PRINTED:	03/28/2020
FORM API	PROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 150017 B. WING 02/19/2020 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7950 W JEFFERSON BLVD LUTHERAN HOSPITAL OF INDIANA FORT WAYNE. IN 46804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE A 0000 Bldg. 00 The visit was for the investigation of a Federal A 0000 EMTALA Hospital complaint. Complaint Number: IN00319485 Unsubstantiated: Lack of sufficient evidence. Unrelated deficiency cited. Survey Date: 2/18-19/2020 Facility Number: 005016 QA: 3/3/2020 A 2400 489.20(l) COMPLIANCE WITH 489.24 Bldg. 00 [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. Based on document review and interview, the A 2400 This is addressed in the response 04/10/2020 facility failed to ensure a physician certification of for Tag S788. the risks and benefits of patient transfer to a facility with additional treatment capabilities was completed (see tag 2409) and failed to ensure copies of all medical records related to the presenting EMC (Emergency Medical Condition) were sent with the patient to the receiving facility (see tag 2409). Findings include: 1. See findings cited at 489.24(e)(1)(ii)(B) and 489.24(e)(2)(iii) A2409. A 2409 489.24(e)(1)-(2) APPROPRIATE TRANSFER Bldg. 00 (1) General

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150017	(X2) MULTIPLE CO A. BUILDING B. WING	DINSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/19/2020	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD / JEFFERSON BLVD	-	
LUTHER	AN HOSPITAL OF	INDIANA		WAYNE, IN 46804		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE COMPLETIO	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	emergency medi been stabilized (i this section), the the individual unl (i) The transfer is (within the mean section); and (ii)(A) The indivic person acting on requests the tran the hospital's obl and of the risk of The request mus the reasons for the	an appropriate transfer ing of paragraph (e)(2) of this lual (or a legally responsible the individual's behalf) sfer, after being informed of igations under this section transfer. t be in writing and indicate he request as well as or she is aware of the risks				
	section 1861(r)(1 certification that, available at the ti benefits reasona provision of appr another medical increased risks to case of a womar the unborn child, certification must risks and benefits (C) If a physician the emergency d individual is trans person (as detern bylaws or rules a certification desc	within the meaning of) of the Act) has signed a based upon the information me of transfer, the medical bly expected from the opriate medical treatment at facility outweigh the o the individual or, in the o the individual or, in the in labor, to the woman or from being transferred. The contain a summary of the s upon which it is based; or is not physically present in epartment at the time an sferred, a qualified medical mined by the hospital in its nd regulations) has signed a ribed in paragraph (e)(1)(ii)				
	defined in section	n after a physician (as n 1861(r)(1) of the Act) in the qualified medical				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/19/2020 150017 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7950 W JEFFERSON BLVD LUTHERAN HOSPITAL OF INDIANA FORT WAYNE. IN 46804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based. (2) A transfer to another medical facility will be appropriate only in those cases in which -(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child; (ii) The receiving facility (A) Has available space and gualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment. (iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e) (1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical Event ID: O4EG11 Facility ID: 005016 Page 3 of 14 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 150017	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING STREET ADDRESS, CITY, STATE, ZIR COL			e survey pleted 9/2020
	PROVIDER OR SUPPLIE			7950 V	ADDRESS, CITY, STATE, ZIP COD V JEFFERSON BLVD WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
IAG	records not read hospital's files) n practicable after (iv) The transfer personnel and tr required, includir medically approp during the transf Based on document facility failed to en- benefits and risks the written patient Emergency Depar to an accepting fau (MR) reviewed (P ensure copies of a presenting EMC (were sent with the for 1 of 20 MR re-	ily available from the nust be sent as soon as transfer; and is effected through qualified ansportation equipment, as ng the use of necessary and oriate life support measures er. nt review and interview, the nsure a physician certified the of patient transfer and obtained consent to transfer for tment (ED) patients transferring cility for 4 of 20 medical records atients #1, 5, 6 & 8) and failed to Il medical records related to the Emergency Medical Condition) patient to the receiving facility viewed (Patient #5).	A	2409	This is addressed in the refor Tag S788.	sponse	04/10/2020
