

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  01P001	<b>(X3) Date Survey Completed</b>  04/18/2014
<b>Name of Provider or Supplier</b>  Legacy Of Hope	<b>Street Address, City, State</b>  516 20th Street South, Birmingham, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>Z0201</b>	<p><b>DEATH RECORD REVIEWS</b> CFR(s): 486.348(b)</p> <p>As part of its ongoing QAPI efforts, an OPO must conduct at least monthly death record reviews in every Medicare and Medicaid participating hospital in its service area that has a Level I or Level II trauma center or 150 or more beds, a ventilator, and an intensive care unit (unless the hospital has a waiver to work with another OPO), with the exception of psychiatric and rehabilitation hospitals. When missed opportunities for donation are identified, the OPO must implement actions to improve performance.</p> <p>This STANDARD is not met as evidenced by: Based on document review, the facility's "Medical Record Review" Policy review and staff interview, the OPO failed to obtain lists to conduct complete monthly death record reviews from three (3) of eight (8) donor hospitals reviewed within the OPO's designated service area (Hospital #s 8, 3 and 4). The findings include: Document review revealed there was no death lists obtained for Hospital # 8. Further review revealed there was incomplete information documented during death record reviews for Hospital #s 3 and 4. During July 2012 - September 2012, the OPO failed to document the following for Hospital #3 during death record reviews: UNOS [United Network for Organ Sharing] Eligible Donor Potential, Missed Referral, DCD [Donation after Cardiac Death] Potential, Timely Referral, Late Referral, Effective Requestor, Requests before Referral, OPO Approaches, and Organ Donors. The OPO failed to document the same data for Hospital #4 during April 2011 - June 2011 as well as the following: Time of Death, Date/Time OPO contacted and documentation if the donor Family was approached. Review of the OPO's "Medical Record Review" policy, dated 12/1/13, documented, "PURPOSE: To assess the potential organ donor pool and ongoing effectiveness of organ recovery and marketing efforts, medical record reviews (MRR) are conducted .</p>

. . The goal of the review is to determine whether any potential donors were missed and to ensure that the hospital's policy is followed regarding the timing of the referral and the use of effective requestors . . . " During interview with the OPO's Senior Manager of Professional Education and the OPO's Manager of Professional Development & [and] Process Improvement on 4/17/14 at approximately 4:50 p.m., they confirmed the OPO did not complete death record reviews for Hospital #8 due to problems encountered collecting data from this hospital as well as confirmed death record reviews were not complete for Hospital #'s 3 and 4 during 2011 and 2012.