

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150024	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2015
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NAME OF PROVIDER OR SUPPLIER ESKENAZI HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 720 ESKENAZI AVENUE INDIANAPOLIS, IN 46202
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A 0000 Bldg. 00	This visit was for a recertification survey of an excluded psychiatric unit. Facility Number: 005040 Date: 8/11/15, 8/12/15, and 8/13/15 QA: cjl 08/26/15	A 0000		
A 9999 Bldg. 00	42 CFR 412.27 (c)(1)(v) Excluded Psychiatric Units: Additional Requirements: Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the following requirements: Development of Assessment/Diagnostic Data. Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the inpatient is treated in the unit.	A 9999	42 CFR 412.27 (c)(1)(v) relates to the requirement for completion of a complete neurological examination at the time of admission. The Plan of Correction includes a revision to the Content of the Medical Record Policy (700-57) to include documentation requirements for a complete psychiatric history and physical to include a focused physical examination. In the event a cranial nerve examination is indicated as part of the neurological exam, cranial nerves II-XII should be commented on individually. The policy revisions were submitted on September 21, 2015 and are currently in the approval process. The policy changes will be discussed at the	10/31/2015

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>When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.</p> <p>This rule is not met as evidenced by:</p> <p>Based on document review and interview, the facility failed to ensure that a detailed description of gross testing for cranial nerves II through XII was conducted for 8 of 10 records reviewed. (medical records #1, #2, #4, #6, #8, #9, #10, and #11) (*There is no pt. #5).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the policy "Content of the Medical Record, 700-57", policy number 849737, last reviewed/ revised on 12/1/13, indicated the specifics of requirement of a History and Physical examination is listed, but the requirements for a psychiatric evaluation was not present in the policy. 2. Review of patient medical records #1, #2, #4, #6, #8, #9, #10, and #11 lacked any documentation regarding cranial nerves, and the evaluation/testing of cranial nerves II through XII. 3. Review of patient medical records #3 and #7 indicated that cranial nerves II through XI were "grossly intact". 		<p>medical leadership meeting which is Chaired by the Behavioral Health Medical Director in October 2015. The policy changes will be posted in visible locations at each documentation station for visual reminders to those responsible for the assessment, examination, and documentation. The Behavioral Health Medical Director is ultimately responsible for the quality and completeness of physical examinations and the associated documentation requirements. Area leadership will conduct random audits over the next 3 months to monitor for compliance with this policy change. 42 CFR 412.27 (c)(2)(v) pertains to the requirement that each patient receive a psychiatric evaluation within 60 hours of admission. The Plan of Correction includes revision to the Content of Medical Record policy (700-57) describing the documentation requirements of a completed psychiatric evaluation within 60 hours of admission. The policy revisions were submitted on September 21, 2015 and are currently in the approval process. The policy changes will be discussed at the medical leadership meeting which is Chaired by the Behavioral Health Medical Director in October 2015. The policy changes will be posted in visible locations at each documentation station for visual reminders to</p>	

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	<p>4. At 4:00 PM on 8/12/15, interview with staff member #51, the behavioral health risk manager, indicated:</p> <p>a. There is no policy, or written guidance, for requirements of the psychiatric evaluation that would indicate that:</p> <p>A. A screening/testing of the cranial nerves is required to determine the need for a neurological consult.</p> <p>B. It is not acceptable to note that cranial nerves are grossly intact, and that they need to be addressed individually.</p> <p>42 CFR 412.27 (c)(2)(i) Excluded Psychiatric Units: Additional Requirements:</p> <p>Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the following requirements:</p> <p>Psychiatric Evaluation. Each inpatient must receive a psychiatric evaluation that must:</p> <p>Be completed within 60 hours of admission:</p> <p>This rule is not met as evidenced by:</p>		<p>those responsible for the assessment, examination, and documentation. The Behavioral Health Medical Director is ultimately responsible for the quality and completeness of physical examinations and the associated documentation requirements. Area leadership will conduct random audits over the next 3 months to monitor for compliance with this policy change.42 CFR 412.27 (c)(4)(v) pertains to the completeness of the Treatment Plan. Each patient must have a comprehensive treatment plan that must be based on an inventory of a patient's strengths and disabilities. The written plan must include substantial diagnoses, short and long term goals, the specific treatment modalities utilized, the responsibility of each member of the treatment team, and adequate documentation to justify the diagnosis and treatment/rehabilitation activities carried out. The Plan of Correction includes the ordering of an inpatient comprehensive treatment plan from a vendor. The arrival of the treatment plan module is pending delivery. The inpatient comprehensive treatment plan includes an inventory of the patient's strengths and disabilities, covers substantial diagnoses, documents the patient's short and long term goals, covers the specific treatment modalities</p>	

