STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150064	A. BUILDING 00 B. WING	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTE REGIONAL HEALTH SYSTEM	1941 VIRGINIA AVE CONNERSVILLE, IN 47331

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S 0000 Bldg. 00	The visit was for investigation of one State hospital complaint. Complaint Number: IN00187089 Unsubstantiated: Lack of sufficient evidence. Unrelated deficiencies are cited. Date: 11/17/16 Facility Number: 005059 QA: 02/24/17 jlh	S 0000		
S 0322 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on administrative document review and interview, the facility failed to follow its policy/procedure and ensure allegations of abuse and neglect were	S 0322	**Review of the policy/procedure Patient Complaint and**	04/30/2017

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

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	investigated and reviewed for one occurrence (patient #1). Findings include: 1. Review of the policy/procedure Patient Complaint and Grievance (revised 1-15) indicated the following: "All verbal or written concerns regarding abuse, neglect, patient harm, or hospital compliance with CMS (Centers for Medicare and Medicaid Services) are considered grievances... communication to the person lodging the grievance... to include... the steps taken on behalf of the patient to investigate and resolve..." The policy/procedure included attachment A-1 titled Complement / Complaint / Grievance Form with designated areas to document the description of the incident, complaint and/or grievance allegations, details of the investigative process, and results of the investigation and actions taken (including a requirement to document the dates of all activity). 2. Review of grievance documentation dated 11-18-15 regarding an ED visit on 11-17-15 by patient #1 failed to indicate the allegations were investigated and documented on the designated areas of the grievance form by the administrative team leader, staff A1.		**Grievance (revised 1-15) indicated the following: "All verbal or written concerns regarding abuse, neglect, patient harm, or hospital compliance with CMS (Centers for Medicare and Medicaid Services) are considered grievances... communication to the person lodging the grievance... to include... the steps taken on behalf of the patient to investigate and resolve..." The policy/procedure included attachment A-1 titled Complement / Complaint / Grievance Form with designated areas to document the description of the incident, complaint and/or grievance allegations, details of the investigative process, and results of the investigation and actions taken (including a requirement to document the dates of all activity).** **Findings include:** **Review of grievance documentation dated 11-18-15 regarding an ED visit on 11-17-15 by patient #1 failed to indicate the allegations were investigated and documented on the designated areas of the grievance form by the administrative team leader, staff A1.**	

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	3. At 1035 hours on 11-17-16, the vice president of patient care services, staff A1 indicated the MR for patient #1 was reviewed, the staff involved with the patient care were interviewed, and the nursing supervisor was interviewed in response to the grievance received by the facility. Staff A1 was requested to provide documentation of the investigative process and none was received prior to exit. 4. At 1205 hours on 11-17-16, the quality analyst, staff A3, and the vice president of patient care services, staff A1 confirmed the administrative documentation associated with patient #1 failed to indicate an investigation was conducted in response to the grievance received by the facility.		**3. At 1035 hours on 11-17-16, the vice president of patient care services, staff A1 indicated the MR for patient #1 was reviewed, the staff involved with the patient care were interviewed, and the nursing supervisor was interviewed in response to the grievance received by the facility. Staff A1 was requested to provide documentation of the investigative process and none was received prior to exit.** **4. At 1205 hours on 11-17-16, the quality analyst, staff A3, and the vice president of patient care services, staff A1 confirmed the administrative documentation associated with patient #1 failed to indicate an investigation was conducted in response to the grievance received by the facility.** **Plan of Correction - Include Details & Timelines for the Full Implementation Plan**	

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			Responsible Position **Expected Date of Completion (EDOC)** **Document / Process Revision:** 1. Review the current policy and update to state process of how to sufficiently conduct investigation grievance/complaint. 2. Review and update power point on grievance/complaints. 3. Provide education for management team concerning grievance/complaint investigation process and necessary documentation. **Document / Process Approval:** 1. Updated policy and education was approved by CEO, CNO, and Quality Analyst. **Education on Document / Process:** 1. Policy, power point with added information will be assigned to all management staff on Net Learning (computer based learning) with a memorandum for all assigned staff to read and acknowledge of understanding. * The education will prevent recurrence by offering further information and enhancing understanding of the investigation process of grievances/complaints. 2. Education was provided at	

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			Quality meeting and Nursing Leadership concerning process of completing grievance/complaint form in its entirety. * The education provided at the meetings will prevent recurrence by allowing for open discussion concerning investigation process and completion of the form. **Deficiency Status: (Select one: In process, resolved or compliant at time of survey):** In process VP of Pt. Care Svcs. and Quality Analyst VP of Pt. Care Svcs. and Quality Analyst VP of Pt. Care Svcs. and Human Resources VP of Pt. Care Svcs. and Quality	

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			Analyst VP of Pt. Care Svcs. 03/17/2017 03/17/2017 11/23/2016 3/17/17 04/15/2017 11/23/2016	

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			4/30/17 **Monitoring & Reporting Plan (Including Evidence Documents)** **Responsible Position** **Frequency** **Implementation Monitoring Indicators:** 1. Continually monitor all grievances/complaints for thoroughness and completion of each investigation documented on forms. Monitoring will assure adherence to the policy concerning documentation of the investigation of each grievance/complaint. Collect findings on a monthly basis and report to the Quality Action Committee on a quarterly basis. VP of Pt. Care Svcs. 1.Monthly until 100% compliance is noted consecutively for 6 months.	

