PRINTED: 8/24/2017 FORM APPROVED 2567-L

	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
	390256			00	07/14/2017		
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0000	This report is the result investigation (HBG17, 2017 and completed or Hershey Medical Centracility was not in comfacility was not in comfacility as not in comfacility as not in comfacility as not in comfacility was not in comfaci	A000H) initiated on a May 4, 2017, at Mi er. It was determined pliance with the requart 482-Conditions o	May 3, ilton S I the uirements	A 0000			
LABORATOPV	DIRECTOR'S OR PROVIDER/SUPPLI	FR REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION: (X3) DATE SUR COMPLETED: A. BLDG:00 B. WING: 07/14/2017			EY					
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		CENTER, THE	STREET ADDRESS, CITY, STATE, ZIP CODE: 500 UNIVERSITY DRIVE P.O. BOX 850 HERSHEY, PA 17033						
(X4) ID PREFIX TAG	MUST BE PRECEED	T OF DEFICIENCIES (EACH DE DED BY FULL REGULATORY OF TIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
A 0020	Continued from page 1 482.11 COMPLIANCE W Compliance with Federal, This REQUIREMENT is a	State and Local Laws		A 0020	1. On April 21, 2017, the Medical Center (HMC) patic officer (PSO) assigned to all intensive care unit (NICU) employees (providers, nurse support staff) a required lear management system course to completed within 30 days. To course content describes tim reporting of patient safety exthe HMC expectations of Pa Safety Event Reporting, and methods to report, and refere the policy "Patient Safety Ex Reporting A-09 HAM." Cour completion is tracked by the nurse manager and NICU medirector in the electronic lear management system. Failure complete this required cours result in the application of the progressive discipline processive discipline processive the Pennsylvania Pat Safety Authority's Program Memorandum # 2015-02: Interpretation of the Definiti	ent safety I neonatal s and ming to be The ely vents, tient the ences enter NICU edical rning e to be will he ess. PSO and staff will ient	Completion Date: 08/23/2017 Status: APPROVED Date: 08/02/2017		

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	Y
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A 0020	Continued from page 2			A 0020	Serious Events Used by the PA-PSRS Analysts and the associated e-learning. The Paramonitor for the memorandur and e-learning completion by patient safety specialist staff Evidence of completion will documented in each patient specialist's personnel file. Far complete the assignments within the application of the program of the executive officer (CEO) will compliance report and ensure successful completion of the education. 3. By August 1, 2017, the send a "Safety Alert" from the of the Dean & CEO to all History employees stressing the important requirements of timely experting of patient safety evand mandated child abuse results. 4. By August 4, 2017, the	m review y all be safety nilure to ill result gressive C chief I receive a e CEO will the Office MC ortance event vents porting.	
					policy "Child Abuse Reporti Care L-16" will be revised to guidance that relevant medic	o include	

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		A. BLDG: _	IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 07/14/2017	ΞY
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A 0020	Continued from page 3			A 0020	summaries or reports of phot or X-rays taken shall be subr with the CY47 form. An elect link to the CY47 form will be directly in the policy "Child Reporting and Care L-16". 5. By August 23, 2017, all providers and staff will comprequired electronic learning of with content describing time reporting of suspected child to ChildLine, which includes documentation within 48 hot specifically outlined by HMG "Child Abuse Reporting and L-16". Course completion with tracked by the NICU nurse in and NICU medical director. complete this required course result in the application of the progressive discipline processive discipline	mitted ctronic de created Abuse I NICU plete a course ely abuse s CY47 urs C policy Care fill be manager Failure to e will ne	

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		(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER 390256		(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 07/14/2017	EY
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A 0020	Based on review of factorecords (MR), and staff determined the facility and federal laws: Milton S Hershey Medicompliance with the formaliance with the formaliance with the formaliance with the factore facility shall report the tothe department and to of the medical facility occurrence of the serior department and the automanner prescribed by the with the department and of any patient or any of information. (b) Incides shall report the occurre authority in a formand.	finterview (EMP), if failed to conform to failed the failed to conform to failed the failed to conform to failed the failed to conformation of the failed the failed to conformation of the failed the failed to conform to conform to constant the failed to conform to con	t was all state in ion of nedical ous event 24 hours t to the form and ultation he name vidual al facility o the	A 0020			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
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A 0020	Continued from page 5			A 0020			
	authority and shall not patient or any other incompatient or any other incompatient or any other incompatient or any other incompatient or any other incomposition of the occurrence of the department within facility's confirmation of the infrastructure fact department shall be in prescribed by the department shall be in prescribed by the department of the county against th	dividual information. eports. A medical far of an infrastructure far 24 hours of the medical far of the occurrence or ilure. The report to the form and manner the form and manner the far and the form and manner the far and	cility shall ailure to ical discovery the r , 23				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
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A 0020	subject of a report and, that a radiological exartests of the child are peror or report of photograph sent to the county agent report is sent, or as soon. This is not met as evident Findings include: A review on May 3, 20 Safety Event Reporting revealed "All events, reported through the Element of the county agent is sent, or as soon.	mination and other merformed. A medical his or X-rays taken sharp at the time the without the reafter as possion thereafter as possion. 117, of facility policy g," effective January including incidents, lectronic Patient Saf	y "Patient 2017, must be fety Event	A 0020			
	as reasonably practicals 24 hours after the even Further review of the p of an incident, a seriou failure as defined by A	ole, but in no event later or discovery of the colicy, revealed the colors event, and an infra	event"				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
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PREFIX MUST BE PRECEEDI	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEI MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
"Incident." An event, of involving the clinical of facility which could had not either cause an unathe delivery of addition patient" Serious eventiation involving the medical facility that repatient safety and resurequiring the delivery eservices to the patient. undesirable or unintensituation involving the facility or the disconting of a service which coupatient. A review of facility do Improvement Plan, efformIt shall be the response immediately notify the and notify the Patient Sevent or situation that event or situation that	care of a patient in a ave injured the patient inticipated injury or nal health care service rent." An event, occur clinical care of a passults in death or combits in an unanticipate of additional health of a infrastructure of a nuation or significant ld seriously comprosed to the company of the	medical nt but did require ces to the urrence or tient in a npromises ed injury care re." An ce or nedical t disruption mise ce revealed artment to ent Safety y unusual	A 0020			

