STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	150169		04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL NORTH	7150 CLEARVISTA DR INDIANAPOLIS, IN 46256

(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	This visit was for investigation of two State hospital complaints. Facility Number: 011437 Date: 4/26/16 and 4/27/16 Complaint Numbers: IN00182631: Unsubstantiated; Lack of sufficient evidence. IN00183268: Substantiated; Deficiency related to allegations cited. QA: 5/27/16 cjl	S 0000		
S 0322 Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H) (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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 150169	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/27/2016
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 7150 CLEARVISTA DR INDIANAPOLIS, IN 46256	

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	Based on document review and interview, the governing board failed to ensure the implementation of its policy related to managing complaints and grievances for 1 of 1 patients medical records reviewed who had filed a complaint with the quality department, patient #1. Findings Include: 1. Review of the policy "Managing Grievances", CLN: 3027, with an effective/reviewed date of 1/16/14 indicated: A. "Within 10 days of the initial complaint, the patient is contacted and their concerns are investigated and follow up entered in Midas (computer system) on the COMMENTS TAB. When investigation is completed Risk Management sends a final letter of outcome." "Within 10 days of receipt, QR/RM (quality resources/risk management) sends "Acknowledgement Letter" and/or Final letter to patient." 2. Review of the August 2015 complaints and grievances indicated that Patient #1 had filed a complaint on 9/1/15, received an acknowledgement letter dated 9/23/15 from staff member #50 (a quality resource and risk management coordinator) 22 days after receipt of the complaint. No other final	S 0322	Accountable Leaders: Director Quality and Risk Management Correction Date: 5/27/16 - Quality Director completed an audit using the same criteria used by the surveyor. The results did not show a trend of missed or late acknowledgment letters or missing close letters. - Root cause analysis completed to understand why the closure letter was missed. The closure letter for cases reviewed in ED QA is written by the ED QA Coordinator. She was on vacation at this time. The RM Coordinator did not understand the correct ED QA referral process during vacation coverage. As a result, the referral didn't occur. The two coordinators have since reviewed the correct coverage process, and the ED QA process was completed - The RM Coordinator and Director Quality Risk reviewed and the Complaint and Grievance policy, with focus on letter completion and timeliness. - Monitoring: MIDAS audit report has been developed to measure acknowledgment and closure letter completion and timeliness. As part of monthly rounding, the RM Coordinator will run and bring this report for all grievances closed since the previous rounding. Any issues will be identified and addressed concurrently, until compliance has been >90% for three months	05/27/2016

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	letter sent to the patient. 3. Review of the 9/23/15 letter to patient #1 indicated: "...You will receive a letter from the physician reviewer when this process is complete, usually within 10-14 working days...". 4. At 12:40 PM on 4/27/16, interview with staff member #50 confirmed: A. This complaint/grievance "fell through the cracks" and did not go through the complete policy process. B. The ED physician was not given the chart and complaint for review, as was stated in the 9/23/15 patient letter indicating that it would, and thus no physician reviewer letter was sent. C. A final letter regarding the complaint investigation was never sent to patient #1 as policy requires.			