

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0000 Bldg. 00	<p>This visit was for investigation of one State hospital complaint.</p> <p>Complaint Number: IN00212528 Substantiated; state deficiency related to allegations is cited.</p> <p>Date: 10-17-16</p> <p>Facility Number: 003776</p> <p>QA: 10/20/16 JL</p>	S 0000		
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</p>			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/17/2016
NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>when care is needed which cannot be provided.</p> <p>Based on document review & interview, the facility failed to ensure that written policies and procedures governing immediate assessment of all patients presenting to the facility and documentation of patient visits to the Emergency Department (ED) was followed for 1 of 20 ED medical records (MR) reviewed. (Patient #1)</p> <p>Findings include:</p> <p>1. Review of policy/procedure Patient Transfer to Another Facility, EMTALA Compliance indicated the following; A. Individuals who come to the dedicated emergency department will receive a medical screening examination appropriate to their presenting signs and symptoms and consistent with the capability and capacity of the hospital to determine whether or not an emergency medical condition exists. This policy/procedure was last reviewed/revised on 12/13.</p> <p>2. On 10-17-16 at 1130 hours staff #40, 41 & 42 confirmed that patient #1 presented to the facility's emergency department (ED) on 09-20-16 for complaint of facial/head trauma, staff #44, triage registered nurse, indicated to</p>	S 1510	<p>1.How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.</p> <p>An action plan was developed in order to address the deficiency and the action plan included the following steps:</p> <p>1.All ED RNs, paramedics, and EMTs are to complete an updated IU Health West EMTALA electronic learning module that has been assigned to them.</p> <p>2.An EMTALA FAQ sheet will be sent to all unit secretaries in the ED.</p> <p>3.EMTALA will be discussed including a Q&A session in ED/Peds staff meetings in November.</p> <p>4.EMTALA overview will be included in daily ED huddles in October.</p> <p>5.EMTALA FAQ sheet will be discussed by the Patient Financial Navigator (PFN)/ Manager at PFN staff meetings in October and November.</p> <p>6.EMTALA PowerPoint was sent to all credentialed ED providers (MD, DO, NP, PA) via email. Proof of opening of the emails will be tallied to ensure all providers have received. Policy ADM 1.31 Patient Transfer to Another Facility,</p>	11/17/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>patient #1 should go to facility #2 and patient #1 left the facility.</p> <p>3. Review of policy/procedure Patient Transfer to Another Facility, EMTALA Compliance indicated the following; D. Documentation 1. The emergency rooms will keep a log of each patient presenting for medical care. This log will include whether the patient refused treatment, was transferred, admitted and treated, stabilized and transferred, or discharged. This policy/procedure was last reviewed/revised on 12/13.</p> <p>4. On 10-17-16 at 1130 hours staff #40, 41 & 42 confirmed that patient #1 presented to the facility's emergency department (ED) on 09-20-16 for complaint of facial/head trauma and patient #1's name was not present on the ED's Log Book.</p> <p>5. Review of the ED Log lacked documentation that patient #1 presented to the facility on 09-20-16.</p>		<p>EMTALA Compliance was revised and approved to include more robust information around appropriate patient transfers including criteria for transfer to another facility, the procedure for appropriate transfer, and any exceptions (yellow highlighted content in uploaded policy).</p> <p>1.How are you going to prevent the deficiency from recurring in the future?</p> <p>1.Audits will be conducted to ensure compliance. Initially, five (5) audits per week will be conducted of ED patients to identify any inconsistencies with medical screening exams (MSEs) or transfer documentation. After a period of 12 weeks or 90 days at 100% compliance, audits will be reduced to five (5) per month. Data from audits will be shared at ED staff meetings and the IU West Quality Council with appropriate corrective actions taken as needed. EMTALA education is currently part of ED staff onboarding and the components of education include EMTALA guidelines for ED. EMTALA education is also on their Competency Assessment Tool and completion of education is signed off by their preceptor. EMTALA is covered in the 5th</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>day of Cerner training for PFNs that each new PFN hire goes through. The 5th day is specific to ED and covers all elements of EMTALA.</p> <p>1. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.?</p> <p>The Director of the Emergency Department will ultimately be responsible for ensuring the above actions are completed.</p> <p>2. By what date are you going to have the deficiency corrected?</p> <p>1. You must provide a specific date the deficiency will be or has been corrected (month, day, and year) in the "Completion Date" column. The maximum correction time allowed is thirty (30) days from the date of the survey.</p> <p>All education will be completed by EOB November 17, 2016. The electronic learning module for nursing staff, paramedics and EMTs has a due date of November 17 for completion and the provider education PowerPoint review is also due by November 17. The ED staff meetings take place on November 11 and 17. 100% of ED secretaries and PFN's will have reviewed the EMTALA</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>FAQ sheet by November 17th.</p> <p>2.If the nature of the deficiency precludes completion within the above-stated thirty (30) days, the Plan of Correction must be written in incremental thirty (30) day phase.</p> <p>11/9/16 ADDENDUM TO PLAN OF CORRECTION</p> <p>EMTALA education is currently part of ED staff onboarding process and the components of education include EMTALA guidelines for ED. EMTALA education is also on their Competency Assessment Tool and completion of education is signed off by their preceptor. EMTALA is covered in the 5th day of Cerner training for Patient Financial Navigators (PFN) that each new Patient Financial Navigation (PFN) hire goes through. The 5th day is specific to ED and covers all elements of EMTALA.</p> <p>Audits will be conducted to ensure compliance. Initially, five (5) audits per week will be conducted. A designated observer will watch the triage</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150158	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER IU HEALTH WEST HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1111 N RONALD REAGAN PKWY AVON, IN 46123
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>and registration of five (5) patients presenting to the ED for the treatment of a medical condition. Following discharge of the five (5) patients observed, an audit of their records will be conducted to identify any inconsistencies with medical screening exams (MSEs) and transfer documentation. The observation and log audits will ensure that each audited patient appears on the log with appropriate, accurate, and comprehensive documentation of all required log elements. After a period of 12 weeks or 90 days at 100% compliance, audits will be reduced to five (5) per month. Data from audits will be shared at ED staff meetings and the IU West Quality Council with appropriate corrective actions taken as needed.</p>	