

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2012
NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713		
(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 # IN00111135 Substantiated: Deficiencies related to the allegations are cited.</p> <p>Facility #: 009443</p> <p>Date: 09-24-12</p> <p>Surveyor: Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>QA: claughlin 09/28/12</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2012	
NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713			
(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			
S0252	<p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(a)(1)</p> <p>(a) The Governing Board is legally responsible for the conduct of the hospital as an institution. The governing board shall do the following: (1) Function as the supreme authority of the hospital.</p> <p>Based on document review and interview, the Governing Board failed to ensure facility policies and procedures are followed for patient/family complaints and grievances for 1 of 1 (P#1) patient medical records reviewed.</p> <p>Findings included:</p> <p>1. Review of the facility titled COMPLAINT AND GRIEVANCE PROCESS on 9-24-12 indicated the following: If a complaint cannot be resolved timely by the Hospital staff member, the staff member shall notify his/her supervisor and complete the Complaint and Grievance form. The Director of Quality Management will investigate the circumstances surrounding the concern or complaint and review the issues with the Hospital's CEO. The investigative procedure should be completed, corrective action taken and a written response sent within 7 days of the receipt of complaint.</p>	S0252	<p>The DQM or designee will continue to educate 100% of new employees on the "Complaint and Grievance" policy during their orientation. Confirmation of this education is maintained in the employee's education file. Compliance with orientation is maintained in the "New Hire Tracker" and reported to the OIC/MEC/GB committee.CNO or designee to review the "Complaint and Grievance policy with 100% of current employees via inservice, with the understanding that non-compliance may result in disciplinary action up to termination. Confirmation of inservice and employee signature located in the employee education file.By October 22, 2012, 50% of employees will be re-educated. 100% of employees will be reeducated by (Addendum: November 22, 2012. The CNO and DQM are responsible for ensuring 100% of staff are re-educated on recognizing and reporting complaints and grievances).</p>	11/22/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2012
NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713		
(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>2. Review of P#1's medical record on 9-24-12 indicated P#1 complained to his/her nurse on 3-5-11 at 0510 that he/she was not receiving their breathing treatment as ordered.</p> <p>3. A review of the facility's complaint log lacked evidence that a complaint/grievance form was completed, an investigation was done, or that a response was provided to the patient as required per facility policy.</p> <p>4. Interview with B#4 on 9-24-12 at 1120 hours confirmed the medical record of P#1 contained documentation of a complaint regarding the lack of breathing treatments; B#4 confirmed the facility complaint/grievance log did not contain a complaint/grievance from P#1 nor any documentation of investigation or follow-up.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--	--