	Medical Treatmer EMTALA (revise "Appropriate trans transferring hospit within its capacity risks to the individ transferring hospit hospital all medica related to the Eme includingtreatmer written consent of 2. Review of the p Care (TOC), Cont Transfer to Anoth	policy/procedure Emergency at and Patient Transfer - d 9-13) indicated the following: sfer occurs when 1) the cal provides medical treatment and capability that minimizes dual's health[and]3) the cal sends to the receiving al records (or copies thereof) rgency Medical Condition, ent provided and the informed certification required" policy/procedure Transition of inuity of Care Document (CCD) - er Facility and Patient d 6-19) indicated the following:					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/19/2020 150017 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7950 W JEFFERSON BLVD FORT WAYNE, IN 46804 LUTHERAN HOSPITAL OF INDIANA (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE "V. Transferring Patient to Another Facility or Hospital...G...If patient is being transported by stretcher/ambulance, have physician complete "Patient Transfer Form" (Emprint ER-3401-2) (aka Physician Certification Statement) ... " 3. Review of the document titled Patient Transfer Form ER-3401-2 (revised 10-19) indicated the following: "To Be Utilized for All Patient Transfers - Emergency and Non-Emergency Complete Sections A and B for All Patient Transfers. Complete Section C Only for Emergency Transfers...Section A...1. Appropriate medical records of the examination and treatment of the patient provided to the receiving facility at the time of transfer...Section B...Risks related to transfer acknowledgement...I acknowledge I have been informed of the above and agree to transfer by the mode determined by the physician... [and]...I have been informed by the physician that the medical benefits of transfer outweigh the risks...[followed by a blank space for a signature of the patient or patient's representative and date & time when signed]...Section C Additional Physician Documentation To Be Completed For Transfers From the Emergency Department and Labor & Delivery...Transfer of the patient to a hospital with additional capacity and/or capabilities is medically indicated...Check only one...The patient is being transferred because of failure, refusal, or inability of an on-call physician to respond...I certify that the medical benefits expected from the provision of appropriate medical care at another facility outweigh the increased risks to the individual...[followed by a blank space for the signature of the Transferring Physician] ... " 4. Review of the MR for Patient #5 indicated a copy of the [facility name] Critical Care Transport Event ID: O4EG11 Facility ID: 005016 Page 5 of 14 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 150017 B. WING 02/19/2020 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7950 W JEFFERSON BLVD LUTHERAN HOSPITAL OF INDIANA FORT WAYNE, IN 46804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Patient Signature Form (authorizing the financial responsibility for services provided) was signed on 11-22-19 by Family Member FM21 for Patient #5 and the patient was transferred to facility F075 on 11/22/19, and the MR lacked documentation of a Patient Transfer Form ER-3401-2 including documentation of the physician certification of the benefits and risks of patient transfer and/or the signed informed patient consent for transfer to facility F075 and/or an indication of the MR copies sent from facility F016 to the receiving facility F075. 5. On 2-19-2020 at 1205 hours, the Interim ED Director A4 confirmed the MR for Pt#5 lacked documentation of a Patient Transfer Form ER-3401-2 including a Physician Certification of Transfer Need, a signed Patient Consent for Transfer, or the MR copies sent with the patient to the accepting facility. 6. Review of the 8-9-19 MR for Patient #1. the 1-23-2020 MR for Patient #6, and the 12-9-19 MR for Patient #8 lacked documentation indicating a Patient Transfer Form ER-3401-2 was completed for each patient including documentation of the physician certification of the benefits and risks of patient transfer and/or a signed patient consent for transfer to the receiving facility F479. 7. On 2-19-2020 at 1205 hours, 1312 hours and 1346 hours, staff A4 confirmed the MRs for Patients #1, 6 & 8 lacked the indicated transfer documentation. S 0000 Bldg. 00 The visit was for the investigation of a State S 0000 hospital licensure complaint. O4EG11 Facility ID: 005016 Page 6 of 14 Event ID: If continuation sheet State Form

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 150017	A. BU B. WI		<u>00</u>	COMPLETED 02/19/2020
	PROVIDER OR SUPPLI			7950 W	ADDRESS, CITY, STATE, ZIP COD / JEFFERSON BLVD NAYNE, IN 46804	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETION DATE
	Complaint Numbo Unsubstantiated: Unrelated deficier	Lack of sufficient evidence.				
S 0788 Bldg. 00	document and co limited to, the fol (9) Copy of trans is referred to the	005016 A DRD SERVICES 4(i)(9) ervice records shall pontain, but not be lowing: effer form, if patient inpatient service tal. If care is not titient or if the d elsewhere, the				
	Based on docume facility failed to e physician certifica written consent fo accepting facility record (MR) for 4 5, 6 & 8). Findings include: 1. Review of the Medical Treatmer	nt review and interview, the nsure a transfer form including a tion of patient transfer and the r patient transfer to an was included in the medical of 20 MR reviewed (Patients #1, policy/procedure Emergency tt and Patient Transfer - d 9-13) indicated the following:	S 07	88	Tag S788 Medical RecordServices: Lack of TransferForm1.How are you going to correctthe deficiency? If alreadycorrected, include the steps taland the date ofcorrection.¿ On February 28, 2020 allEmergency Department (ED)Nursing staff received educationvia email regarding the Transfer	ken n

