

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150021	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/28/2015
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NAME OF PROVIDER OR SUPPLIER PARKVIEW REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11109 PARKVIEW PLAZA DRIVE FORT WAYNE, IN 46845
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S 0000 Bldg. 00	<p>The visit was for investigation of a State complaint.</p> <p>Complaint Number: IN00170423</p> <p>Substantiated: Deficiencies related to the allegations are cited and an unrelated deficiency is cited.</p> <p>Date: 7-27/28-15</p> <p>Facility Number: 005020</p> <p>QA: cjl 09/03/15</p> <p>IDR Committe met on 11-12-15; No change. JL</p>	S 0000		
S 0748 Bldg. 00	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(3)</p> <p>(e) All entries in the medical record shall be:</p> <p>(3) authenticated and dated promptly in accordance with subsection (c)(3). Based upon document review and interview, the facility failed to ensure all entries in the medical record (MR) were authenticated, dated and timed for 1 of 6 records reviewed (patient 27).</p>	S 0748	<p>Tag S 748 410 15-1.5-4 - Medical Record Services All entries in the medical record shall be: authenticated and dated promptly in accordance with subsection (e) (3) Findings: The case management/discharge</p>	10/30/2015

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.

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	<p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Medical Records (approved 5-14) indicated the following: "All entries in the medical record will be dated, timed, and authenticated by written signature, initials, electronic signature or other unique author identification...the author's role/discipline will be identified by written credentials on paper entries ..." The case management/discharge planning document titled Patient Information and Selection Form observed in the MR for patient 27 indicated the name of a skilled nursing facility and indicated the signature of the patient. The document failed to indicate a date or time when signed by the patient and failed to indicate a witness signature, date or time as indicated on the document. During an interview on 7-27-15 at 1155 hours, the quality and accreditation specialist A3 confirmed that the Patient Information and Selection Form for patient 27 lacked a signature, date and time when witnessed by the responsible case management/discharge planning nurse and lacked a date and time when signed by the patient. 		<p>planning document titled Patient Information and Selection Form in the MR for patient 27 indicated the name of a skilled nursing facility and indicated the signature of the patient. The document failed to indicate a date or time when signed by the patient and failed to indicate a witness signature, date or time as indicated on the document. 1. How are you going to correct the deficiency? All case managers were re-educated regarding the authentication and witness documentation requirements at their department meeting on September 22, 2015. 2. How are you going to prevent the deficiency from recurring in the future? Random chart audits of at least 30 patients will be completed to verify that the process has been fully corrected. 3. Who is going to be responsible for # 2? The Director of Case Management 4. By what date will the deficiency be corrected? October 30, 2015</p>	

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S 1312 Bldg. 00	<p>410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10(e)(1)</p> <p>(e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that:</p> <p>(1) facilitates the provisions of follow-up care; Based upon document review and interview, the facility failed to follow its policy/procedures and ensure that effective patient discharge planning was provided to facilitate the provision of follow-up care for 1 of 6 medical records (MR) reviewed (patient 27).</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Discharge Planning (approved 5-13) indicated the following: "Outcomes ...Assure that each patient who has post-discharge needs and/or follow-up has a planned program to meet those needs." The MR for patient 27 indicated a physical therapy recommendation on 3-23-15 at 1331 hours for skilled nursing facility placement with physical therapy 5 times a week for strength building and wound care and included a 	S 1312	S1312 410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10(e)(1) (e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that: (1) facilitates the provisions of follow-up care; The patient was admitted on 3/17/15 with mucous plugging and hypoxemia. The medical record indicates that on 3/18/2015 the Parkview Case Manager received a call from the patient's Home Health Care Case Manager. The record indicates that the Home Health Care Case Manager informed the Parkview Case Manager that the patient was considering placement at Bryan Care and Rehab prior to the patient's transfer from Bryan Hospital. The Parkview Case Manager confirmed this plan with patient and his mother. The Parkview Case Manager proceeded to have the patient	11/17/2015			

