

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 153037	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/16/2016
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NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA REHABILITATION HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 3104 BLACKISTON BLVD NEW ALBANY, IN 47150
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S 0000 Bldg. 00	<p>This visit was for the investigation of a State complaint.</p> <p>Complaint #IN00179923 Substantiated: A deficiency related to the allegations is cited. A deficiency unrelated to the allegations is cited.</p> <p>Survey date: 2/16/16</p> <p>Facility # 006205</p> <p>QA: cjl 03/17/16</p>	S 0000		
S 0102 Bldg. 00	<p>410 IAC 15-1.2-1 COMPLIANCE WITH RULES 410 IAC 15-1.2-1 (a)</p> <p>(a) All hospitals shall be licensed by the department and shall comply with all applicable federal, state, and local laws and rules.</p> <p>Based on document review and interview, the hospital failed to implement policies/procedures (P&P) in compliance with Federal regulation 42 CFR 482.13(a)(2)(iii) by not providing the patient (P2) or responsible party with</p>	S 0102	On March 15, 2016, the Director of Case Management revised the Patient and/or Family Complaints and Grievances policy and procedure to include written notice of its decision including the name of the contact person, steps taken on	04/27/2016

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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	<p>written notice of its decisions including the name of the contact person, steps taken on behalf of the patient to investigate the grievance, the results of the process and the date of completion.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Federal Regulation 42 CFR 482.13(a)(2)(iii) indicated the following: At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process and the date of completion. 2. Review of facility P&Ps indicated the following: <ol style="list-style-type: none"> a. P&P 9.18, titled Patient Grievance Policy, indicated: The patient and/or family member should first express concerns to the Case Manager (CM). The CM will meet with the patient and/or family within 5 working days and attempt to resolve the issue. Should the patient and/or family member still feel that the issue has not been resolved...the President will review the facts and meet with the patient and/or family...The final decision will be rendered within 10 days of when the 		<p>behalf of the patient to investigate the grievance, the results of the process and the date of completion of its decision for grievance resolutions or the family. The revised policy and procedure will be presented to Quality Council on 4/27/16 for approval. The deficiency will not reoccur because the patient complaint form has been revised to include resolution and administrative review. Quality Council will review patient complaints and be responsible for providing written notice of its decision, steps taken, results and date of completion.</p>	

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	<p>initial concerns were brought to the attention of the Hospital. The decision will be confirmed in writing to the patient and/or family.</p> <p>The Administrative P&P was approved 11/17/14.</p> <p>b. P&P 9.13, titled Patient Complaint Tracking, indicated: Complaints from patients and/or their families shall be responded to in the following manner: Each complaint and its resolution will be documented on a Complaint Tracking form. One copy of this form will remain...and one copy will be forwarded to Hospital Administration to be kept in a special file.</p> <p>The Administrative P&P was approved 11/17/14.</p> <p>3. Review of the document titled Patient Complaint Tracking Form, dated 7/30/15 4:30pm, and attached documentation, indicated FM1 and FM2 reported verbal, mental/threatening abuse and possible physical abuse of P2 by S1 as reported by P2.</p> <p>4. Review of the Hospital's complaint/grievance book and log spreadsheet from June 1, 2015, to present lacked documentation of a complaint or grievance related to P2.</p> <p>5. On 2/16/16 at 2:45pm, A1, Director of</p>			
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	<p>Quality Management, indicated all complaints and grievances should be documented on the complaint forms and filed in the complaint book and should also show up on the complaint log with the general information in spreadsheet format. A1 further indicated the complaint/grievance book and logs lacked documentation of any complaint/grievance, on the Acute Care side, related to abuse of a patient between 6/1/15 and present. At 5:05pm A1 indicated the complaint/grievance for P2 had not been reviewed by the QAPI committee.</p> <p>6. On 2/16/16 at 3:10pm, A2, Director of Nursing (DON), indicated he/she recalled an encounter that A5, Administrator Progressive Care Unit, had with patient P2 and family. A2 indicated there was a complaint reported by P2 family members that indicated the patient was being taunted by a caregiver (S1). A5 indicated this information had also been told to a therapist, but was not documented. A2 indicated a conference was held with the patient, patient's family, an occupational therapist (OT), a physical therapist (PT) and the patient's physician and that the patient then denied some of what was said and the physician indicated the patient may be experiencing delusional thinking due to a UTI (urinary</p>			

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	<p>tract infection) and ordered an urinalysis.</p> <p>7. On 2/16/16 at 3:40pm, A5, Progressive Care Unit Administrator, indicated he/she was acting CEO on 7/30/15 when a complaint was received from P2's family related to possible threatening (mental)/physical abuse by a caregiver (S1). A5 indicated he/she met, the next day, with the Case Manager (CM) and 2 therapists (PT and OT) which led to a finding that a request had been made that only specific gender caregivers provide care for P2.</p> <p>8. On 2/16/16 at 5:00pm, A5 confirmed the complaint/grievance logs and book lacked documentation of the event, and that the President, A7, was not involved in the resolution, but indicated the forms were sent to the Administrative office. A5 indicated no further follow-up or documentation was available.</p> <p>9. Review of the document titled Charge Nurse Shift Report, dated 7/17 (year not included) indicated P2 was to have no (gender specific) caregivers for bathroom assist or baths per therapy.</p> <p>10. On 2/16/16 at 5:00pm, A7, President, indicated he/she had not been involved with and did not have knowledge of the complaint/grievance of P2, therefore had</p>			

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S 0934 Bldg. 00	<p>not included the documentation with other complaints/grievances and consequentially the grievance had further follow-up.</p> <p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(b)(5)</p> <p>(b) The nursing service shall have the following:</p> <p>(5) A registered nurse shall assign the care of each patient to nursing personnel in accordance with the patient's need and the specialized qualifications and competence of the nursing staff available.</p> <p>Based on document review and interview, the nurse executive failed to ensure patient care was assigned in accordance with patient needs for 1 of 5 patients (P2).</p> <p>Findings:</p> <p>1. Review of the document titled Organization-Wide Plan for Providing Patient Care indicated the following: a. III. Delivery of Care Methodology: This is a care delivery system consisting of three elements: 1. Coordination of patient care activities... 2. Daily assignment of care... 3. Direct</p>	S 0934	On March 15, 2016, the Director of Nursing educated associate unit managers regarding the standards compliance and coordination of care to honor patient request of no male caregivers. Associate Unit Managers will be responsible for monitoring patient request so it will not occur again.	03/15/2016	

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	<p>person-to-person communication</p> <p>b. The primary nurse is responsible for development of the patient's/resident's nursing care plan, and is responsible for continuity and consistency via standards compliance and coordination of care.</p> <p>c. The Plan was approved 7/12/15.</p> <p>2. Review of the document titled Charge Nurse Shift Report, dated 7/17 (year not documented), indicated P2 was to have no male caregivers.</p> <p>3. Review of P2's medical record (MR) indicated S1, CNA (certified nursing assistant), provided patient assistance on and after 7/17/15 as follows: On 7/17/15 at 21:55hrs, assisted with patient care. On 7/18/15 at 22:25hrs, assisted with patient care. On 7/19/15 at 18:00hrs, provided patient meal observation and at 22:00hrs, S1 documented patient refused grooming hygiene. On 7/21/15 at 15:20hrs, provided patient care assistance, at 18:00hrs, S1 documented meal observation and at 22:15hrs, S1 documented patient elimination status.</p> <p>4. On 2/17/16 at 3:25pm, S5, RN (registered nurse), indicated he/she did document, on 7/17/15, that P2 was to have no patient assistance/care by male</p>			

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	caregivers.				