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	<p>Based on document review and interview, the facility failed to ensure that a psychiatric evaluation was conducted within 60 hours of admission for 7 of 10 records reviewed. (medical records #2, #3, #6, #7, #8, #10, and #11).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of medical records indicated: <ol style="list-style-type: none"> a. Pt. #2 was admitted on 8/4/15 and had an "admission note" (psychiatric evaluation) dated 8/3/15. b. Pt. #3 was admitted 7/22/15 and had an "admission note" (psychiatric evaluation) dated 7/21/15. c. Pt. #6 was admitted 7/31/15 and had an "admission note" (psychiatric evaluation) dated 7/30/15. d. Pt. #7 was admitted 7/23/15 and had an "admission note" (psychiatric evaluation) dated 7/22/15. e. Pt. #8 was admitted 8/5/15 and had an "admission note" (psychiatric evaluation) dated 8/4/15. f. Pt. #10 was admitted on 6/26/15 and had an "admission note" (psychiatric evaluation) dated 6/23/15. g. Pt. #11 was admitted on 6/19/15 and had an "admission note" (psychiatric evaluation) dated 6/17/15. 2. At 11:45 AM on 8/13/15, interview with staff members #51, the behavioral risk manager, and #52, the nurse manager 		utilized, defines the responsibility of each member of the treatment team, and provides adequate documentation to justify the diagnosis and the treatment/rehabilitation activities carried out. The expected date of arrival of this module is 10/21/2015. The Behavioral Health Medical Director is ultimately responsible for the quality and completeness of physical examinations and the associated documentation requirements. Area leadership will conduct random audits over the next 3 months to monitor for compliance with this policy change.	

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	<p>of behavioral health, indicated:</p> <p>a. There is no policy, or written guidance, for requirements of the psychiatric evaluation that would indicate that it is required to be completed within 60 hours of admission.</p> <p>b. The admission notes/psychiatric evaluations for the patients listed in 1. above were completed while the patient was in either triage, or observation, but not yet admitted to the psych unit, therefore they were not completed after actual admission to the behavioral unit.</p> <p>c. Patients may remain in the observation unit, receiving psychiatric care, waiting on an open bed on the unit for a day, or more. For patient #10, it was 3 days, for pt. #11, it was two days.</p> <p>d. There was no indication by the psychiatrist that the admission assessment/note completed prior to admission was accepted with no changes, or with any changes noted for any of the 7 records listed in 1. above.</p> <p>42 CFR 412.27 (c)(2)(vii) Excluded Psychiatric Units: Additional Requirements:</p> <p>Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit,</p>			

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	<p>and that meet the following requirements:</p> <p>Psychiatric Evaluation. Each inpatient must receive a psychiatric evaluation that must:</p> <p>Include an inventory of the inpatient's assets in descriptive, not interpretative fashion.</p> <p>This rule is not met as evidenced by:</p> <p>Based on document review and interview, the facility failed to ensure that a psychiatric evaluation included the inpatient's assets for 10 of 10 medical records reviewed. (Medical Records #1 through #4, and #6 through #11.)</p> <p>Findings:</p> <p>1. Review of the medical records for patients #1 through #4, and #6 through #11, indicated a listing, or inventory, of patient assets was not included in any of the admission notes/psychiatric evaluations within the medical records.</p> <p>2. At 11:45 AM on 8/13/15, interview with staff members #51, the behavioral risk manager, and #52, the nurse manager of behavioral health, indicated:</p> <p>a. There is no policy, or written guidance, for requirements of the psychiatric evaluation that would indicate</p>			

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	<p>that it is required to list an inventory of patient assets.</p> <p>b. Patient assets, called strengths at this facility, are noted by social services and nursing staff, but are not present in any of the 10 psychiatric evaluations completed by practitioners.</p> <p>42 CFR 412.27 (c)(3)(i) Excluded Psychiatric Units: Additional Requirements:</p> <p>Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, and that meet the following requirements:</p> <p>Treatment Plan. Each inpatient must have an additional comprehensive treatment plan that must be based on an inventory of the inpatient's strengths and disabilities. The written plan must include a substantiated diagnosis; short-term and long-term goals; the specific treatment modalities utilized; the responsibilities of each member of the treatment team; and adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out: and</p> <p>This rule is not met as evidenced by:</p>			

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	<p>Based on document review and interview, the facility failed to ensure that patient treatment plans for 10 of 10 patients lacked indications of the patient's strengths and disabilities, substantiated diagnosis, or short and long term goals. (Medical Records #1 through #4 and #6 through #11.)</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Based on review of the policy "Ia-528-21-Assessment, Diagnosis & amp (sic); Treatment Documentation of Mental Health Services", policy number 1172959, last reviewed/revised 11/12/14, indicated in section 4.: "The Person Centered Treatment Planning process will include:...2. Identification of strengths and needs, including symptoms. 3. Goals directed at resolving identified needs...". 2. Review of medical records #1 through #4 and #6 through #11 indicated: <ol style="list-style-type: none"> a. The patients' diagnosis was not listed on the treatment plan for any of the 10 patients. b. Goals were listed, but there was no delineation for short term and long term goals. c. Patient strengths and limitations were not noted on the treatment plans. 			

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	<p>3. At 11:45 AM on 8/13/15, interview with staff members #51, the behavioral risk manager, and #52, the nurse manager of behavioral health, indicated:</p> <p>a. The treatment plans for patients #1 through #4 and #6 through #11 are lacking a diagnosis, short and long term goals specified, and that goals are based on patient strengths and limitations.</p> <p>b. A new treatment plan has been developed for several months, which includes missing documentation as listed in 3. a. above, but has not been implemented, due to delays caused by the facility's time frame for the implementation of a new electronic medical record system.</p>			