

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 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER OF EVANSVILLE INC	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
S000000	<p>This visit was for the investigation of one (1) State complaint.</p> <p>Date of survey: 04-03-14</p> <p>Facility number: 005089</p> <p>Complaint number: IN00137328 Substantiated: Deficiency related to allegation cited.</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 05/02/14</p>	S000000		
S001318	<p>410 IAC 15-1.5-10 UTILIZATION REVIEW & DISCHARGE PLANNING 410 IAC 15-1.5-10 (e)(3)(A)(B)(C) (D)(E)(F)</p> <p>(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:</p> <p>(3) transfers or refers patients, along with the necessary medical information and records, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. The information shall include, but not be limited to, the following:</p>			

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 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2014	
NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER OF EVANSVILLE INC				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>(A) medical history; (B) current medications; (C) activities status; (D) nutritional needs; (E) outpatient service needs; (F) follow-up care needs; and</p> <p>Based on document review and interview, the facility failed to ensure patients were transferred with the necessary information for follow-up care and failed to follow policy related to appropriate transfer forms for 1 of 4 patients. (patient #2)</p> <p>Findings include;</p> <p>1. Review of patient #2 medical record indicated the following: (A) He/she was admitted on 9/14/13 with increased temperature and resolving diarrhea. (B) He/she was discharged on 9/18/13 and the discharge diagnoses included, but was not limited to UTI ecoli and salmonella and diarrhea likely salmonella gastroenteritis. (C) An order was written on 9/18/13 at 11:40 a.m. to discharge to a skilled nursing facility (SNF). (D) The medical record contained a form titled "Discharge Home Instructions" which indicated the patient was being discharged to home. The document did not include the diagnosis of Salmonella, therefore the SNF would not have</p>	S001318	<p>Preparation and execution of this response and plan of correction do not constitute an admission or agreement by the provider of the truth 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 provisions of federal and state</p> <p>Credible Allegation of Compliance: For the purpose of any allegation 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><u>TAG 1318 Utilization Review& Discharge Planning</u></p> <p>St. Mary's recognizes the importance of quality patient care, including seamless care continuity, as required by 410 IAC 15-105-10 "Utilization Review and Discharge Planning".</p>	06/01/2014			

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 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER OF EVANSVILLE INC	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>knowledge of the patients diagnoses based on the form that was used.</p> <p>2. Staff member #A1 verified the medical record information at 1:55 p.m. on 4/3/14.</p> <p>3. Facility policy titled "TRANSFER OF A PATIENT TO ANOTHER MEDICAL FACILITY" (last review 06/06/05) states under policy process on page 1: "A.....To provide information which will allow continuity of nursing care at the receiving facility." Page 2 states: "3. When placement plans are in progress, Social Services will place the appropriate transfer form on the chart for completion."</p>		<p>Any allegation that this standard is not routinely met represents the exception rather than the norm at St. Mary's.</p> <p>The complaint states that Patient #2 was discharged to a skilled nursing facility and her discharge instructions did not include the diagnosis of Salmonella. While the physician order did state "OK to discharge to SNF" the patient was, in fact, discharged to an assisted living facility and received Home Discharge Instructions. On 5/15/2014 Risk Management contacted John Lee, Indiana State Department of Health Supervisor over Acute Care to discuss the discrepancy and subsequent need for continuity of care transfer forms. While the distinction of when to utilize transfer documentation remains vague, St. Mary's has addressed the issue to improve the quality of our discharge processes.</p> <p>To address this gray area of patient discharge, St. Mary's has added a section in the policy "Discharge Planning (General Hospital)" to include pertinent health information when a patient is to receive outpatient care in the skilled portion of an assisted living facility:</p> <p>When a provider for post-discharge services has been selected by the patient the provider representative may have ongoing access to the patient for the purpose of arranging</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 04/03/2014
NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER OF EVANSVILLE INC			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>the care necessary for the patient. “A Continuity of Care form will be sent when a patient is transferring to a skilled nursing facility, intermediate nursing facility, swing bed, acute rehab and an assisted living facility if outpatient services have been ordered or resumed.”</p> <p><u>First 30 Days</u> The Director of Case Management will edit the policy (Discharge Planning (General Hospital) to include the above addition (Attachments A & B). Completed 5/19/2014</p> <p>The Director of Case Management will educate appropriate staff regarding the policy change and process to inform assisted living facilities of pertinent patient information. Completion date 6/1/2014</p> <p><u>Second and Third 30 Days</u> The Director of Case Management will audit 10 (ten) charts in which the patient was discharged to assisted living to monitor compliance. The results of the audit will be reported to the Vice President of Corporate Compliance, Risk and Accreditation, the Executive Director of St. Mary's Care Partners and the Manager of Accreditation. Completion date 7/31/2014</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 04/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER OF EVANSVILLE INC	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