Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HL110017	A. BUILDING: _____ B. WING _____	05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCOMPASS HEALTH REHAB HOSPITAL OF TREASU	1600 37TH ST VERO BEACH, FL 32960

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H 000	INITIAL COMMENTS An unannounced Licensure complaint survey, complaint number 2022002368, was conducted on to at Encompass Health Rehab Hospital of Treasure Coast. The facility had deficiencies at the time of the survey.	H 000		
H 120 SS=D	59A-3.243(5), FAC NURSING SERVICE - Care Process (5) The nursing process of assessment, planning, intervention and evaluation shall be documented for each hospitalized patient from admission through discharge. (a) Each patient's nursing needs shall be assessed by a registered nurse at the time of admission or within the period established by each hospital's policy. (b) Nursing goals shall be consistent with the , , prescribed by the responsible member of the organized medical staff. (c) Nursing intervention and patient response, and patient status on discharge from the hospital, must be noted on the medical record. This Statute or Rule is not met as evidenced by: Based on staff interview and administrative and clinical record review, the facility failed to provide timely nursing intervention during patient deterioration, as evidenced by lack of timely physician notification and initiation of a Rapid Response, and when identified, failed to provide evidence of timely and adaquate implementation of corrective action plan to minimize the risk of reoccurrence for 1 or 3 patients reviewed, Patient #1. The findings included: Review of the facility's policy, titiled, #160,	H 120		

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Change in Patient Condition, last reviewed , documented, "The Rapid Response Team (RRT) will be utilized in all areas of the hospital. The goal of the RRT is to provide early and rapid intervention in order to prevent adverse events, promote better outcomes to reduce the frequency of sending patients to a higher level of care. Any staff or family member may call an RRT when the patient's condition needs immediate evaluation by the additional support of the RRT. Criteria to consider in calling the RRT may include some of the following, Acute change in rate from baseline; acute change in , from baseline; acute change in , rate or threatened airway; acute change in level of .
The nurse or unit secretary will initiate physician contact by placing a call to the attending physician when the team is activated. Physician's orders must be given to a nurse should they be necessary.
Once the page is received, the Rapid Response Team will report to the specified department or room number immediately. In the event the team is already present in the room, the code will be called to alert other clinicians of the critical situation occurring should additional help be needed.
Documentation: The staff nurse will document the time the RRT is called, the team members who respond, assessment findings, and interventions provided to the patient in the patient medical record. Documentation by the RRT will be completed in the medical record. Nursing leadership will review the documentation and take appropriate follow-up actions as needed."

The facility's policy, titled, #180, Emergency Services, last reviewed , documented, "Physicians must be available in-person or on-call

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H 120	Continued From page 2 24 hours per day, every day of the year. Appraisal of Emergencies: Patients are routinely assessed by registered nurses (RNs) and other clinical staff to identify any situation that might require a change in treatment or a doctor's urgent attention. In most instances, clinical staff within our hospital will be able to prevent and manage complications through early recognition of symptoms and quick interventions. At times, however, the assessment will result in identifying a clinical emergency that will require immediate action. If an urgent or potentially life-threatening situation is identified, a physician is immediately contacted for medical direction while a trained registered nurse (RN) manages the bedside treatment protocol. The physician is contacted directly if he/she is in the hospital or by telephone/pager if no physician is in the hospital. In any emergency, the nurse will assess the situation, utilize additional resources available in the hospital, and begin initial treatment and basic life support as warranted." Review of the facility adverse events revealed one entry related to Patient #1, dated ..... Clinical record and administrative record reviews conducted on and revealed Patient #1 experienced a delay in receiving a physician assessment in a noted emergency. Patient #1 presented to the facility on ..... at 9:03 PM. The patient's rate (HR) was accelerated at 133. There was no evidence that the Attending Physician was notified of the patient's arrival and/or elevated HR. The patient was medicated with her , medication and later her rate was again checked and although the rate had decreased, the patient's	H 120		

