

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150074	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/24/2016
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY HOSPITAL EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219
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S 0000  Bldg. 00	<p>This visit was for investigation of one State hospital complaint.</p> <p>Complaint Number: IN00201216 Substantiated; State deficiency related to allegations is cited. Unrelated deficiencies cited.</p> <p>Facility Number: 005068</p> <p>Date of Survey: 05-23&amp;24-16</p> <p>QA: jlh 3/26/16</p>	S 0000		
S 0178  Bldg. 00	<p>410 IAC 15-1.3-2 POSTING OF LICENSE 410 IAC 15-1.3-2(a)</p> <p>(a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system.</p> <p>Based on observation &amp; interview, the facility failed to ensure that a copy of the facility's license be conspicuously posted in an area open to patients and public on the premises of each separate hospital</p>	S 0178	How was deficiency corrected Posted Community Hospital East Indiana Hospital License on the west wall of the Crisis lobby on 6/13/16. Permanent sign is posted in entrance area of BHS	08/22/2016

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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S 0732 Bldg. 00	<p>building for 1 of 1 offsite.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 05-23-16 at 0935 hours during the facility tour of the Crisis Offsite no copy of the Indiana Hospital License was posted in a conspicuous area open to patients &amp; public.</li> <li>On 05-23-16 at 0935 hours staff #41 confirmed no copy of the Indiana Hospital License was posted in a conspicuous area open to patients &amp; public.</li> </ol> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4)</p> <p>(d) The medical record shall contain sufficient information to:</p> <ol style="list-style-type: none"> <li>identify the patient;</li> <li>support the diagnosis;</li> <li>justify the treatment; and</li> <li>document accurately the course of treatment and results.</li> </ol> <p>Based on document review &amp; interview, the facility failed to ensure the medical</p>	S 0732	<p>pavilion; visible to those in Crisis as well as those entering inpatient areas How will correction prevent recurrence Monitor presence of posted Indiana Hospital License by performing quarterly audit &amp; reporting findings at Inpatient &amp; Outpatient Behavioral Health Outcomes &amp; Performance Committee Meetings; a summary of this report will ultimately be reported to the Board of Directors' Quality of Care Committee. Responsible Party Director of Operations, Crisis &amp; Access Services Preparation and execution of this response and plan of correction do not constitute an admission or agreement by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/ or executed solely because it is required by the provision of federal and state law.</p> <p>How was deficiency corrected Reviewed expectations as set out</p>	08/29/2016

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	<p>record (MR) contain sufficient information to document accurately the course of treatment and results for 1 of 25 MRs reviewed. (Patient #1)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of policy/procedure CLN# 2073, Documentation Standards, General, Patient Medical Record, indicated the following;               <ol style="list-style-type: none"> <li>12. Timing entries:                   <ol style="list-style-type: none"> <li>a. Documentation should be entered concurrently, as close to the actual time of the activity or event as possible.</li> <li>b. All entries must be in military time and reflect the time the data was obtained.</li> <li>g. If narrative information for an activity/event from a previous day needs to be entered in the Centricity, include the date and time of the actual occurrence in the narrative.</li> </ol> </li> </ol> </li> <li>This policy/procedure was last reviewed/revised on 10/28/14.</li> <li>2. Review of facility documentation dated 5-10-16 indicated that patient #1 came to the Crisis offsite on 05-07-16.</li> <li>3. Review of patient #1's MR Call Documentation Note dated 05-21-16 at 07:39 AM lacked documentation of the date and time that patient #1 was at the</li> </ol>		<p>in CLN 2073 (Documentation Standards, General, Patient Medical Record) at Crisis and Access mandatory all staff meeting. Staff unable to attend the education about CLN 2073 on 8/22/16 will receive follow up on an individual basis. This information will be included in new employee orientation. How will correction prevent recurrence Perform random audit, beginning 8/29/16, of a minimum of 30% of charts of clients seen in Crisis for appropriate triage/documentation. This will be conducted for 60 days with further audit dependent on achievement of error rate of 5% or less. Audit results will be reported at the Inpatient &amp; Outpatient Behavioral Health Outcomes &amp; Performance Committee meetings; a summary of this report will ultimately be reported to the Board of Directors. Appropriate actions will be taken as necessary in response to noncompliance in accordance with network policies and procedures. Responsible Party BHS Director of Quality &amp; Risk Preparation and execution of this response and plan of correction do not constitute an admission or agreement by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/ or executed solely because it is required by the provision of</p>	