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 390256		(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVEY COMPLETED: 07/14/2017	
NAME OF PRO	VIDER OR SUPPLIER:	390250	STREET ADDRESS				
	S. HERSHEY MEDICAL C	ENTER, THE	500 UNIVERS				
CTATE LICENIC	e number: 135101		P.O. BOX 850				
STATE LICENS	E NUMBER. 133101		HERSHEY, P	A 17033			
(X4) ID		OF DEFICIENCIES (EACH DE		ID	PROVIDER'S PLAN OF CORRE	`	(X5)
PREFIX TAG		ED BY FULL REGULATORY O FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SE CROSS-REFERENCED TO THE		COMPLETE DATE
A 0020	Continued from page 8						
A 0020	Continued from page 8			A 0020			
	Patient Safety Officer,	or designee, notifies	the				
	CMO, and others as in	dicated. An investiga	ation of				
	the event is performed	to determine confirm	nation of				
	a sentinel event, seriou	is event or incident	.Specific				
	to DOH, Act 13 and A	ct 52 reporting requi	rements:				
	Serious events and infr		ill be				
	reported to the DOH w						
	confirmation of occurr	ence via the Pennsyl	vania				
	Patient Safety Reporting	ng System. Serious e	vents will				
	be reported to the Patie						
	hours of confirmation						
	Pennsylvania Patient S	afety Reporting Sys	tem"				
	A review on May 3, 20	017, of MR1 NICU					
	Interdisciplinary Narra	tive dated April 16,	2017				
	revealed "Focused asse	essment completed-r	10				
	changes since last asse	ssment-infant comfo	ortable				
	and not fussy. Went to	bed #10 to help that	mom				
	breast feed. Could hear	r infant crying very l	oudly.				
	Asked mom if that was	s him crying. Mom t	hen asked				
	that I come to the beds	ide because there wa	as				
	something wrong with	infants arm. She sta	ted that it				
	was limp. When this n	urse look at arm it w	ras				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390256			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 07/14/2017	ΞY
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limp-the right arm was a laid by his side. Then he and cried out in pain. The discoloredThe infant or discomfort during the (name redacted) to infants arm". She agreed with the arm and ordere immobilize the arm as the holding him and he has given per order." A fract radius was confirmed via A review of the facility facility failed to report the Pennsylvania State Reported the unwitnesse had not caused harm to on April 28, 2017 indicated described as infrastructured facility documentation in accurately report the injection.	he raised his arm up, he site was not swoldid not show and s/se 1200 or 1500 asse the bedside to look d that there was a pred a X-ray. Will conthis soothes him. More fallen asleep after the trure of the left ulnatia x-ray on April 16 documentation reverthe above event to the orting System (PSR 28, 2017. The facilitied fracture as an incitate patient. A secondated the fracture was ure failure. A review revealed the facility	grimaced llen or s of pain essment. at roblem ntinue to om is also tylenol was and 5, 2017. ealed the he RS), until ty first ident that nd report as w of r failed to	A 0020			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER. 390256			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 07/14/2017	
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A 0020	event. A review of facility en April 30, 2017 reveale As an update, CYS wa 29, 2017). We worked attached safety plan fo stay (medical record # email transmission). L also here with us late I we had spoken with you An interview conducte AM with EMP5 and E failed to follow the Me Reduction of Error Ac Improvement Plan and April 28, 2017. EMP5 no event report on this have been reported improvement via telephor reported. An interview conducted.	d, " as here on Saturday (a with them to develous the duration of the redacted for purpose ocal police detective Friday (April 28, 201 ou and called them' and MP16 confirmed the edical Care Availability and the Performance I report the serious ever further stated, "There particular case." "It mediately." EMP16 he that it should have	April p the patient's e of s were 7) after " t 10:40 e facility lity and ee vent until re was should	A 0020			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
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A 0020	Continued from page 11			A 0020			
	PM with EMP1 reveals provide documentation a medical summary or X-rays taken was sent required by the The Ch	that a written repor report of photograph to the county agency	t and /or ns or as				
A 0057				A 0057			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	t:			(X3) DATE SURVEY COMPLETED:	
		390256		1		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION) A 0057 Continued from page 12 482.12(b) CHIEF EXECUTIVE OFFICER The governing body must appoint a chief executive who is responsible for managing the hospital. This REQUIREMENT is not met as evidenced by:		STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	B. WING: CITY, STATE, Z SITY DRIVI	IP CODE:	O7/14/2017 CTION (EACH DULD BE APPROPRIATE Hershey f Liality he he he	Completion Date: 08/23/2017 Status: APPROVED Date: 08/01/2017	
					Authority's Program Memora 2015-02: Interpretation of the Definition of Serious Events by the PA-PSRS Analysts an associated e-learning. The Correceive a compliance report a ensure successful completion education. 2. By August 1, 2017, the send a "Safety Alert" from the of the Dean & CEO to all HM employees stressing the important and requirements of timely ereporting of patient safety even and mandated child abuse results. 3. By August, 23, 2017, the conjunction with the CQO woversee the implementation oplans of correction related to	Used and the EO will and an of the CEO will are Office MC portance event eents porting.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
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A 0057	Continued from page 13			Department of Health site survey conducted on May 3 and 4, 2017, concerning compliance with the Pennsylvania MCARE law and Child Protective Services law. The CEO will receive ongoing updates from the CQO on plans of correction progress and will ensure timely completion. 4. Beginning August 23, 2017, the CEO will receive monthly updates from the CQO on serious safety events and the associated PA-PSRS submission-timeframe reports that will be generated by the patient safety officer.		2017, the and Child c CEO s from ion ely 2017, the pdates fety A-PSRS ts that		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
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A 0057	Continued from page 14		A 0057				
	Based on review of facility documents, med records (MR), and staff interview (EMP), it determined the CEO failed to ensure implent of facility policy and state law (The Medical Availability and Reduction of Error Act, 40 1303.101 et seq. and CPSL-The Child Prote Services Law, 23 Pa.C.S. § § 6301. This is not met as evidenced by: Findings include: A review on May 3, 2017, of the facility's "It of Penn State Health," adopted April 1, 2013 revealed "Section 4.8. President/CEO. The President/CEO shall supervise the implementall policies, order, and resolutions of the Box Directors and shall execute all contracts and agreements authorized by the Board of Directors the Corporation the power to execute contract the ordinary course of business or as otherw		t was mentation al Care 0 P.S. § mective "Bylaws 15, ne entation of oard of d ectors, ficers of eacts in				

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A 0057	A review of the Medic reduction of Error Act facility shall report the to the department and to of the medical facility's occurrence of the serio Child Protective Servic "required reporters. In make, required reporters. In make, required reporter child abuse to ChildLine make a written report of Department to the cour where the suspected child A review on May 3, 20 Abuse Reporting And December 2016, reveal shall be made for: An independently mobile of the serior of the seri	indicates that "A me occurrence of a seriche authority within as confirmation of the us event". A review ces Law indicates the addition to other represent shall report suspense". "within 48 hours, a required reported on forms provided by the agency in the confild abuse occurred" Ol7, of the facility's "Care" policy effective ded "A consult to the organization of the solution of the facility of the facili	edical ous event 24 hours e of the at ports they eted rs of shall y the unty "." "Child ye he CPT	A 0057						

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NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
A 0057	A review on May 3, 20 Interdisciplinary Narra EMP8 documented, "F completed-no changes comfortable and not fut that mom breast feed. Or loudly. Asked mom if then asked that I come was something wrong that it was limp. When limp-the right arm was laid by his side. Then hand cried out in pain. The discolored" A fracture was confirmed via x-ray A review on May 3, 20 Interdisciplinary Narra EMP17 documented, "nurse about pt's arm fraspent time speaking with not made aware of this attending and she indicate."	tive dated April 16, ocused assessment since last assessment say. Went to bed #10 Could hear infant cry that was him crying, to the bedside because with infants arm. She this nurse look at ar moving but his left he raised his arm up, the site was not swo to of the left ulna and any on April 16, 2017 and 17, of MR1 NICU tive dated April 18, SW updated by beds acture and that nurse the parents at length, incident. SW spoke	nt-infant 0 to help lying very Mom lise there le stated lim it was ligrimaced lilen or li radius . 2017: liside li manager SW was	A 0057			

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· /		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 390256			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P	SITY DRIVI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE .	OULD BE	(X5) COMPLETE DATE	
A 0057	investigated and that the CPT team at this time of about how injury occur or injury inflicted by purse manager {name is she was involved sever her perception from sputhis was not an injury if asked {name redacted} that they are not involved further discuss with me CPT was not formally. The facility failed to for Reporting and Care Pour to refer this injury to the manner for discussion. An interview conducted PM with EMP12 reveal for a fracture. I've never be something forceful was caused by "bending the property of the something forceful was caused by "bending the property of the p	even though there is red and if this was a arents. SW spoke furedacted} and she stral partied to investige eaking with parents inflicted by parents. It about CPT and she wed at this point. SW ed. team during social consulted until May believe as evidenced the CPT team in a time and investigation. Indicate the control of the control o	question a nursing rther with ated that gate and was that SW also e stated will al rounds." 3, 2017. e e failure nely t 12:30 al place t had to e fracture	A 0057			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER 390256			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 07/14/2017		
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		ENTER, THE	STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
A 0057	reviewed the x-ray wit confirmed the results we fractures included two the left radius. "Certain baby. It didn't happen for out to be related to There was no callous for revealed when asked if EMP12 stated "I can't asked if MR1 came the Department would child EMP12 stated "yes." A review of the facility facility reported the about to the Pennsylvania State (PSRS), 12 days after the was submitted as an infrast 2017 at 17:38 with a Nation facility documentation data base revealed the	on the left ulna and ally someone did harm from routine care. It birth trauma. It was formation." Further it child abuse was sustemment on that." Very the Emergency of the Emergency of the Emergency of the Emergency over event on April 2 ate Reporting System the event. The first recident on 4/28/2017 A second report was ructure failure on April 2 of Harm Score. A read the Department	The one on m to the was too new. interview spected When y d? ealed the 28, 2017, n eport at 05:30 as oril 28, eview of of Health	A 0057			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER.		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 07/14/2017	
MILTON	NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES)		STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
A 0057	Continued from page 19		A 0057				
	Performance Improver injury to MR1 within 2 investigate the injury at Cross reference with: 482.11 Compliance wi	24 hours and classify s a serious event.					

