STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152012	A. BUILDING 00 B. WING	10/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL NORTHWEST INDIANA	5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320

(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 a state licensure hospital complaint. Complaint Number: IN00218353 Substantiated: State deficiencies related to the allegations are cited. Date: 10/16/18 Facility Number: 008899 QA: 11/7/18	S 0000	S 732 410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d) (1) (2) (3) (4) **Immediate Corrective Action:** Senior leadership along with the Chief Executive Officer, Chief Clinical Officer, Director of Quality and Health Information Supervisor met and reviewed the findings from the survey. It was recommended to review the process of medical record completeness involving completeness of treatment, accurate radiology results, ultrasound reports and consultation services. It was determined that an increase in oversight was needed for medical record completeness and accuracy. Daily tracking of radiology, ultrasound completeness and accuracy, and consultations was needed. A complete medical record review was completed and no similar findings were noted. **Systemic Change:** The Chief Executive Officer, Chief Clinical Officer, Director of Quality Management, and Health Information Management Supervisor reviewed the process on ordering procedures and consultations. It was determined that daily verbalization and discussion on all radiology and ultrasound orders and consultations from the previous	

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.

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			day be reviewed with the leadership team and tracked on a procedure/consult log. The procedure log contains staff entry into EMR, patient name, test ordered, ordering physician, order date, order completion, and who dictated the procedure. The consultation log contains the Physician being consulted, when the consult was ordered, and when the consultation was completed and dictated. It was determined that all unit clerk staff be re-educated on the current process for procedures and notifying consultations. All EMR orders, procedures and consultations will be reviewed by the unit clerk frequently throughout the day. Prior to the end of the shift, the unit clerk will review for any outstanding orders and complete order entry and log them as needed. Once radiology/ ultrasound results are completed, the assigned nurse will review the report and verify the test ordered was completed and accurate. In the event a significant result is determined, the assigned nurse will communicate the information to the ordering physician, place a change in condition into the EMR, and revise the Kardex indicating the significant result. Editing the Kardex will ensure accurate information is communicated during handoff report. The director of rehabilitation will review all orthopedic consultation notes and communicate	

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			significant items to the therapy department as well as the leadership team. The HIM supervisor will ensure preliminary ultrasound results are sent to the dictating physician and verify completion within the appropriate timeframe; this is reported and tracked daily. **Monitoring Corrective Actions:** Daily tracking of significant events, procedures ordered, and consultations will be reviewed by the DQM and communicated during daily leadership meetings. The DQM will verify and track editing of the Kardex. Any non-compliance in the process will result in remediation of the employee by their department leader. The nurse manager or designee will monitor for completeness of non-collected labs and completion of 12 hour and 24 hour chart checks and report to the committee for recommendations. Results of all auditing specifically timeliness and completion of the procedure and consults will be aggregated, analyzed, and reported weekly to the CEO, CCO, and DQM. Results will be reviewed and discussed at the monthly dashboard meeting, quarterly leadership committee, Quality Council, Medical Executive Committee, and the Governing Board. Responsible Party: Chief Clinical Officer **S 870 410 IAC 15-1.5-5**	

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			MEDICAL STAFF 410 IAC 15-1.5-5(b) (3) (N) Immediate Corrective Action: Senior leadership along with the Chief Executive Officer, Clinical Officer, Director of Quality Management, Director of Rehabilitation, and Health Information supervisor reviewed the findings from the survey and was directed to review the process of medical record completeness involving completeness of treatment, and review of medical staff bylaws pertaining to consultative services. It was determined that an increase in oversight was needed for medical record completeness and accuracy. It was also determined that daily tracking of consultative services, order review including overdue orders, chart checks, non-collected labs, and supportive devices be reviewed daily and discussed at the morning meeting, any delay in consultation services will be escalated to the Chief Executive Officer for review. A complete medical record review was completed and no similar findings were noted. **Systemic Change:** The Chief Executive Officer, Chief Clinical Officer, Director of Quality Management, Director of Rehabilitation, and Health Information Management Supervisor reviewed the process of consultations ordered and	

