PRINTED: 07/03/2019 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLE		ETED	
		150082	B. WI	NG		05/28/	2019
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			600 MA			
DEACON	IESS HOSPITAL IN	C			WILLE, IN 47747		
DEACON	IESS HOSFITAL IN			EVAINS	VILLE, IN 47747		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S 0000							
Bldg. 00							
		vestigation of a state hospital	S 00	000			
	complaint.						
	a liva i	D 10000 4500					
	Complaint Number:	1N00294/98					
	Substantiated D.E.	ciancy related to the					
	allegations is cited.	ciency related to the					
	anegations is cited.						
	Date of Survey: 5/2	28/2019					
	But of Bulley. Erz	30,2019					
	Facility Number: 0	05074					
	QA: 5/30/19						
			İ				
S 0930	410 IAC 15-1.5-6						
	NURSING SERVI						
Bldg. 00	410 IAC 15-1.5-6	(b)(3)					
	(b) The amount is a second	maine ale all le avec Ale a					
		rvice shall have the					
	following:						
	(3) A registered no	urse shall supervise					
	` '	care planned for and					
	provided to each p	· · · · · · · · · · · · · · · · · · ·					
	•	review and interview, the	S 09	930	CORRECTIVE ACTION PLAN		07/10/2019
		et the dietary needs of 1 of 10			ISDH Substantiated Complain		0,1,10,2017
	_	per medical record (MR)			#IN00294798 (Date: 5/28/2019		
	review.				·		
					Deficiency:		
	Findings included:				Corrective Action to be Take	n;	
	-	re in the Patient Care			Prevention of Future		
		ook titled: Dysphagia Diet,			Deficiencies:		
	,	which indicated that when					
	_	supervision one to one			Monitoring:		
		mall bites/sips (1/2 spoon bite			Deemonalkia Dawii - fari		
	size for food/liquid)	. Upright as possible for all			Responsible Parties for		
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	₹	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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		RVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLET	ED
		150082	B. W	ING		05/28/20)19
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		600 MA			
DEACON	NESS HOSPITAL IN	IC .			VILLE, IN 47747		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n upright for 20-30 minutes			columns 2 and 3		
	after meals				Target Date: Give specific		
					dates		
	_	nt #1's MR Clinical Swallow			Status effective Date of		
		0/13/2018, at 1359 hours,			Submission of POC		
		ember #4, Speech and ist, indicated: Aspiration Risk:			State		
		•			\$930	vioo	
		nmendation: Dysphagia Level Swallowing Strategies: Upright			410 IAC 15-1.5-6 Nursing Ser 410 IAC 15-1.5-6 (6)(3)	VICE	
		ral intake. Remain upright for			410 1/10 10 1.0 0 (0)(0)		
		meals, one to one assist with			This Rule is not met as eviden	nced	
		sips (1/2 spoon bite size for			by: Based on document revie		
		mmendations: Speech			and interview, the facility failed		
	~ .	ds patient to remain on the			meet the dietary needs of 1 of		
		Dysphagia II - puree and			patients (patient #1) per medic	cal	
		based on the results of the			record (MR) review		
	swallow evaluation				The Registered Nurse		
					demonstrates accountability for		
	3. Review of patien	nt #1's MR Pulmonary and			the initial dysphagia assessme	ent	
	Critical Care Consu	ıltation Note, dated			and ongoing supervision and		
	10/15/2018, at 0059	hours, authored by QMP #3,			evaluation of the care planned and provided for the dysphagi		
	MD, Pulmonary, in	dicated: Patient was left			patient as outlined in Deacone		
		diet). Concerned that they			Hospital, Inc. (DH) policies	,55	
		with worsening O2 saturation			evident by electronic medical		
	_	ting in they being on a non			record documentation		
		tting 82%. Impression: Acute			Review the identified		
		failure, aspiration with			hospital policies for dysphagia	ı [
	mucous plugging.				care management		
	4 Paviarra afraction	nt #1!a MD Discharge			Exhibit A Mosby Aspirat	tion	
	*	nt #1's MR Discharge /17/2018, at 1604 hours,			Precautions		
		\$2, MD, Internal Medicine,			Exhibit B Mosby Feedin	ig	
		course: After transferring to			Assistance for Oral Nutrition Exhibit C Mosby Nursin	_	
	_	s placed on ventilation			Documentation at Deaconess	-	
		care was consulted, patient			· Exhibit D Deaconess		
	* *	suscitate and placed on			Hospital, Inc. RN minimal	[
		plan for placement at hospice,			standards of documentation		
	_	nd unresponsive, was declared			requirements; PCT minimal		
		ours, secondary to aspiration			standards of documentation	[
		ute hypoxic respiratory failure			requirement		
	due to dysphagia.	· · · · · · · · · · · · · · · · · · ·			· Exhibit E Policy 40-29S		