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 07/14/2017	
MILTON S	VIDER OR SUPPLIER: 5. HERSHEY MEDICAL C E NUMBER: 135101	<u> </u>	STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIV			
(X4) ID PREFIX TAG	EFIX MUST BE PRECEEDED BY FULL REGULATORY (TAG IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
A 0057	Continued from page 20			A 0057			
A 0115				A 0115			

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		390256				07/14/2017	
MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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		
A 0115	Continued from page 21 482.13 PATIENT RIGHTS A hospital must protect and This REQUIREMENT is n	promote each patient's		A 0115	1. By August 1, 2017, the Medical Center (HMC) Chile Protection Team medical dir be responsible to review and the HMC policy "Child Abus Reporting and Care L-16" to and ensure federal, state, and laws are upheld. 2. By August 1, 2017, the chief executive officer (CEO send a "Safety Alert" from the of the Dean & CEO to all HM employees stressing the important requirements of timely experience of patient safety experience and mandated child abuse results. 3. By August 23, 2017, all intensive care unit (NICU) pand staff will complete a requirement describing timely report suspected child abuse to	d ector will revise se verify flocal HMC o) will ne Office MC ortance event rents porting. I neonatal roviders uired ith porting	Completion Date: 08/23/2017 Status: APPROVED Date: 08/01/2017
					ChildLine, which includes C documentation within 48 hor specifically outlined by the I policy "Child Abuse Reporti Care L-16". Course complete	ars HMC ng and	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	R:		PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	ΣΥ
		390256		B. WING:		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0115	Continued from page 22			A 0115	be tracked by the NICU nurs manager and NICU medical Failure to complete this requ course will result in the appl of the progressive discipline process.	director. iired ication	

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		(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER 390256	R:		PLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED: 07/14/2017	ΞY
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
A 0115	Continued from page 23		A 0115				
	Based on a review of facility documents and records (MR), and staff interviews (EMP), it determined that the facility failed to ensure protection and promotion of the rights of parand failed to provide care in a safe setting for one medical record reviewed (MR1) Findings include: A review of facility policy "Child Abuse Reffective December 2016, revealed "nothing law requires the mandated reporter to identify person responsible for the child abuse to marreport of suspected child abuseClinical In of Possible Physical AbuseAny fracture in infant < 12 months, especially one who is is mobileWhen there is "reasonable cause to suspect" abuse, the Mandated Reported MU immediately call ChildLine to make an oral (1-800-932-0312), available 24 hours a day days a yearAfter the oral report to ChildL mandated reporter shall also submit a written		it was the atients for one of eporting" g in the aify the ake a ndicators n an s not to UST 1 report 7 365 Line, a				

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 390256		(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 07/14/2017	EY
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIV			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
A 0115	Team) consult shall no substitute for a mandat to ChildLine and other there is reasonable suspolicePennsylvania I hospital/medical perso state police any injurie means. Accordingly, cabuseshall be reported ChildLine and to the agand Youth Services agand A review on May 3, 20 Interdisciplinary Narra revealed "Focused assectanges since last assectanges since last assectand not fussy. Went to breast feed. Could hear Asked mom if that was that I come to the beds something wrong with was limp. When this milimp-the right arm was	red reporter to make appropriate authority picion of abuseRepaw requires tht nnel report to the locus resulting from crime cases of suspected check to the police in adappropriate county Clency" 117, of MR1 NICU tive dated April 16, essment completed-ressment-infant comforts bed #10 to help that are infant crying very less him crying. Mom to ide because there was infants arm. She staturse look at arm it were warred to the staturse look at arm it were as well as him crying at a many control of the staturse look at arm it were appropriate authority as him crying.	a report ties when port to cal or minal mild dition to mildren 2017 no ortable a mom oudly, hen asked as ted that it eas	A 0115			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTI A. BLDG: _ B. WING: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 07/14/2017	
MILTON	OVIDER OR SUPPLIER: S. HERSHEY MEDICAL O SE NUMBER: 135101	CENTER, THE	STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P	SITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEED IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE	
A 0115	layed by his side. Ther grimaced and cried ou swollen or discolored. s/s of pain or discomfor assessment (name look at infants arm. Shiproblem with the arm continue to immobilize Mom is also holding hafter tylenol was given left ulna and radius was 16, 2017. An interview conducted PM with EMP1 and arm May 5, 2017, at 11:00 failed to immediately or report about the existed MR1. MR1 is an infant defined by the facility' Policy, this injury shou interview also confirm submit a written report or report of photograp.	t in pain. The site was. The infant did not so out during the 1200 of the redacted) to the bedue agreed that there was and ordered a X-ray. The the arm as this soot im and he has fallen a per order." A fractual as confirmed via x-ray and on May 4, 2017, an interview with EMI AM, revealed the factall ChildLine to mall child and the confirmed via x-ray and the x-ray and x-r	how and r 1500 dside to was a Will thes him. asleep are of the yon April t 1:00 P 10 on cility ke an oral njury to rage. As rting buse. The niled to ammary	A 0115			

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 07/14/2017	ΞY
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
A 0115	county agency at the ti submitted to ChildLine The facility's failure to complete a timely inve by MR1 placed this path Cross reference with: 482.13(a)(2) Patient R 482.13(c)(3) Patient R Abuse/Harrassment	recognize, report, and stigation of the injurtient and others in jettights: Grievances	nd ry suffered	A 0115			

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			(X2) MULTIPLE CONSTRUCTION: A BLDG: 00		(X3) DATE SURVEY COMPLETED:	
	390256				07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			ITY DRIVI			
			ID PREFIX TAG	CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE DATE
Continued from page 27			A 0115			
			A 0118			
	VIDER OR SUPPLIER: 5. HERSHEY MEDICAL C E NUMBER: 135101 SUMMARY STATEMENT MUST BE PRECEEDE IDENTII	RECTION (POC) IDENTIFICATION NUMBER 390256 VIDER OR SUPPLIER: 5. HERSHEY MEDICAL CENTER, THE E NUMBER: 135101 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)	ASSECTION (POC) IDENTIFICATION NUMBER: 390256 VIDER OR SUPPLIER: 5. HERSHEY MEDICAL CENTER, THE E NUMBER: 135101 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	RECTION (POC) IDENTIFICATION NUMBER: 390256 STREET ADDRESS, CITY, STATE, Z 500 UNIVERSITY DRIVI P.O. BOX 850 HERSHEY, PA 17033 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 27 A. BLDG: B. WING: A. BLDG: B. WING: A. BLDG: B. WING: A. BLDG: B. WING: POOL OF THE PROPERTY OF LEAD A. BLDG: B. WING: A. BLDG: B. WING: B. WING: A. BLDG: B. WING: B. WING: A. DITY OF THE PROPERTY OF LARGE AND ADDRESS, CITY, STATE, Z SOO UNIVERSITY DRIVI P.O. BOX 850 HERSHEY, PA 17033 A 0115	RECTION (POC) IDENTIFICATION NUMBER: 390256 A. BLDG:00	RECTION (POC) IDENTIFICATION NUMBER: 390256 A. BLDG: _00 _ B. WING: 07/14/2017 STREET ADDRESS, CITY, STATE, ZIP CODE: 500 UNIVERSITY DRIVE P.O. BOX 850 HERSHEY, PA 17033 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH CORSS-REFERENCED TO THE APPROPRIATE CONTINUED FROM THE PROPRIATE CONT

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		390256		1		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES)		STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P	SITY DRIVI		CTION (EACH	(X5)	
PREFIX TAG	MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			PREFIX TAG CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		OULD BE	COMPLETE DATE
A 0118	Continued from page 28 482.13(a)(2) PATIENT RIGHTHM The hospital must establish of patient grievances and meto contact to file a grievance. This REQUIREMENT is meaning the second seco	a process for prompt re nust inform each patient ee.		A 0118	1. By August 1, 2017, the Medical Center (HMC) chie executive officer (CEO) will "Safety Alert" from the Offic Dean & CEO to all HMC enstressing the importance and requirements of the grievance resolution and investigation process. 2. By August 4, 2017, the director of patient experience review and revise the HMC "Resolution of Patient Compand Grievances PC-25" to old grievance resolution and investigation process. 3. By August 23, 2017, all intensive care unit (NICU) pand staff will complete a required electronic learning course we content describing the grievaresolution process. Course completion will be tracked by NICU nurse manager and Nimedical director. Failure to of this required course will result application of the progressive	f I send a ce of the inployees HMC e will policy plaints arify the I neonatal providers quired ith innce hy the ICU complete alt in the	Completion Date: 08/23/2017 Status: APPROVED Date: 08/01/2017