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		150017	B. WING		02/19/2020		
JAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD			
	RAN HOSPITAL OF			V JEFFERSON BLVD WAYNE, IN 46804			
	T		FORT	WATNE, IN 40804			
X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
REFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)			
TAG	1	R LSC IDENTIFYING INFORMATION	TAG		DATE		
		fer occurs when 1) the		Form and requirements for			
		al provides medical treatment		completion, including all section	ns		
		and capability that minimizes		of the form and for 100% of			
		ual's health[and]3) the		transfers. 100% of ED Nursing			
		al sends to the receiving		staff will have a personal			
		ll records (or copies thereof)		conversation with the Nurse			
		tment provided and the		Manager regarding transfer for	ms		
	informed written c	onsent of certification		and sign a roster attesting to			
	required "			understanding and competency	y of		
				the policy and requirement for			
	2. Review of the p	oolicy/procedure Transition of		transfer forms by March 27, 20	20.		
	Care (TOC), Cont	inuity of Care Document (CCD) -		¿ ED Provider education			
	Transfer to Another Facil	er Facility and Patient		regarding the Transfer form,			
		6-19) indicated the following:		including the physician			
		atient to Another Facility or		certification of patient transfer a	and		
	-	tient is being transported by		the written consent for patient			
		ce, have physician complete		transfer to an accepting facility,			
		Form" (Emprint ER-3401-2) (aka		will be added to the meeting	,		
	Physician Certifica			agenda of the April Emergency	,		
				Medicine Operations meeting.			
	3 Review of the c	locument titled Patient Transfer		These meeting minutes are sha	ared		
		revised 10-19) indicated the		with all Emergency Room			
		Utilized for All Patient Transfers		providers. (2400/A2409)			
	-	Non-Emergency Complete					
		for All Patient Transfers.		2. How are you going to prever	nt		
		C Only for Emergency		the deficiency from recurring in			
	· ·	A1. Appropriate medical		future?			
		nination and treatment of the			the		
		the receiving facility at the		¿ To prevent recurrence of deficiency, 100% of the transfe			
		ection BRisks related to		forms and checklist will be	'		
		Igement I acknowledge I have		audited. Monday through Frida	N .		
		he above and agree to transfer			у		
		nined by the physician		ED Manager or designee will complete the audits and provide			
	-				C		
		informed by the physician that ts of transfer outweigh the		immediate feedback to staff if			
		-		deviation is found. ED Charge			
	-	y blank space for a signature of		Nurses will audit 100% of the	.		
	· ·	ent's representative and date &		transfer forms on Saturday and			
		Section C Additional		Sunday and provide information	n to		
	-	entation To Be Completed For		the ED Manager for follow up.			
	Transfers From the	e Emergency Department and		Results will be reported to the			