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S 1510 Bldg. 00	410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C) (b) The emergency service shall have the following: (2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following: (A) Provision for the care of the disturbed patient. (B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care. (C) Provision for transfer of patients when care is needed which cannot be provided. Based on document review and interview, the facility failed to follow its policy/procedure and and ensure its emergency department (ED) services were provided in accordance with its ED standards of practice for 1 of 5 medical records (MR) reviewed (patient #1). Findings include: 1. Review of the Emergency Department Standards of Care (revised 2-16) indicated the following: "Standard of	S 1510	Records (patient responses to treatment) **Findings include:** **This Standard is not met as evidenced by: Based on document review and interview, it was determined that in patient #1 (MR) pain was not reassessed and vital signs not obtained when the patient signed out AMA after a 2 hour ER visit.**	04/30/2017

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	Care / Desired Outcome: Reassessment as appropriate for the nature and severity of condition... reassess as indicated by condition [and] evaluate for response to treatments/medications and interventions for pain control... recheck VS (vital signs) as (sic) discharge if length of stay longer than 1 hour..." 2. Review of patient #1's MR on 11-17-15 at 1805 hours indicated the patient presented to the ED with a chief complaint of chest pain. The MR entry at 1805 hours by the triage nurse, staff N11 indicated the patient rated their level of pain as 10 out of 10 and indicated a blood pressure measurement of 171/96 on arrival. The MR entry at 1811 hours by the ED physician, staff MD11 lacked documentation indicating the patient was treated for their complaint of pain and re-evaluated for improvement during the ED visit. No MR documentation from 1815 hours to 1957 hours indicated the patient was reassessed for pain and vital signs rechecked when the patient verbalized the intent to leave the ED against medical advice (AMA) or prior to leaving the facility. 3. At 1415 hours on 11-17-16, the quality analyst, staff A3 and the vice president of patient care services, staff A1 confirmed the MR for patient #1		**Plan of Correction - Include Details & Timelines for the Full Implementation Plan** **Responsible Position** **Expected Date of Completion (EDOC)** **Document / Process Revision:** 1. Review the current policy and identify where education needs completed. a. Standards of care (revised 2-16) states that vital signs need to be retaken if length of stay is over an hour and pain should be reassessed within 60 minutes after a pain medication.	

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	lacked documentation indicating the 10 out of 10 pain reported on arrival was addressed or resolved during the 2 hour ED visit.		2. Develop a QAPI audit form for nursing reassessment of pain after medication 3. Discuss at unit meeting the necessity for nurses to obtain vital signs on discharge of patient in accordance to policy. 4. Discuss that all refusals by patients should be documented in the medical record even if the patient is leaving AMA. 4. Change the current policy to be more specific in regards to what patients need repeat vital signs upon discharge. **Document / Process Approval:** 1. New policy for standards of care will be written and given to the medical direction, CNO and CEO for approval. **Education on Document / Process:** 1. New policy for standards of care and expectations regarding vital sign recheck and a reiteration of the need to recheck pain level of patients to be placed on net learning. 2. Education will be provided at unit meetings for all nursing staff. * The education provided at the unit meeting will prevent recurrence by allowing for open discussion concerning recheck of vital signs, pain follow-up, and discharge standards.	

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			Deficiency Status: (Select one: In process, resolved or compliant at time of survey): In process Director of Emergency Department Director of Emergency Department Director of Emergency Department and Human Resources Director of Emergency	

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			Department	
			03/16/2017	
			01/01/2017	
			04/12/2017	
			04/12/2017	
			03/24/2017	
			04/30/2017	
			04/12/2017	

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			4/30/17 **Monitoring & Reporting Plan (Including Evidence Documents)** **Responsible Position** **Frequency** **Implementation Monitoring Indicators:** 1. Continue monitoring pain reassessment after medication (QAPI) by checking patient charts for pain medications given. All charts from every other day are examined for pain medication given and the follow-up provided. 2. Audit 10 patient charts monthly that are being discharged or transferred to assure they have a discharge vital taken within 30 minutes of discharge, if clinically appropriate. 1.Director of Emergency Department	

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			1.Director of Emergency Department 1.Audit monthly and report to the quality council bimonthly. To continue for the rest of 2017. 1.Audit monthly for 6 months or until an average of 90% for a 6 month duration	