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			completed, order review including non-collected labs and supportive devices. It was determined that daily verbalization and discussion of all consultations from the previous day be reviewed with the leadership team and tracked on a consult log. The consultation log contains the Physician being consulted, when the consult was ordered, and when the consultation was completed and dictated. Any consults greater than time allocated will be escalated to the CEO or designee. It was determined that all unit clerk staff be re-educated on the current process for procedures and notifying consultations. A daily report on non-collected labs and order review for supportive devices will be discussed during the morning meeting. Additional oversight on completion of a 12 hour and 24 hour chart check will be completed by the Nurse Manager/ or designee and communicated to the CCO daily and discussed at quarterly meeting, up to including Governing Board. **Monitoring Corrective Actions:** Daily tracking of consultative services, non-collected labs, supportive devices, and chart checks will be reviewed by the leadership team and communicated during daily meetings. The DQM will verify and track consultative services, the Director of Rehabilitation will verbalize and supportive devices,	

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			and nursing services will monitor patient chart checks for overdue orders. Any non-compliance in the process will result in remediation of the employee by the department leader. The unit clerk will review all charts for the possible orders for leg/knee braces. When identified the unit clerk will print the order and notify the primary nurse. The nurse will also notify the Director of Rehabilitation. The Director of Rehabilitation will notify the materials manager for ordering. Daily tracking will be completed until the supportive device is received. A master list of patients with supportive devices such as a knee brace will be tracked on the assignment sheet and discussed during interdisciplinary conferences. Results of all auditing specifically timeliness and completion of the consults, non-collected lab, supportive devices and overdue orders will be aggregated, analyzed, and reported weekly to the CEO, CCO, and DQM. Results will be reviewed and discussed at the monthly dashboard meeting, quarterly leadership committee, Quality Council, Medical Executive Committee, and the Governing Board. Responsible Party: Chief Executive Officer **S 930 410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(b) (3)**	

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			Immediate Corrective Action: Senior Leadership along with The Chief Executive Officer, Chief Clinical Officer, Director of Quality Management, Director of Rehabilitation Nurse Manager, reviewed the findings from the survey and was directed to review the process of nursing oversight of patient care related to therapy services, communication between nursing and non-nursing personnel, communication of significant results to physician, order review, and restorative services. It was determined that an increase in oversight was needed for clinical and physician services on completeness and accuracy of the medical record. It was also determined that daily tracking of order review of radiology reports, overdue orders, chart checks, and non-collected labs be reviewed daily and discussed at the morning meeting. A complete medical record review was completed and no similar findings were noted. **Systemic Change:** The Chief Clinical Officer, Director of Quality Management, Director of Rehabilitation and Nurse Manager reviewed the process of order processing and review, physician notification of significant results with verification of correct exam ordered and completed, and restorative therapy documentation requirements. It was determined	

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			that daily discussion of scheduled restorative services be reviewed and documentation verified by the Director of Rehabilitation or designee, and identify a plan for holiday coverage. All documented change in conditions will be discussed from the previous day by the Director of Quality Management with all leadership members. It was determined that all nursing staff be reeducation on order review and execution and performing end of shift and 24 hour chart reviews prior to the end of their shift. A daily report on non-collected labs and orders for supportive devices will be discussed during the morning meeting. **Monitoring Corrective Actions:** Daily tracking of non-collected labs, supportive devices, chart checks, and restorative documentation will be reviewed by the leadership team and communicated during daily meetings. Restorative therapy documentation will be reviewed by the Director of Rehabilitation. Communication taken place in the morning meeting of significant matters will be communicated to the staff via their department leader. The DQM will verify and track consultative services, the Director of Rehabilitation will verbalize and supportive devices and nursing services will monitor patient chart checks for overdue orders. Any non-compliance in	

