

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150017	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/13/2016
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NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOSPITAL OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 7950 W JEFFERSON BLVD FORT WAYNE, IN 46804
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S 0000  Bldg. 00	The survey was for investigation of a State hospital complaint.  Complaint Number: IN00204438 Substantiated: A deficiency related to the allegations is cited. Deficiencies unrelated to the allegations are cited.  Date: 7-11/13-16  Facility Number: 005016  QA: 7/20/16 jlh	S 0000		
S 0340  Bldg. 00	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(P)  (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:  (P) Safe, appropriate, and adequate transport of patients. Based on document review and interview, the facility failed to provide appropriate training for all transfer center staff and ensure the safe and appropriate transport of all patients requesting or requiring transfer to the facility.	S 0340	<b>1.How are you going to correct the deficiency? If already corrected, include the steps takenand the date of correction.</b> ·TheNetwork Vice President of Regional Service Development	10/18/2016

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>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the educational history documentation located in the personnel files for the transfer center lead dispatcher, staff A38, and the transfer center supervisor, staff A39, failed to indicate either staff had received training on the EMTALA (Emergency Medical Treatment and Labor Act) regulations.</li> <li>2. During an interview on 7-12-16 at 1730 hours, the quality manager, staff A37 confirmed that the personnel files for staff A38 and A39 lacked documentation of EMTALA training.</li> <li>3. During an interview on 7-12-16 at 1800 hours, the chief nursing officer, staff A31 confirmed the transfer center staff had not been assigned the annual EMTALA training that was required for the registration staff, emergency department, and labor and delivery personnel.</li> </ol>		<p>has directed that all Transfer Center staff be trained in EMTALA requirements by completing the Advanced Learning Center (ALC) lesson, "Annual EMTALA Training- EMTALA: Better Compliance, Better Care". This lesson focuses on the importance of EMTALA compliance and treatment decisions, from patient's arrival, to the medical screening, and from triage to discharge, admission, or transfer. Additionally, the lesson specifies the EMTALA requirements when on the receiving end of transfer.</p> <p>The Transfer Center Supervisor is participating in live training with the corporate ED Director. This training will review potential and actual EMTALA situations, to better understand and apply EMTALA rules to different situations. Additionally, within 3 weeks of each training session, the Transfer Center Supervisor will share the lessons learned from the training with all Transfer Center staff.</p> <p><b>2. How are you going to prevent the deficiency from recurring in the future?</b></p> <p>The Network Vice President of Regional Service Development revised the education requirements so that all Transfer Center staff are required to be competent in EMTALA compliance by completing the ALC "Annual EMTALA Training-</p>		

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			<p>EMTALA: BetterCompliance, Better Care" lesson within 30 days of hire and annually thereafter.</p> <ul style="list-style-type: none"> <li>·Tobe sure all staff are compliant and timely with completing the lesson, theTransfer Center Supervisor is responsible for tracking and documenting staffcompletion of the lessons and training (upon hire and annually). The TransferCenter Supervisor is reporting the monitoring results to the Quality Council,Medical Executive Committee (MEC) and up to the Board for 4 consecutive months,and then periodically thereafter.</li> <li>·TheQuality Manager is monitoring and tracking live training being provided by thecorporate ED Director to the Transfer Center Supervisor, and by the TransferCenter Supervisor to all Transfer Center staff.</li> <li>·TheTransfer Center Supervisor is responsible for providing training to new staff,within 30 day of hire, to address potential EMTALA situations, including thecited case, to better understand and apply EMTALA rules to differentsituations. Additionally, EMTALA training will be presented at the quarterlystaff meetings.</li> <li>·TheTransfer Center Supervisor is responsible for tracking and documenting thisadditional training provided to Transfer Center staff. This monitoring will</li> </ul>	

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S 0418 Bldg. 00	410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT		<p>berreported to the Quality Council, MEC and up to the Board for 4 consecutivemonths as well as periodically thereafter to ensure compliance.</p> <p><b>3. Who is going to be responsible for numbers 1 and 2above; i.e., director, supervisor, etc.?</b></p> <ul style="list-style-type: none"> <li>·TheNetwork Vice President of Regional Service Development will be responsible forthe plan of correction.</li> </ul> <p><b>4. By what date are you going to have the deficiencycorrected?</b></p> <ul style="list-style-type: none"> <li>·AllTransfer Center staff completed the ALC "Annual EMTALA Training- EMTALA: BetterCompliance, Better Care" lesson by August 1, 2016.</li> <li>·TheTransfer Center Supervisor will participate in two sessions of live training with the corporateED Director. This training will review potential and actual EMTALA situations,to better understand and apply EMTALA rules to different situations. This livettraining scheduled to be completed on August30, 2016 and September 27, 2016. Additionally, within 3 weeks of each trainingsession, the Transfer Center Supervisor will share the lessons learned from thetraining with all Transfer Center staff.</li> </ul>	