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	<p>recommendation for 24 hour a day/7days a week assistance at home with home health agency services including physical therapy, occupational therapy and registered nurse staffing if the patient refuses skilled nursing facility placement based on poor patient safety and hygiene awareness.</p> <p>3. The MR for patient 27 indicated an occupational therapy recommendation on 3-23-15 at 1348 hours for short-term skilled nursing facility (SNF) placement with occupational therapy 3 to 5 times a week and indicated a recommendation (if short-term SNF placement was declined by the patient) for discharge home with home health care with occupational therapy services and 24 hours a day/7 days a week supervision/assistance.</p> <p>4. The MR entry for patient 27 on 3-23-15 at 1738 hours by case manager CM41 indicated the following: "CM met with patient to discuss patient return to home at discharge, arrangements for home oxygen made through [a medical gas provider] ...transport arranged with a 6 pm (3-23-15 at 1800 hours) pick up time through [an ambulance service] ... [a medical gas provider] representative A10 to room with portable tank for when patient arrives home and number given for patient to call for home delivery of</p>		<p>selection form signed and made a referral to Bryan Care and Rehab. On 3/20/15 the liaison from Bryan Care and Rehab discussed this option with the patient and completed an assessment. The Parkview Case Manager noted in the record that the plan was to discharge to Bryan Care and Rehab and that the patient had been accepted to the facility. On the day of discharge, the Parkview Case Manager met with the patient to coordinate transfer. The patient adamantly stated that he wanted to return home at discharge. The Parkview Case Manager made arrangements for home oxygen and ambulance transport to home. The Parkview Case Manager documented the need for a family member to meet patient at home upon arrival. The patient stated his mother would be waiting for him at his apartment. The Parkview Case Manager noted that the patient had previously had home health care and asked the patient if she could notify the home health care agency of his return. The patient stated that he would contact the home health care agency himself. Given that Parkview was never notified of a 10-day notice and that the patient was competent, this was an appropriate discharge plan. In this case, the 51 year old patient was competent and making decisions for himself. There are</p>	

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	<p>concentrator through [a community home health provider]. No additional discharge needs identified." The MR entry failed to indicate the physical therapy recommendation for 24 hour a day/7days a week assistance at home with home health agency services or the occupational therapy recommendation for discharge home with home health care and 24 hours a day/7 days a week supervision/assistance.</p> <p>5. The late entry for patient 27 on 3-27-15 at 0725 hours by case manager CM41 indicated the following: "...case manager inquired about home health services, patient stated he would contact the agency upon return to home to resume services ..." The MR failed to indicate the case manager identified the name of the home health provider or identified the home health services recommended for the patient upon discharge.</p> <p>6. During an interview on 7-27-15 at 1430 hours, the case manager CM41 confirmed the entry on 3-23-15 and the late entry on 3-27-15 by case manager CM41 failed to identify the name of the home health service provider referred to by the patient and failed to identify the patient's home health services needed upon discharge.</p>		<p>many dynamics involved with a 51 year old competent patient. We are always respectful of patient's wishes in regards to contacting family. The case manager offered to contact patient's mother. The patient stated that he would call his mother himself. The patient also requested to contact the HHC company himself. There were no new HHC orders. Progress Note in chart 03/18/2015: "Received a call from pt's home care star whom staff's pt apr for care. her name and contact Leanne Bachalman 1 877-388-7917. Prior to pt's transfer from Bryan hospital pt was being looked at for placement to Bryan care and rehab. I have confirmed with pt and mother of this plan, selection form signed and on chart, referral made and pass port faxed. Janice coming tomorrow to do assessment. Cm following" Action Plan: Education was provided to the entire case management department at the 11/17 case management meeting. The team discussed the importance of education to these patients along with the appropriate documentation when a patient declines the interdisciplinary team's recommendation. We also discussed the importance of assuring the patient understands how this will impact their</p>				

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			<p>recovery. The smart text has been built, below is the template and an example. Here is an example filled out: CASE MANAGEMENT NOTE: CM/SW met with patient to discuss interdisciplinary team and physician discharge recommendations. Recommend services include: Home Healthcare and DME Patient is his own decision maker and has declined these services against the recommendation of the interdisciplinary team and physician. Patient is able to verbalize the impact of not receiving the services and wishes to assume responsibility for his own plan of care. EDUCATION sent via email to the team as well. A new smart phrase has been added to use in the charting. When the interdisciplinary team and physician make a recommendation for discharge planning, but the patient refuses, please use the new smart phrase .CMDECLINE. This smart phrase includes verbiage required to show clear documentation of the patient's refusal.MONITORING PLAN:</p> <ul style="list-style-type: none"> The plan of correction to ensure appropriate documentation within the electronic medical record of patient refusal of discharge planning recommendations: <p>0 December</p> <p>§ Case management manager will</p>	

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S 1318 Bldg. 00	<p>410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(3)(A)(B)(C) (D)(E)(F)</p> <p>(e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that:</p> <p>(3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following: (A) medical history; (B) current medications; (C) activities status;</p>		<p>round and review education that was provided previously in the November 17th case management meeting and validate understanding of new process with each case manager.</p> <p>o January</p> <p>§ 5 charts per case manager will be reviewed for accuracy.</p> <p>§ Should any fallouts be found, they will be re-reviewed the following month until we reach at least 90% compliance.</p>	