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H 120	Continued From page 3 rate remained over 100 at , at 11:00 PM. Another vital signs (VS) check completed at 4:12 AM revealed that the patient was again experiencing (fast rate) at a rate of 133 beats per min (bpm). The Night Registered Nurse (RN) was not informed by the aide who took the VS of this rate acceleration until more than an 1 hour later at 5:30 AM. At 5:45 AM, the Charge Nurse (CN) / Nursing Supervisor was informed. The Night RN had medicated the patient with , 30 mg ER tablet (extended release) by , and noted that the patient's abdomen was firm and distended. The nurse later informed the Physician Assistant (C-PA) and the , ( ), who were both on duty about approximately 6:00 AM, of the patient's elevated rate. The performed an (elcetrokardiogram) at 6:42 AM, which showed, ' - cannot rule out infarct, abnormal , '. The CN was made aware of elevated HR. Again, there was no evidence of the physician being informed at this time. At 7:34 AM, the CN sent a text-message to the Hospitalist (Consulting Physician) providing a copy of the and the VS. Per the Hospitalist text-message records, she sent an order via text at 7:42 AM to the CN to give the patient 'Metropolol 25 mg by one time dose'; and at 7:55 AM, the nurse acknowledged the text-message from the MD. The nurse denied receiving orders, thus the medication was not given to the patient. The record provided that at 8:04 AM, an order for , Upper with KUB ABD x 2 (with , and Abdomenn); and the Abd noted in the electronic system, documented this order was prescribed by the C-PA. Interview on	H 120		

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H 120	Continued From page 4 . . . . . at 9:45 AM revealed the PA denied giving this order or assessing the patient. The patient was given her morning medication at 9:05 AM by the Day-RN. At 9:15 AM, the nurse noted a significant drop in the patient's . . . . , to , an done with , . . the C-PA and CN were notified. Again there is no evidence of MD notification, emergent intervention or an evaluation by a medical physician, despite the noted change and decline in the patient's condition. The Hospitalist acknowledged being notified of the patient's . . . Another nurse had notified the Hospitalist at 9:28 AM of the patient being . . . , mottling of LE (lower extremities), ( ) and patient being given opiods. Again, there was no evidence of emergent intervention despite the noted decline and emergent change in the patient's condition. At 9:38 AM, the Hospitalist gave a verbal order for an ( ) and Narcan ( ). The staff nurses were unable to initiate and obtain access. There was no evidence of physician notification or of the emergency system being activated to obtain additional clinical assistance or medical intervention despite the patient's obvious decline and change in condition. It was not until 9:55 AM, when the Medical Director (MD) briefly assessed the patient, that immediately the MD ordered 911 to be called. It should also be noted that the MD was in the facility performing rounds with the C-PA since approximately 7:00 AM on this morning. The PA, rounding with the MD, had been made aware of the patient's abnormal and elevated HR, sometime after the 6:42 AM . . was completed. It should also be noted that this medical evaluation occurred some 12 hours after the patient's arrival to the facility with , ;	H 120		

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H 120	Continued From page 5 some 5 hours after the [illegible] was noted again on by the RNT [Rehab Nursing Tech]; over 4 hours since the RN was informed; approximately 3 hours after the PA was informed; and over 2 hours after the Hospitalist was texted the abnormal and elevated HR results. (Emergency Medical Services) arrived at the facility at 10:05 AM on . The patient subsequently expired. The facility completed an investigation and a root cause analysis (RCA) noting there was a delay in the timeliness of the reporting of the vital signs to the RN; the C-PA was on campus and was notified the patient had abnormal and that her rate was elevated but no new orders were received; the Day-Nursing Supervisor/CN texting of information to Family Practice Physician, and the Family Practice Physician texting medical orders that were reported as not received. The analysis included that Texting is not consistent with hospital policy. The corrective action put in place to be implemented included Staff education for Assessment / Reassessment Policy # 003; Change in Condition Policy #160; and Texting Policy #702, to all staff within 30 days; report of potential HIPPA Breach to corporate to investigate; Case Review by Medical Executive Committee per meeting minutes; and texting policy provided to all medical staff and extenders on . Further review of the facility's corrective action plan, revealed the facility had not completed the mandated in-service training within 30 days, as per the corrective action plan. As of [illegible], there were 21 nursing personnel who had not completed the educational training (almost 3 months after the mandated time goal). The facility	H 120		