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410	<p>IAC 15-1.4-2(b)(1)(2)</p> <p>(b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action shall be documented.</p> <p>(2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care.</p> <p>Based on document review and interview, the facility failed to identify a lapse in its incident management process and address a breach in patient safety for 1 serious adverse patient event.</p> <p>Findings include:</p> <p>1. The policy/procedure Event Reporting Policy (approved 2-16) indicated the following: "...Persons who witness, discover, or have direct knowledge of the event should be considered a witness for purposes of completing the event report... (E). Licensed or registered employee or non-employee practicing beyond scope of practice by law ... (H). Delay of treatment, test, or procedure which causes an adverse occurrence ... (O). Any untoward or adverse occurrence."</p> <p>2. On 7-12-16 at 1010 hours, On 7-12-16 at 1030 hours, the executive director of</p>	S 0418	<p><b>1.How are you going to correct the deficiency? If already corrected, include the steps takenand the date of correction.</b></p> <ul style="list-style-type: none"> <li>·TheNetwork Vice President of Regional Service Development directed all TransferCenter Staff, with regard to all transfer patients, not to ask any questionsabout the patients' insurance provider. Insurance information will be obtainedby Case Management after patients' arrival to the hospital.</li> <li>·TheQuality Manager and VP of Quality reviewed and revised Event Reporting Policy-PT03.45 to state expressly that EMTALA issues of concern should also be reportedthrough an incident report to the Director of Quality Management, who in turn reportsthe concerns up to the Corporate Director of Survey Management and to CorporateLegal Counsel.</li> <li>·TheNetwork Vice President of</li> </ul>	09/01/2016

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	<p>quality, staff A30, the chief nursing officer, staff A31, the administrative director of nursing, staff A32, and the risk manager, staff A33 were requested to provide documentation of an incident report associated with a patient transfer request on 6-30-16 and none was provided prior to exit.</p> <p>3. On interview on 7-12-16 at 1025 hours, the vice president of business development, staff A36 indicated they were briefed on a 6-30-16 transfer request that had upset a transfer center staff (A39) on return to work after a personal leave. The vice president, staff A36, indicated they had administrative responsibility for the transfer center and indicated they were not aware of an incident report regarding the patient event on 6-30-16.</p> <p>4. On interview on 7-12-16 at 1140 hours, the transfer center supervisor, staff A39, confirmed they had failed to complete an incident report about the 6-30-16 ambulance transfer patient that was delayed during transport for insurance reasons and diverted to another facility in response.</p> <p>5. On interview on 7-12-16 at 1235 hours, the risk manager, staff A33 confirmed that an incident report about</p>		<p>Regional Service Development educated all TransferCenter staff on the revised Event Reporting Policy-PT03.45 with focus on the procedure for reporting potential EMTALA issues or concerns.</p> <ul style="list-style-type: none"> <li>·AllTransfer Center staff will be required to complete the Event Reporting System(ERS), Advanced Learning Center lesson which provides education on the purposeand use of the ERS. This lesson will also be required to be completed by newhires, within 30 days of hire.</li> </ul> <p><b>2. How are you going to prevent the deficiency fromrecurring in the future?</b></p> <ul style="list-style-type: none"> <li>·Inaddition to the education of current Transfer Center staff described above, TheTransfer Center Supervisor is responsible for educating All Transfer Centerstaff within 30 days of hire regarding the correct reporting of potentialEMTALA matters, according to Event Reporting Policy-PT03.45.</li> <li>·TheTransfer Center Supervisor is also responsible for providing refreshereducation to all Transfer Center staff annually regarding the reporting ofpotential EMTALA issues or concerns in accordance with the Event ReportingPolicy-PT03.45.</li> <li>·AllTransfer Center staff will be required to complete the Event Reporting System(ERS), Advanced Learning Center lesson which provides education on the</li> </ul>				

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	the 6-30-16 transfer event had not been submitted to the risk manager for review.		<p>purposeand use of the ERS. This lesson will also be required to be completed by newhires, within 30 days of hire.</p> <p>·For4 consecutive months, ten audits per month of the Transfer Center call log willbe completed by the Quality Manager to monitor for potential EMTALA violationsor situations in which interference in a patient transfer may have occurred.100% compliance with the EMTALA requirements for accepting transfers is thegoal, for the four consecutive months. Compliance will then be monitoredperiodically thereafter by the Quality Manager. The Quality Manager isresponsible for reporting all monitoring results to the Quality Council, MECand Board, monthly.</p> <p><b>3. Who is going to be responsible for numbers 1 and 2above; i.e., director, supervisor, etc.?</b></p> <p>·TheNetwork Vice President of Regional Service Development is responsible for theplan of correction.</p> <p><b>4. By what date are you going to have the deficiencycorrected?</b></p> <p>·All Transfer CenterStaff were directed, with all transfer patients, not to ask any questions about the patients'insurance provider on June 30, 2016.</p> <p>·Event Reporting Policy-PT03.45was revised to read expressly that EMTALA issues of concern should be</p>	

