STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152012	A. BUILDING 00 B. WING	03/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL NORTHWEST INDIANA	5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320

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S 0000 Bldg. 00	This visit was for investigation of a state licensure hospital complaint. Complaint Number: IN00206458 Substantiated: deficiencies related to the allegations are cited. Date: 3/6/18 Facility Number: 008899 QA: 5/14/18	S 0000		
S 0270 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(6) (a) The governing board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (6) Review, at least quarterly, reports of management operations, medical staff actions, and quality monitoring, including patient services provided, results attained, recommendations made, actions taken and follow-up. Based on document review and interview, the governing board failed to review at least quarterly, quality monitoring related to the patient complaint/grievance process for receiving, reviewing, investigating, resolving, and recommending quality improvement; including summarization, aggregation, analyzation, and	S 0270	S270 410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1 (a)(6) **Immediate Corrective Actions:** Governing Board reviewed the findings from the survey and directed leadership to review	08/17/2018

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

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	trends identified, for 1 of 5 (#1) patient medical records reviewed. Findings include: 1. Review of policy #H-PC 09-001 titled, "Patient Rights and Responsibilities", revised/reapproved 6/17, indicated on pg. 1, under: A. Purpose section, "This policy establishes guidelines to provide an environment that both respects and protects the rights of patients and patient's families." B. Policy section, point 1., "The list of Patient Rights and Responsibilities (PRR) is provided to each patient at admission as part of the admission packet." 2. Review of policy #H-ML 04-008 PRO titled, "Patient Complaint/Grievance Process", revised/reapproved 6/16, indicated on pg: A. 1, under Rationale section, points 1., 2. and 3., "The purpose of this policy is to provide a process to review, investigate, and resolve a patient's/patient representative's complaint or grievance within a reasonable time frame. Provide a process to help identify, investigate and resolve systemic problems through identification and analysis of trends in complaints and grievances. Provide a quality improvement approach to evaluate the effectiveness of the complaint and grievance process and to identify and implement improvement as indicated." B. 2, under Procedure section, point 5., "DQM (Director of Quality Management) Responsibilities: Enter all patient names in the complaint log when notified either by the risk hotline or by receipt of a complaint form." C. 4, under Procedure section, point 7., "CEO (Chief Executive Officer) Obligations: Assure investigation, action, respond, and document.		policies H-ML-04-008 *Patient Complaint/Grievances* and H-PC 09-001 *Patient Rights and Responsibilities*. It was determined by Governing Board that no changes in policy were required; that compliance to the policies must be enforced. The Director of Quality Management reviewed the 1st and 2nd quarter complaints and grievances ensuring all were documented on the complaint and grievance log. The Governing Board recommended using the weekly leadership meeting to review the investigation and resolution for all complaints and grievances so that recommendations can be made with appropriate follow up, as needed. **Systemic Changes:** ·The Chief Executive Officer, Chief Clinical Officer, and Director of Quality Management met with all department leaders and reviewed the policy H-ML-004-008 on patient complaints and grievances and policy H-PC 09-001 on Patient Rights and Responsibilities. It was determined that all clinical staff be educated on these policies and their responsibility in ensuring compliance to the policies. The Education Coordinator is facilitating execution of the education and provides a weekly update to the Director of Quality Management on who has completed the	

