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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150082 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/02/2012 |
| NAME OF PROVIDER OR SUPPLIER DEACONESS HOSPITAL INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 600 MARY ST EVANSVILLE, IN 47747 | | |
| (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 | |
| S0000 | <p>This visit was for the investigation of one State licensure complaint.</p> <p>Complaint Number: IN00094129 Unsubstantiated: Deficiencies unrelated to the allegations are cited.</p> <p>Facility #: 005074</p> <p>Survey Dates: 02-02-12</p> <p>Surveyor: Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>QA: claughlin 02/21/12</p> | S0000 | | | |

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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| S0322 | <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 facility failed to follow their established and approved policy related to complaints/grievances for 1 of 1 (P#1) patient complaints reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the facility complaint log on 2-2-12 indicated the patient representative of P#1 had filed a complaint/grievance on 3-18-11 at 1515 hours with staff member B#9 by phone. Review of facility documents on 2-2-12 lacked evidence that the complaint from the patient representative of P#1 had been treated as a grievance/complaint and that the facility followed their policy related to complaints/grievances. Review of facility policy titled PATIENT GRIEVANCE/COMPLAINT | S0322 | <p>CORRECTIVE ACTION PLAN for Complaint IN00094129 Deficiency: Corrective Action to be Taken: Prevention of Future Deficiencies: Responsible Parties: Target Date: Status effective Date of Submission of POC: S 322 Revise Policy and Procedure 40-13 "Patient Grievance/Complaint Procedure" to address: ·Definitions of complaint and grievance ·Documentation requirements, and ·Quality Assurance process Education will be provided for Patient Relations Coordinators and Grievance Committee members for Policy and Procedure 40-13 Review of P&P and documentation requirements for the completion of follow-up will be provided in weekly meetings through March 15, 2012 Patient Relations Manager P&P revisions completed by February 28, 2012</p> | 02/17/2012 | | | |

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| | <p>PROCEDURE on 2-2-12 indicated the following: Grievance: A formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient's representative, when a patient issue cannot be resolved promptly by staff present. Patient complaints that cannot be resolved promptly by staff present and that are referred to the Patient Relations Department or Hospital Management are considered Patient grievances. Deaconess Hospital's Manager of Patient Relations will monitor the review of Patient Grievances, coordinate efforts to analyze and resolve identified issues, and facilitate the process to ensure that the patient or patient's representative receives a written response to identified Patient Grievances. The hospital will facilitate a written response to the patient or patient's representative within seven (7) days from the date of receipt of a Patient Grievance.</p> <p>4. Interviews with B#5 and B#6 on 2-2-12 at 1430 hours confirmed the facility has documentation that a complaint was conveyed by phone call by the patient representative of P#1 to staff member B#9 on 3-18-11 at 1515 hours and the complaint was documented by staff member B#9; B#5 and B#6 confirmed this complaint was not treated as a complaint/grievance and did not follow the facility's policy PATIENT</p> | | <p>Final Policy approval by Board Quality Committee March 23, 2012 meeting P&P effective March 26, 2012 Education of Patient Relations staff regarding process changes and review process by March 15, 2012 Draft revisions completed To be completed by March 23, 2012 To be effective March 26, 2012 Initiated February 29, 2012 S 322 Incorporate ongoing review of all new complaints/grievances into weekly Grievance – Hold list meetings to assure appropriate application of definitions and follow-up. Review of all new complaints and grievances will be initiated beginning with February 29, 2012. All complaints which are resolved at the time of the complaint by staff available will receive a follow-up letter acknowledging receipt and resolution of their complaint. Patient Relations Manager February 29, 2012 March 1, 2012 Initiated February 29, 2012 Initiated with complaints received as of March 1, 2012</p> <p>Deficiency: Corrective Action to be Taken: Prevention of Future Deficiencies: Responsible Parties: Target Date: Status effective Date of Submission of POC: S322 Adherence to completing investigation, documentation, resolution, and follow-up with patients in accordance with hospital policy Documentation audits for 20 random closed</p> | | | | |

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| | GRIEVANCE/COMPLAINT PROCEDURE; there was no investigation into the complaint filed by the patient's representative or written response provided to the patient's representative as required by facility policy; the documentation of receiving the complaint was filed as a "FYI". | | complaints/ grievances per month: · % complaints meeting policy definition · % grievances meeting policy definition · % with appropriate documentation and issues are addressed within policy timelines Patient Relations Manager Audit tool developed by February 29, 2012. Audits to begin March 2012 with monthly audits with initial goal of 90% compliance February 29, 2012 To begin for March 2012 | | |