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER				PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY	
		390256			<u></u>	07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIEN MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0118	Continued from page 29			A 0118			
					discipline process.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER					(X3) DATE SURVE COMPLETED:	(X3) DATE SURVEY COMPLETED:	
		390256		B. WING: _		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	SITY DRIVI			
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
A 0118	Continued from page 30			A 0118			
	Based on review of factorecords (MR), and staff determined that the factorinvestigate a patient's findings include: This is not met as evided. This is not met as evided. This is not met as evided. A review of facility pool "Resolution of Patient effective November 20 patient grievance is a fiverbal complaint that it patient, or the patient's patient's care (when the time of the complaint that the time of the complaint that it patient, issues of Particular Medicare beneficiary to Relations, Quality, Patient's care department of the complaint that it patient is care (when the time	finterview (EMP), is called to recognize amily members concerned by: licy on May 3, 2017 Complaints And Grie of the complaints of the hospital or informal was made to the hospital representative, regate complaint is not resint by staff present), cipation (CoP's), or is concerned to the complaintThe ient Safety and Risk ents will meet weekly	t was nize and cerns as a a, revealed fevances evance: A ritten or al by a rding the solved at abuse or is a the Patient y to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBE 390256				PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 07/14/2017	ΞY	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE .	OULD BE	(X5) COMPLETE DATE	
A 0118	Committee for the Med 7 days for the response appropriate. However, that endanger the patie will be reviewed immed of the allegations and to patient" A review on May 3, 21 2017, revealed "I receed 4/17/2017 when I arrive 4/16/2017 in the late endanger the patient that day. To follow up with the famous recovery process as we what may have happend email revealed "I had a (name redacted) fine at 12(12:00 PM) at 15 (15:00 PM) then left called me over to bed so limpordered an XRA fractures	e of most grievances grievances about sit nt, such as neglect or ediately, given the seche potential for harman 107, of email dated Meived the below email ed to work. It was weening by the RN can his email prompted in the grieven odd thing happen to a CCN bed# 9, infarrand when I assessed in to help bed # 10 are sayin his arm was	is cuations or abuse, criousness in to the May 1, ail on written in cring for me to be on as to of the oday with int was him at and mom	A 0118			

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
		390256		B. WING: _		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			500 UNIVERS P.O. BOX 850 HERSHEY, P	SITY DRIVI			
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
A 0118	Further review of the edocumented concerns voiced on April 16, 20 described a nurse as behad stated that they did to care for their baby a conducted on May 3, 2 EMP7 revealed when I grievances/complaints by saying that when pathey triage them and tanurse. EMP7 was asked concerns were resolved grievance wouldn't have responded, "No, there resolution. The fracture "Patient Relations Worgrievance was not door three days after it was Cross reference with:	that the patient's fame in 17. The patient's fare ing rough with patient's many rough with patient't want that particularly many and interview in 1:30 PM with EMP7 was asked about a sked about the unit, they respond to the unit, they respond if MR1's mother's and if MR1's mother's and to the point where we to be entered. The was not immediate the still exists." Review the sked that the unital April 2 was a still exists.	nily mily ents and lar nurse w h out ponded through nd the a ey w of the this	A 0118			

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390256		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
A 0118	Continued from page 33			A 0118			
	482.13 Patient Rights						

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 07/14/2017			
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, CITY, STATE, ZIP CODE: 500 UNIVERSITY DRIVE P.O. BOX 850 HERSHEY, PA 17033						
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI								
A 0118	Continued from page 34			A 0118					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED:		
		390256		B. WING:	<u></u>	07/14/2017	
MILTON S. HERSHEY MEDICAL CENTER, THE			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
A 0118	Continued from page 35			A 0118			
A 0145				A 0145			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION: (X3) DATE SURVE COMPLETED: A. BLDG: _00 B. WING: 07/14/2017		EY					
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH D		EENTER, THE	STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI			
(X4) ID PREFIX TAG	MUST BE PRECEED.	F OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		OULD BE	(X5) COMPLETE DATE
A 0145	Continued from page 36 482.13(c)(3) PATIENT RI ABUSE/HARASSMENT The patient has the right to or harassment. This REQUIREMENT is r	be free from all forms o		A 0145	1. By August 1, 2017, the Medical Center (HMC) chief executive officer (CEO) will "Safety Alert" from the Office Dean & CEO to all HMC emstressing the importance and requirements of timely event reporting of patient safety event and mandated child abuse regard mandated child abuse regard "Care L-16" will be revised to guidance that relevant medic summaries or reports of photor X-rays taken shall be submit the CY47 form. An election link to the CY47 form will be directly in the policy "Child Reporting and Care L-16". To policy revision will include the addition of a statement address the implementation of a patient safety plan. 3. By August 23, 2017, all intensive care unit (NICU) pand staff will complete a requelectronic learning course with the office of the safety will complete a requelectronic learning course will safety will safety will complete a requelectronic learning course will safety will s	f I send a ce of the inployees I t vents exporting. HMC ing and include cal ttographs mitted extronic increased Abuse The the essing ent I neonatal providers quired	Completion Date: 08/23/2017 Status: APPROVED Date: 08/01/2017

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

l '		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		390256		B. WING:		07/14/2017	
MILTON S	VIDER OR SUPPLIER: S. HERSHEY MEDICAL C SE NUMBER: 135101	ENTER, THE	500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0145	Continued from page 37			A 0145	content describing timely report of suspected child abuse to ChildLine, which includes Codocumentation within 48 hot specifically outlined by HMG "Child Abuse Reporting and L-16". Course completion witracked by the NICU nurse nand NICU medical director. complete this required course result in the application of the progressive discipline process.	eY47 curs C policy Care ill be nanager Failure to e will	

CMS-2567L 3VS311 IF CONTINUATION SHEET Page 38 of 42

		(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER:		(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 07/14/2017	ΞY
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
A 0145	Based on review of factorecords (MR), and staff determined that the factorecords (MR), and staff determined that the factorecords (MR). This is not met as evident as evident and the factorecords (MR). This is not met as evident as evident as a factor of facility pool and Care" effective Downwood of the factor of Possible 1 in an infant <12 month mobile When there is suspect abuse, the Maimmediately call Child (1-800-932-0313), availing days a year)Report	f interview (EMP), is cility failed to ensure as of abuse by not implied abuse for one of one	eporting led, d reporter hild abuse Clinical y fracture o is not DUST l report	A 0145			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 390256			(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 07/14/2017	ΞY	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI			
(X4) ID PREFIX TAG	MUST BE PRECEED!	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
A 0145	requires that hospital/n local or state police and criminal means. Accordidation to ChildLine and Children and Youth Sean and the state of facility end April 30, 2017 revealed As an update, CYS was 29, 2017). We worked attached safety plan for stay (medical record # email transmission). Lealso here with us late F we had spoken with your Areview of facility polynomials no policy to address to child abuse. An interview conducted AM with EMP10 reveals.	y injuries resulting fidingly, cases of suspeported to the police and to the appropriate ervices agency" nail to the Department, " shere on Saturday (with them to develor the duration of the redacted for purpose ocal police detective eriday (April 28, 201 ou and called them" elicies revealed that the same apatient safety plant of the part of the duration of the redacted for purpose ocal police detective eriday (April 28, 201 ou and called them"	April op the patient's e of es were 7) after " the facility an related to 11:00	A 0145			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

		(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 07/14/2017	ΞY
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		ENTER, THE	STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI			
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
A 0145	reported to ChildLine after the injury to MRI also noted that the faci enforcement and count Services until April 28 plan was not put into p The facility's failure to comprehensive investigations at risk for harrores reference with: 482.13 Patient Rights	was detected. The lity did not notify the y Children and Your, 2017. Additionally lace until April 29, 2 conduct a timely an gation placed MR1	interview e law th , a safety 2017.	A 0145			

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PRINTED: 8/24/2017 FORM APPROVED 2567-L

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390256		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0145	Continued from page 41			A 0145			

CMS-2567L 3VS311 IF CONTINUATION SHEET Page 42 of 42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		390256		A. BLDG: 00 B. WING: 07/14/2017			
MILTON S	S. HERSHEY MEDICAL C	ENTER, THE	STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVE			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	ED BY FULL REGULATORY O		ID PREFIX TAG	CTION (EACH OULD BE APPROPRIATE	(X5) COMPLETE DATE	
P 0000	S. HERSHEY MEDICAL CENTER, THE P.O. BOX 850						
LABORATORY I	DIRECTOR'S OR PROVIDER/SUPPLI	ER REPRESENTATIVE'S SIGN	ATURE		TITLE:	(X6) DATE:	

State Form 3VS311 IF CONTINUATION SHEET Page 1 of 41

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		390256	A. BLDG:00 B. WING:				
MILTON S	VIDER OR SUPPLIER: 5. HERSHEY MEDICAL C E NUMBER: 135101	ENTER, THE	STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
P 0153				P 0153			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 390256			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 07/14/2017		
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		ENTER, THE	500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH D MUST BE PRECEEDED BY FULL REGULATORY IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH		OULD BE	(X5) COMPLETE DATE
P 0153	Continued from page 2 101.151 CHILD ABUSE 101.151 Principle All hospitals shall comply the Child Protective Servic with any regulations promunder by the Department of Welfare. This REGULATION is not	es Law and algated there f Public		P 0153	1. By August 1, 2017, the Medical Center (HMC) chief executive officer (CEO) will "Safety Alert" from the Office Dean & CEO to all HMC emstressing the importance and requirements of timely event reporting of patient safety evand mandated child abuse regard mandated child abuse regard "Care L-16" will be revised to guidance that relevant medic summaries or reports of photor X-rays taken shall be subr with the CY47 form. An election link to the CY47 form will be directly in the policy "Child Reporting and Care L-16". To policy revision will include to addition of a statement address the implementation of a paties afety plan. 3. By August 23, 2017, all intensive care unit (NICU) pand staff will complete a requelectronic learning course with the original staff will complete a requelectronic learning course with the original staff will complete a requelectronic learning course with the original staff will complete a requelectronic learning course with the original staff will complete a requelectronic learning course with the original staff will complete a requelectronic learning course with the original staff will complete a requelectronic learning course with the original staff will complete a requelectronic learning course with the original staff will complete a requelectronic learning course with the original staff will complete a requelectronic learning course with the original staff will complete a requestion of the original staff will complete a requestion of the original staff will be subtracted to the original staff will be	f send a ce of the aployees sents porting. HMC ang and coinclude cal cographs mitted ctronic ce created Abuse che che cessing cent sents and coinclude cal cographs mitted ctronic ce created and coinclude ctronic ce created and ctronic ce	Completion Date: 08/23/2017 Status: APPROVED Date: 08/01/2017

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	BER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		390256		B. WING: 07/14/2017					
MILTON S	VIDER OR SUPPLIER: 5. HERSHEY MEDICAL C SE NUMBER: 135101	CENTER, THE	STREET ADDRESS, CITY, STATE, ZIP CODE: 500 UNIVERSITY DRIVE P.O. BOX 850 HERSHEY, PA 17033						
(X4) ID PREFIX TAG	MUST BE PRECEED!	T OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
P 0153	Continued from page 3			content describing timely report of suspected child abuse to ChildLine, which includes CY4 documentation within 48 hours specifically outlined by HMC p "Child Abuse Reporting and Ca L-16". Course completion will be tracked by the NICU nurse man and NICU medical director. Fair complete this required course we result in the application of the progressive discipline process.		EY47 urs C policy Care ill be nanager Failure to e will			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
390256				1	00	07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 0153	Based on review of factorecords (MR), and staff determined the facility and federal laws: Milton S Hershey Med compliance with the formula of the compliance with the formula of the factorecords (MR), and staff determined the facility and federal laws: Milton S Hershey Med compliance with the formula of the factorecords (MR), and federal laws: Milton S Hershey Med compliance with the formula of the factore with the factore with the factorecords (MR), and federal laws: Milton S Hershey Med compliance with the factor formula of the factore with the factore with the factore with the factore of the factore with the factore with the factore of the factore with the factore of the factore with the factore with the factore of the factore with the factore with the factore of the factore with the factore of the factore with the factore of th	f interview (EMP), if failed to conform to to c	t was all state in , 23 aired to a report reporting e a spartment ne who is the ed, ensure	P 0153			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		390256		B. WING:		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 0153	Continued from page 5			P 0153			
	tests of the child are person report of photograph sent to the county agent report is sent, or as soon. This is not met as evident as evident as a soon. This is not met as evident as a report of a care of facility pool and the person of facility the person of the person of facility the p	licy "Child Abuse Recember 2016, reveal equires the mandated responsible for the chapected child abuse Physical Abuse:	eporting led, d reporter hild abuse Clinical y fracture to is not DUST l report 7 365 lLine, a en report ropriate				

State Form 3VS311 IF CONTINUATION SHEET Page 6 of 41

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		390256		B. WING: _		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
P 0153	Continued from page 6			P 0153			
	Continued from page 6 consult shall not be a reason for delay or a sur for a mandated reporter to make a report to ChildLine and other appropriate authorities we there is reasonable suspicion of abuseReport PolicePennsylvania law requires that hospital/medical personnel report to the local state police any injuries resulting from crimin means. Accordingly, cases of suspected child abuseshall be reported to the police in addit ChildLine and to the appropriate county Child and Youth Services agency" A review on May 3, 2017, of MR1 NICU Interdisciplinary Narrative dated April 16, 20 revealed "Focused assessment completed-no changes since last assessment-infant comforts and not fussy. Went to bed #10 to help that means feed. Could hear infant crying very lour Asked mom if that was him crying. Mom the that I come to the bedside because there was something wrong with infants arm. She stated was limp. When this nurse look at arm it was limp-the right arm was moving but his left arms.		s when port to cal or minal ild dition to mildren 2017 no ortable mom oudly, hen asked as ted that it cas				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER 390256			A. BLDG: <u>00</u>		(X3) DATE SURVE COMPLETED: 07/14/2017		
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI		,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
P 0153	and cried out in pain. I discoloredThe infant or discomfort during the (name redacted) to infants arm". She agree with the arm and order immobilize the arm as holding him and he has given per order." A fra radius was confirmed where the man and the ma	did not show and some 1200 or 1500 assets the bedside to look and that there was a pred a X-ray. Will contain this soothes him. More fallen asleep after the cture of the left ulnary in a timely manner. ChildLine until Aprel injury to MR1 was and on May 4, 2017, and the facility was not that a written report of photograph to the county agency	s of pain essment. at roblem ettinue to om is also ylenol was and 5, 2017. t 11:00 t The fil 28, t 1:00 ot able to t and /or ns or of at the	P 0153			

State Form 3VS311 IF CONTINUATION SHEET Page 8 of 41

		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		390256		B. WING:		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI			
(X4) ID PREFIX TAG	X MUST BE PRECEEDED BY FULL REGULATORY OR LSC			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
P 0153	Continued from page 8			P 0153			
P 0317				P 0317			

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	PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER: A. BLDG: _00		(X3) DATE SURVI COMPLETED: 07/14/2017	EY			
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		ENTER, THE	500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 0317	Continued from page 9 103.4 (3) FUNCTIONS (3) Take all reasonable ste conform to all applicable F State, and local laws and regulations. This REGULATION is not	ederal,		P 0317	1. On April 21, 2017, the Medical Center (HMC) patie officer (PSO) assigned to all intensive care unit (NICU) employees (providers, nurses support staff) a required lear management system course to completed within 30 days. To course content describes time reporting of patient safety eventhe HMC expectations of Patignary Event Reporting, and methods to report, and refere the policy "Patient Safety Eventhe Policy "Patient Safety Ev	ent safety neonatal s and ning to be he ely vents, tient the ences vent rse NICU edical ming to be e will he ess. HMC D) will he Office MC ortance	Completion Date: 08/01/2017 Status: APPROVED Date: 08/02/2017