(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
S0912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on document review and interview, the nurse executive failed to ensure 1 of 1 patients (P#3) was transferred by physician order according to facility policy.</p>	S0912	CNO or designee to re-educated 100% of nurses on policy T01-A "Transfer of a Patient to Another Facility" and D03-G "Discharge, Discharge Planning and Instructions" regarding the need	11/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2012
NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713		
(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>Findings included:</p> <ol style="list-style-type: none"> Review of the medical record of P#3 on 9-24-12 indicated the patient was admitted to the facility on 3-14-11; transferred to another hospital on 3-22-11 for possible surgery; transferred back to Select Specialty Hospital on 3-27-11, and discharged on 4-18-11. The medical record of P#3 lacked documentation of a physician order for transfer on 3-22-11. Review of facility policy titled TRANSFER OF A PATIENT TO ANOTHER FACILITY on 9-24-12 indicated the following: Physician orders for the transfer of a patient shall be reduced to writing in the patient's record, signed by the hospital staff member receiving the order, and countersigned by the physician. Interview with P#4 on 9-24-12 at 1305 hours confirmed the medical record of P#3 lacked documentation of a physician order to transfer the patient on 3-22-11 as required by facility policy. 		<p>to obtain an order to transfer/discharge the patient out of the facility with the understanding that non compliance may result in disciplinary action up to termination. Confirmation of inservice and employee signature located in the employee education file. By October 22, 2012, 50% of nurse will be re-educated. 100% of nurses will be reeducated by (Addendum: November 22, 2012. The CNO and DQM are responsible for ensuring 100% employees are re-educated on on obtaining an order prior to the patient being transferred to another facility). 100% of discharged patient medical records will be audited for a mininum of 4 weeks or until the goal of 100% is achieved for 4 weeks. Compliance results are reported to the OIC/MEC/GB.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2012	
NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713			
(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			
S2018	<p>410 IAC 15-1.6-7 RESPIRATORY CARE SERVICES 410 IAC 15-1.6-7(d)(1)</p> <p>(d) Respiratory care services shall be; (1) delivered in accordance with medical staff directives;</p> <p>Based on document review and interview, the Respiratory Therapist failed to provide medications as ordered by a physician for 1 of 1 (P#1) patients.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the patient medical record for P#1 on 9-24-12 indicated P#1 was admitted to the facility on 3-2-11 at 1540 hours; the physician admitting orders for P#1 indicated the following dated 03-02-11: Albuterol 2.5/3ml HHN Q 6 H; Brovana 15 mcg HHN Q 12 H. Review of the facility policy on 9-24-12 titled MEDICATIONS: STANDARD ADMINISTRATION TIMES, indicated the following: New orders with frequencies greater than or equal to twelve hours should be initiated within the current shift and then placed on the normal schedule. Review of the facility policy on 9-24-12 titled FORMULARY indicated the following: If an acceptable formulary agent cannot be identified, the prescriber 	S2018	The Lead RT or designee will re-educate 100% of all RT's on policy M01-N-"Medication Administration" and F04-P"Formulary" with the understanding that non compliance may result in disciplinary action up to termination. Confirmation of inservice and employee signatures located in the employee education file.The Lead RT or designee will audit 10 medical records a week for a minimum of 4 weeks or until the goal of 90% is achieved for 4 weeks. Compliance results are reported to the OIC/MEC/GB.	10/22/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--	--

(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>will be notified on the non-formulary status of the prescribed medication.</p> <p>4. Review of P#1's medical record on 9-24-12 indicated the following: 3-2-11, the medical record of P#1 lacked documentation of a dose of Brovana being given upon admission. 3-3-11, the 0100 dose of Albuterol 2.5/3ml lacked documentation of being given. 3-3-11, the medical record of P#1 lacked documentation of either doses of Brovana being given; documentation at 0100 indicated Brovana not on profile unable to give tx. The medical record lacked documentation that the prescriber was notified that the medication was not on the profile. 3-4-11, the medical record of P#1 lacked documentation of the 0100 dose of Albuterol 2.5/3ml being given. 3-4-11, the medical record of P#1 indicated Brovana, ordered Q 12 H, was given at 0124, 0712, and 1905. 3-5-11, the medical record of P#1 lacked documentation that the 0100 dose of Albuterol 2.5mg/3ml was given.</p> <p>5. Interview with B#2 at 1315 hours confirmed the following: Brovana 15 mcg was ordered for P#1 Q 12 H and Albuterol 2.5/3ml was ordered for P#1 Q 6 H; B#2 confirmed the 3-2-11 dose of Brovana is not documented as given; the 3-3-11 dose of Albuterol due at 0100 is</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 152014	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SELECT SPECIALTY HOSPITAL-EVANSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SE 4TH ST EVANSVILLE, IN 47713
--	--

(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>not documented as given; the Q 12 H doses of Brovana are not documented as given on 3-3-11; the 0100 dose of Albuterol on 3-4-11 is not documented as given; Brovana is documented as given 3 times on 3-4-11 when ordered Q 12 H; the 0100 dose of Albuterol is not documented as given on 3-5-11; the medical record lacked documentation that the physician was notified if Brovana was not available.</p> <p>6. Interview with B#7 on 9-24-11 at 1430 hours indicated that if a medication is not available, the pharmacy is to call the physician for a substitution; B#7 confirmed the medical record and pharmacy records lacked documentation that the physician was contacted regarding Brovana not being available.</p> <p>7. Review of P#1's medical record on 9-24-12 indicated the patient complained to his/her nurse that he/she was not receiving breathing treatments as ordered.</p>			