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had 42 Registered Nurses and review of the list of staff still needing to complete the assessment / reassessment training identified that there were 9 RNs who still had not received the education, but the majority of the staff on the list had worked over 300 hours since this mandate; and of the 5 LPNs on staff, 2 have not completed the in-service education and had worked over 400 hours. The facility had 30 Rehab Nursing Techs, and 10 RNTs had not taken the in-service education.

In review of the corrective action plan, it did not address the lack of accessing timely medical intervention, defining the medical roles of physician extenders, and the role of the nurse to initiate emergency assistance when necessary.

Interviews with the nurses revealed they informed the PA, who was present in the building, immediately, as well as the CN. The PA did not provide orders.
Interviews were conducted as follows regarding the Patient #1's condition:

An interview was conducted on at 9:45 AM with the PA, who revealed that as a PA, she is not to see the patient until after the physician first sees the patient and she also does not provide orders until after this time. She can respond in an emergency (Rapid Response or Code Blue) if she is in the building, whether she has seen the patient or not. She denied seeing Patient #1, denied seeing the ; and denied ordering anything for the patient. The PA stated the nurse must have entered the orders under the PA's name in error. She confirmed being informed regarding the abnormal but had informed the nurse to call the Hospitalist (consulting physician). She further confirmed she was in the

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H 120	Continued From page 7 facility early to conduct rounds with the Medical Director. She was uncertain about the time the Medical Director was in the building, but it could be surmised that is was around 7:00 AMish. It should be noted that although the PA was aware of the patient's abnormal and , prior to beginning their rounds with the Medical Director, the Medical Director did not go see the patient until almost 2 hours later, after completing rounds in the facility. Prior to this time, it is not apparent that any Medical Doctor saw this patient. Upon the Medical Director examing the patient, he immediately ordered the patient be sent to the emergency room for further evaluation via 911. The Medical Director was unavailable for interview at the time of the survey. An interview was conducted on at 10:05 AM with the Hospitalist / physician, who confirmed she was assigned as primary consultant for Patient # 1. The Hospitalist stated that when this is done (assigned a patient), we receive a . . . sheet with the patient's name and room number. The Hospitalist then comes in the next morning to review the medical record. She stated for this patient, she received the vital signs and the Abnormal via text from the CN at 7:34 AM. She called to get additional information and received that the patient was tachycardic, and had further inquired about other information regarding the patient. When the surveyor specifically asked if she had received other information, she denied recieving further information on the patient. She stated she texted and verbally gave the order for the , 25 mg x 1. The physician stated she received an acknowledgement text message at 7:55 AM, that the text was acknowledged. She was later informed that this medicaiton was not given. She	H 120		

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didn't hear any more from the nurses, so she called at 9:19 AM, spoke to the CN, but the nurse did not provide any updated information and the VS provided were from earlier that morning at 8:00 AM. She denied being informed of the patient's severe condition. She stated she received a call from Staff A-RN at 9:28 AM who said she was helping out and wanted to inform her of the condition of the patient. She was informed that the patient was , LE were mottled, was , and the patient had received her routine , medication. She informed the nurse to get an started and to give the Narcan and she would be in. She was not informed that the nurses could not get the started until she arrived at the facility at approximately 10:15 AM. The Medical Director had called 9ll and was leaving for the hospital when she arrived. She also denied that she assessed the patient and she denied ordering an .