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PLAN OF CORRECTION (POC) IDENTIFICATION NUMB		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 07/14/2017	
		390256		B. WING		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI				
(X4) ID PREFIX TAG	REFIX MUST BE PRECEEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
P 0317	Continued from page 10			P 0317	reporting of patient safety evand mandated child abuse results and mandated child abuse results are safety specialist safety specialist safety Authority's Program Memorandum # 2015-02: Interpretation of the Definition Serious Events Used by the PA-PSRS Analysts and the associated e-learning. The Pamonitor for the memorandum and e-learning completion by patient safety specialist staff. Evidence of completion will documented in each patient safety specialist's personnel file. Facomplete the assignments within the application of the programments of the programmen	porting. PSO and taff will tent on of SO will the review of all the safety	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		390256		1	00	07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI			
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P 0317	Based on review of face records (MR), and staff determined the facility and federal laws: Milton S Hershey Med compliance with the formal federal laws: Milton S Hershey Med compliance with the formal federal laws: The Medical Care Ava Error Act, 40 P.S. § 13 § 1303.313 Medical Factorifications (a) Serion facility shall report the to the department and to of the medical facility's occurrence of the serion department and the automanner prescribed by the with the department and of any patient or any of information. (b) Incides shall report the occurrence authority in a formand	finterview (EMP), if failed to conform to failed the failed to conform to failed to conform to failed to conformation of the failed to conformation of the failed to conformation of the failed to conformation to conformation to conformation of the failed to conformation to conformat	t was all state in ion of nedical ous event 24 hours t to the form and ultation he name vidual al facility o the	P 0317			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER 390256			A. BLDG:00		(X3) DATE SURVEY COMPLETED: 07/14/2017		
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
P 0317	authority and shall not patient or any other incompared the occurrence of the department within facility's confirmation of the infrastructure fail department shall be in this is not met as evid. This is not met as evid. Findings include: A review on May 3, 20 Safety Event Reporting revealed "All events, reported through the E Reporting system imm as reasonably practical 24 hours after the event of an incident, a serious	dividual information eports. A medical far of an infrastructure far 24 hours of the medical far of the occurrence or illure. The report to the form and manner enced by: 117, of facility policy g," effective January including incidents, lectronic Patient Saf ediately or as soon to ble, but in no event later or discovery of the policy, revealed the desired and incidents, and incidents, and incidents are the policy, revealed the desired and incidents.	cility shall ailure to ical discovery the r y "Patient 2017, must be tety Event hereafter ater than event"	P 0317			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		390256		B. WING:		07/14/2017		
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE		
P 0317	failure as defined by A "Incident." An event, of involving the clinical of facility which could had not either cause an unathe delivery of addition patient "Serious evisituation involving the medical facility that repatient safety and result requiring the delivery of services to the patient. undesirable or unintendical situation involving the facility or the disconting of a service which coupatient. A review of facility do Improvement Plan, efficient in the service with the response immediately notify the	eccurrence or situation are of a patient in a live injured the patient inticipated injury or hall health care service ent." An event, occur clinical care of a parsults in death or combits in an unanticipate of additional health or "Infrastructure failured event, occurrence infrastructure of a mutation or significant described by a comprosite cument "Performance ective May 2, 2017, insibility of each dep	on medical at but did require sets to the rrence or tient in a appromises and injury seare re." An see or medical at disruption mise	P 0317				

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, , , , , , , , , , , , , , , , , , ,		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	(I) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		390256		B. WING: _		07/14/2017		
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE		
P 0317	and notify the Patient Sevent or situation that of Patient Safety Officer, CMO, and others as inthe event is performed a sentinel event, serious to DOH, Act 13 and A Serious events and informed to the DOH we confirmation of occurre Patient Safety Reporting the reported to the Patienhours of confirmation of Pennsylvania Patient Serious events and informed to the Patienhours of confirmation of Pennsylvania Patient Serious events and many 3, 20 Interdisciplinary Narra revealed "Focused asset changes since last asset and not fussy. Went to breast feed. Could hear Asked mom if that was that I come to the beds	caused patient harm. or designee, notifies dicated. An investigate to determine confirms event or incident ot 52 reporting requirastructure failures within 24 hours of ence via the Pennsylng System. Serious event Safety Authority of occurrence via the afety Reporting System. O17, of MR1 NICU tive dated April 16, essment completed-nessment-infant comforbed #10 to help that infant crying very less him crying. Mom the	The sthe ation of mation of Specific rements: vill be vania events will within 24 extern"	P 0317				

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PLAN OF CORRECTION (POC) IDENTIFICATION		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED: 07/14/2017	
NAME OF PRO	VIDER OR SUPPLIER:	390256	STREET ADDRESS,			07/14/2017	
	S. HERSHEY MEDICAL C	ENTER, THE	500 UNIVERS				
STATE LICENS	E NUMBER: 135101		P.O. BOX 850 HERSHEY, P.	A 17033			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
P 0317	Continued from page 15			P 0317			
		in Company Classic	a a diada a a da				
	something wrong with was limp. When this no						
	limp-the right arm was						
	laid by his side. Then h	ne raised his arm up,	grimaced				
	and cried out in pain. T						
	discoloredThe infant		•				
	or discomfort during th						
	`	the bedside to look					
	infants arm". She agree with the arm and order	•					
	immobilize the arm as	-					
	holding him and he has						
	given per order." A fra	-	-				
	radius was confirmed v						
	A review of the facility						
	facility failed to report						
	Pennsylvania State Rep		·				
12 days later on April 28, 2017. The facili		-					
	reported the unwitnessed fracture as an inc						
	had not caused harm to	-	-				
	on April 28, 2017 indicates described as infrastruct						
	described as infrastruct	iure ranure. The fev	IEW OI				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		390256		B. WING: _		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 0317	facility documentation accurately report the in event. An interview conducte AM with EMP5 and Elfailed to follow the Me Reduction of Error Act Improvement Plan and event until April 28, 20 "There was no event re" It should have been reconfirmed via telephon reported.	d on May 3, 2017, a MP16 confirmed the dical Care Availabil and the Performance did not report the second for the second on this particular ported immediately.	t 10:40 e facility lity and ee erious tated, ar case."	P 0317			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
390256				B. WING:		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
P 0317	Continued from page 17			P 0317			
P 0369				P 0369			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER SUPPLIET IDENTIFICATION NUMBER 1990256				(X2) MULTIPLE CONSTRUCTION: (X3) DATE SURVE COMPLETED: A. BLDG:00 B. WING: 07/14/2017			EY	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, CITY, STATE, ZIP CODE: 500 UNIVERSITY DRIVE P.O. BOX 850 HERSHEY, PA 17033					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIEN MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	(X5) COMPLETE DATE		
P 0369	Continued from page 18 103.24 (1) INVESTIGATIOPROCEDURES 103.24 Investigation and eprocedures The hospital shall adopt procedures The hospital shall adopt procedures and fair investigation of violations opatient's rights and to ensure enforcement. These procedensure that: (1) A system is established identify formal written complaare recorded and investigate (3) complaint records and dispositions are kept for on until the next annual survey available to the Department request; (4) investigation and resolution, when possible, complaints shall be timely; (5) disciplinary and remededucation procedures will be for members of the hospital medical staff who consister patient relationship problem.	nforcement ocedures of the re their ures shall d to aplaints; ints ed; case e year or or and made t upon of formal and dial be developed I and antly cause ans.		P 0369	1. By August 1, 2017, the Medical Center (HMC) chies executive officer (CEO) will "Safety Alert" from the Office Dean & CEO to all HMC enstressing the importance and requirements of the grievance resolution and investigation process. 2. By August 4, 2017, the director of patient experience review and revise the HMC p"Resolution of Patient Compand Grievances PC-25" to el grievance resolution and investigation process. 3. By August 23, 2017, all intensive care unit (NICU) p and staff will complete a required electronic learning course with content describing the grievare completion will be tracked by NICU nurse manager and NI medical director. Failure to enthis required course will result application of the progressive	f I send a ce of the inployees HMC e will policy plaints arify the I neonatal providers quired ith innce hy the ICU complete alt in the	Completion Date: 08/23/2017 Status: APPROVED Date: 08/01/2017	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390256		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 0369	Continued from page 19			P 0369	discipline process.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		390256		A. BLDG: _ B. WING: _		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 0369	Based on a review of farecords (MR), and staff determined that the fact investigate a patient's farevance. This is not met as evident is not met as evident in the fact investigate a patient's farevance. This is not met as evident is not met as evident in the fact investigate a patient's facility por "Resolution of Patient effective November 20 patient grievance is a fact of the complaint that is patient, or the patient's patient's care (when the time of the complaint in the	f interview (EMP), is called to recognize a mily members conceed by: licy on May 3, 2017 Complaints And Grie of the formal or informal was made to the hospital representative, regate complaint is not resint by staff present), cipation (CoP's), or is conceed to the formal or informal was made to the hospital representative, regate complaint is not resint by staff present), cipation (CoP's), or is conceed to the formal or informal was a complaint in the complain	t was nize and cerns as a , revealed evances evance: A ritten or al by a rding the solved at abuse or is a ne Patient	P 0369			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 390256			(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 07/14/2017	ΞY	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE .	IOULD BE	(X5) COMPLETE DATE
P 0369	Committee for the Med 7 days for the response appropriate. However, that endanger the patie will be reviewed immed of the allegations and to patient" A review on May 3, 21 2017, revealed "I receed 4/17/2017 when I arrive on 4/16/2017 in the latter for the patient that day follow up with the famous recovery process as we what may have happene email revealed "I had a (name redacted) fine at 12(12:00 PM) at 15(15:00 PM) then left called me over to bed so limpordered an XRA fractures	e of most grievances grievances about sit nt, such as neglect or ediately, given the set he potential for harm 107, of email dated Meived the below emarked to work. It was we evening by the RN 1. This email promptially to start the service ell as the investigation and "Further review a odd thing happen to 1. CCN bed# 9, infarrand when I assessed It to help bed # 10 and sayin his arm was	is uations r abuse, riousness in to the May 1, ail on written a caring sed me to be on as to of the oday with at was him at d mom	P 0369			