Event ID: 04EG11 Facility ID: 005016

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	· /	E SURVEY LETED
		150017	B. WING		02/19/2020	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C V JEFFERSON BLVD	COD	
LUTHEF	RAN HOSPITAL OF	INDIANA		WAYNE, IN 46804		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S	RRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETIC DATE
TAG	Labor & Delivery. hospital with addit capabilities is med oneThe patient is failure, refusal, or to respondI certi expected from the medical care at and increased risks to the blank space for the Physician]" 4. Review of the I copy of the [facilit Patient Signature I responsibility for s on 11-22-19 by Fa #5 and the patient on 11/22/19, and t a Patient Transfer documentation of the benefits and rist the signed informed the receiving facilit 5. On 2-19-2020 a Emergency Depart MR for Pt#5 lackee Transfer Form ER Certification of Tr Patient Consent fo 6. Review of the S 1-23-2020 MR for for Patient #8 lack	Transfer of the patient to a ional capacity and/or ically indicatedCheck only s being transferred because of inability of an on-call physician fy that the medical benefits provision of appropriate other facility outweigh the the individual[followed by e signature of the Transferring MR for Patient #5 indicated a y name] Critical Care Transport Form (authorizing the financial services provided) was signed mily Member FM21 for Patient was transferred to facility F075 the MR lacked documentation of Form ER-3401-2 including the physician certification of sks of patient transfer and/or ed patient consent for transfer to ity F075. at 1205 hours, the Interim tment Director A4 confirmed the d documentation of a Patient -3401-2 including a Physician ansfer Need and/or a signed		Quality Council, Media Executive Committee Board of Trustees. until 100% compliance achieved for three cor- months. 3. Who is going to be for numbers 1 and 2 at ¿ ED Nursing Staf and auditing will be co- the ED Charge Nurse/ Manager/Director. The responsible for comple maintaining the audit of trending and addressi deviations and reportin Quality Council, Media Executive Committee Board of Trustees. ¿ The ED Provide will be presented to th Emergency Services 0 by the ED Director. 4. By what date are you have the deficiency co ¿ April 10, 2020	and the e is nsecutive responsible above? f Education ompleted by / ey will be eting and results, ng the ng results to cal and the r education e Committee	DATE
	including documen certification of the transfer and/or a si	intation of the physician benefits and risks of patient gned patient consent for iving facility F479.				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/19/2020	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 150017	A. BU B. WI	JILDING	00		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
LUTHEF	RAN HOSPITAL OF	INDIANA			/ JEFFERSON BLVD WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	 process (which inc Medical Treatment Patient Access and the patient is seen ED. 4. On 2-19-2020 a Quality Manager A lacked documentat Medical Treatment 	ludes the written Consent for t) is not completed by the l Registration staff until after by the medical provider in the at 1050 hours, staff A3 and the A5 confirmed the MR for Pt#5 ion indicating a Consent for t was signed by the patient or entative during the ED visit.			requirements for Consent to Tr and expectations for compliance ¿ To prevent recurring deficiencies, 20 charts will be audited per week for compliance with the current Consent to Tree process beginning March 28, 2020. Audits will continue until 100% compliance is obtained a maintained for 3 consecutive months. Results of the audit w be reported to the Quality Count Medical Executive Committees the Board of Trustees. on a monthly basis. ¿ Upon go live of new process, Patient Access Staff w be educated on the new process and expectations for compliance 3. Who is going to be responsis for numbers 1 and 2 above? ¿ Patient Access Manager will educate the Patient Accesss team regarding the completion the Consent for the Medical Treatment as well as complete audits. 4. By what date are you going have the deficiency corrected? ¿ April 12, 2020	ce. ce eat I and vill ncil, and will ss ce. ble s of the to	
1522 Ildg. 00	410 IAC 15-1.6-2 EMERGENCY SI 410 IAC 15-1.6-2	ERVICES					
	(b) The emergent the following:	cy service shall have					

State Form

Event ID: 04EG11 Facility ID: 005016

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/19/2020 150017 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7950 W JEFFERSON BLVD LUTHERAN HOSPITAL OF INDIANA FORT WAYNE. IN 46804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (5) Adequate gualified medical and nursing personnel available to meet the needs anticipated by the facility in accordance with 410 IAC 15-1.4-1 and 410 IAC 15-1.5-6, which includes. but is not limited to, the following: (A) A registered nurse on duty and available to patients presenting with an emergency condition, on a twenty-four (24) hour per day, seven (7) day per week basis. (B) A physician available at all times in accordance with 410 IAC 15-1.4 (d) (3) and attending to patients with an emergency condition. Tag S1522 Emergency Based upon document review and interview, the S 1522 04/10/2020 facility failed to ensure that a Registered Nurse Services: Qualified Medical (RN) was readily available to patients arriving to and Nursing Personnel to meet the emergency department (ED) with an Anticipated needs/Patients Left emergency condition for 2 of 20 medical records Prior to Triage (Lack of (MR) reviewed (Patients #15 & 17). Documentation) Findings include: 1. How are you going to correct the deficiency? If already 1. Review of the policy/procedure Staffing in the corrected, include the steps taken Emergency Department (approved 10-19) and the date of correction. indicated the following: "A six week work Upon review of staffing for schedule will be formulated by the Nurse Manager the day in question compared to (or designee) using an average number of policy "Staffing in the Emergency associates required to assure that all areas on all Department" it was discovered that shifts of Emergency Services are staffed...to there was no deficiency related to provide safe and adequate associate numbers to the staffing algorithm. The care for patients ... " deviations that were found were discovered to be timely 2. Review of the policy/procedure Triage of ED documentation of the disposition Patients (revised 5-19) indicated the following: of patients who left without being "Promptly identify patients requiring immediate, treated. This was noted by the definitive care according to the [ESI] Emergency surveyor at the time of survey. Event ID: O4EG11 Facility ID: 005016 Page 12 of 14 If continuation sheet State Form