An interview was conducted on at 10:52 AM with the Staff A-RN, who stated she was assisting another nurse in the urgent care of Patient #1. She was not assigned as the primary nurse, but was the nurse who contacted the Hospitalist and provided the physician with the update on the patient regarding the patient's abnormal , HR and noted the decline in the patient's condition. The physician informed her she would be there with 10 minutes. Before the Hospitalist arrived, the Medical Director had walked in and prescribed for them to contact 911 for an acute transfer to the hospital for Patient # 1.
She further explained that at approximately 9:30 AM on , she noted that the patient's were mottled, had shallow breathing, the patient's pupils were fixed and dilated, had intermittent responsiveness, and would just stare off in space.

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H 120	Continued From page 9 She stated the RN and CN were aware of the patient's condition. She also denied calling a Rapid Response or a Code Blue for the patient's above scenario. She stated she was 'just helping out, she wasn't the nurse.' An interview was conducted on at 12:35 PM with the Day-RN, Staff B, who was primary nurse assigned to Patient #1 Staff B-RN reported that she works 7:00 AM to 7:00 PM. She couldn't recall what she was specifically told in report but knew that the had performed an and the patient had . She was aware that the PA was informed of the patient's abnormal and increased rate. She and the PA had looked through the chart to see who the nurse was for the previous shift. She also stated she told the CN about the patient. She recalled the patient being , she had been helping her eat, she became clammy, and she was in and out of responsiveness. She recalled two nurses trying to get an started and being unsuccessful. She denied speaking with the physician, but had spoken with the Physician Assistant. She further stated the CN got orders from the physician. She further acknowledged some of the other changes occurring with the patient with the distention but couldn't remember about the patient's . She further stated that she felt that the patient should have gone out during the night for further evaluation with her but acknowledged she did not call a Rapid Response or Code Blue, although the patient's condition deteriorated. An interview was conducted on at 1:06 PM with the CN / Nursing Supervisor for the 7 AM -7 PM shift. She stated that the had been done earlier, and she and the PA were aware of the abnormal and the , but the	H 120		

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PA didn't give any orders. She stated she tried calling the Hospitalist but she did not get an answer, so she eventually texted her about the patient's HR and . She then said she was informed that the physician would be there in 10 minutes, but the physician never showed in 10 minutes, then it became 1 hour then 2 hours. The surveyor then questioned her regarding her response to not having the physician show up for that amount of time. She stated, 'we were in the room', then later stated she was intermittently in the room with the patient. The surveyor repeatedly questioned her about obtaining medical assistance within the facility for a patient with changes in their condition or decline. She stated she informed the PA and texted the Hospitalist. The nurse's response was, "we can't just send out without an order." The nurse never stated how she would summons help within the facility with the above situation. It was not apparent that the nurse was aware of how to summons emergency medical help when necessary. She further denied receiving any orders on her phone and stated another nurse took the orders for the fluids.

Review of the nurses' notes, prior to the MD seeing the patient, documented that the patient's , were fixed and dilated, and her . mottled, B/P (,) decreasing, yet the staff still did not call a Rapid Response or Code Blue to summons medical intervention for the critical and declining patient.

An interview was conducted on at approximately 2:30 PM with the Director of Nursing (DON). The surveyor questioned her regarding the nurses reporting that they informed the PA and the CN, but the PA apparently did not see the patient because, according to the PA, she

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H 120	Continued From page 11 can't see the patient until the physician sees the patient. The DON confirmed there is some regarding the role of the PA because, 'she is always here, and she provides orders'. She further confirmed that the staff did not initiate a Rapid Response or Code Blue, despite the patient's declining condition, which delayed the patient being evaluated by a Medical Doctor until hours after the fact. An interview was conducted with Quality / Risk Director and Nurse Manager on in the afternoon, regarding the staff education. The Risk Director informed the surveyor that she was not the Risk Manager in charge when this incident occurred in , (2022). She further acknowledged that all the nursing staff had not received the education as previously outlined in their corrective action plan.	H 120		