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	Oversee the complaint and grievance process by holding managers and directors accountable for: Conducting a thorough, accurate and timely investigation; Initiating prompt intervention; Escalating unresolved issues." D. 5, under Procedure section, point: a. 8., "Managing the Log: Complaints and Grievances are entered on the Complaint/Grievance Log...H-ML 04-008 A Complaint/Grievance Log. b. 9., "Trending, Analyzing and Reporting Complaints and Grievances for Quality Improvement: The entries on the Complaint/Grievance log shall be summarized, aggregated, analyzed, and trends identified and presented to the Quality Council, Medical Executive Committee and the Governing Board on a regular basis for review and recommendations related to quality improvement." 3. Letters sent to administration were reviewed on 3/6/18 at approximately 1210 hours and indicated: A. one dated 7/20/16 by patient 1's family member 1 requested the removal of staff 4 (R.N., Case Manager) from patient 1's case related to case management/discharge planning. B. one dated 7/27/16 by patient 1's family member 1 requested MR (medical record) copies related to lack of notification of discharge to family member 1 prior to patient's discharge and hospital charges related to patient's stay. 4. Review of the Complaint/Grievance log for June and July of 2016 on 3/6/18 at approximately 1215 hours lacked documentation of the complaints from patient 1's family member 1 that were sent to administration via written letters dated 7/20/16 and 7/27/16.		education and who has yet to do so. ·Complaints and grievances are discussed with the Chief Executive Officer, Chief Clinical Officer, Director of Quality Management, and Director of Case Management during weekly leadership meetings. Recommendations from the group are implemented as a way to prevent future issues. The complaints and grievances reported during the daily leadership meeting are reconciled with the complaint/grievance log, and letters initiated with appropriate action. ·Once a patient complaint or grievance has been identified, including those related to case management interactions and those obtained during patient rounding by leadership, a patient complaint and grievance form is initiated and reported to the department leader and Director of Quality. The process outlined in the policy and procedure H-ML-04-008 *Patient Complaints/Grievances* is then initiated. All complaints and grievances are discussed during the daily leadership meeting; actions are assigned to the appropriate leader at this meeting. The Director of Quality Management reviews the log weekly ensuring all appropriate action items and timelines are completed.	

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	5. Review of Quality Council meeting minutes on 3/6/18 at approximately 1220 hours for the first through third quarters of 2016 lacked documentation of review of complaints/grievances with summarization, aggregation, analyzation, and trends identified. 6. Review of patient 1's medical record (MR) on 3/6/18 at approximately 1236 hours indicated: A. Review of Patient Rights and Responsibilities dated 6/7/16, states the patient has the right to present any conflicts or complaints he/she has in regard to the quality of care...all issues will be reviewed, investigated and responded to in a timely manner. B. Case Management/Social Services Notes indicated staff 4, R.N. (Registered Nurse), was assigned to patient 1 and notes were documented by this staff member throughout their length of stay from 6/7/16 through 7/25/16. 7. Staff 1 (Chief Clinical Officer) was interviewed on 3/6/18 at approximately 1455 hours and confirmed, a written complaint/grievance was dated 7/20/16 and received from family member 1 requesting removal of staff 4 (R.N., Case Manager) from patient 1's case related to case management/discharge planning. There was also a written complaint/grievance dated 7/27/16 and received from family member 1 requesting MR copies related to lack of patient 1 discharge notification to family member 1 prior to discharge and hospital charges for patient's stay. Neither of these complaints/grievances were logged in the Complaint/Grievance log and there was no documentation indicating they were reviewed, investigated, and resolved as required per facility policy and procedure and/or PRR. Also, complaints/grievances are not being presented to the Quality Council, Medical Executive		**Monitoring Corrective Actions:** Results of all complaint and grievance monitoring are aggregated, analyzed and reported to the quarterly Leadership Committee, Quality Council, Medical Executive Committee and the Governing Board. **Responsible Party:** Chief Executive Officer	