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			<p>reported to the Director of Quality Management on August 3, 2016.</p> <ul style="list-style-type: none"> <li>·All Transfer Center staff were educated on the revised Event Reporting Policy-PT03.45 and the correct procedure for reporting potential EMTALA issues or concerns by August 12, 2016.</li> <li>·All Transfer Center staff will be required to complete the Event Reporting System (ERS), Advanced Learning Center lesson which provides education on the purpose and use of the ERS by September 1, 2016.</li> </ul> <p>In addition to those actions, the hospital submits the following additional information:</p> <ul style="list-style-type: none"> <li>·The Quality Manager and VP of Quality reviewed and confirmed that the Event Reporting System (ERS) is a reporting system in which staff are educated to report potential events of harm to patients and/or visitors. As noted in the Event Reporting Policy-PT03.45 before its revision, examples of reportable events included:               <ol style="list-style-type: none"> <li>1. surgical complications such as wrong site or wrong patient</li> <li>2. injuries or death related to products/devices, elopement events, medication errors, blood administration, falls, environmental causes, radiology events, and criminal events</li> <li>3. Centers for Medicare and Medicaid Services (CMS) Hospital Acquired Conditions (HAC)</li> <li>4. Joint Commission Sentinel Events</li> </ol> </li> </ul>	

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			<p>5.Any untoward or adverse occurrence</p> <p>6.Delay of treatment, test, or procedure <b>which causes an adverse occurrence or injury either directly or indirectly</b> (emphasis added).</p> <p>·Also noted in our Event Reporting Policy-PT03.45 before its revision were directions as to what should be included in the ERS and what should not be put into the ERS. Per our Event Reporting Policy-PT03.45 the following was documented:</p> <p><b>Event NOT reported on EVENT REPORT What to use instead Example of this type event</b></p> <p>EMTALA issue Director(s) of Survey Management-Regulatory Survey Reporting System and Corporate Legal Counsel Patient brought to ER and told to go to clinic because it is open</p> <p>·Additionally, the Network Vice President of Regional Service Development as well as the Quality Manager reviewed the event and confirmed that the Transfer Center never refused the transfer of the patient. Transfer Center staff accepted the transfer of the patient; only then did Transfer Center staff quickly confirm the patient's insurance coverage as a service to the patient; and when the Transfer Center staff called the transferring hospital back only 20 minutes later, the transferring hospital</p>	

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S 1510 Bldg. 00	<p>410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following:</p> <p>(A) Provision for the care of the disturbed patient.</p> <p>(B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care.</p> <p>(C) Provision for transfer of patients when care is needed which cannot be provided.</p> <p>Based upon document review and interview, the facility failed to ensure immediate availability of staff to make a decision as to need for immediate care for patients presenting to the Emergency department (ED) for treatment in 4 of 21</p>	S 1510	<p>haddecided to transfer the patient elsewhere. These actions did not cause a delay that resulted in an adverseoccurrence or injury.</p> <p>·Based on the above reference in our policy and the results of the investigation, ourstaff was not expected to report potential EMTALA issues through the ERS system.</p> <p><b>1.How are you going to correct the deficiency? If already corrected, include the steps takenand the date of correction.</b></p> <p>·TheQuality Manager as well as the ED Director reviewed the</p>	08/19/2016	

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	<p>medical records (MR) reviewed (patient #s 2, 3, 4 &amp; 5).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The policy/procedure Triage of Patients (revised 6-14) indicated the following: "Every patient entering Emergency Department shall be triaged and priorities of care determined... Promptly identify patients requiring immediate, definitive care according to the Emergency Severity Index (Level 5 Triage)... Make a decision as to need for immediate care on the basis of gross observation. Document triage category according to ESI (Emergency Severity Index), along with the established time of triage. The patient category is established upon initial presentation rather than when history is elicited."</li> <li>2. Administrative documentation indicated more than 4200 patients were seen in the ED during March, 2016 with an average door to Triage time of 14.38 minutes.</li> <li>3. Administrative documentation dated 3-2016 of patients that left the ED without being seen (LWBS) indicated the following:               <ol style="list-style-type: none"> <li>A. Patient #2 came in to the ED on 3-3-16 at 1603 hours with a complaint of</li> </ol> </li> </ol>		<p>triage policy and process, and confirmed that they were followed in the cited cases. The Policy, 'Triage of Patients' 3.11.13 reads as follows: "Every patient entering Emergency Department shall be triaged and priorities of care determined, in accordance with physical, developmental and psychological needs, as well as factors influencing patient flow through the emergency care system". The policy also states under section V, Priority of Care, that staff should first "Make a decision as to need for immediate care on the basis of gross observation". The process is that a patient presents to the ED Registration area, where the trained registration staff complete the ED Consent to Treatment form. The ED Consent to Treatment form includes the time of arrival and chief complaint. Simultaneously the triage RN is called to the registration area to complete a gross observation of the patient. If at anytime the patient complains of chest pain, shortness of breath, or appears to require an immediate life-saving intervention or is found to be in a high risk situation, he/she is taken directly back to the triage area or directly to an ED room.</p> <p>It was noted during the survey that the ED Consent to Treatment form does not require RN signature to demonstrate that an RN completed the required "gross observation". In order to</p>	