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	OF DEFICIENCIES AND RECTION (POC)	` '	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		390256		B. WING: _		07/14/2017		
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	(X5) COMPLETE DATE		
P 0369	Further review of the edocumented concerns voiced on April 16, 20 described a nurse as behad stated that they did to care for their baby a conducted on May 3, 2 EMP7 revealed when I grievances/complaints by saying that when pathey triage them and tanurse. EMP7 was aske concerns were resolved grievance wouldn't have responded, "No, there resolution. The fracture "Patient Relations Worgrievance was not door three days after it was a second to the s	that the patient's fame in 17. The patient's fame ing rough with patient's fame ing rough with patient's want that particulary more. An interview in 2017, at 1:30 PM with EMP7 was asked about the unit, they respond to the unit, they respond if MR1's mother's and if MR1's mother's at to the point where we to be entered. The was not immediate the still exists." Review the sheet revealed that the unmented until April 2019.	nily mily ents and lar nurse w h out ponded through nd the a ey w of the this	P 0369				

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STATEMENT OF DEFICIENCIES AND (XI) PROVIDER/SUPPLIER/C PLAN OF CORRECTION (POC) IDENTIFICATION NUMBER.			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:		
		390256		A. BLDG: _ B. WING: _	00	07/14/2017	
MILTON S	VIDER OR SUPPLIER: 5. HERSHEY MEDICAL C E NUMBER: 135101		STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
P 0369	Continued from page 23			P 0369			
P 0377				P 0377			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		390256		1		07/14/2017		
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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		(X5) COMPLETE DATE	
P 0377	Continued from page 24			P 0377				
	103.33 (b)(1-11) RESPONE 103.33 (b) The chief executive off should be responsible for: (1) designation of an indivact for him in his absence. (2) management of the hoseommensurate with the aut conferred by him by the go and consonant with its exprand policies; (3) attending all meetings governing body and appropring body and appropring body and appropring the administ functions of the hospital, do and establishing formal meaccountability on the part of subordinates; (5) establishing such departs as are indicated, providing departmental and interdepartmental and in	idual to spital, hority verning body ressed aims of the oriate off; trative elegating, ans of of rtments for rtmental being gs, and nental staff			1. By August 1, 2017, the Medical Center (HMC) chief executive officer (CEO) in conjunction with the chief quofficer (CQO) will oversee the completion of education by the Patient Safety Team regarding Pennsylvania Patient Safety Authority's Program Memora 2015-02: Interpretation of the Definition of Serious Events by the PA-PSRS Analysts are associated e-learning. The Coreceive a compliance report a ensure successful completion education. 2. By August 1, 2017, the send a "Safety Alert" from the of the Dean & CEO to all History employees stressing the important requirements of timely experiting of patient safety events and mandated child abuse results. 3. By August, 23, 2017, the conjunction with the CQO we oversee the implementation of plans of correction related to	f uality he the the ng the andum # e Used he the EO will and he of the CEO will he Office MC ortance event vents porting. The CEO in will of all	Completion Date: 08/23/2017 Status: APPROVED Date: 08/04/2017	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
					00	07/14/2017	
		390256		B. WING.		07/14/2017	
MILTON S. HERSHEY MEDICAL CENTER, THE P.			500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 OF		
P 0377	Continued from page 25			P 0377			
	requested to do so by the m staff; (6) appointing the heads of administrative departments (7) reporting to the govern and to the medical staff on overall activities of the hos well as on appropriate Federand local developments that health care in the hospital; (8) reviewing the annual at the financial operations of thospital; (9) fiscal planning and fina management of the hospital (10) developing, in cooper with the departmental head appropriate staff, an overall organizational plan for the which will coordinate the financial, when possible. (11) Ensuring that the agree with service providers the such as laundry, laboratory specifically indicate that compliance will be maintait applicable State regulations apply to the same services directly by the hospital.	ing body the pital as eral, State t affect udit of the ancial l; and ation s and other l hospital unctions, of the ements at is, , and x-ray med with s as would			Department of Health site suconducted on May 3 and 4, 2 concerning compliance with Pennsylvania MCARE law, Protective Services law and Abuse Reporting And Care pand associated consults to th Protection Team. The CEO veceive ongoing updates from CQO on plans of correction and will ensure timely compand will ensure timely compand the CQO on serious safe events and the associated PA submission-timeframe report will be generated by the patisafety officer.	the Child the Child colicy e Child will m the progress letion. 2017, the pdates fety L-PSRS ts that	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390256		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 07/14/2017	ΞY
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 0377	Continued from page 26 This REGULATION is not	met as evidenced by:		P 0377			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:			
		390256		1		07/14/2017			
		390230							
	VIDER OR SUPPLIER: 5. HERSHEY MEDICAL C	FNTER THE	STREET ADDRESS, 500 UNIVERS						
MILIONS	HEROHET MEDICAL C	ENTER, THE	P.O. BOX 850						
STATE LICENSE NUMBER: 135101			HERSHEY, P.	A 17033					
(X4) ID		OF DEFICIENCIES (EACH DE		ID	PROVIDER'S PLAN OF CORRE	CTION (EACH	(X5)		
PREFIX TAG		ED BY FULL REGULATORY OF FYING INFORMATION)	R LSC	PREFIX TAG	CORRECTIVE ACTION SH CROSS-REFERENCED TO THE		COMPLETE DATE		
P 0377	Continued from page 27			P 0377					
	Based on review of fac	cility documents me	dical						
	records (MR), and staff	•							
	determined the CEO fa	` '							
	of facility policy and st	tate law (The Medica	al Care						
	Availability and Reduc	ction of Error Act, 40) P.S. §						
	1303.101 et seq. and C	PSL-The Child Prot	ective						
	Services Law, 23 Pa.C	.S. § § 6301.							
	This is not met as evide	enced by:							
	Findings include:								
	A review on May 3, 20	017, of the facility's '	'Bylaws						
	of Penn State Health,"	adopted April 1, 201	15,						
	revealed "Section 4.8								
	President/CEO shall su								
	all policies, order, and								
	Directors and shall exe								
	agreements authorized	-	· ·						
	except that he/she may	-							
	the Corporation the por								
	the ordinary course of		vise may						
	be authorized by the B	oard"							

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		390256		B. WING:		07/14/2017	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
(X4) ID PREFIX TAG	MUST BE PRECEED!	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OI FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
P 0377	A review of the Medic reduction of Error Act facility shall report the to the department and of the medical facility's occurrence of the serior Child Protective Service "required reporters. In make, required reporters. In make, required reporter child abuse to ChildLine make a written report of Department to the count where the suspected child A review on May 3, 20 Abuse Reporting And December 2016, reveated the shall be made for: An independently mobile of the serior of the May 3, 20 A review on May	indicates that "A me occurrence of a serithe authority within 2s confirmation of the us event". A review ces Law indicates that addition to other reports shall report suspende". "within 48 hours, a required reported on forms provided by the agency in the countil abuse occurred" Ol7, of the facility's 'Care" policy effectiveled "A consult to the y infants <12 months with a fracture"	edical ous event 24 hours of the at oorts they eted es of shall y the unty "." 'Child ye he CPT	P 0377			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBE 390256			(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 07/14/2017	EY	
NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
P 0377	Interdisciplinary Narra EMP8 documented, "Frompleted-no changes comfortable and not furthat mom breast feed. I loudly. Asked mom if then asked that I come was something wrong that it was limp. When limp-the right arm was laid by his side. Then hand cried out in pain. I discolored"A fracture was confirmed via x-rad A review on May 3, 20 Interdisciplinary Narra EMP17 documented, "nurse about pt's arm fraspent time speaking with not made aware of this attending and she indiction investigated and that the	cocused assessment since last assessment say. Went to bed #16 Could hear infant crying, to the bedside because with infants arm. She this nurse look at are moving but his left he raised his arm up, The site was not swo e of the left ulna and ay on April 16, 2017 17, of MR1 NICU tive dated April 18, SW updated by bedsacture and that nurse ith parents at length, incident. SW spoke cated incident being	nt-infant 0 to help ying very Mom use there e stated rm it was arm just grimaced llen or radius . 2017: side e manager SW was with	P 0377			

