transcription company, as a courtesy to the agency, copied and pasted a portion of the patient's original dictated H&P to the discharge summary. This included information regarding history of present illness, past medical/surgical history, drug allergies, medications on admission, family history, and social history. The MRD stated that the physician's electronic signature was applied to the discharge summary by hospital medical records personnel and that the physician did not actually review the completed discharge summary or sign it.