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S 1510 Bldg. 00	<p>Crisis offsite on 05-07-16 .</p> <p>4. On 05-23-16 at 1100 hours staff #43 confirmed that patient #1 was seen at the Crisis offsite on 05-07-16.</p> <p>410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(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.</p> <p>Based on document review &amp; interview, the facility failed to ensure that written policies and procedures governing medical care for immediate assessment of all patients presenting to the facility was followed for 2 of 10 Crisis medical records (MR) reviewed. (Patient #1 &amp; 9)</p>	S 1510	<p>federal and state law.</p> <p>How was deficiency corrected Educated Crisis staff about the duties and responsibilities of the Triage Specialist at mandatory Crisis and Access all staff meeting on 8/22/16. Staff unable to attend the education about CLN 2073 on 8/22/16 will receive follow up on an individual basis.</p>	08/29/2016

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	<p>Findings include:</p> <p>1. Review of policy/procedure CLN #2031, EMTALA: Emergency Medical Screening, Stabilization and Transfer, indicated the following: At CHNw (Community Hospital Network), individuals that are qualified to perform a medical screening exam (MSE) at a Hospital are members of the Hospital's medical staff (physician, resident or allied health professional members) with the appropriate clinical privileges, or the employees designated in this Policy. Specifically, those individuals who may perform the MSE are as follows:</p> <p>iii. MSEs for mental health issues:</p> <p>2. Those individuals presenting to the Behavioral Health pavilion may receive the MSE by licensed Crisis Department clinical staff in consultation with a physician, or by a physician or allied health professional member of the medical staff with appropriate clinical privileges. This policy/procedure was last reviewed/revised on 8/7/15.</p> <p>2. Review of facility documentation dated 5-10-16 indicated that patient #1 came to the Crisis offsite on 05-07-16.</p>		<p>This information will be included in new employee orientation. How will correction prevent recurrence Perform random audit, beginning 8/29/16, of a minimum of 30% of charts of clients seen in Crisis for appropriate triage/documentation. This will be conducted for 60 days with further audit dependent on achievement of error rate of 5% or less. Audit results will be reported at the Inpatient &amp; Outpatient Behavioral Health Outcomes &amp; Performance committee meetings; a summary of this report will ultimately be reported to the Board of Directors. Quality of Care Committee. Appropriate actions will be taken as necessary in response to noncompliance in accordance with network policies and procedures. Responsible Party BHS Director of Quality &amp; Risk Preparation and execution of this response and plan of correction do not constitute an admission or agreement by the provider of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/ or executed solely because it is required by the provision of federal and state law.</p>		

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	<p>3. Review of patient #1's MR the Call Documentation Note dated 05-21-16 at 7:39 AM indicated that the patient presented to Crisis and staff #55 (triage specialist) staffed the case with MD #1.</p> <p>4. Review of patient #9's MR indicated the patient presented to Crisis on 5/6/16 and the Crisis Clinical Triage Note dated 5/6/16 at 6:26 AM indicated that staff #56 (triage specialist) staffed the case with MD #2.</p> <p>5. On 05-23-16 at 0950 hours staff #43 confirmed that licensed clinical staff can to do assessments on patients presenting to Crisis and then are to staff with a physician for disposition. The triage specialists are not licensed clinical staff, but are usually 4 year degree individuals that are not licensed.</p>			