STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150100	A. BUILDING 00 B. WING	02/03/2020

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S 0000 Bldg. 00	This visit was for investigation of a state licensure hospital complaint. Complaint Number: IN00261453 Substantiated; Deficiency related to the allegation is cited. Unrelated deficiency is cited. Survey Date: 2/3/20 Facility Number: 005089 QA: 2/19/2020	S 0000		
S 0256 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(2)(A)(B) (a) The Governing Board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (2) Ensure that the hospital: (A) meets all rules and regulations for licensure and certification, if applicable; and (B) makes available to the commissioner upon request all reports, records, minutes, documentation, information, and files required for licensure. Based on interview, the governing board failed to	S 0256	S256 410 IAC 15-1.4-1(a)(2)(A)(B)	02/29/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	ensure the hospital made personnel files available upon request for 3 of 4 personnel files requested (S1, S3 and S4). Findings include: 1. On 2/3/20, staff member A1, Manager of Risk Management, indicated in interview at approximately 12:15 PM, that personnel files may not be readily available due to being located in city #2. 2. On 2/3/20, between approximately 2:00 and 3:00 PM, personnel files for staff members S1 (RN) and S2 (RN) were requested. 3. On 2/3/20, between approximately 4:00 and 5:00 PM, personnel files for staff members S3 (Case Manager) and S4 (Social Worker) were requested. 4. The personnel files for S1, S3 and S4 were not available prior to exit on 2/3/20 at 6:00 p.m.		HR Delivery (HR Partner & HR Advisor) ¿ Contact HR Operations via email to begin process ¿ Notify HR Assistant of the listing of names the surveyor wants to see ¿ Advise if the personnel files should be presented digitally or physically HR Operations (HR Assistant, Supervisor, HR Coordinator) ¿ Initiate Onsite Audit/Survey Notification Request ¿ Initiate MyLearning Request ¿ Notify all parties involved of all the names the surveyor wants to review ¿ Create a survey folder and a folder for each associate under the shared Joint Commission folder to organize all documents received ¿ Populate the Joint Commission Files - TEMPLATE_V2 file, upload to a HR portal ticket, and submit ¿ Initiate a ticket with the MyLearning team ¿ Notify all parties of the tickets initiated ¿ Request OAHP of their assistance ¿ Print a PDF of the Job Data/Employment Data screen of each associate	

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			¿ Pull most recent annual Evaluation for each associate from Performance GPS ¿ Run a job description report for each job code ¿ Pull personnel files from the file room Ministry Service Center ¿ Gather requested License, Background Check and Education information on each associate on the file submitted via ticket ¿ Email License, Background Check, and Education information to HR Assistant ¿ Prepare to pull additional information if surveyor requests more names ¿ Close ticket once surveyor leaves site myLearning ¿ Prepare MyLearning transcripts for associate, per request ¿ Email requested MyLearning transcripts to HR Assistant ¿ Prepare to pull additional information if surveyor requests more names ¿ Close ticket once surveyor leaves site Occupational Health ¿ Prepare to receive a listing of names from HR Assistant that the surveyor wants to see	

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			Department Manager ¿ Prepare to receive a listing of names from HR Assistant that the surveyor wants to see **Date of completion: 2/29/2020** **Monitor or Metric**: Compliance will be monitored by timeliness of response to records request. A log is maintained of all ticket that are opened and when the ticket was closed. HR will monitor ticket reports to ensure all requests for employee files are submitted as requested, and in a timely manner. Oversight: HR Business partners at facility and Chief Operating Officer	
S 1316 Bldg. 00	410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(2) (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: (2) is initiated in a timely manner within time frames as established by written hospital policy; Based on document review and interview, the hospital failed to ensure discharge planning was implemented in accordance with their Policies and Procedures (P&P) for 2 of 5 patients (P1 and P2).	S 1316	S1316	08/31/2020

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	Findings include: 1. Review of the policy titled Discharge Planning, approved 12/19/2017, indicated the following: Identification of discharge planning needs is included in the nursing admission assessment and is revised based on the individual needs of the patient. Discharge plans will be developed by the Care Coordinator or Social Worker in conjunction with the patient and/or family, as indicated by the assessment evaluation or by a physician, nursing or family request. The patient and/or family are counseled for preparation of post hospital care. A list of CMS (Centers for Medicare and Medicaid Services) approved home health agencies or skilled nursing facilities for the patient's requested geographic area is given to the patient for choice of post-acute facility. The hospital, as part of the discharge planning process, will inform the patient or the patient's family of their freedom to choose. Keeping the patient and the patient's family informed of the projected level of care needed after discharge is a necessary part of the plan of care. When the patient's condition warrants, documentation of the information given to the patient and the family concerning the discharge process will include (list is not all inclusive): The conditions that may result in transfer to another level of care; The clinical basis for discharge; The anticipated need for continued care, treatment, and services following discharge; The arrangements agreed upon by the patient, family, and health care team; and The patient/family response to the information given. 2. Medical record review: Review of the Medical Records (MR) for		Finding:410 IAC 15-1.5-10 (e)(2) Utilization Review & Discharge Planning- Medical Records lacked documentation of patient or family being given a list of post acute facility choices. Ultimate Accountability for Correction: Director of Case Management St. Vincent Leadership recognizes the importance of competency and responsibilities. Additionally, all St. Vincent associates and contingent workers are aware of hospital policy. Any allegation that these standards are not routinely met represents the exception, not the norm. Corrective Action: All Case Management Staff will receive information on Hospital Policy: Discharge Planning, to ensure understanding and adherence to this policy which is specifically related to patient or family choice in post acute facilities. All case managers will read all policies owned by the case management department, including the policy, Discharge Planning and sign a Statement of understanding once completed. February 4- March 13 2020 CM	