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			the process will result in remediation of the employee by the department leader. Results of all auditing specifically timeliness and completion of the consults, non-collected lab, supportive devices and overdue orders will be aggregated, analyzed, and reported weekly to the Chief Executive Officer, Chief Clinical Officer, and Director of Quality Management. Results will be reviewed and discussed at the monthly dashboard meeting, quarterly leadership committee, Quality Council, Medical Executive Committee, and the Governing Board. Responsible Party: Chief Executive Officer	
S 0732 Bldg. 00	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4) (d) The medical record shall contain sufficient information to: (1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results.			
	Based on document review and interview, the facility failed to ensure that the medical record contained accurate information of treatment and results related to x-ray result, ultrasound report and consult for 1 of 5 (#3) patient medical records reviewed. Findings include:	S 0732	S 732 410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d) (1) (2) (3) (4) **Immediate Corrective Action:** Senior leadership along with the Chief Executive Officer, Chief Clinical Officer, Director of Quality and Health Information	12/14/2018

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	1. Review of policy #H-IM 02-001 titled, "General Documentation Guidelines", released 8/14 and in effect at time of patient #3's stay, indicated to facilitate consistency and continuity in patient care, the medical record contains very specific data and information including...all diagnostic and therapeutic procedures and test results...Consultation Reports shall contain pertinent history and physical findings. 2. Review of patient 3's medical record (MR) on 10/16/18 at approximately 1317 hours indicated: A. Radiology Report dated 12/12/16 indicated inconsistent documentation of whether the right or left knee was x-rayed. The report stated, "Procedure(s) Performed: CR (x-ray) Knee Right 1 or 2 views" at 2205 hours. The final report section stated, "Exam: Left knee with AP (anterior posterior) and lateral views; Indication: Swelling and pain of left knee; Findings: There is a comminuted transversely oriented fracture involving the distal metaphysis of the femur". B. An ultrasound of the right leg was ordered on 12/10/16 at 2355 hours and MR lacked documentation of the ultrasound report. C. An Orthopedic Consult was ordered on 12/13/16 at 1031 hours and did not specify whether or not it was the right or left leg. 3. Staff #1 (Director of Quality Management) was interviewed on 10/16/18 at approximately 1638 hours and confirmed, there is inconsistency between the x-ray report and the Orthopedic Consultation Report and it is not clear if it was the right or left knee. Also, MR review indicated a right leg ultrasound was ordered, but lacks documentation of the ultrasound report.		Supervisor met and reviewed the findings from the survey. It was recommended to review the process of medical record completeness involving completeness of treatment, accurate radiology results, ultrasound reports and consultation services. It was determined that an increase in oversight was needed for medical record completeness and accuracy. Daily tracking of radiology, ultrasound completeness and accuracy, and consultations was needed. A complete medical record review was completed and no similar findings were noted. **Systemic Change:** The Chief Executive Officer, Chief Clinical Officer, Director of Quality Management, and Health Information Management Supervisor reviewed the process on ordering procedures and consultations. It was determined that daily verbalization and discussion on all radiology and ultrasound orders and consultations from the previous day be reviewed with the leadership team and tracked on a procedure/consult log. The procedure log contains staff entry into EMR, patient name, test ordered, ordering physician, order date, order completion, and who dictated the procedure. The consultation log contains the Physician being consulted, when the consult was ordered, and	

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			when the consultation was completed and dictated. It was determined that all unit clerk staff be re-educated on the current process for procedures and notifying consultations. All EMR orders, procedures and consultations will be reviewed by the unit clerk frequently throughout the day. Prior to the end of the shift, the unit clerk will review for any outstanding orders and complete order entry and log them as needed. Once radiology/ ultrasound results are completed, the assigned nurse will review the report and verify the test ordered was completed and accurate. In the event a significant result is determined, the assigned nurse will communicate the information to the ordering physician, place a change in condition into the EMR, and revise the Kardex indicating the significant result. Editing the Kardex will ensure accurate information is communicated during handoff report. The director of rehabilitation will review all orthopedic consultation notes and communicate significant items to the therapy department as well as the leadership team. The HIM supervisor will ensure preliminary ultrasound results are sent to the dictating physician and verify completion within the appropriate timeframe; this is reported and tracked daily. **Monitoring Corrective Actions:** Daily tracking of significant	

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			events, procedures ordered, and consultations will be reviewed by the DQM and communicated during daily leadership meetings. The DQM will verify and track editing of the Kardex. Any non-compliance in the process will result in remediation of the employee by their department leader. The nurse manager or designee will monitor for completeness of non-collected labs and completion of 12 hour and 24 hour chart checks and report to the committee for recommendations. Results of all auditing specifically timeliness and completion of the procedure and consults will be aggregated, analyzed, and reported weekly to the CEO, CCO, and DQM. Results will be reviewed and discussed at the monthly dashboard meeting, quarterly leadership committee, Quality Council, Medical Executive Committee, and the Governing Board. Responsible Party: Chief Clinical Officer	
S 0870 Bldg. 00	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(N) (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:			

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	(N) A requirement that all physician orders shall be: (i) in writing or acceptable computerized form; and (ii) shall be authenticated by the responsible individual in accordance with hospital and medical staff policies.			
	Based on document review and interview, the medical staff failed to ensure there was a physician order in writing or acceptable computerized form and completed according to facility policy and procedure for 1 of 5 (#3) patient medical records reviewed. Findings include: 1. Review of policy #H-PC 02-001 PRO titled, "Assessment/Re-Assessment - Interdisciplinary Patient", released 10/16 and in effect at time of patient #3's stay, indicated the physician is responsible for the patient's treatment based upon the medical assessment, evaluation and diagnosis. 2. Review of policy #H-IM 02-001 titled, "General Documentation Guidelines", released 8/14 and in effect at time of patient #3's stay, indicated to facilitate consistency and continuity in patient care, the medical record contains very specific data and information including...diagnostic and therapeutic orders. Consultation Reports should be completed timely from time ordered to time patient is seen by consultant. 3. Review of patient 3's medical record (MR) on 10/16/18 at approximately 1317 hours indicated: A. An Orthopedic Consult was ordered on 12/13/16 at 1031 hours and not completed until 9 days later on 12/22/16. This order did not specify whether or not it was the right or left leg. B. The Orthopedic Consultation Report dated	S 0870	**S 870 410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b) (3) (N)** Immediate Corrective Action: Senior leadership along with the Chief Executive Officer, Clinical Officer, Director of Quality Management, Director of Rehabilitation, and Health Information supervisor reviewed the findings from the survey and was directed to review the process of medical record completeness involving completeness of treatment, and review of medical staff bylaws pertaining to consultative services. It was determined that an increase in oversight was needed for medical record completeness and accuracy. It was also determined that daily tracking of consultative services, order review including overdue orders, chart checks, non-collected labs, and supportive devices be reviewed daily and discussed at the morning meeting, any delay in consultation services will be escalated to the Chief Executive Officer for review. A complete medical record review was completed and no similar findings were noted.	12/14/2018

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	12/22/16 recommend patient wear a knee immobilizer. C. Infectious Disease Progress Note dated 12/28/16 indicated patient has left knee immobilizer. D. Lacked documentation of an order for the knee immobilizer. E. Physician Progress Note dated 12/28/16 indicated patient had a "CBC and CMP (comprehensive metabolic panel) ordered, it is collected, waiting for the results". F. Physician Orders dated 12/28/16 indicated the CBC and CMP orders were canceled on 12/29/16 because "specimen never received". A CBC and CMP were resulted on 12/29/16, but MR lacked a reorder for these tests. 4. Staff #1 (Director of Quality Management) was interviewed on 10/16/18 at approximately 1638 hours and confirmed, an order was lacking for a knee immobilizer and a repeat CBC and CMP for the above-mentioned patient. Also, the order for the Orthopedic Consult was dated 12/13/16 at 1031 hours, but not done until 9 days later on 12/22/16.		**Systemic Change:** The Chief Executive Officer, Chief Clinical Officer, Director of Quality Management, Director of Rehabilitation, and Health Information Management Supervisor reviewed the process of consultations ordered and completed, order review including non-collected labs and supportive devices. It was determined that daily verbalization and discussion of all consultations from the previous day be reviewed with the leadership team and tracked on a consult log. The consultation log contains the Physician being consulted, when the consult was ordered, and when the consultation was completed and dictated. Any consults greater than time allocated will be escalated to the CEO or designee. It was determined that all unit clerk staff be re-educated on the current process for procedures and notifying consultations. A daily report on non-collected labs and order review for supportive devices will be discussed during the morning meeting. Additional oversight on completion of a 12 hour and 24 hour chart check will be completed by the Nurse Manager/ or designee and communicated to the CCO daily and discussed at quarterly meeting, up to including Governing Board. **Monitoring Corrective Actions:** Daily tracking of consultative services, non-collected labs,	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL NORTHWEST INDIANA	5454 HOHMAN AVE 5TH FL HAMMOND, IN 46320

(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
			supportive devices, and chart checks will be reviewed by the leadership team and communicated during daily meetings. The DQM will verify and track consultative services, the Director of Rehabilitation will verbalize and supportive devices, and nursing services will monitor patient chart checks for overdue orders. Any non-compliance in the process will result in remediation of the employee by the department leader. The unit clerk will review all charts for the possible orders for leg/knee braces. When identified the unit clerk will print the order and notify the primary nurse. The nurse will also notify the Director of Rehabilitation. The Director of Rehabilitation will notify the materials manager for ordering. Daily tracking will be completed until the supportive device is received. A master list of patients with supportive devices such as a knee brace will be tracked on the assignment sheet and discussed during interdisciplinary conferences. Results of all auditing specifically timeliness and completion of the consults, non-collected lab, supportive devices and overdue orders will be aggregated, analyzed, and reported weekly to the CEO, CCO, and DQM. Results will be reviewed and discussed at the monthly dashboard meeting, quarterly leadership committee, Quality	

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			Council, Medical Executive Committee, and the Governing Board. Responsible Party: Chief Executive Officer	
S 0930 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3) (b) The nursing service shall have the following: (3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient. Based on document review and interview, the facility failed to ensure that a registered nurse supervised and evaluated patient care related to lack of therapy services as recommended/ordered; lack of communication between nursing and non-nursing personnel; lack of documentation of x-ray results; lack of completion of physician orders for x-ray and specimen processing for 1 of 5 (#3) patient medical records reviewed. Findings include: 1. Review of policy #POL: 02.23 titled, "Restorative Services", released 10/16 and in effect at time of patient #3's stay, indicated the restorative plan for each patient is developed through a collaborative effort between nursing and therapy. The Restorative Aide will complete verbal hand off with a patient's supervising nurse prior to and post each episode of treatment to assure nursing communication and approval is completed for each session. The tech will document this for each session. 2. Review of policy #H-PC 02-001 PRO titled,	S 0930	**S 930 410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(b) (3)** Immediate Corrective Action: Senior Leadership along with The Chief Executive Officer, Chief Clinical Officer, Director of Quality Management, Director of Rehabilitation Nurse Manager, reviewed the findings from the survey and was directed to review the process of nursing oversight of patient care related to therapy services, communication between nursing and non-nursing personnel, communication of significant results to physician, order review, and restorative services. It was determined that an increase in oversight was needed for clinical and physician services on completeness and accuracy of the medical record. It was also determined that daily tracking of order review of radiology reports, overdue	12/14/2018