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	Committee and the Governing Board on a regular basis for review. 8. Staff 4 (R.N., Case Manager) was interviewed on 3/6/18 at approximately 1430 hours, and confirmed he/she was assigned to patient 1 for case management/discharge planning and was not aware of any complaint related to patient/family requesting removal of staff 4 from patient's case. He/She was the Case Manager for patient 1 from 6/7/16 through 7/25/16.			
S 1312 Bldg. 00	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; Based on document review and interview, the facility failed to facilitate the provision of follow-up care related to providing a list of post discharge providers and/or community resources, for 4 of 5 (patient #1, 3, 4 and 5) patient medical records reviewed. Findings include: 1. Review of policy #H-PC 02-004 PRO titled, "Discharge Planning", revised/reapproved 5/15, indicated on pg. 1, under Procedure section, points 3. h. and 4., "Once an assessment and evaluation has been completed the Case Manager (or if applicable, Social Worker) will develop a discharge plan, in collaboration with the patient,	S 1312	S1312 410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e) (1) **Immediate Corrective Actions:** All patients with active discharge plans were immediately reviewed by Case Management to ensure documentation that a list of post discharge providers and/or community resources was given to the patient/family. Any records found deficient were immediately corrected as well as follow up with the patient/family to ensure they received the list.	08/17/2018

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	family, physician, ancillary staff and specialists, focused on...Availability of post discharge providers and community resources...Should the patient have an identified need for a post discharge provider, the Case Manager provides the patient/family with a list of hospice, home health agencies or skilled nursing facilities that are available to the patient, that participate in the Medicare or patient's third party payer program and that serve the geographic area the patient requests. The Case Manager documents that this list was presented to the patient or to the individual acting on the patient's behalf". 2. Review of patient medical records (MRs) on 3/6/18 at approximately 1236 hours indicated: A. Review of patient #1's Case Management/Social Services Notes dated 7/7/16 indicated family member 1 (POA [power of attorney]) was aware patient would be discharged to a SNF (skilled nursing facility). MR lacked documentation that a facility list/patient choice form was provided to the patient or their family for hospice, home health agencies, or SNF's available to the patient until date of discharge on 7/25/16. B. Review of patient #3's Case Management/Social Services Notes dated 1/31/18 indicated patient/family requested discharge to an acute care rehabilitation facility and referrals were initiated. Discussion was held with patient/family 2/5/18 for referral to SNF due to patient's declining medical/physical status. MR lacked documentation that a facility list/patient choice form was provided to the patient or their family for hospice, home health agencies, or SNF's available to the patient until date of discharge on 2/19/18. C. Review of patient #4's Case		The Chief Executive Officer, District Director of Case Management, Director of Case Management, and Director of Quality Management met and reviewed Policy H-PC-02-004 *Discharge Planning*. This leadership team directed all members of the case management team to review the policy. **Systemic Changes:** ·Education on discharge planning process and documentation expectations was conducted by the Director of Case Management to all Case Managers. The Case Managers will document in the electronic medical record that the applicable post discharge provider list/choice forms (hospice, skilled nursing facility or home health) was given to the patient or family mid-way through their stay. The Director of Case Management validates all discharged patients were provided the post discharge provider list/choice form. ·The Case Management department will provide patient and/or families the appropriate post discharge provider type list/choice form from Medicare.gov website for Medicare patients. The case managers were educated on how to pull these lists from the	

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	Management/Social Services Notes dated 2/13/18 indicated patient/family in agreement with discharge to SNF. MR lacked documentation that a facility list/patient choice form was provided to the patient or their family for hospice, home health agencies, or SNF's available to the patient until date of discharge on 2/28/18. D. Review of patient #5's Case Management/Social Services Notes dated 1/31/18 indicated a discussion was held with family regarding the benefit of discharge to SNF. MR lacked documentation that a facility list/patient choice form was provided to the patient or their family for hospice, home health agencies, or SNF's available to the patient until date of discharge on 2/21/18. 3. Staff 2 (Director of Case Management) was interviewed on 3/6/18 at approximately 1217 hours and confirmed, documentation was lacking in the above-mentioned patient MR's that a list of hospice, home health agencies or SNF's available to the patient, that participate in the Medicare or patient's third party payer program and that serve the geographic area the patient requests as required per facility policy and procedure, were provided prior to discharge to the patient/family in order to make an informed decision related to patient's health care.		Medicare.gov website. The Director of Case Management will review and validate the completion of delivery of the post discharge provider list/choice form was provided and signed by the family acknowledging receipt of listing. ·The Director of Case Management will audit all discharged patients to ensure proper discharged provider lists/choice forms from Medicare have been given and documented in the electronic medical record. Daily discussion of patients discharge planning will prompt the case managers to provide the post discharge provider type list/choice forms. Trends will be reported at the Value Driven Committee quarterly meeting, Medical Executive Committee for recommendations and to Governing Board for oversight quarterly. **Monitoring Corrective Actions:** Results of the Case Management audit are aggregated, analyzed and reported to the quarterly Value Driven Transitions Committee, Quality Council, Medical Executive Committee and the Governing Board. **Responsible Party:** Chief Executive Officer	
S 1326	410 IAC 15-1.5-10			