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	patient P1, admission 2/20/18 to 2/23/18, lacked documentation of identification of discharge planning needs having been included in the nursing admission assessment. Review of the MR for patient P2, admission 2/5/18 with discharge on 2/8/18 to a rehabilitation facility, indicated the following: The MR lacked documentation of identification of discharge planning needs having been included in the nursing admission assessment; The MR lacked documentation of the patient and/or family having been given a list for choice of approved skilled nursing facilities (SNF) in the patient's area prior to discharge/transfer. Review of the MR for patient P2, admission 3/12/18 with discharge on 3/27/18 to a nursing home/SNF, indicated the following: The MR lacked documentation of identification of discharge planning needs having been included in the nursing admission assessment; The MR lacked documentation of the patient and/or family having been given a list for choice of approved skilled nursing facilities in the patient's area prior to discharge/transfer. Review of the MR for patient P2, admission 4/3/18 with discharge on 4/10/18 to a nursing home/SNF, indicated the following: The MR lacked documentation of identification of discharge planning needs having been included in the nursing admission assessment; The MR lacked documentation of the patient and/or family having been given a list for choice of approved skilled nursing facilities in the patient's area prior to discharge/transfer. 3. On 2/3/20, between approximately 12:00 PM and 1:00 PM, A2, Risk Manager, verified the MR		will read policy and sign case management policies and sign a statement of understanding Completion date: March 13, 2020 Compliance goal: 100% of case management staff Oversight Provided by Director of Case Management Expectations of case management will be presented by the Director of Case Management during a department meeting. Staff are required to attend in person or read meeting minutes. Completion date March 13, 2020 Compliance goal: 100% Oversight Provided by the Director of Case Management Enhancements to the case management documentation system (Allscripts Care Manager) were made in the Fall of 2019 by adding a checkbox feature to the progress note to both ease in	

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	findings for patient P1. Between approximately 2:00 PM and 4:00 PM, A2 verified the MR finding for P2.		documentation and standardize wording of providing patient or family with post acute facility choices. Completion date Fall 2019 Compliance goal: 100% Oversight Provided by the Director of Case Management All actions completed on this date: _3/13/2020_____ Monitor or Metric: Policy Compliance for delivery of patient choice list will be monitored by completing audits of patients charts who discharged to SNF, HHC, LTACH, and Acute Rehab. Frequency of Monitoring For the next 6 months Monthly audit of 25 charts for patients discharged to SNF, HHC, Acute Rehab Quarterly audit of 15 charts for patients discharged to LTACH After 6 months we will reevaluate to see if further actions need taken	

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			(i.e hard stops set in case management documentation). Data collected Chart reviews will be made for compliance or noncompliance of the presence of documentation of delivery of post acute facility choices to patients. Audit will be scored as compliant or noncompliant with a goal of 100% sustained compliance. Data Reported Reports will be made to the Ancillary and Ambulatory PI Council every 6 months. *All action plans must be measurable via audits/ tracers/ data collection. No matter the level of the finding, there must be data collected and reported in a manner that reaches the Board of Directors.* S1316 410 IAC 15-1.5-10 (e)(2) Root Cause Analysis: Our Adult Patient Profile that is completed on admission has evolved over time. In efforts to create less	

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			"clicks" for nursing, areas have been hidden from view. The area addressing anticipated discharge needs has been hidden to individual users. Plan: We are providing education to nursing staff with instructions to reactivate. Sign-in sheets will be completed. Please see attached pages for materials. Follow-up: 30 inpatient charts a month will be audited. The goal is 90% compliance. Date Follow-up Responsible Party April 1st to April 30th 50% of nurses will be educated, as evidenced by sign-in sheets Directors and their assigned designees May 1st- May 31st	

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			The remaining 50% of nurses will be educated Directors and their assigned designees June 1st- June 30th 30 inpatient charts to be audited per month Clinical Nurse Specialist July 1st- July 31st 30 inpatient charts to be audited per month Clinical Nurse Specialist August 1st- August 31st 30 inpatient charts to be audited per month Clinical Nurse Specialist	