

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 WASHINGTON AVE EVANSVILLE, IN 47750
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0000 Bldg. 00	<p>This visit was for the investigation of one (1) State complaint.</p> <p>Complaint Number: IN00177487 Unsubstantiated; Lack of Sufficient Evidence. Unrelated deficiency cited.</p> <p>Date of survey: 8/4/15</p> <p>Facility number: 005089</p> <p>QA: cjl 09/03/15</p>	S 0000		
S 0322 Bldg. 00	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(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.</p> <p>Based on document review and interview, the Emergency Department</p>	S 0322	Credible Allegation of Compliance: For the purpose of any allegation	11/01/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/04/2015
NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 WASHINGTON AVE EVANSVILLE, IN 47750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>(ED) failed to follow Against Medical Advice (AMA) and Complaint/Grievance policies for 1 of 5 patient (patient #1) medical records reviewed.</p> <p>Findings include:</p> <p>1. Facility policy titled "Against Medical Advice, Patient who Leaves" last reviewed/revised 7/29/15 (unchanged from previous approval date of 9/18/13) states under procedure: "A. The physician caring for the patient should be notified if at all possible and appropriate discharge instructions and their medication reconciliation sheet should be obtained from the physician and given to the patient. If the patient leaves before discharge instructions are given, a copy should be mailed to the patient's home address by the nurse assigned to the patient." and "D. If the patient refuses to sign the "Release of Responsibility" form #7230-147 after an explanation, at least two (2) Emergency Department staff members should witness the back of the Emergency Department chart and state that the patient refused to sign the form."</p> <p>2. Facility policy titled "Patient Complaint Management/Grievance Process" last reviewed/revised 4/2/14 states under policy statement: ".....Patients, families or others who have</p>		<p>that St. Mary's Medical Center (St. Mary's) is not in substantial compliance with Indiana Administrative Code IAC 15-1.4-2.2 (a)(1)and accompanying regulations, this response constitutes St. Mary's allegations of compliance.</p> <p>Tag S322 410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>St. Mary's Health recognizes the importance of following approved policies. Any allegation that his standard is not routinely met represents the exception, not the norm, at St. Mary's.</p> <p>The St. Mary's Health Policy "Against Medical Advice, Patient Who Leaves" will be revised by the emergency department clinical manager to no longer include mailing discharge instructions and/or medication reconciliation sheet to patient's listed address. The policy will be reviewed and approved by the Executive Director of Emergency Services. Emergency Services care providers and administrative staff will receive education on the new policy via department meetings and safety huddles. The Medical Director of TEAMHealth, the Executive Director of Emergency Services and the Director of Clinical Services will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150100		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/04/2015	
NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3700 WASHINGTON AVE EVANSVILLE, IN 47750			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>concerns about the care or service provided by St. Mary's, its subsidiaries, or the medical staff, have a right to expect that their concerns and grievances will be taken seriously, and responded to in a timely manner." Page 3 of 5 states "A Grievance Committee will review all grievances, including resolution and timeliness of resolution....."</p> <p>3. Review of patient #1 medical record indicated the following: (A) The patient was examined by M.D. #1 at 10:01 a.m. on 5/14/15. Under Medical Decision Making, the document stated "The patient has decided to leave against medical advice. (B) The medical record contained document titled "Release of Responsibility" which certified the patient was leaving against medical advice. The document was not signed by the patient and two (2) staff members signed the document under "Left Before Treatment/Against Medical Advice", however failed to write on the document that the patient refused to sign per policy. Additionally, the document had a section for the staff witness to sign and check "Patient/Legal Representative Refused to provide Signature". This section was left blank. (C) The medical record lacked evidence that the patient was given discharge</p>		<p>be responsible for delivering the education to emergency department staff. Education compliance will be monitored by sign in sheets. Policy revised and approved: 11/1/2015 The emergency department clinical manager and emergency department process facilitator will revise St. Mary's "Against Medical Advice (AMA) Form" to include an area to document a patient's refusal to sign the AMA form. Additionally, the revised document will require two (2) staff to acknowledge, by signature, the patient's refusal to sign. Emergency Services care providers and administrative staff will receive education on the new form via department meetings and safety huddles. Education will cover changes to the AMA form, including staff signatures acknowledging patient's refusal to sign. The Medical Director of TEAMHealth, the Executive Director of Emergency Services and the Director of Clinical Services will be responsible for delivering the education to emergency department staff. Education compliance will be monitored by sign in sheets. AMA form revised and in use: 11/1/2015 To ensure compliance, the emergency department facilitator will audit ten (10) charts x three (3) months starting November 1, 2015. Results of the audit will be forwarded to Executive Director of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/04/2015
NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3700 WASHINGTON AVE EVANSVILLE, IN 47750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>instructions or that discharge instructions were mailed to him/her.</p> <p>4. Review of the list of patients with a complaint to contracted service #1 indicated that patient #1 filed a complaint against the physician on 5/15/15.</p> <p>5. Patient #1 was not listed on facility #1 patient relations log of patient/family complaints.</p> <p>6. Staff member #2 indicated in interview beginning at 11:30 a.m. on 8/4/15 that a complaint from patient #1 was investigated by contracted ED service #1 but not facility #1. He/she receives the complaints from contracted service #1 and they are reviewed by facility #1 Vice President of Medical Affairs on a monthly basis. He/she indicated that the complaint from patient #1 was "missed".</p> <p>7. Staff member #1 verified in interview beginning at 1:15 p.m. on 8/4/15 that the facility failed to follow the AMA policy and the facility had no evidence that any discharge instructions were sent to patient #1 per policy. He/she checked with the ED and there is no log maintained or evidence that discharge paperwork is sent to the patient per policy.</p>		<p>Emergency Services, the Medical Director of TEAMHealth and the Chief Risk Officer. Compliance will continue to be monitored on an ongoing basis following the 3 month audit. Compliance goal: 95% Completion date for chart audit: 1/31/2016</p> <p>TEAMHealth administrative assistant will email Patient Relations upon opening all complaints for entry into Patient Relation's complaint/grievance database. Patient Relations will be included in all TEAMHealth follow up and will be notified when the file is closed.</p> <p>Patient Relations notification on all complaints/grievances: 8/5/2015 Patient Relations and TEAMHealth will conduct a comparative audit the last day of the month x three (3) months to ensure Patient Relations has received all complaints/grievances. Notation will be made on both the complaint/grievance log and Patient Relations database of compliance for the month. Results of audit will be forwarded to Executive Director of Emergency Services, the Medical Director of TEAMHealth and the Chief Risk Officer. Compliance goal: 100% Completion date of audit: 1/31/2016</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150100	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 WASHINGTON AVE EVANSVILLE, IN 47750
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE