

DRAFT



October 3, 2016

Administrator
Portneuf Medical Center
777 Hospital Way
Pocatello, ID 83201

Dear Administrator:

Re: CMS Certification Number: 130028
Condition of Participation Not Met
Removed Deemed Status
90-day Termination Track

**IMPORTANT
PLEASE READ CAREFULLY**

The Centers for Medicare and Medicaid Services (CMS) has determined that Portneuf Medical Center no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. Your deemed status with the Joint Commission is removed and you are placed under the State's jurisdiction. Your deemed status will be restored when you get back in substantial compliance with Medicare regulatory requirements.

BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a facility must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a facility is found to be out of compliance with the Medicare Condition of Participation, The Social Security Act Section 1866(b) authorizes the Secretary to terminate a facility's Medicare provider agreement because the facility no longer meets the requirements for participation as a provider of services in the Medicare program. 42 CFR § 489.53 authorizes the Centers for Medicare and Medicaid Services to terminate Medicare provider agreements when a provider no longer meets the Condition of Participation. Consequently, it is our intention to terminate Portneuf Medical Center participation in the Medicare program. The projected date on which the agreement will terminate is **01/01/2017**.

On 09/14/2016, the Bureau Of Facility Standards (State survey agency) completed a complaint survey at your facility. The deficiencies identified are cited in the enclosed Statement of Deficiencies.

The deficiency (ies) limit the capacity of Portneuf Medical Center to furnish services of an adequate level and quality. The details of the above deficiency are listed on the enclosed Statement of Deficiencies and Plan of Correction (Form CMS - 2567).

The finding that the Portneuf Medical Center is not in compliance with the Conditions of Participation does not affect your facility's JC accreditation, its Medicare payments, or its current status as a participating provider in the Medicare program. However, you are required to submit an acceptable plan of correction regarding these deficiencies. After the approved plan of correction has been implemented, and we have found that all of the Medicare Conditions of Participation are met, we will discontinue the state's survey jurisdiction. A copy of this letter is being forwarded to JC and the Bureau Of Facility Standards.

POTENTIAL TERMINATION AND OPPORTUNITY TO CORRECT

To avoid potential termination action, CMS must receive and approve a credible allegation of compliance, in sufficient time to verify, with an unannounced revisit by the State survey agency, that the deficiencies have been corrected. Complete your plan of correction in the space provided on the CMS-2567 within the **next 10 calendar days**.

Please send your plan of correction to (1) the State Survey Agency and (2) to CMS to the attention of Manuel Bravo at:

manuel.bravo@cms.hhs.gov

Or, when not emailed, fax at 443.380. 7048.

An acceptable plan of correction, which includes acceptable completion dates, must contain the following elements:

- Plan of Correction for each specific deficiency cited.
- Procedure/process for implementing the acceptable plan of correction for each deficiency cited.
- Monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements.
- Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice.
- A completion date for correction of each deficiency cited.
- The plan must include the individual responsible for implementing the acceptable plan of correction with signature and title.

Appeal Rights

If you disagree with this determination, you have the right to appeal this determination by requesting a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). The regulations governing this process are set out in 42 CFR § 498.40 et seq.

You will find the DAB's e-filing procedures on the internet at the following URL:

<http://www.hhs.gov/dab/divisions/civil/Procedures/filing-and-service.html>

A request for a hearing should identify the specific issues, and the findings of fact, and conclusions of law with which you disagree. The request should also specify the basis for contending that the findings and conclusions are incorrect. Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own expense. A hearing request must be filed not later than **60 days** after the date you receive this letter.

The DAB requires you to e-file your appeal request unless you do not have access to a computer or internet service. In such circumstances, you may file in writing, but must provide an explanation as to why you cannot file submissions electronically and request a waiver from e-filing in the mailed copy of your request for a hearing. If you seek a waiver from e-filing, you must also file a written request for appeals no later than sixty (**60**) calendar days from the date you receive this notice.

You must submit it to the following address:

Chief, Civil Remedies Division Departmental Appeals Board MS 6132 Cohen Building, Room 637-D 330 Independence Avenue, SW Washington, D.C. 20201	Please also send a copy to:	Chief Counsel, DHHS Office of General Counsel 701 Fifth Avenue, Suite 1620 M/S RX-10 Seattle, WA 98121-2500
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Thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. If you have any questions, please contact Manuel Bravo at (206) 615-2648.

Sincerely,

Julius P. Bunch Jr
Manager, Seattle Regional Office
Division of Certification & Enforcement

cc: Bureau Of Facility Standards
Joint Commission
Office of General Counsel - DHHS

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

PRINTED: 09/30/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/14/2016
NAME OF PROVIDER OR SUPPLIER PORTNEUF MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 777 HOSPITALWAY POCATELLO, ID 83201		
(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	
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your hospital from 9/12/16 to 9/14/16. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Kristin Inglis, RN, HFS Acronyms used in this report include: 1:1 - One Staff Member to One Patient CM - Case Manager CNA - Certified Nursing Assistant d/c - Discharge DME - Durable Medical Equipment ED - Emergency Department H&P - History and Physical Examination LPN - Licensed Practical Nurse OT - Occupational Therapy PCP - Patient Care Provider Pt - Patient QAPI - Quality Assessment Performance Improvement SO - Significant Other ST - Speech Therapy TBI - Traumatic Brain Injury	A 000			
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on staff and caregiver interview, review of medical records and hospital policies, it was determined the hospital failed to ensure patients' rights were protected and promoted. This resulted in the failure of the hospital to ensure basic human rights were protected in accordance	A 115			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Daniel Ordeya

CEO

10/11/16

09/28/2016

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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A 131	Continued From page 2 Idaho state law at Title 66 Chapter 3, 66-320 states a "...person may be detained at a hospital...[if a] peace officer or a physician...has reason to believe that the person is gravely disabled due to mental illness or the person's continued liberty poses an imminent dangerto that person or others, as evidenced by a threat of substantial physical harm...Whenever a person is taken into custody or detained under this section without court order, the evidence supporting the claim of grave disability due to mental illness or imminent danger must be presented to a duly authorized court within twenty-four (24) hours from the time the individual was placed in custody or detained." The law then states a court will assign a designated examiner to review the case. Idaho state law at Title 66 Chapter 3, 66-320 further states "(3) if the director of the facility [hospital] determines that the patient should be hospitalized under the provisions of this chapter, the patient may be detained up to three (3) days, excluding Saturdays, Sundays and legal holidays, for the purpose of examination by a designated examiner and the filing of an application for continued care and treatment...(d) A patient admitted for examination pursuant to section 20-520 or 18-211, Idaho Code, may not be released except for purposes of transportation back to the court ordering, or party authorizing, the examination." State law was not followed by the hospital in relation to 2 of 2 patients (#2 and #9) who were placed on involuntary holds by the hospital and were not allowed to leave the hospital against medical advice. Examples include: 1. Patient #9 was a 46 year old male who was	A 131	Monitoring and Tracking: The House Supervisors track the use of patient holds daily with a newly developed checklist to ensure compliance with Policies, Procedures, and State laws. The compliance rates are reported to the Chief Nursing Officer, CQO, and the Medical Executive Committee, and LHP Corporate Quality Department weekly for the first three months of tracking and monthly thereafter. Process Improvement: Provider education by the Director of Psychiatry via a PowerPoint presentation. Clinical staff education by the Nursing and Department Directors of their respective units. The effectiveness of the education will be measured by the elimination of inappropriate medical holds. Performance will be benchmarked (as identified in previous paragraph) and continuous review to sustain and/or improve compliance with Policies, Procedures, and State laws. Responsible Party: CNO and Nursing Director, Behavioral Health Services	10/11/2016	10/17/2016

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A 131	<p>Continued From page 3</p> <p>admitted to the Rehabilitation Unit 8/25/16 following treatment for TBI and multiple facial fractures. He was discharged to home on 8/29/16 at 4:30 PM.</p> <p>The H&P by the physiatrist, dated 8/22/16 at 5:01 PM, determined Patient #9 was appropriate for admission to the Rehabilitation Unit. It stated Patient #9 was "...alert, mildly agitated, easily distractible. He knew the year and month, not the day. He was oriented to self." The H&P stated Patient #9 had 1 episode of combativeness while in the Intensive Care Unit, where he was treated for alcohol detoxification.</p> <p>Following admission to the Rehabilitation Unit, the first physician progress note, dated 8/25/16 at 2:09 PM, stated "TBI [prior to admission], agitated requiring 1:1." The note did not describe behaviors of Patient #9. A physician progress note, dated 8/26/16 at 2:29 PM, stated "TBI [prior to admission], agitated requiring 1:1 on medical hold." Again, the note did not describe Patient #9's behavior or why he was placed on a medical hold.</p> <p>A physician order, dated 8/26/16 at 2:38 PM, stated "Medical Hold please. [Diagnosis] TBI. Agitated/confused." There was no documentation of specific behaviors that indicated how Patient #9 was a danger to himself or others.</p> <p>After the order to place Patient #9 on a medical hold, no further mention of the hold was documented. Nursing notes stated Patient #9 remained with 1:1 staff until his discharge on 9/29/16. The implementation of a legal process was not documented after Patient #9 was placed</p>	A 131		

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A 131	<p>Continued From page 4</p> <p>on a hold. There was no record that the court was notified of the hold or that a Designated Examiner was notified and a request for examination was made.</p> <p>A "Visual Observation Sheet" for 8/26/16, listed behaviors for Patient #9 every 15 minutes recorded by the 1:1 staff member. The sheet stated Patient #9 was angry from midnight to 12:30 AM, from 6:45 to 7:00 AM, and from 8:45 to 10:30 AM. The sheet stated he was "Pacing off and on throughout the day." No other behaviors were noted on the sheet.</p> <p>Patient #9's nursing notes stated he exhibited confusion at times but said he communicated with staff, followed directions, and was cooperative. A nursing note on 8/26/16 at 7:20 AM stated Patient #9 was pleasant and compliant. A nursing note on 8/26/16 at 9:00 AM stated Patient #9 was calm and cooperative. A nursing note on 8/26/16 at 2:00 PM stated Patient #9 was up in a chair doing occupational therapy homework. One nursing note, dated 8/27/16 at 3:05 PM, stated security was called for Patient #9 due to "increased agitation/aggression. Pt walking with security at this time." Specific behaviors were not documented. A nursing note, dated 8/27/16 at 8:30 PM, stated Patient #9 was angry when he was not allowed to walk onto an elevator. Otherwise, no negative or threatening behaviors were mentioned in nursing notes.</p> <p>Following the involuntary hold order, a physical therapy note on 8/26/16 at 4:55 PM stated Patient #9 ".was agitated early a.m. but participated well this p.m. [Patient #9] reported plan to leave to smoke and return before [nursing] notices he is gone. Discussed need to stay in rehab until</p>	A 131			

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A 131	<p>Continued From page 5</p> <p>[discharged by the physician]." No negative behaviors were mentioned in therapy notes.</p> <p>A nursing note, dated 8/26/16 at 11:00 PM, stated Patient #9 "...was wanting to leave again. Redirection done. Pt requested to have security officers to tell him that it's not ok for him to leave. Security officers in and explained the situation." A nursing note, dated 8/27/16 at 12:01 AM, stated Patient #9 was "...starting to ramp up. Wanting to go home. Multiple redirection done with multiple approaches. Pt still perseverates in going home & or wanting to go to the store to smoke." The note stated Patient #9 was given antipsychotic medication in response to his requests to go home. A nursing note, dated 8/27/16 at 3:14 AM, stated Patient #9 "...started to ramp up. Stating that he wants to go home. Security requested for redirection."</p> <p>The documented behaviors exhibited by Patient #9 all related to his desire to smoke.</p> <p>Patient #9 was discharged to home on 8/29/16 at 4:30 PM accompanied by his wife. The hold was not rescinded by the court prior to discharge.</p> <p>No documentation was present in Patient #9's medical record that stated he was a danger to himself or others. Justification for denying Patient #9's freedom was not documented. No efforts to protect Patient #9's rights or to allow him to refuse care were documented. No efforts to follow a legal process were documented after Patient #9 was placed on a hold prior to his discharge. The court was not notified of the hold. No efforts to allow Patient #9 the opportunity to refute the hold in court were documented.</p>	A 131			

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A 131	<p>Continued From page 6</p> <p>After Patient #9 was placed on the hold, no determination was documented that Patient#9 was not a danger to himself or others prior to his discharge.</p> <p>The policy "AMA/ELOPEMENT & REFUSAL OF TREATMENT AGAINST MEDICAL ADVICE," revised 9/12, stated "The [hospital] seeks court intervention in accordance with State or Federal statutes could result in death or serious harm in situations when...the patient's mental competence is in question..." The same policy also stated if a patient represented "...a significant threat of harm to him or herself or others, every attempt is made to convince the patient to stay including...Initiating Protective Custody proceedings." An accompanying procedure defining the process to determine whether the patient represented a threat of serious harm to himself or others was not present. An accompanying procedure defining the process to seek court intervention was not present. A policy and procedure providing direction to staff in the above situations was not present.</p> <p>The Director of Behavioral Health was interviewed on 9/13/16 beginning at 8:15 AM. He stated the hospital had not developed a policy or procedure for involuntary holds because holds were defined in Idaho law. He stated there were holds by law enforcement officers and administrative holds. He stated he did not know what the term "medical hold" meant. He stated a physician must examine a patient and document the reasons to place a patient on an administrative hold.</p> <p>Patient #9's physician was interviewed on 9/13/16 beginning at 8:55 AM. He stated the term</p>	A 131			

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A 131	<p>Continued From page 7</p> <p>"medical hold" meant a patient was detained involuntarily and could not leave the hospital against medical advice. He stated patients were placed on medical holds if they were a danger to self or others. He stated the hold meant nurses were notified of this and if the patient attempted to leave the hospital security force would physically prevent the patient from leaving. He stated he was not familiar with the policy but said he thought one existed.</p> <p>The RN who noted the order when Patient #9 was placed on the medical hold was interviewed on 9/13/16 beginning at 4:00 PM. She stated Patient #9 was pleasant and all of his behaviors related to him wanting a cigarette. She stated when a patient was placed on a medical hold, the nurse notified other nursing staff and security of the hold. She stated if the patient then tried to leave against medical advice, security would detain them and prevent them from leaving. The RN reviewed Patient #9's medical record. She stated Patient #9's POC was not updated when he was placed on a medical hold. She also stated the POC did not direct nursing staff in addressing Patient #9's behaviors. She stated she was not aware if the hospital had a policy for medical holds.</p> <p>The hospital did not allow Patient #9 to refuse treatment. The hospital deprived Patient #9 of his physical freedom and his ability to participate in his care. When he requested to leave, the hospital detained him and then failed to notify the court which prevented him from receiving due process. The hospital then discharged Patient #9 before a judgement to determine that he was not a danger to himself or others.</p>	A 131			

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A 131	<p>Continued From page 8</p> <p>In addition, the hospital failed to develop policies and procedures to direct staff in the application of involuntary holds.</p> <p>2. Patient #2 was a 47 year old female admitted on 8/15/15, for injuries caused by a motorcycle accident. Injuries included a TBI, fractured ribs, fractured left scapula, pneumothorax, probable splenic laceration and multiple skin lacerations. She required 2 surgeries and intubation during her stay in the ICU. She was transferred to the Rehabilitation Unit on 9/09/15.</p> <p>Patient #2's record stated she was suffering from emotional lability, impaired judgement and impulsiveness secondary to her TBI. She had documented episodes of confusion, agitation and aggressive behavior. Examples include:</p> <ul style="list-style-type: none"> - A nursing note dated 9/11/15 at 9:57 PM stated "Pt was agitated and throwing shoes on her friend. [sic] Kept saying 'let's go, let's go right now' patient was confused and wandering in hallway Redirected but not effective this time. PRN med given." - A nursing note dated 9/12/15, at 6:06 PM stated "at the window pt thought her brother's trailer was outside and she became agitated and verbally aggressive when she was told he was not there...7:05 PM Ativan given for agitation...7:15 PM Haldol given for increasing agitation toward SO" - A nursing note dated 9/14/15 at 7:00 AM stated "pt came out of the room, very agitated, swearing difficult to redirected [sic], yelling at her SO and nurses at the desk, Haldol given...7:02 AM Pt becoming more angry and agitated, aggressive 	A 131			

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A 131	<p>Continued From page 9</p> <p>[sic] and yelling at person in the hall, unable to redirect, yelling at passerby in hall and getting combative, Haldol [sic] given continues 1:1... 8:44 AM pt very agitated, swearing at S.O. and nurses, ativan, hydro [sic] for generalized pain, haldol given for agitation"</p> <p>- A nursing note dated 9/14/15, at 7:12 PM stated "Pt up in hallway very agitated restless confused wanting to go home-pt began yelling trying to leave 1:1 w/pt security also called and present, pt escalating yelling at girlfriend that she wants to leave, reassured pt that she will be [discharged] on Wednesday, pt redirectable. Support offered. Unable to distract [sic] pt. pt back to room yelling again at SO, turned and picked up chair raised into air and threw it at security guard. Pt. given haldol."</p> <p>- A nursing note dated 9/14/15 at 9:10 PM stated " Unable to distract pt, pt back to room yelling again at SO, turned and picked up chair raised and threw it at security guard [sic] Pt given haldol."</p> <p>- A nursing note dated 9/15/15 at 12:40 PM stated "Pt came out of room agitated. Pt demanding to go off unit. Refused verbal redirection. Multiple staff tried to redirect. Pt behavior escalated. Pt state 'you don't want to [expletive] with me right now' Pt made threats security was called for pt safety...Patient placed on medical hold."</p> <p>- A nursing note dated 9/16/15, the morning patient was scheduled for discharge, at 7:08 AM, stated Patient #2 had paranoia about being attacked by bees and stated she was medicated with hydrocodone (for pain) and Haldol (for agitation), at 8:30 AM "with much coercion."</p>	A 131		

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A 131	<p>Continued From page 10</p> <p>A nursing note dated 9/15/15 stated Patient #2's rehabilitation physician was called at 12:40 PM. An order for "Medical Hold" was taken by the Staff RN from the physician at 12:45 PM. There was no further mention of a medical hold in the nurses notes, care plan or case management notes. A physician note timed 1:07 PM stated "called by NS [nurses] patient agitated confused angry-sig other not present ambulating well security called for medical hold...Plan DC [discharge] 9/16/15."</p> <p>Patient #2's record did not include documentation that the courts were notified she was placed on a hold.</p> <p>Patient #2's record stated she was discharged with her SO on 9/16/15 at an unspecified time. There was no documentation the hold was recinded by the court prior to discharge.</p> <p>Patient #2's Physician was interviewed on 9/13/16 beginning at 8:55 AM. He stated he put patients on medical hold when someone wanted to leave against medical advice or was a danger to themselves or others. He stated the medical hold order meant that nursing was put on alert to call security to help redirect the patient to stay. He stated he was not familiar with any policy related to a medical hold. The Physician stated it was a judgement call. He stated he wanted to make sure that things were "organized" before Patient #2 left the rehabilitation unit.</p> <p>The Staff Nurse caring for Patient #2 on 9/15/15 that took the medical hold order was interviewed on 9/13/16 at 3:10 PM. She stated she remembered the patient came out in the hallway yelling and screaming. She stated staff tried to</p>	A 131			

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A 131	Continued From page 11 redirect but they needed to call security as the patient did not calm down. She stated she remembered she called and explained the specific situation to the physician and he ordered a medical hold to keep the patient in the hospital for Patient #2's safety. She stated she was not familiar with a policy regarding medical holds.	A 131			
	The hospital did not follow State law regarding Patient #2's hold. The hospital detained her and failed to notify the court which prevented her from receiving due process. The hospital discharged Patient #2 before a judgement to determine that she was not a danger to herself or others had been rendered by the court.	A 806	Plan of Correction: Case management initial assessment in the software program "Morrisey Concurrent Care Manager" (MCCM) was reevaluated and updated to include the following assessments: a) patient and/or guardian involvement in discharge planning, b) evaluation for post hospital services and availability, and c) evaluation for capacity for self-care or returning to prior to living arrangements.	Initial update 9/13/2016	
A 806	482.43(b)(1), (3), (4) DISCHARGE PLANNING NEEDS ASSESSMENT (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician. (3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. (4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment	A 806	Procedure/Process for Implementation: <ul style="list-style-type: none"> Additional questions were placed in "live" documentation environment (MCCM) Education was conducted for all case management staff. Monitoring/Tracking Procedure <ul style="list-style-type: none"> Retrospective baseline audit for case management initial assessment documentation for appropriate content and completion of required elements as follows: a) patient and/or guardian involvement in discharge planning, b) evaluation for post hospital services and availability, and c) evaluation for capacity for self-care or returning to prior to living arrangements. 	9/13/2016 Initial education on 10/03/2016 and 10/05/2016 Case management audit 9/19/2016 Quality performed audit 10/07/2016	

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A 806	Continued From page 12 from which he or she entered the hospital. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure the discharge planning evaluation included an evaluation of the likelihood of 1 of 9 patients (Patient #9) needing post-hospital services and of the availability of the services. This resulted in a lack of resources for patients following discharge. Findings include: Patient #9 was a 46 year old male who was admitted to the Rehabilitation Unit 8/25/16 following treatment for TBI and multiple facial fractures. He was discharged to home on 8/29/16 at 4:30 PM. The H&P by the physiatrist, which determined Patient #9 was appropriate for admission to the Rehabilitation Unit, was dated 8/22/16 at 5:01 PM. It stated Patient #9 was "...alert, mildly agitated, easily distractible." The H&P stated Patient #9 had 1 episode of combativeness while in the Intensive Care Unit. The H&P stated Patient #9 was in an alcohol related motorcycle accident. The H&P stated Patient #9's blood alcohol level was over 3 times the legal limit. The H&P stated Patient #9 was treated for alcohol intoxication on admission. Patient #9's initial occupational therapy evaluation was dated 8/25/16 at 3:06 PM. It stated the motor vehicle accident that resulted in Patient #9's admission was his third motor vehicle accident in 2016. It stated Patient #9 had a problem with alcohol abuse. Patient #9's initial discharge planning assessment was dated 8/26/16 at 1:30 PM. The assessment	A 806	<ul style="list-style-type: none"> Weekly case management audits of 30 randomly selected patient records will be reviewed for appropriate content and completion of required elements as follows: a) patient and/or guardian involvement in discharge planning, b) evaluation for post hospital services and availability, and c) evaluation for capacity for self-care or returning to prior to living arrangements. <p>Weekly audits will continue until four consecutive weeks of 95% compliance is obtained. Thereafter, <u>monthly</u> audits of 30 randomly selected patient records will then be performed on continuous basis to ensure compliance.</p> <p>Performance Improvement/Incorporation of Improvement Actions</p> <ul style="list-style-type: none"> Audits will be analyzed weekly until compliance is met and monthly thereafter. Analyzed data and information will be shared weekly until compliance is met and monthly thereafter with case management staff and needs for improvement of processes and documentation will be discussed and implemented. Based on the results of the analyzed audits, if additional education is required it will be provided by the Case Management Director. Analysis and any revisions to processes and documentation will be reported monthly to the Utilization Management Committee by the Case Management Director. 	10/10/2016 Begin 10/17/2016 10/20/2016	

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A 806	Continued From page 13 did not mention Patient #9's alcohol abuse and his need for substance abuse treatment. Patient #9's discharge plan did not mention the addiction nor did it include referrals or other information regarding treatment of substance abuse. Patient #9's discharge planning evaluation and discharge plan were reviewed with the Data Abstractor on 9/13/16 beginning at 3:35 PM. She stated Patient #9's discharge planning notes did not address his alcoholism.	A 806	<ul style="list-style-type: none"> Analysis and revisions to processes and documentation will be reported by the Case Management Director monthly to the Quality Management department who will in turn report the information to the QAPI committee. Analysis and revisions to processes and documentation will be reported quarterly by the CQO to the Medical Staff Quality Committee. 	By the 15 th of each month beginning in November	
A 820	The hospital failed to provide Patient #9 with a complete discharge planning evaluation. 482.43(c)(3), (5) IMPLEMENTATION OF A DISCHARGE PLAN (3) The hospital must arrange for the initial implementation of the patient's discharge plan. (5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This STANDARD is not met as evidenced by: Based on a review of medical records, hospital policies, and staff and caregiver interviews, it was determined that the hospital failed to prepare the patient's caregivers for post hospital care for 1 of 9 patients (Patient #2) whose records were reviewed. This resulted in a patient being discharged without their caregivers having the knowledge and ability to meet their post-hospitalization needs. Findings include: The hospital's policy "Discharge Planning," revised on 4/11, stated "... As needed, the patient and family members are counseled to prepare them for post-acute care." The policy also stated	A 820	Responsible Party: Director of Case Management; report to MSQC by CQO Plan of Correction The Discharge Planning Policy was reviewed and revised to include...patient's discharge plan will be reassessed for factors that affect continuing care needs and appropriateness of the discharge plan "such as change in the patient's condition, change in support, and change in post hospital care requirements. Changes in patient condition are communicated with interdisciplinary team members on an ongoing basis." In addition, "as needed the patient and family members/significant others are counseled to prepare them for post-acute care by the appropriate disciplines." Policy was revised to include documentation process by nursing and case management. Policy reviewed and approved by CNO, Case Management Physician advisor, and Risk Management and approved by MEC.	12/2016 10/6/2016 Approved by MEC 10/07/2016	

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A 820	<p>Continued From page 14</p> <p>"Case Management transfers and refers patients along with necessary medical information to appropriate facilities, agencies or outpatient services, as needed, for follow-up or ancillary care."</p> <p>Patient #2 was admitted on 8/15/15, for care related to injuries caused by a motorcycle accident. Injuries included a TBI, fractured ribs, fractured left scapula, pneumothorax, probable splenic laceration and multiple skin lacerations. She required 2 surgeries and intubation during her stay in the ICU. She was transferred to the Rehabilitation Unit on 9/09/15.</p> <p>Patient #2's record included a Case Manager's documentation, dated 9/10/15 at 3:39 PM, stated "Currently, therapy attempting to complete full assessments and their hopes to collaborate with patient have proved problematic d/t [due to] symptoms of impulsivity and poor attention."</p> <p>Further documentation by the Case Manager, dated 9/10/15 at 5:42 PM, stated the expectation was for the patient to be discharged home the week of 9/14/15 "and receive outpatient therapy." The documentation stated Patient #2's SO was making plans for Medicaid coverage and transfer to a hospital in another state to continue rehabilitation. Additionally, Patient #2's record stated she was denied admission to inpatient rehabilitation due to self-pay status.</p> <p>The Case Manager documented at 1:01 PM he contacted the out of state hospital again to inquire about Patient #2 being transferred as an inpatient. The Case Manager documented clinical notes were sent and questions were answered regarding a possible transfer. He</p>	A 820	<p>Procedure/Process for Implementation:</p> <ul style="list-style-type: none"> Discharge Planning Committee assembled and meeting held. During the meeting the existing policy was reviewed for compliance with the standards. Suggested modifications were incorporated into the policy to be in compliance with standards and practice. Case Management education regarding the revised policy was conducted. Nursing education on policy revision. Nursing/Case Management education regarding their role and responsibilities in the preparation of patient/caregivers for post hospital care through using the "teach back" methodology; and appropriate documentation of patient/caregiver understanding. Revision of nursing discharge checklist-discussed at Discharge Planning Committee; revisions will be incorporated into the EHR. If unable to fully implement in the electronic record by 10/28/2016, a hardcopy of the revised checklist will be utilized until incorporation into the EHR. 	<p>9/22/2016 and 10/06/2016</p> <p>10/05/2016</p> <p>Completed by 10/28/2016</p> <p>Completed by 10/28/2016</p> <p>Initiated 10/6/2016 and implement by 10/28/2016</p>	

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A 820	<p>Continued From page 15</p> <p>documented at 1:36 PM, the out of state hospital reported back that they declined placement. The Case Manager documented "Plans underway to facilitate [discharge] 9/16 with 24/7, SO [name] to setup CNA support and find PCP, no DME needs and [name] will ensure outpt [sic] therapy is obtained through [hospital name] as recommended."</p> <p>Case Management notes dated 9/16/16 at 12:06 PM stated "PCP selected and patient will follow up with the [hospital name] for outpatient OT/ST. Plan to enlist CNA our [sic] ongoing. No other CM interventions required at this time."</p> <p>There was no further documentation in the Case Manager's notes or the nursing discharge instructions related to arrangements for Patient #2 to be an out-patient at the out of state hospital. There was no documentation of specific arrangements for follow up with the patient's new PCP.</p> <p>Patient #2 was discharged on 9/16/16 at an unspecified time. The discharge instructions included a list of medications, directions on wound care, signs of depression, and status at discharge, including the direction someone was to be at patient #2's side 24 hours a day. The discharge instructions stated they were to make an appointment with Patient #2's PCP. There was no contact information listed for the PCP. There was no contact listed for the out of state hospital.</p> <p>During an interview on 9/13/16, at 9:30 PM, the LPN who discharged Patient #2 reviewed her record and stated what was documented were all the discharge instructions given to Patient #2's significant other. She stated Patient #2's</p>	A 820	<p>Monitoring/Tracking Procedure</p> <ul style="list-style-type: none"> Each case manager's documentation in the record of care will be reviewed using the CMS "Discharge Planning Audit". Initially, as a baseline a minimum of one audit of documentation in the record of care will be reviewed per case manager during the week of October 10-14. Upon completion of the initial review a discussion will be held with the case management staff regarding opportunities for improvement. Audits will continue weekly. Opportunities for improvement will be addressed upon completion of each audit. Baseline audit of the nursing discharge planning checklist and documentation. To be completed by 10/28/2016. Thereafter a random sample of 30 medical records encompassing all nursing units will be audited monthly until a 95% compliance is achieved. 	10/10-14/2016	Baseline audit to be completed 10/28/2016 Monthly audit to begin 11/01/2016

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A 820	Continued From page 16 significant other had medications as ordered but she was not aware of any paperwork related to a transfer or referral. She stated there was no discussion of patient transfer to another facility that she could remember. She agreed there was nothing documented regarding Patient #2's referral to another facility. During a telephone interview on 9/13/16, at 3:45 PM, Patient #2's significant other was interviewed by phone. She stated Patient #2 was transported to another state the day of discharge in a private car. She stated she understood she would take Patient #2 to the out of state hospital the next day, walk in, and she "would be listed in the computer and they would admit her for continued rehabilitation." She stated there was a "colossal miscommunication" because the out of state hospital had no information regarding an anticipated admission, outpatient or inpatient. Patient #2 was admitted to the out of state hospital through the ED by her significant other due to her emotional lability and aggressive behavior. The hospital failed to ensure Patient #2's referral information was complete and her caregiver fully understood the discharge plan and had the necessary resources.	A 820	Performance Improvement/Incorporation of Improvement Actions <ul style="list-style-type: none"> Action plans for correction will be developed for each deficiency. Implementation of action plans will commence. An analysis of the findings will be reported by the Case Management Director during the monthly Utilization Management Committee meeting. An analysis of the findings of the nursing audit will be reported to the CNO and the Unit Educators for follow up with the nursing staff. Analysis and revisions to processes and documentation as a result of the audits will be reported monthly to the Quality Management department who will in turn report the information to the Quality/Patient Safety committee. Responsible Party: Director of Case Management and CNO	10/14/2016 10/17/2016 Results of baseline audit 10/20/2016 10/28/2016 Monthly-reported 1 st Friday 10/28/2016
A 821	482.43(c)(4) REASSESSMENT OF A DISCHARGE PLAN The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan. This STANDARD is not met as evidenced by: Based on a review of medical records and	A 821	Plan of Correction: The Discharge Planning Policy was reviewed and revised to include...patient's discharge plan will be reassessed for factors that affect continuing care needs and appropriateness of the discharge plan "such as change in the patient's condition, change in support, and change in post hospital care requirements".	10/6/2016 Approved by MEC 10/07/2016

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A 821	<p>Continued From page 17</p> <p>policies, staff and caregiver interviews, it was determined that the hospital failed to reassess discharge plans for 2 of 9 patients (#2 and #9) whose records were reviewed. This had the potential to result in patients being inadequately prepared for discharge. Findings include:</p> <p>The hospital's policy "Discharge Planning", revised on 4/11, stated "case management reassesses the discharge planning process at periodic intervals to evaluate the appropriateness of previous assessments and plans ...patients are reevaluated at discharge to ensure plans still appropriate and in place."</p> <p>1. Patient #2 was a 47 year old female, admitted on 8/15/15, for care related to injuries caused by a motorcycle accident. Injuries included a TBI, fractured ribs, fractured left scapula, pneumothorax, probable splenic laceration and multiple skin lacerations. She required 2 surgeries and intubation during her stay in the ICU. She was transferred to the Rehabilitation Unit on 9/09/15.</p> <p>a. The Case Manager's documentation on 9/10/15, at 3:39 PM stated "Currently, therapy attempting to complete full assessments and their hopes to collaborate with patient have provided [sic] problematic d/t [due to] symptoms of impulsivity and poor attention."</p> <p>Further documentation by the Case Manager on 9/10/15, at 5:42 PM, stated the expectation was for the patient to be discharged home the week of 9/14/15, and receive outpatient therapy "as plan is developed for safety." The Case Manager also documented Patient #2's significant other was making plans for Medicaid coverage and transfer</p>	A 821	<p>Changes in patient condition are communicated with interdisciplinary team members on an on-going basis." In addition, "as needed the patient and family members/significant others are counselled to prepare them for post-acute care by the appropriate disciplines." Policy was revised to include documentation process by nursing and case management. Policy reviewed and approved by CNO, Case Management Physician advisor, and Risk Management and approved by MEC.</p> <p>Procedure/Process for Implementation:</p> <ul style="list-style-type: none"> Discharge Planning Committee assembled and meeting held. During the meeting the existing policy was reviewed for compliance with the standards. Suggested modifications regarding reassessing the patients discharge plan were incorporated into the policy. Case Management education regarding the revised policy and focusing on reassessment of the patients discharge plan was conducted. Case Management education regarding their role and responsibilities in reassessing the patients discharge plan; and the necessity for adequate documentation of changes in the plan, as appropriate. 	9/22/2016 10/03 and 10/05/2016 10/05/2016	

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A 821	<p>Continued From page 18</p> <p>to a hospital in another state to continue rehabilitation. The Case Manager documented Patient #2 was denied admission due to self-pay status.</p> <p>The Case Manager's note dated 9/14/15, at 1:01 PM, stated he contacted the out of state hospital again to inquire about Patient #2 being transferred as an inpatient. He documented that clinical notes were sent and questions answered regarding possible transfer. At 1:36 PM, the Case Manager documented the out of state hospital reported back that they declined Patient #2 as an inpatient, but would consider her as an outpatient. The Case Manager documented "Plans underway to facilitate [discharge] 9/16 with 24/7, SO [name] to setup CNA support and find PCP, no DME needs and [name] will ensure outpt [sic] therapy is obtained through [hospital name] as recommended." There was no documentation her significant other was notified of the changes.</p> <p>On 9/16/15 at 12:06 PM, the Case Manager notes discussed Patient #2's brother's concerns regarding discharge. It was noted "PCP selected and patient will follow up with the [hospital name] for outpatient OT/ST."</p> <p>There was no documentation in the Case Manager's notes related to Patient #2's aggressive behavior, and how it was considered in her discharge plan.</p> <p>b. Patient #2's chart included documentation in the nursing notes of multiple events of confusion and agitation due to her TBI during her rehabilitation stay. These events included aggressive and violent behavior. Examples included:</p>	A 821	<p>Monitoring/Tracking Procedure</p> <ul style="list-style-type: none"> Initially, as a baseline a minimum of one record of care audit (medical record) using CMS "Discharge Planning Audit" was completed. Results reported to case management. Each case manager's documentation in the record of care will be reviewed using the CMS "Discharge Planning Audit". Initially, as a baseline, one audit of the documentation in the record of care will be reviewed per case manager during the week of October 10-14. Upon completion of the initial review a discussion will be held with the case management staff regarding opportunities for improvement. Audits will continue weekly. Opportunities for improvement will be addressed upon completion of each audit cycle. 	10/7/2016 10/14/2016 10/14/2016	

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A 821	Continued From page 19 - A nursing note dated 9/11/15 at 9:57 PM stated "Pt was agitated and throwing shoes on her friend. Kept saying 'let's go, let's go right now' patient was confused and wandering in hallway Redirected but not effective this time. PRN med given." - A nursing note dated 9/12/15 at 6:06 PM stated "at the window pt thought her brother's trailer was outside and she became agitated and verbally aggressive when she was told he was not there... 7:05 PM Ativan given for agitation... 7:15 PM Haldol given for increasing agitation toward SO" - A nursing note dated 9/14/15 at 7:00 AM stated "pt came out of the room, very agitated, swearing difficult to redirected [sic], yelling at her SO and nurses at the desk, Haldol given... 7:02 Pt becoming more angry and agitated, aggressive [sic] and yelling at person in the hall, unable to redirect, yelling at passerby in hall and getting combative, Haldol [sic] given continues 1:1... 8:44 pt very agitated, swearing at S.O. and nurses, ativan, hydro [sic] for generalized pain, haldol given for agitation" - A nursing note dated 9/14/15 at 9:10 PM stated " Unable to distract pt, pt back to room yelling again at SO, turned an picked up chair raised and threw it at security guard [sic] Pt given haldol." - A nursing note dated 9/15/15 at 12:40 PM stated "Pt came out of room agitated. Pt demanding to go off unit. Refused verbal redirection. Multiple staff tried to redirect. Pt behavior escalated. Pt state 'you don't want to [expletive] with me right now' Pt made threats security was called for pt safety." Patient placed	A 821	Performance Improvement/Incorporation of Improvement Actions <ul style="list-style-type: none"> Action plans for correction will be developed for each deficiency. Implementation of action plans will commence. An analysis of the findings will be reported by the Case Management Director during the monthly Utilization Management Committee meeting. Analysis and revisions to processes and documentation as a result of the audits will be reported monthly to the Quality Management department who will in turn report the information to the QAPI committee. Responsible Party: Director of Case Management	10/14/2016 10/17/2016 10/20/2016 10/28/2016

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A 821	<p>Continued From page 20 on "medical hold".</p> <p>- A nursing note dated 9/16/15 at 7:08 AM, the morning patient was scheduled for discharge, stated Patient #2 had paranoia about being attacked by bees. She was medicated with hydrocodone (for pain), and Haldol (for agitation), at 8:30 AM "with much coercion."</p> <p>Patient #2 was discharged on 9/16/16 at an unspecified time and placed in a private vehicle with her significant other and a friend, who were instructed by the physician to use the child locks to keep her in the car. Patient #2's discharge instructions included the medications Haldol 5mg by mouth every hour as needed until response, and Ativan 1 mg by mouth every 4 hours as needed for agitation. Her discharge instructions included directions on wound care, signs of depression, and status at discharge, which included someone was to be at patients side 24 hours a day. The directions stated they were to make an appointment with Patient #2's physician. There was no documentation of an evaluation of the Patient #2's behaviors as listed above, her remaining on medical hold, or the safety of her being transported by private vehicle.</p> <p>On 9/13/16, at 3:45 PM, Patient #2's significant other was interviewed by phone. She confirmed that she was transported to another state the day of discharge in their car. She stated she was concerned about Patient #2's safety as well as her own. She stated she had a friend fly down to drive back with she and Patient #2 to help keep them safe. She stated the first 5 hours of the 11 hour trip were peaceful, as patient #2 was very sedated. She stated she and her friend gave Patient #2 "as much medication as they dared"</p>	A 821			