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PLAN OF CORRECTION (POC) IDE		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390256		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 07/14/2017	
MILTON	OVIDER OR SUPPLIER: S. HERSHEY MEDICAL C SE NUMBER: 135101	ENTER, THE	STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	SITY DRIVI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETE DATE
P 0377	Continued from page 30 CPT team at this time of about how injury occur or injury inflicted by purse manager {name is she was involved sever her perception from sputhis was not an injury if asked {name redacted} that they are not involve further discuss with more CPT was not formally. The facility failed to for Reporting and Care Pout to refer this injury to the manner for discussion. An interview conducted PM with EMP12 reveation a fracture. I've never be something forceful was caused by "bending reviewed the x-ray with the source of the source of the care of t	arents. SW spoke furedacted} and she stral parties to investige eaking with parents inflicted by parents. It about CPT and she yed at this point. SW ed. team during social consulted until May bllow its Child Abus licy as evidenced the CPT team in a time and investigation. In May 4, 2017, and alled "It's an "unusuer seen this before. It in my opinion" The gor twisting." EMP	a nursing rither with atted that gate and was that SW also stated will all rounds." 3, 2017. e e failure nely t 12:30 tal place thad to e fracture 12	P 0377			

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		(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER:		(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVEY COMPLETED: 07/14/2017		
MILTON S								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENC MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE	
P 0377	confirmed the results we fractures included two the left radius. "Certain baby. It didn't happen is far out to be related to There was no callous for revealed when asked if EMP12 stated "I can't casked if MR1 came the Department would child EMP12 stated "yes." A review of the facility facility reported the about to the Pennsylvania State (PSRS), 12 days after the was submitted as an infrast 2017 at 17:38 with a New facility documentation data base revealed the Performance Improversi	on the left ulna and ally someone did hard from routine care. It birth trauma. It was formation." Further it child abuse was sustenant on that." Wough the Emergency Id abuse be suspected abuse be suspected abuse be suspected abuse be suspected abuse be first recident on April 28, 2 score. A second repructure failure on April 28 of Harm Score. A reand the Department facility failed to follow	one on m to the awas too new. interview spected When with the sealed the seal	P 0377				

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		(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER 390256		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 07/14/2017	
MILTON S	VIDER OR SUPPLIER: S. HERSHEY MEDICAL C SE NUMBER: 135101	ENTER, THE	STREET ADDRESS, CITY, STATE, ZIP CODE: 500 UNIVERSITY DRIVE P.O. BOX 850 HERSHEY, PA 17033				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 0377	injury to MR1 within 2 investigate the injury a		⁷ and	P 0377			

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PLAN OF CORRECTION (POC) IDENTIFIC		(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED: 07/14/2017	
MILTON S	VIDER OR SUPPLIER: S. HERSHEY MEDICAL C SE NUMBER: 135101	STREET ADDRESS, CITY, STATE, ZIP CODE: 500 UNIVERSITY DRIVE P.O. BOX 850 HERSHEY, PA 17033					
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P 0377	Continued from page 33			P 0377			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:				
		390256		B. WING:	<u></u>	07/14/2017				
MILTON S. HERSHEY MEDICAL CENTER, THE P.O.			500 UNIVERS P.O. BOX 850	IREET ADDRESS, CITY, STATE, ZIP CODE: 00 UNIVERSITY DRIVE .O. BOX 850 IERSHEY, PA 17033						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE			
P 0377	Continued from page 34			P 0377						
P 0924				P 0924						

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER 390256		A. BLDG: _	TIPLE CONSTRUCTION: (X3) DATE SURV COMPLETED: 07/14/2017		:	
MILTON	NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		500 UNIVERS P.O. BOX 850 HERSHEY, P	SITY DRIVI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCE MUST BE PRECEEDED 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		(X5) COMPLETE DATE	
P 0924	Continued from page 35 109.23 (b)(1-5) WRITTEN 109.23 (b) Nursing care policies a procedures shall be consist professionally recognized nursing practice and shall accordance with the Profes Nursing Law and regulation promulgated by the State Fexaminers. These policies include procedures for the (1) noting diagnostic and therapeutic orders (2) assigning the nursing of patients (3) infection control (4) patient safety (5) implementing orders medication and treatment, with 107.61-107.65 of this This REGULATION is no	and tent with standards of be in ssional ons Board of shall following: care for consistent subpart.	LICIES	P 0924	1. On April 21, 2017, the Medical Center (HMC) pation officer (PSO) assigned to all intensive care unit (NICU) employees (providers, nurse support staff) a required lear management system course completed within 30 days. To course content describes time reporting of patient safety eventher than the policy "Patient Safety Eventher Reporting, and methods to report, and refere the policy "Patient Safety Eventher S	ent safety I neonatal s and rning to be The tely vents, tient I the tences vent tirse S NICU tedical trning to to the	Completion Date: 08/10/2017 Status: APPROVED Date: 08/02/2017	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		A. BLDG: _	(X3) DATE SUR COMPLETED: 00 07/14/2017		ETED:	
MILTON S	VIDER OR SUPPLIER: 6. HERSHEY MEDICAL C E NUMBER: 135101	CENTER, THE	STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, PA	ITY DRIVI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIE MUST BE PRECEEDED 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		(X5) COMPLETE DATE	
P 0924	Continued from page 36			P 0924	staff to report near-miss paties afety events. 3. By August 1, 2017, the nurse manager will educate delegated staff to ensure evereported through the Great C reporting mechanism are coldaily and entered into the intelectronic event reporting sy within 24 hours of submission Weekly, the NICU nurse manager/designee will audit Great Catch submissions and internal electronic event repordate. An audit log will be maby the NICU nurse manager days. 4. By August 10, 2017, the nurse manager will alert all 1 nursing staff as to the appropriate of the Great Catch report mechanism via electronic communication, staff meetin unit council. Attendance at simeetings will be documented signature log.	NICU Ints Catch Catch Catch Clected Cernal Caternal Cate		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		390256		1	<u></u>	07/14/2017	
MILTON S. HERSHEY MEDICAL CENTER, THE			STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI			
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P 0924	Continued from page 37 Based on review of factorecords (MR), and staff determined that the factorecords (MR) is a second of the factorecord of th	f interview (EMP), i	t was	P 0924			
	determined that the facility failed to follow facility policy for one patient.						
	This is not met as evidenced by:						
	Findings include:						
	A review of facility policy "Patient Safety Event Reporting" effective January 2017, revealed "Events reported through the Great Catch reporting mechanisms are expected to be entered into MIDAS within 24 hours of submission" A review on May 3, 2017, of facility document, "Great Catch for Patient Safety," dated April 16,						
	2017 from EMP8 reveal bedside-concerned and mult. fractures of L dis The document was plaw was then followed up to 2017 to all nurse mana	aled "(EMP12) cal ordered x-ray-show tal ulnar + radial boaced in the box on the by an email, dated A	led to yed nes" e unit and pril 16,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:		
		390256				07/14/2017		
MILTON S	NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101		STREET ADDRESS, 500 UNIVERS P.O. BOX 850 HERSHEY, P.	ITY DRIVI				
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P 0924	wrote, "I have written and iView, but feel fremanswers" The Great Coof the box until 5/3/20. An interview conducte PM with EMP7 revealed submission by EMP8 wincorrectly." EMP7 state been put into MIDAS in Catch box is a plexi gla. "The goal is to get in the content of the property of the proper	e to call me if you not catch note was not part of the call me if you not part of the call on May 3, 2017, and that the Great Catwas "left in the box ted that the event shammediately. The Grass box that is on the	eed more bulled out t 1:30 tch could have reat e unit.	P 0924				

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	(XI) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 07/14/2017				
MILTON S	VIDER OR SUPPLIER: S. HERSHEY MEDICAL C SE NUMBER: 135101	HERSHEY MEDICAL CENTER, THE 500 UNIVERSITY DRIVE P.O. BOX 850					
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 0924	Continued from page 39			P 0924			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 390256 NAME OF PROVIDER OR SUPPLIER: MILTON S. HERSHEY MEDICAL CENTER, THE STATE LICENSE NUMBER: 135101			A. BLDG: _ B. WING: _ CITY, STATE, Z		(X3) DATE SURVI COMPLETED: 07/14/2017	EΥ	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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		(X5) COMPLETE DATE
P 0924	Continued from page 40			P 0924			

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Certified End Page

MILTON S. HERSHEY MEDICAL CENTER, THE

STATE LICENSE NUMBER: 135101 SURVEY EXIT DATE: 07/14/2017

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Sharmon M. Baker

Shannon M. Baker Acting Deputy Secretary for Quality Assurance



Rachel L. Levine, MD

Acting Secretary of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY