

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  05/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEALTHSOUTH DEACONESS REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 COVERT AVE EVANSVILLE, IN 47716
---	--

(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	<p>This visit was for one State hospital complaint investigation.</p> <p>Complaint number: IN00198308 Substantiated: deficiencies related to allegations are cited.</p> <p>Survey date: May 31, 2016</p> <p>Facility Number: 005164</p> <p>QA: 7/7/16 jlh</p>	S 0000	Plan of correction is being submitted for cited deficiencies	
S 0522  Bldg. 00	<p>410 IAC 15-1.5-1 DIETETIC SERVICES 410 IAC 15-1.5-1(c)(1)(2)(A)(B)(C)</p> <p>(c) The dietary service shall do the following:</p> <p>(1) Provide for liaison with the hospital medical staff for</p>			

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:  153025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEALTHSOUTH DEACONESS REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 COVERT AVE EVANSVILLE, IN 47716
---	--

(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>recommendation on dietetic policies affecting patient treatment.</p> <p>(2) Correlate and integrate dietary care functions with those of other patient care personnel which include, but are not limited to, the following:</p> <p>(A) Patient nutritional assessment and intervention. (B) Recording pertinent information on the patient's chart. (C) Conferring with and sharing specialized knowledge with other members of the patient care team.</p> <p>Findings:</p> <p>1. Policy/procedure 600.17, Diabetic Diets - Distribution of Calories, indicated: A. it is the policy of the Dietary Department that the Diabetic diet caloric levels will be divided into 3 meals plus 1 evening nourishment feeding (four meal feeding pattern).</p> <p>2. Review of patient 1's MR indicated: A. physician order dated 3/21/16 at 1412 hours per medical staff 1 (Nurse Practitioner) indicated a diabetic, no added salt diet to begin 3/21/16 at 1412 hours. B. physician order dated 3/23/16 at 2054 hours per medical staff 2 (Physician) indicated initiation of a diabetic snack to be given daily at</p>	S 0522	<p>1) All staff were re-educated on implementing and following physician orders with emphasis on snacks by the Chief Nursing Officer or her designee on 7/30/16</p> <p>2) All staff were re-educated on policy and procedure regarding evening snack and appropriate documentation in the electronic medical record by the Chief Nursing Officer or her designee on 7/30/16</p> <p>3) Chief Nursing Officer or designee will complete monthly chart reviews to assess ongoing compliance</p> <p>4) All patients records with a dietary evening snack was reviewed by the Chief Nursing Officer or her designee on 7/15/16</p>	07/30/2016

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  05/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEALTHSOUTH DEACONESS REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 COVERT AVE EVANSVILLE, IN 47716
---	--

(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 0912 Bldg. 00	<p>bedtime.</p> <p>C. flow sheets lacked documentation that evening snack was provided on 3/21/16, 3/22/16, 3/27/16, 3/29/16, 4/3/16, 4/4/16.</p> <p>3. On 5/31/16 at approximately 1330 hours, staff 1 (Chief Nursing Officer) confirmed evening nourishment snack was not implemented on 3/21/16 as part of the diabetic diet order. Staff 1 confirmed patient 1's evening nourishment snack was initiated on 3/23/16. Staff 1 confirmed patient 1's evening nourishment snack was to be initiated on 3/21/16.</p> <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>			

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  05/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEALTHSOUTH DEACONESS REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 COVERT AVE EVANSVILLE, IN 47716
---	--

(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) 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>Findings:</p> <p>1. Review of Fall Safety Protocol indicated:</p> <p>A. ensure the patient has necessary items, including call bell, telephone and personal items in easy reach.</p> <p>B. assure supervision and assistance are provided with elimination, transfers and ambulation.</p> <p>C. assess patient to with regard to use of: Bed alarm/Zone 2.</p>	S 0912	<p>1) All fall patients were reviewed for compliance by the Chief Nursing officer or her designee on 7/15/16 2) Nursing staff were re-educated on the policy regarding fall protocol by the Chief Nursing Officer or her designee on 7/30/16 3)Nursing staff were re-educated on documentation of the fall protocol in the electronic medical record by the Chief Nursing Officer or her designee on 7/30/16 4)Chief Nursing Officer or designee will conduct monthly chart reviews to assess ongoing</p>	07/30/2016

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  05/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  HEALTHSOUTH DEACONESS REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 COVERT AVE EVANSVILLE, IN 47716
---	--

(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 patient 1 MR indicated:</p> <p>A. fall risk protocol initiated on 3/21/16 at 1418 hours indicated: patient determined to be at risk for injury.</p> <p>B. the MR lacked documentation that fall protocol was followed on 3/23/16, 3/24/16, 3/25/16, 3/28/16, 3/30/16, 3/31/16, 4/2/16, 4/3/16, 4/4/16, 4/5/16.</p> <p>C. the MR lacked documentation that fall protocol was followed for the use of bed alarms on 3/23/16, 3/24/16, 3/25/16, 3/26/16, 3/27/16, 3/28/16, 3/29/16, 3/30/16, 3/31/16, 4/1/16, 4/2/16, 4/3/16, 4/4/16, 4/5/16.</p> <p>3. On 5/31/16 at approximately 1300 hours, staff 1 (Chief Nursing Officer) confirmed patient 1 was left alone in bathroom on 3/24/16. Staff 1 confirmed staff 3 and 4 did not follow facility Fall Safety Protocol. Staff 1 confirmed all staff need to follow facility Fall Safety Protocol.</p>		compliance	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  153025	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2016
NAME OF PROVIDER OR SUPPLIER  HEALTHSOUTH DEACONESS REHABILITATION HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 4100 COVERT AVE EVANSVILLE, IN 47716		
(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	