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	<p>rib pain and was not present at 1647 hours (44 minutes after arrival; 3 times greater than the average time to triage).</p> <p>B. Patient #3 came in to the ED on 3-3-16 at 1403 hours with a complaint of mouth pain and was not present at 1506 hours (63 minutes after arrival; more than 4 times greater than the average time to triage).</p> <p>C. Patient #4 came in to the ED on 3-8-16 at 0358 hours with a chief complaint of nausea/vomiting and was not present at 0440 hours (43 minutes after arrival; 3 times greater than the average door to triage time).</p> <p>D. Patient #5 came in to the ED on 3-11-16 at 1512 hours with a chief complaint of flu with vomiting and was not present at 1632 hours (80 minutes after arrival; more than 5 times greater than the average door to triage time).</p> <p>4. Review of the MR for patient #s 2, 3, 4 &amp; 5 indicated a one-page document was prepared with the date and time of arrival, the name, age, and gender of the individual, and a chief complaint. No documentation indicated a triage category was established on arrival for each patient by a registered nurse and no other documentation (including an MSE) was present in the MR for each patient visit.</p> <p>5. On interview on 7-12-16 at 1550</p>		<p>clarify and improve the triage process, Policy 'Triage of Patients' 3.11.13 was revised to read as follows:</p> <p>1. For ambulatory patients presenting to the ED with the following conditions, ACS, neurological deficits, airway compromise, uncontrolled hemorrhaging, or possible loss of limb- immediately take back to ED treatment room.</p> <p>2. All other ambulatory patients presenting to the ED will receive a gross observation by a triage trained RN, documented by date, time, and signature on the ED Consent to Treatment form.</p> <p>3. At point of triage, an ESI level will be established as well as complete vital signs to be done by an RN.</p> <p>· The ED Director is educating all ED staff on the revision of the triage policy and process.</p> <p><b>2. How are you going to prevent the deficiency from recurring in the future?</b></p> <p>· In addition to providing education to all ED staff on the revised policy and process, the ED Director will monitor and track that this education was provided to all ED staff. After August 19, 2016, any ED staff member who has not received the education must complete it before he/she can work another shift.</p> <p>· Until ED staff have demonstrated full compliance</p>				

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NAME OF PROVIDER OR SUPPLIER  LUTHERAN HOSPITAL OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 7950 W JEFFERSON BLVD FORT WAYNE, IN 46804
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	hours, the quality manager, staff A37, confirmed that the MR documentation failed to indicate a triage assessment was documented as indicted above.		<p>with the process for 4 consecutivemonths, the ED Director is reviewing 100% of the Consent to Treatment formsweekly to confirm that patients were either immediately taken back to atreatment room or received the gross observation by the triage RN, whodocumented the observation with date, time, and signature on the Consent toTreatment forms. The ED Director alsocontinues ongoing monitoring of the LWBS log and of time from door to triage tocalculate average door to triage times and identify any trends. The Quality Manager is responsible forreporting the monitoring results monthly to the Quality Council, MEC, and Board.</p> <p><b>3. Who is going to be responsible for numbers 1 and 2above; i.e., director, supervisor, etc.?</b></p> <ul style="list-style-type: none"> <li>·The Director ofEmergency Services is responsible for the plan of correction.</li> </ul> <p><b>4. By what date are you going to have the deficiencycorrected?</b></p> <ul style="list-style-type: none"> <li>·The Policy 'Triageof Patients' 3.11.13 was revised on August 4, 2016 by the ED Director.</li> <li>·The ED Directorwill educate all ED staff to the revision of the triage policy and process byAugust 19, 2016. In addition to thoseactions, the hospital submits the following information:</li> </ul> <p>As noted bythe surveyor, more</p>	

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			than 4200 patients were seen in the ED during March 2016with an average door to Triage time of 14.38 minutes. The hospital submits that4 patient records reviewed out of a total of 21 records does not provide anaccurate appraisal of door to Triage times due to outlying cases and patientflow efforts at any given time. Furthermore, comparing a monthly average to theabsolutes listed in the 4 records does not provide the opportunity to draw anaccurate or reliable conclusion.		