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	<p>(D) nutritional needs; (E) outpatient service needs; (F) follow-up care needs; and Based upon document review and interview, the facility failed to follow its policy/procedures and ensure that follow-up care including the transfer of necessary medical information was arranged with an appropriate provider for 1 of 6 medical records (MR) reviewed (patient 27).</p> <p>Findings:</p> <p>1. The policy/procedure Discharge Planning (approved 5-13) indicated the following: "The discharge instructions are communicated to any individual or organization responsible for the patient's continuing care, which may be family, a physician, home health agency, rehabilitation center, or extended care facility."</p> <p>2. The MR for patient 27 indicated a physical therapy recommendation on 3-23-15 at 1331 hours for 24 hour a day/7days a week assistance at home with home health agency services including physical therapy, occupational therapy and registered nurse staffing if the patient refuses skilled nursing facility (SNF) placement based on poor patient safety and hygiene awareness.</p>	S 1318	<p>S1318 410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(3)(A)(B)(C) (D) (E)(F) (e) To facilitate discharge as soon as an acute level of care is no longer required, the hospital shall have effective, ongoing discharge planning that: (3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following: (A) medical history; (B) current medications; (C) activities status; (D) nutritional needs; (E) outpatient service needs; (F) follow-up care needs; In this case, the 51 year old patient was competent and making decisions for himself. There are many dynamics involved with a 51 year old competent patient. We are always respectful of patient's wishes in regards to contacting family. The case manager offered to contact patient's mother. The patient stated that he would call his mother himself. The patient also requested to contact the HHC company himself. There were no new HHC orders; there was no physician order for Physical Therapy or Occupational Therapy which is required for</p>	11/17/2015

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	<p>3. The MR for patient 27 indicated an occupational therapy recommendation on 3-23-15 at 1348 hours for discharge home with home health care with occupational therapy services and 24 hours a day/7 days a week supervision/assistance (if short-term SNF placement was declined by the patient).</p> <p>4. The MR entry for patient 27 on 3-23-15 at 1738 hours by case manager CM41 indicated the following: "CM met with patient to discuss patient return to home at discharge, arrangements for home oxygen made through [a medical gas provider] ... No additional discharge needs identified." The MR entry failed to indicate arrangements for home health agency (HHA) services with up to 24 hours a day / 7 days a week supervision/assistance had been established with a HHA provider and failed to indicate appropriate MR documentation including recommendations by a physical therapist and an occupational therapist were transmitted, transported, or otherwise communicated to the HHA coordinating the services to be provided upon discharge to home.</p> <p>5. The late entry for patient 27 on 3-27-15 at 0725 hours by case manager</p>		<p>out-patient disposition. The patient had an established care plan with his Home Health agency prior to the 03/17/2015 admission. There was no change in the care plan, therefore, no further communication with the Home Health agency was required. Action Plan: CASE MANAGEMENT NOTE: CM/SW met with patient to discuss interdisciplinary team and physician discharge recommendations. Recommend services include: Home Healthcare and DME Patient is his own decision maker and has declined these services against the recommendation of the interdisciplinary team and physician. Patient is able to verbalize the impact of not receiving the services and wishes to assume responsibility for his own plan of care. Education was provided to the entire case management department at the 11/17 case management meeting. The team discussed the importance of education to these patients along with the appropriate documentation when a patient declines the interdisciplinary team's recommendation. We also discussed the importance of assuring the patient understands how this will impact their recovery. The smart text has been built. EDUCATION sent via email to the team as well. A new smart phrase has been</p>	

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	<p>CM41 indicated the following: "...case manager inquired about home health services, patient stated he would contact the agency upon return to home to resume services ..." The MR failed to indicate the case manager contacted the HHA provider and provided MR documentation indicating the home health services recommended for the patient upon discharge.</p> <p>6. During an interview on 7-27-15 at 1430 hours, the case manager CM41 confirmed the entry on 3-23-15 and the late entry on 3-27-15 by case manager CM41 failed to indicate that a HHA provider was contacted and agreed to provide services and was provided with MR documentation indicating the home health services recommended for the patient upon discharge. Case manager CM41 confirmed that no MR documentation was sent with the patient indicating the recommendations by a physical therapist and an occupational therapist for home health agency (HHA) services with up to 24 hours a day/7 days a week supervision/assistance.</p>		<p>added to use in the charting. When the interdisciplinary team and physician make a recommendation for discharge planning, but the patient refuses, please use the new smart phrase .CMDECLINE. This smart phrase includes verbiage required to show clear documentation of the patient's refusal.MONITORING PLAN:</p> <ul style="list-style-type: none"> ·The plan of correction to ensure appropriate documentation within the electronic medical record of patient refusal of discharge planning recommendations: ·December ·Case management manager will round and review education that was provided previously in the November 17th case management meeting and validate understanding of new process with each case manager. ·January ·5 charts per case manager will be reviewed for accuracy. ·Should any fallouts be found, they will be re-reviewed the following month until we reach compliance. 		