03/28/2020

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	ILDING	ONSTRUCTION <u>00</u>	(X3) DATE S COMPL	ETED
		150017	B. WI	NG		02/19/	2020
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					V JEFFERSON BLVD		
LUTHEF	RAN HOSPITAL OF	INDIANA		FORT	WAYNE, IN 46804		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Severity Index (5 l	Level Triage) Ambulatory			¿ Education was provided	to	
		to the ED with the following			nursing staff regarding the		
	conditions: ACS (-			expectation of real-time		
		e immediately taken back to			documentation of the triage		
		Il other ambulatory patients			process and of the immediate		
		D will receive a gross			disposition of Left Without		
		iage trained RN documented			Treatment patients in an e-ma	il	
	-	signature on the consent to		dated February 28, 2020.			
	treat form."				ز 100% of ED Nursing sta	ff	
					will have a personal conversat	tion	
		inistrative documentation listing			with the ED Nurse Manager		
	-	t left before triage for the period			regarding the above noted em		
		u 1-31-2020 indicated the			Policy 3.16.32 ED- Assessme	nt	
	following:				and Reassessment, and real t		
		ne to the ED on 10-7-19 at 1332			documentation. They will sign		
		complaint of chest pain and			roster attesting to understandi	-	
	-	not present at 1415 hours (43			and competency of the policy	and	
	minutes after arriv	·			requirement for real time		
		ne to the ED on 12-9-19 at 1442			documentation by April 10, 20	20.	
		complaint of chest pain and					
		and was not present at 1636			2. How are you going to preve		
	hours (114 minute	s after arrival).			the deficiency from recurring in	n the	
					future?		
		MR for Patient #15 lacked			¿ Timely triage documenta	ation	
		licating the chief complaint			by ED Nursing staff will be	c .	
		el was established and/or a			assessed through the auditing	OT	
	-	was performed and/or lacked			20 charts weekly. The audit		
		t the patient was immediately atment room during the 43			results will be reported to the		
		ounter by the Registered Nurse			Quality Council, Medical Executive Committee and the		
	•	the ED Clinical Summary.			Board of Trustees each month		
	KIN02 Identified III	the ED Chincal Summary.			Board of Trustees each month		
	5 Review of the N	MR for Patient #17 lacked			3. Who is going to be respons	ihla	
		licating the chief complaint			for numbers 1 and 2 above?	ibic	
		el was established and/or a			ز The ED Director/Manage	er	
	-	was performed and/or lacked			will provide the verbal and writ		
		t the patient was immediately			education to the Emergency		
		atment room during the 114			Room Nursing staff.		
		ounter by the Registered Nurse			¿ The ED Manager or		
	_	the ED Clinical Summary.			designee will complete the tim	elv	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

				OMB NO. 0938-039
T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED
150017 B. WING		00	02/19/2020	
		7950 V	V JEFFERSON BLVD	
SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPR	
REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
			triage documentation audits	and
6. During an interv	iew on 2-19-2020 at 1835 hours		forward to the ED Director.	
and 1905 hours, the	ED Nurse Manager A3		¿ Results of the audit wil	ll be
confirmed the abov	e findings and confirmed no		reported to the Quality Coun	cil,
other documentatio	n was available.		Medical Executive Committee	e and
			the Board of Trustees on a	
			monthly basis.	
			4. By what date are you goir	ng to
			have the deficiency correcte	d?
			¿ April 10, 2020	
	DF CORRECTION ROVIDER OR SUPPLIEF AN HOSPITAL OF SUMMARY (EACH DEFICIEN REGULATORY OF 6. During an interv and 1905 hours, the confirmed the abov	OF CORRECTION IDENTIFICATION NUMBER	DF CORRECTION IDENTIFICATION NUMBER A. BUILDING 150017 B. WING ROVIDER OR SUPPLIER STREET AN HOSPITAL OF INDIANA FORT SUMMARY STATEMENT OF DEFICIENCIE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION TAG 6. During an interview on 2-19-2020 at 1835 hours and 1905 hours, the ED Nurse Manager A3 confirmed the above findings and confirmed no ID	DF CORRECTION IDENTIFICATION NUMBER A. BUILDING OO 150017 B. WING STREET ADDRESS, CITY, STATE, ZIP COD ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD AN HOSPITAL OF INDIANA SUMMARY STATEMENT OF DEFICIENCIE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDERS PLAN OF CORRECTION (EACH OFFICIENCY OR LSC IDENTIFYING INFORMATION) PREFIX 6. During an interview on 2-19-2020 at 1835 hours and 1905 hours, the ED Nurse Manager A3 confirmed the above findings and confirmed no other documentation was available. triage documentation audits forward to the ED Director. ¿ Results of the audit will reported to the Quality Courn Medical Executive Committee the Board of Trustees on a monthly basis. 4. By what date are you goir have the deficiency corrected

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