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A 821	<p>Continued From page 21</p> <p>but the second half of the trip Patient #2 became disoriented, yelling and screaming, grabbing their hair and continually trying to leave the car. She stated Patient #2 continued to be difficult to manage after arrival to their home city and was admitted through the ED the day after discharge from the hospital. She stated Patient #2 remained in isolation in the ED for a few days as the hospital had no beds.</p> <p>During an interview on 9/13/16, at 11:50 AM, the Clinical Director of Rehabilitation stated she remembered Patient #2's outbursts. She stated Patient #2 was "angry at the nurses" and "using profanity" and one nurse stated she had "thrown a chair."</p> <p>During an interview on 9/13/16 at 3:10 PM, the staff nurse that had cared for Patient #2 on 9/15/15, stated "she was yelling and screaming in the hallway" and that security was called to keep the staff and patient safe. She stated she had called the physician and he had ordered a medical hold to keep the patient in the hospital.</p> <p>During an interview on 9/13/16, at 9:30 PM, the LPN that discharged patient #2 stated Patient #2's significant other had medications as ordered. She stated she was unaware of Patient #2 having a medical hold ordered the day before due to aggressive behavior. She stated she and another nurse were concerned regarding Patient #2 sitting in the back seat of the car "with lots of their stuff."</p> <p>During an interview with the Case Manager on 9/13/16, at 11:15 AM, he stated that Patient #2's aggressive behavior was never documented in the IDG (interdisciplinary group) notes or discharge planning notes. He stated he never</p>	A 821			

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A 821	<p>Continued From page 22</p> <p>saw her outbursts of aggressive behavior though he was "aware of some." He stated "(SO name) did a good job of managing patient." He stated he was unaware of the medical hold.</p> <p>Patient #2's discharge plan was not reassessed and updated to address her potentially dangerous aggressive behavior and safety after discharge.</p> <p>2. Patient #9 was a 46 year old male who was admitted to the Rehabilitation Unit 8/25/16 following treatment for TBI and multiple facial fractures. He was discharged to home on 8/29/16 at 4:30 PM.</p> <p>The H&P by the psychiatrist was dated 8/22/16 at 5:01 PM. It stated Patient #9 was "...alert, mildly agitated, easily distractible. The H&P stated Patient #9 had 1 episode of combativeness while in the Intensive Care Unit. The H&P stated Patient #9 was in an alcohol related motorcycle accident. He was treated for alcohol intoxication on admission.</p> <p>A physician progress note, dated 8/26/16 at 2:29 PM, stated "TBI [prior to admission], agitated requiring 1:1 on medical hold." The note did not describe Patient #9's behavior or why he was placed on a medical hold.</p> <p>An order dated 8/26/16 at 2:38 PM stated "Medical Hold please. [Diagnosis] TBI. Agitated/confused."</p> <p>Patient #9 was discharged to home on 8/29/16 at 4:30 PM accompanied by his wife. The hold was not rescinded prior to discharge.</p> <p>The CM's initial assessment for discharge</p>	A 821			

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A 821	Continued From page 23 planning was dated 8/26/16, after Patient #9 was placed on an involuntary hold. The assessment did not document that Patient #9 had been placed on a hold. The only other discharge planning note was dated 8/29/16 at 5:20 PM, after the patient's discharge. This note stated Patient#9 required "24/7 family oversight." The note did not mention the hold nor did it specifically mention ways to keep Patient #9 safe. Patient #9's discharge planning assessment and discharge plan were reviewed with the Data Abstractor on 9/13/16 beginning at 3:35 PM. She stated Patient #9's discharge planning notes did not address his involuntary hold or his specific behaviors.	A 821			
A 843	The hospital did not reassess Patient #9's discharge plan to address his involuntary hold status and specific ways to keep him safe. 482.43(e) REASSESSMENT OF DISCHARGE PLANNING PROCESS The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs. This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the hospital failed to ensure its discharge planning process was reassessed including a review of discharge plans to ensure that they were responsive to discharge needs. This resulted in the inability of the hospital to fully assess its discharge planning process. Findings include:	A 843	Plan of Correction: The discharge planning policy was revised to include at least a quarterly review to ensure that discharge plans are responsive to the patients discharge needs. In addition, the review process was discussed at the discharge planning committee. Policy reviewed and approved by CNO, Case Management Physician advisor, and Risk Management and approved by MEC. Baseline audits were initiated. Procedure/Process for Implementation: <ul style="list-style-type: none"> Discharge Planning Committee assembled and meeting held. During the meeting the existing policy was reviewed to verify that a mechanism was in place for ongoing reassessment of the discharge planning process. Case Management education regarding the revised policy and the necessity of ongoing review of the discharge planning process. 	9/22/2016 10/6/2016 10/6/2016 9/22/2016 and 10/6/2016 10/05/2016	

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A 843	Continued From page 24 The hospital gathered some data related to discharge planning, including the percentage of initial assessments completed within 24 hours and patient satisfaction data. However, no documentation indicated staff reviewed discharge planning evaluations and discharge plans to ensure the plans addressed needs identified by the evaluations. The Director of Case Management was interviewed on 9/14/16 beginning at 9:05 AM. She stated discharge plans were reviewed but she was not able to provide documentation of this. The hospital did not have evidence its discharge planning process was evaluated including a review of discharge plans.	A 843	<p>Monitoring/Tracking Procedure</p> <ul style="list-style-type: none"> Baseline record of care audit (medical record) using CMS "Discharge Planning Audit "was completed. Results reported to case management. Quality Management will audit, using the CMS "Discharge Planning Audit "to assure that the discharge planning process is reassessed on an on-going basis. Performance will be reassessed with 5 case reviews weekly using CMS "Discharge Planning Audit". Once 95% performance has been achieved compliance will continue to be assessed by performing review of 10 cases monthly <p>Performance Improvement/Incorporation of Improvement Actions</p> <ul style="list-style-type: none"> Action plans for correction will be developed for each deficiency. Implementation of action plans will commence. An analysis of the findings will be reported by the Case Management Director during the monthly Utilization Management Committee meeting. Analysis and revisions to processes and documentation as a result of the audits will be reported monthly to the Quality Management department who will in turn report the information to the QAPI committee. <p>Responsible Party: Director of Case Management and CQO</p>	10/7/2016 10/10/2016 10/10/2016 10/10/2016 10/14/2016 10/17/2016 10/20/2016 10/28/2016	