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Bldg. 00	UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(4) (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: (4) utilizes available community and hospital resources to provide appropriate referrals or make available social, psychological, and educational services to meet the needs of the patient. Based on document review and interview, the facility failed to utilize hospital resources related to Case Management to meet the needs of the patient, for 1 of 5 (#1) patient medical records reviewed. Findings include: 1. Review of policy #H-PC 09-001 titled, "Patient Rights and Responsibilities", revised/reapproved 6/17, indicated on pg. 1, under: A. Purpose section, "This policy establishes guidelines to provide an environment that both respects and protects the rights of patients and patient's families." B. Policy section, point 1., "The list of Patient Rights and Responsibilities (PRR) is provided to each patient at admission as part of the admission packet." 2. A letter sent to administration dated 7/20/16 by patient 1's family member 1 requesting removal of staff 4 (R.N., Case Manager) from patient 1's case related to case	S 1326	S1326 410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e) (4) **Immediate Corrective Actions:** All patients/families were interviewed by the Director of Case Management asking if they had any questions or concerns with their assigned Case Manager. No issues were identified. The Chief Executive Officer, District Director of Case Management, Director of Case Management, and Director of Quality Management met and reviewed Policy H-PC-09-001 *Patient Rights and Responsibilities*. This leadership team directed all members of the case management team to review the policy.	08/17/2018

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	management/discharge planning was reviewed on 3/6/18 at approximately 1210 hours. 3. Review of patient 1's medical record (MR) on 3/6/18 at approximately 1236 hours indicated: A. Patient Rights and Responsibilities dated 6/7/16, states the patient has the right to accept medical care or refuse treatment. B. Case Management/Social Services Notes indicated staff 4, R.N. (Registered Nurse), was assigned to patient 1 and notes were documented by this staff member throughout their length of stay from 6/7/16 through 7/25/16. 4. Staff 1 (Chief Clinical Officer) was interviewed on 3/6/18 at approximately 1455 hours and confirmed, a written complaint/grievance was dated 7/20/16 and received from family member 1 requesting removal of staff 4 (R.N., Case Manager) from patient 1's case related to case management/discharge planning. Staff 4 was not removed from this case.		**Systemic Changes:** ·The Director of Case Management during weekly rounds with patient and families identify concerns or complaints with the assigned case manager. Additionally, formal rounding that is performed by all hospital leaders includes inquiry into issues or concerns related to their assigned case manager. Findings are reported at the daily leadership meeting to ensure appropriate actions are being taken and resolution is achieved. ·The Director of Case Management is notified of any complaint or grievance requesting an exchange in the assigned case manager. The Director of Case Management meets and investigates the concern with the patient and or family and with the assigned case manager. Appropriate actions are taken in response to the reported concern(s). If resolution cannot be achieved, the Director of Case Management assumes responsibility for that case and continues the discharge process with the patient and or family. ·The Director of Case Management tracks changes made in case manager assignment as a result of patient/family request. This information is used to identify trends and potential performance issues that need addressing.	

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			Monitoring Corrective Actions: The Case Management data on number of assignment changes made due to patient/family requests are aggregated, analyzed and reported to the quarterly Value Driven Transitions Committee, Quality Council, Medical Executive Committee and the Governing Board. **Responsible Party:** Chief Executive Officer	