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PRINTED: 07/03/2019 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 150082	A. BUILDING B. WING	00	COMPLETED 05/28/2019		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 600 MARY ST				
DEACON	ESS HOSPITAL IN	С	EVANSVILLE, IN 47747				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				Patient Assessment / Reassessment Plan · Exhibit F Mosby Plan for the Provision of Nursing Care			
				2. Educate Gateway Ortho Medical staff via E-Learning management system related t dysphagia policies. Assignme staff will occur on 7/10/2019. (Exhibit G)			
				3. Utilize daily safety huddle on Gateway Ortho Medical Ur (B600) for RN to coordinate dysphagia care management related to policies/ precautions (Exhibit H)	nit		
				4. Evaluate compliance of Gateway Ortho Medical RN st assessment and supervision according to identified policies dysphagia care management audit tool (Exhibit I) 1. Submit policy and review plan of correction for discussion at Nursing Shared Governance.	s via		

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	OF CORRECTION	IDENTIFICATION NUMBER: 150082	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 05/28/2019
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	1
DEACON	IESS HOSPITAL IN	C	EVANS	SVILLE, IN 47747	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
				Practice Council on July 9, 2 Gateway Ortho Medical Unit Meeting on July 9, 2019; and Nursing Leadership Council July 18, 2019. Update discus from the identified meetings occur at the Gateway Ortho Medical Unit Staff Meeting of August 13, 2019. The inform will be shared and document with 100% Gateway Ortho Medical Staff.	Staff I on ssion will n ation
				2. Submit education compreport from the E-Learning management system to Chie Nurse Executive/VP ensuring 100% staff completion. Gate Ortho Medical Nurse Managemonitor progress of educatio activity and communicate completion updates to Gatew Ortho Medical Staff weekly.	f g way er will nal
				3. Ortho Medical Unit (B60 census will be printed daily to function as daily safety hudd coordination log and provider nursing leadership for review capturing dysphagia care management coordination for days. Log information will be reviewed weekly by unit man and monthly by Gateway director/CNO, and Chief Nursexecutive/VP	o de la de la decembra de la decembr
				4. Complete audits from Gateway Ortho Medical Unit (B600) on a monthly basis. A of all identified dysphagia pa	udits

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING	00	COMPLETED
		150082	B. WING		05/28/2019
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
DEACON	IESS HOSPITAL IN	IC	600 MARY ST EVANSVILLE, IN 47747		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
I I	*			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) (via daily safety huddle coordination log) will be completed until a compliance of 100% is achieved for three consecutive months. Complia will be reviewed monthly by us manager, Gateway director/C and Chief Nurse Executive/VF 1. Chief Nurse Executive/VF Gateway Director/CNO; Orthom Medical Nurse Manager	rate ance nit NO, o

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150082	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/28/2019
	ROVIDER OR SUPPLIE		600 MA	ADDRESS, CITY, STATE, ZIP CODE ARY ST SVILLE, IN 47747	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(X5) E COMPLETION DATE
				2. Chief Nurse Executive/ Gateway Director/CNO; Orth Medical Nurse Manager	
				3. Chief Nurse Executive/ Gateway Director/CNO; Orth Medical Nurse Manager	•

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	OF CORRECTION	IDENTIFICATION NUMBER: 150082	A. BUILDING B. WING	00	COMPLETED 05/28/2019		
	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 600 MARY ST EVANSVILLE, IN 47747				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				4. Chief Nurse Executive/VI Gateway Director/CNO; Ortho Medical Nurse Manager			
				Plan of correction activition will start 7/9/2019. Policy review at identified meetings will be completed 8/13/2019.	es		

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 150082	A. BUILDING B. WING	00	COMPL 05/28/	ETED	
DEACON	ROVIDER OR SUPPLIE	NC	STREET ADDRESS, CITY, STATE, ZIP CODE 600 MARY ST EVANSVILLE, IN 47747				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE	
				2. Assignment to staff wil occur on 7/10/2019. Education will be completed 8/10/2019			

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150082	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/28/2019
	ROVIDER OR SUPPLIEF		600 MA	ADDRESS, CITY, STATE, ZIP CODE ARY ST SVILLE, IN 47747	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) COMPLETION DATE
				3. Daily safety huddle with review will start 8/11/2019 a continue for 90 days. 90 day review completion will be 11/11/2019	nd
				4. Audit compliance moni	way
				Ortho Medical Unit (B600) a education complete 8/10/20 1. In progress	

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	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER: 150082	A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 28/2019
	ROVIDER OR SUPPLIER ESS HOSPITAL IN		600 MA	ADDRESS, CITY, STATE, ZIP COI RY ST VILLE, IN 47747	DE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION JLD BE ROPRIATE	(X5) COMPLETION DATE
				2. In progress		

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	OF CORRECTION	IDENTIFICATION NUMBER: 150082	A. BUILDING B. WING	00	COMPLETED 05/28/2019		
NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE			
DEACON	ESS HOSPITAL IN	IC	600 MARY ST EVANSVILLE, IN 47747				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				3. In progress			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150082	ì í	ILDING	ONSTRUCTION 00	(X3) DATE COMPL 05/28 /	ETED
NAME OF PROVIDER OR SUPPLIER DEACONESS HOSPITAL INC				600 MA	ADDRESS, CITY, STATE, ZIP CODE RY ST VILLE, IN 47747		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
					4. In progress		

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