

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 153025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2012
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NAME OF PROVIDER OR SUPPLIER HEALTHSOUTH DEACONESS REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 COVERT AVE EVANSVILLE, IN 47714
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility #: 005164</p> <p>Survey Dates: 02-06/07-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>Ken Zeigler Laboratorian</p> <p>QA: claughlin 02/20/12</p> <p>6/22/12 revised due to IDR</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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S0420	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2 (a)(1)</p> <p>Reportable events</p> <p>Sec. 2.2. (a) The hospital's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the hospital:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both.</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention.</p>			
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	<p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the hospital. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the hospital. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability associated with patient elopement.</p>			

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	<p>(iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the hospital, defined as events that result from patient actions after admission to the hospital. Excluded are deaths resulting from self-inflicted injuries that were the reason for admission to the hospital.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug-drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the hospital. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the hospital.</p>			

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	<p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or Stage 4 pressure ulcers acquired after admission to the hospital. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the hospital.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the hospital. Excludes events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or</p> <p>(BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the hospital.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the hospital.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the hospital.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p>			

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	<p>(ii) Abduction of a patient of any age. (iii) Sexual assault on a patient within or on the grounds of the hospital. (iv) Death or significant injury of a patient or staff member resulting from a physical assault, that is, battery, that occurs within or on the grounds of the hospital.</p> <p>Based on document review and interview, the hospital's quality assessment and performance improvement (QAPI) program failed to include a comprehensive listing of serious adverse events to be monitored and a process for determining occurrences.</p> <p>Findings included:</p> <p>1. Review of facility policy titled ROOT CAUSE ANALYSIS/SENTINEL EVENTS on 2-6-12 lacked evidence that patient death/disability related to contaminated drugs, devises, or biologics, death/disability related to hypoglycemia, Stage 3 or stage 4 pressure ulcers, death/disability related to electric shock while in the hospital, burns incurred while in the hospital, and death/disability related to bedrails were included in the facility's policy related to serious adverse events.</p> <p>2. Interview with B#2 on 2-6-12 at 1545 hours confirmed the facility policy related to serious adverse events titled ROOT CAUSE ANALYSIS/SENTINEL EVENTS lacked evidence that patient</p>	S0420	The hospital's sentinel event policy # Adm 12.6 was reviewed and modified on 2/24/12 to include the additional required reporting events: Patient death or serious disability related to contaminated drugs, devises, or biologics; death/disability related to hypoglycemia, Stage 3 or Stage 4 pressure ulcers; death/disability related to electric shock while in the hospital; burns incurred while in the hospital, and death/disability related to bedrails. The policy lists all events which require State reporting on Attachment A. The Director of Quality/Risk is responsible for assuring that the policy is updated to reflect any required reporting parameters required by the State of Indiana. The Director of Quality is responsible for reporting such events to the Corporate Risk Management Department and the State.	03/01/2012			

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	death/disability related to contaminated drugs, devises, or biologics, death/disability related to hypoglycemia, Stage 3 or stage 4 pressure ulcers, death/disability related to electric shock while in the hospital, burns incurred while in the hospital, and death/disability related to bedrails were included in the policy and procedure to identify/investigate serious adverse events by the QAPI committee.			

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S0422	<p>410 IAC 15-1.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-1.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the hospital's quality assessment and improvement program to have occurred within the hospital.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) improvement program shall be designed by the hospital to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the hospital in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the serious adverse event is determined to have occurred by the hospital's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and</p> <p>(D) identify the reportable event, the quarter of occurrence, and the hospital, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) hospital employee involved; or any other information.</p> <p>(2) A potential reportable event may be identified by a hospital that:</p>			

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	<p>(A) receives a patient as a transfer; or</p> <p>(B) admits a patient subsequent to discharge;</p> <p>from another health care facility subject to a reportable event requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The hospital's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each hospital. The department's public report will be issued annually.</p> <p>(e) Any reportable event listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the hospital between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p> <p>(2) has not been previously reported;</p>			

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	<p>must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-1.4-2.2)</p> <p>Based on document review and interview, the facility failed to develop a process for reporting to the Indiana State Department of Health (ISDH) each serious adverse event determined by the facility's Quality Assurance and Performance Improvement (QAPI) committee.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled ROOT CAUSE ANALYSIS/SENTINEL EVENTS on 2-6-12 lacked evidence that the facility's QAPI committee had developed a process to report serious adverse events to the ISDH, submitted not later than 15 working days after the serious adverse event is determined to have occurred. 2. Interview with B#2 on 2-6-12 at 1545 hours confirmed the facility's QAPI committee had not developed a process to report serious adverse events to the ISDH, submitted not later than 15 working days after the serious adverse event is determined to have occurred. 	S0422	The Hospital's sentinel event reporting flow chart was modified to include a process for reporting State required events as listed in Policy # 12.6. The Director of Quality is responsible for assuring that any sentinel events requiring state reporting follows the timeline of fifteen (15) days or less as indicated in the process flow chart. Required reporting events will also be reported to and monitored by HealthSouth Corporate Risk Management Department. The Director of Quality will educate the hospital's management staff at the monthly staff meeting on 3/21/12.	03/01/2012	

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S0872	<p>410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(P)</p> <p>(b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following:</p> <p>(P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.</p> <p>Based on document review and interview, the facility failed to ensure that the completion of the medical record within 30 days in 16 of 30 (N1, N4, N5-10, N14, N15-17, N20, N21, N23, N24, and N25) medical records reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of medical records indicated that the discharge summaries in the medical records of N1, N4, N5-10, N14, N15-17, N20, N21, N23, N24, and N25 lacked documentation of the date of the signature. On 2-7-2012 at 2:30 PM during interview with S2, S2 stated: <ol style="list-style-type: none"> verified the above findings confirmed that all above medical records, the patient had been discharged 	S0872	S 0872 Plan of CorrectionThe Plan of Correction to assure that all physicians are dating and timing signatures on the discharge summary includes the following:All admitting/discharging physicians were notified of the requirement to date and time signatures on the discharge summary. This was completed on 2/10/12.The company used for transcription services was notified to include along with the signature line, a space for dating/timing the signature. This was completed on 2/10/12.The Medical Records Department Manager was notified of the requirement to date/time the discharge summaries on 2/8/2012. Department employees began screening discharge summaries for completion on 2/20/12. The ongoing medical record review will now include an audit to assure that discharge summaries include the date/time	03/21/2012			

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	<p>more than 30 days.</p> <p>c. indicated that absent a date of signature, it could not be reliably determined when the physician had signed the discharge summaries and thus the facility could not reliably determine that the record had been signed within 30 days of the patients' discharge.</p> <p>d. the facility policy regarding the requirements of completion of the medical record was requested but not provided prior to exit.</p>		<p>along with the signature of the physician. February audits will be completed by 3/5/12. Findings will be reported monthly to the Director of Quality to address any outliers. Physicians will be notified of any records not in compliance. Monitoring will be ongoing as part of the internal medical record audit process.</p>		