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	"Assessment/Re-Assessment - Interdisciplinary Patient", released 10/16 and in effect at time of patient #3's stay, indicated the RN (Registered Nurse) directs the nursing care of every patient through delegation and supervision to other nursing and non-nursing personnel. The nurse assigned to the patient or supervising the care of the patient is responsible for notification of and communication to the patient's primary physician or designee...for assuring that there is physician response. 3. Review of patient 3's medical record (MR) on 10/16/18 at approximately 1317 hours indicated: A. Physical Therapy (PT) evaluation on 12/2/16 indicated patient was not qualified to be enrolled in skilled PT due to poor rehabilitation potential and was enrolled in Restorative Therapy Services for ROM (range of motion) of BLE (bilateral extremities) to be done five times per week. These notes indicate patient was okay to receive treatment/therapy. The patient either refused therapy or was sleeping on 12/14/16, 12/19/16 and 12/23/16. There is no documentation of Restorative Aide Therapy on 12/7/16, 12/20/16, 12/26/16, 1/2/17 and 1/4/17, which indicates it was not done five times per week as recommended. B. Nurses Notes indicated on: a. 12/10/16 at 2045 hours, a change of condition of right knee edema and a right knee x-ray was ordered at 2339 hours to be done in the morning, but the x-ray was not done until 12/12/16 at 2205 hours. Lacked documentation that nursing staff ensured order was completed. b. 12/17/16 at 0800 hours, "due to fracture can't be on right side per nurse". Patient was repositioned to right side on 12/19/16 at 0200 hours, 1000 hours and 1400 hours. C. Radiology Report dated 12/12/16 indicated "Procedure(s) Performed: CR (x-ray) Knee Right		orders, chart checks, and non-collected labs be reviewed daily and discussed at the morning meeting. A complete medical record review was completed and no similar findings were noted. **Systemic Change:** The Chief Clinical Officer, Director of Quality Management, Director of Rehabilitation and Nurse Manager reviewed the process of order processing and review, physician notification of significant results with verification of correct exam ordered and completed, and restorative therapy documentation requirements. It was determined that daily discussion of scheduled restorative services be reviewed and documentation verified by the Director of Rehabilitation or designee, and identify a plan for holiday coverage. All documented change in conditions will be discussed from the previous day by the Director of Quality Management with all leadership members. It was determined that all nursing staff be reeducation on order review and execution and performing end of shift and 24 hour chart reviews prior to the end of their shift. A daily report on non-collected labs and orders for supportive devices will be discussed during the morning meeting. **Monitoring Corrective Actions:** Daily tracking of non-collected	

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	1 or 2 views" at 2205 hours..."Findings: There is a comminuted transversely oriented fracture involving the distal metaphysis of the femur". D. Restorative Aide Therapy Notes and Nursing Notes lack documentation of knee x-ray results on 12/12/16 or thereafter. 4. Staff #5 (Physical Therapy Program Director) was interviewed on 10/16/18 at approximately 1450 hours, and confirmed before the Restorative Aide completes range of motion therapy on a patient, they get the okay from the nurse. The nurse is supposed to inform Restorative Aide staff of x-ray results and whether or not patient is okay for treatment as recommended. There is no documentation of the x-ray results from nursing staff to Restorative Aide staff. The expectation is for the Restorative Aide to document why range of motion treatment/services were not completed on days they should have been. This was not done on 12/7/16, 12/20/16, 12/26/16, 1/2/17 and 1/4/17. The Restorative Aide staff do not work on holidays and 12/26/16 and 1/2/17 were holidays. 5. Staff #1 (Director of Quality Management) was interviewed on 10/16/18 at approximately 1638 hours and confirmed, the right knee x-ray ordered 12/10/16 that was supposed to be done the next morning was not done until 12/12/16. There is lack of documentation that nursing staff ensured the order was completed, lack of documentation of communication between nursing staff and Restorative Aide staff regarding the x-ray result and not turning/repositioning patient to the right side after the x-ray result of a fracture on 12/12/16. They continued to turn/reposition patient to the right side.		labs, supportive devices, chart checks, and restorative documentation will be reviewed by the leadership team and communicated during daily meetings. Restorative therapy documentation will be reviewed by the Director of Rehabilitation. Communication taken place in the morning meeting of significant matters will be communicated to the staff via their department leader. The DQM will verify and track consultative services, the Director of Rehabilitation will verbalize and supportive devices and nursing services will monitor patient chart checks for overdue orders. Any non-compliance in the process will result in remediation of the employee by the department leader. Results of all auditing specifically timeliness and completion of the consults, non-collected lab, supportive devices and overdue orders will be aggregated, analyzed, and reported weekly to the Chief Executive Officer, Chief Clinical Officer, and Director of Quality Management. Results will be reviewed and discussed at the monthly dashboard meeting, quarterly leadership committee, Quality Council, Medical Executive Committee, and the Governing Board. Responsible Party: Chief Executive Officer	