| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 390100 | A. BLDG: 00<br>B. WING: | 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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| LANCASTER GENERAL HOSPITAL, THE<br>STATE LICENSE NUMBER: 120801 | 555 NORTH DUKE STREET<br>LANCASTER, PA 17604 |

| (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 |
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| A 0000 | INITIAL COMMENT | A 0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 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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| **LANCASTER GENERAL HOSPITAL, THE** | **555 NORTH DUKE STREET LANCASTER, PA 17604** |
| STATE LICENSE NUMBER: **120801** | |

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| A 0000 | Continued from page 1<br><br>This report is the result of an unannounced onsite complaint investigation (CHL19C064H) completed on February 15, 2019. It was determined that the facility was not in compliance with the requirements of 42 CFR, Title 42, Part 482-Conditions of Participation for Hospitals.<br><br>Immediate Jeopardy was called on February 15, 2019, at 3:25 pm due to the facility's failure to provide goods and services necessary to avoid physical harm. The facilty failed to provide adequate supervision for one (1) patient, MR 1, who was cognitively impaired and occasionally wandered off the unit without staff's knowledge. Staff failed to develop and evaluate an individualized care plan based on the patient's needs. The patient left the facility after 9:00 pm on October 12, 2018 without staff's knowledge and traveled to a nearby hospital allegedly on foot. The patient was only wearing a pair of scrubs and shoes. Staff was unaware the patient left the building until a nurse doing rounds at 11:00 pm discovered that MR1 was not in the room and a search of the hospital was not | A 0000 | | |

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| A 0000 | Continued from page 2<br><br>successful. The facility's failure to develop a policy and procedure, for supervision of wandering cognitively impaired patients, placed MR 1 and other patients of the hospital (MR 2 and MR 3) at risk for serious injury, harm, and/or death.<br><br>The facility's action plan to abate the jeopardy was accepted on February 15, 2019 at 4:59 pm. The facility's immediate action plan included: notification of the CNO of all elopement risks within the hospital on a daily basis; discussion of all elopement risks at daily Safety Huddle; development of a policy for patient elopement of cognitively impaired patients; education provided to all nursing staff and hospital managers/directors regarding the policy and implementation of the policy; a tracking tool/log will be developed and implemented to audit/monitor all identified elopement risks; a computer based learning module for mitigating risks of elopement and policy will be created; and development of an assessment tool for cognitively impaired patients within Epic. | A 0000 | | |

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| A 0000 | Continued from page 3 | A 0000 | | |
| A 0043 | | A 0043 | | |

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| A 0043 | Continued from page 4<br><br>482.12 GOVERNING BODY<br><br>There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...<br><br>This REQUIREMENT is not met as evidenced by: | A 0043 | The Chief Executive Officer and Chief Clinical Officer to provide a presentation to the Board of Trustees regarding the October 12, 2018 elopement of a cognitively impaired patient, the regulatory deficiencies identified, and the corrective actions being implemented to ensure compliance with all CMS Conditions of Participation and Department of Health state regulation. Complete Date 3/21/19<br><br>The Chief Nursing Officer to provide a presentation to the Board of Trustees Quality Committee regarding the October 12, 2018 elopement of a cognitively impaired patient, the regulatory deficiencies identified, and the corrective actions being implemented to ensure compliance with all CMS Conditions of Participation and Department of Health state regulations. Complete Date 4/8/19 | Completion Date: **04/08/2019** Status: **APPROVED** Date: **03/19/2019** |

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| A 0043 | Continued from page 5<br><br>Based on review of facility documents and medical records, and interviews with staff, the Governing Body failed to function effectively and ensure the hospital consistently operated in a manner that protected the health and safety of its patients.<br>Findings include:<br>The Governing Body failed to ensure that the facility operated in a manner that ensured continued compliance with the federal regulations that promote and protect patients ' health and safety as evidenced by the hospital's history of noncompliance over the past 12 months.<br>A review of survey results from February 2018 revealed that the facility failed to ensure that patients consistently received physician ordered respiratory treatments. A review of survey results from November 2018 revealed that the facility failed to ensure that patients were free from abuse and failed to conduct timely and comprehensive investigations when allegations of abuse were alleged by patients.<br><br>As a result of the surveys in February and November, 2018, mentioned above, the facility responded with a plan to correct the deficient | A 0043 | | |

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| A 0043 | Continued from page 6<br><br>practices. During each follow up survey, it was determined that the facility implemented their plan of correction and had achieved compliance but the period of compliance did not last more than a few months.<br><br>In February, 2019, it was determined that the hospital did not have a plan in place to supervise wandering cognitively impaired patients and as a result, a patient, MR 1, eloped from the facility at night and walked by herself through town to another hospital. MR1 would have walked 1.3 miles taking approximately 23 minutes to arrive in 49 degree weather wearing only hospital scrubs and crocs. | A 0043 | | |
| A 0057 | | A 0057 | | |

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| A 0057 | Continued from page 7<br><br>482.12(b) CHIEF EXECUTIVE OFFICER<br><br>The governing body must appoint a chief executive officer who is responsible for managing the hospital.<br><br>This REQUIREMENT is not met as evidenced by: | A 0057 | The Chief Executive Officer (CEO) called an emergency executive leadership meeting on Sunday, February 17, 2019 to discuss the immediate jeopardy deficiency and establish an executive action plan with timelines for implementation. The individuals included:<br>1. CEO<br>2. EVP and Chief Administrative Officer<br>3. Chief Clinical Officer<br>4. Chief Financial Officer<br>5. Chief Human Resources Officer<br>6. SVP and General Counsel<br>7. SVP, Hospital Operations<br>8. SVP, Quality<br>9. Chief Nursing Officer<br>10. SVP, Service Lines & Population Health<br>11. President, Physician Services<br>Complete Date 2/17/19<br><br>The CEO made the decision to create a Chief Operating and Integration Officer position to oversee all clinical operations. The job description was finalized and an agreement was signed with an executive search firm | Completion Date: **03/20/2019** Status: **APPROVED** Date: **03/19/2019** |

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| A 0057 | Continued from page 8 | A 0057 | to launch a national search. Complete Date 2/20/19<br><br>The CEO sent an organization-wide communication to all leaders directing them to curtail all meeting/conference travel outside of Lancaster to focus on primary responsibilities of protecting our patients from potential harm and meet all regulatory standards for patient safety. Complete Date 2/26/19<br><br>The CEO led an Executive Leadership Briefing to discuss the regulatory deficiencies that resulted in loss of CMS deemed status three times over the past year. CEO provided clear prioritization and need for immediacy in achieving organizational compliance with all CMS Conditions of Participation and Department of Health state regulations. Complete Date 3/7/19<br><br>The Hospital Regulatory Steering Committee was redesigned with updated membership, committee | |

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| A 0057 | Continued from page 9 | A 0057 | charter, and implementation of monthly meetings for the next 6 months. Regulatory and CMS chapter leads began meeting weekly on 3/8/19 to clarify standards, identify potential gaps in compliance, and implement corrective actions. In addition, on 3/8/19 a hospital lawyer was fully dedicated to the regulatory review of hospital policies to ensure they were complaint with CMS, DOH, and TJC regulatory requirements. The SVP of Quality and SVP, Legal Counsel are the responsible leaders providing oversight of the regulatory review and improvements. Complete Date 3/20/19 | |
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| A 0057 | Continued from page 10<br><br>Based on a review of the facility's compliance history, it was determined that the facility's chief executive officer did not provide the supervision and oversight necessary to ensure staff consistently provided the necessary care and treatment needed by the patients.<br><br>Findings include:<br><br>Based on a review of the Department of Health deficiency reports for the past 12 months from February 2018 to February 2019, revealed that the facility had been cited for its non compliance in these areas: failure to follow physicians' orders for respiratory treatments; failure to conduct timely and comprehensive investigations of alleged patient abuse; and failure to ensure that cognitively impaired patients received adequate supervision to keep them safe. In each of these situations, the facility had developed and implemented a plan of correction however, the facility failed to maintain compliance thus placing patients at risk for harm. | A 0057 | | |

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| A 0057 | Continued from page 11 | A 0057 | | |
| A 0115 | | A 0115 | | |

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| A 0115 | Continued from page 12<br><br>482.13 PATIENT RIGHTS<br><br>A hospital must protect and promote each patient's rights.<br><br>This REQUIREMENT is not met as evidenced by: | A 0115 | Effective immediately, the CNO created a process to ensure that she was notified on a daily basis of any patient that would be considered an elopement risk to ensure that appropriate resources and interventions were in place to prevent a potential patient elopement. This process will continue until a formal policy and procedures are established, implemented, and audited to demonstrate compliance to ensure patient safety. Complete Date 2/15/19<br><br>The CNO provided education to high priority departments (security, nursing supervisors, nursing directors, and ED leadership) and the immediate actions that needed to take place to keep patients with cognitive deficiencies safe from elopement. Complete Date 2/18/19<br><br>An Elopement Screening Tool was adopted and a process developed to screen every patient on arrival to a nursing unit within the hospital. If | Completion Date: **04/15/2019**<br>Status: **APPROVED**<br>Date: **03/19/2019** |

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| A 0115 | Continued from page 13 | A 0115 | positive for risk of elopement, the status will continue for the duration of the patient's hospitalization unless it is determined by an interdisciplinary care team that the patient is no longer an elopement risk. Patients who screen negative for risk for elopement will be rescreened upon transfer of level of care or change in condition. The CNO is responsible for the implementation and daily tracking of compliance to the screening and will ensure that any lack of compliance will be identified, analyzed and corrective actions implemented. Complete Date 3/8/19<br><br>The Elopement Screening Tool was built in the Epic medical record and the Director of Business Intelligence is the responsible person for ensuring daily reports of screening tool compliance are provided to the CNO and nursing managers. A visual (red/green) cue was built into Epic to alert the nurse if the screening tool was completed on | |

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| A 0115 | Continued from page 14 | A 0115 | admission. Complete Date 3/8/19<br><br>An Epic report was created to identify any patient that was admitted prior to the admission elopement screening implementation. The nursing directors rounded on the clinical units and completed the Elopement Screening Tool on those patients. Complete Date 3/11/19<br><br>The CNO led a taskforce that developed and implemented a Policy for "Elopement Risk Interventions for Patients Who Are Cognitively Impaired". The policy included: assessment frequency; interventions for patients at risk; collaboration with patient and family; the role of security; and documentation requirements. Education was provided to nursing staff and hospital managers/ directors regarding the policy prior to implementation. Complete Dare 3/8/19<br><br>A computer-based learning (CBL) module for mitigating risks of | |

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| A 0115 | Continued from page 15 | A 0115 | elopement was developed and implemented by the Director of Nursing Professional Development. It is mandatory for all staff to complete the CBL by April 1, 2019 (unless on extended leave). Any noncompliance will be addressed through the employee disciplinary process. Complete Date 3/4/19<br><br>The CNO created a tracking log to monitor cognitively impaired patients identified at risk for elopement and audit compliance with screening, interventions implemented, documentation within the medical record, and compliance to the policy. The CNO will review any deviations, identify any opportunities for improvement, and implement corrective actions. Complete Date 3/18/19<br><br>The CNO (or her delegate) will provide a monthly elopement compliance update at the Patient Safety Committee until there are three consecutive months of full compliance with the policy. The | |

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| (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 |
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| A 0115 | Continued from page 16 | A 0115 | Patient Safety Committee minutes are approved at the Board Quality Committee Meeting and the Board of Trustees Meeting. Complete Date 4/15/19 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| A 0115 | Continued from page 17<br><br>Based on the facility's failure to ensure cognitively impaired ambulatory patients were provided with consistent and appropriate supervision (MR 1), it was determined that cognitively impaired ambulatory patients (MR 1, MR 2, and MR 3)were at risk for harm. Findings include:<br>Medical record review on 2/15/19 revealed that MR 1 was transferred by ambulance to the emergency department on 9/20/19, due to the patient's refusal to take medications and attempts to harm staff and other patients at the facility that MR 1 lived. Nursing documentation indicated that following admission to the hospital on 9/20/18, MR 1 began to wander in and out of the room and the unit. Based on a review of documentation in the medical record, the hospital failed to have a system in place which protected the wandering patient and implemented a plan of care that met the patient ' s needs. This failure placed MR1, and other cognitively impaired patients (MR 2 and MR 3), at risk for harm if they left their room, unit, or building without staff ' s knowledge or assistance. | A 0115 | | |

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| A 0115 | Continued from page 18 | A 0115 | | |
| A 0144 | | A 0144 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| A 0144 | Continued from page 19<br><br>482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING<br><br>The patient has the right to receive care in a safe setting.<br><br>This REQUIREMENT is not met as evidenced by: | A 0144 | The Director of Security and the Director of Safety will develop and implement an Elopement Response Plan within the Emergency Management Plan. Education will be provided to all departments impacted. A debriefing will occur after each activation of the elopement response plan or drill and opportunities for improvement identified. Complete Date 4/18/10<br><br>The CNO developed a bedside Standard of Work document for bedside nurses regarding the procedure for screening and launching the interventions for patients who screen positive for risk of elopement. The leader Standard of Work document that is used for daily quality rounds by the unit manager/facilitator was modified to include daily auditing of compliance to the elopement policy and standard work. Complete Date 3/8/19<br><br>Creating and modifying the patients' individualized "interdisciplinary plan | Completion Date: **04/18/2019** Status: **APPROVED** Date: **03/19/2019** |

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| A 0144 | Continued from page 20 | A 0144 | of care" is an expectation as outlined in the Policy for Interdisciplinary Documentation and Charting. The CNO implemented a process for the nursing directors (including hospital nursing supervisor on duty during weekends/holidays) to review each care plan on a daily basis, for each patient screened positive for risk of elopement, with the nurse manager and the bedside nurse to provide coaching/education on the what to consider for an individualized plan of care. Once the daily review is consistently compliant at 100%, the daily review of the care plans will be completed by the nurse managers/facilitators and documented in the leaders Standard of Work document utilized during their daily quality rounds. Opportunities for improvement will be identified and improvement actions implemented through collaboration between the nursing directors to ensure consistency across the hospital (Duke Street Hospital and Women and Babies Hospital). Complete Date 3/18/19 | |

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| A 0144 | Continued from page 21 | A 0144 | The policy for Interdisciplinary Documentation and Charting will be revised with more specific instructions on how and when to individualize the Interdisciplinary Plan of Care documentation. The CNO is the owner of the policy and will oversee the revision of the policy. Complete Date 4/18/19 | |

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| A 0144 | Continued from page 22<br><br>Based on the review of medical records and facility documents, and staff interviews, it was determined that the facility failed to ensure each patient received the supervision necessary based on their assessed needs. This failure placed a cognitively impaired ambulatory patient (MR 1) and other patients with similar diagnoses (MR 2 and MR 3), at risk for harm. Findings include:<br>According to the medical record, on 9/20/18, MR1 was transferred to the facility from another healthcare facility ' s locked dementia unit. MR 1 had a diagnosis of acute encephalopathy and vascular dementia with behavioral disturbances and a history of bipolar and schizoaffective disorder. On 9/20/18, at 4:44 pm, MR 1 was brought to the emergency room due to the refusal to take medications and attempts to harm other patients and staff. Assessment in the emergency room by the physician on 9/20/18 signed at 11:01 pm, revealed that MR 1 was " adamantly agitated pacing in the room intermittently " and " restless ". Nursing documentation indicated that both a sitter and a bed alarm were utilized while the patient was in the emergency department due to the patient ' s behaviors at the other facility. | A 0144 | | |

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| A 0144 | Continued from page 23<br><br>Documentation also revealed that case management was involved and recommended hospitalization for placement.<br>The admitting physician note written on 9/20/18 at 7:31 pm indicated that MR 1 was going to be admitted to the hospital to get the patient back on medications which would help with the problematic behaviors. Nursing documentation revealed that on 9/22/18 at 8:39 pm, the patient tried to leave the floor without the assistance or knowledge of the staff. Additional nursing documentation from 9/22/18 through 10/12/18, revealed that the patient attempted to and/or successfully left the unit unattended without staff ' s knowledge, on seven (7) occasions. According to documentation in the medical record and interview with staff (EMP 2 and EMP 3), the facility failed to develop a plan to keep MR 1 safe. Further interview confirmed that interventions to stop MR 1 from wandering off the unit unattended were not consistently documented and/or implemented.<br>Medical record review for MR 2 on 2/15/19, indicated that the patient was admitted on 1/22/19. The patient had diagnoses which | A 0144 | | |

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| A 0144 | Continued from page 24<br><br>included: behavioral disturbances, encephalopathy, heroin abuse, ambulatory dysfunction-falling at home, and medication non-compliance. According to interview with EMP 4 on 2/15/19, MR 2 was to have a constant sitter because the patient was so weak and unsteady. Nursing documentation indicated that the patient ambulated around the room and to the restroom but was considered a high fall risk. Due to agitated and combative behaviors, MR 2 was restrained per doctors' order and the restraints were to be discontinued when the behaviors improved. The patient was assessed as cognitively impaired with delirium and visual hallucinations according to notes written in a psych consult and that some of MR 2's behaviors and delirium were associated with self-medicating with multiple medications including psychiatric medications.<br>Based on MR 2's condition and past history, the patient was assessed as an elopement risk but according to staff, EMP 4, on 2/15/19, " she is too weak to get out ". Staff indicated that they were concerned that when MR 2's condition improves, the patient may try to elope from the unit. Staff failed to develop an individualized care plan that | A 0144 | | |

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| A 0144 | Continued from page 25<br><br>addressed the need to provide supervision to MR 2 so that patient would not leave the facility without staff or staff's knowledge of the patient's whereabouts.<br>Medical record review for MR 3 on 2/15/19, revealed the patient was admitted in 1/19 due to the patient's need for psychiatric assessment and treatment. The patient was admitted from home which was facilitated by the spouse who was aware and concerned about the decisions that the patient was making. The patient was ambulatory and the delirium that was present at home continued upon admission to the facility. Due to the patient's impaired cognition, staff felt that MR 3 may be an elopement risk. Staff failed to develop an individualized plan of care for MR 3 to ensure that the patient did not elope from the facility and potentially suffer harm. | A 0144 | | |
| A 0145 | | A 0145 | | |

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| A 0145 | Continued from page 26<br><br>482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT<br><br>The patient has the right to be free from all forms of abuse or harassment.<br><br>This REQUIREMENT is not met as evidenced by: | A 0145 | A workforce strategy was created to reduce lag time between a staffing vacancy occurring and the time to fill the position. Human Resources will create "evergreen requisitions" in Workday that will allow the recruitment of skilled staff continually throughout the year rather than waiting until a vacancy occurs. The evergreen requisitions will be created based on historical trends of turnover and organizational needs. The Vice President of Human Resources is the responsible party for communicating and implementing this strategy that will help to ensure that there is adequate staffing to meeting the needs of the patients. 4/18/19<br><br>Compliance to Active Nursing Orders for all patients identified at risk for elopement will be audited daily by the nursing manager and/or facilitator in association with the RN responsible for the patient. Barriers identified in the workflow of nursing orders will be identified and escalated to the nursing directors | Completion Date: **04/18/2019** Status: **APPROVED** Date: **03/19/2019** |

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| A 0145 | Continued from page 27 | A 0145 | and CNO for resolution. Noncompliance by the staff RN will be addressed through coaching at the bedside by the manager and utilizing as Human Resources disciplinary process if indicated. 3/18/19<br><br>Nursing department policy for daily "Chart Check Procedure" will be reviewed and modified to ensure current practice and policy are consistent with best practice and regulatory standards. The CNO is the owner of the policy and is responsible for completion of the review and revisions. Complete Date 4/18/19 | |

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| A 0145 | Continued from page 28<br><br>Based on the facility's failure to develop and implement a plan of supervision to ensure the safety of cognitively impaired patients, placed the patients at risk for serious injury, harm, and death. Three patients were identified as being in jeopardy due to their impaired cognition and ambulatory status, MR 1, MR2, and MR 3.<br>Findings include:<br>Medical record review on 2/15/19 revealed that MR 1 was brought to the hospital's emergency department on 9/20/18, from another healthcare facility where the patient lived on a locked dementia unit. According to documentation from the hospital emergency room record on 9/20/18, MR 1 had been refusing medications and was exhibiting behaviors some of which could have harmed others. In addition, the record stated that MR1 had been pounding on the walls daily and yelling to be let out of the locked unit.<br>Medical record review revealed that MR1 was assessed by the physician in the emergency room at 9:01 pm. The assessment revealed a history of schizoaffective disorder and dementia. In addition, the physician documented the "ED diagnosis" was Acute metabolic encephalopathy. The physician | A 0145 | | |

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| A 0145 | Continued from page 29<br><br>wrote that the patient required inpatient admission due to the diagnoses and that the patient could not be treated safely as an outpatient.<br>Medical record review revealed that MR 1 was admitted to the hospital on 9/20/18 and a consult with a psychiatrist the following day, 9/21/18, at 8:51 am, revealed an additional diagnosis of vascular dementia with behavioral disturbance and a note that indicated that MR 1's decision making capacity was compromised with no recollection of behaviors at the the prior facility. Nursing documentation indicated that the use of a sitter would continue since the patient, MR 1, had been a danger to others at the facility the patient lived prior to admission.<br>Medical record review revealed that two (2) days following admission, on 9/22/18, MR 1 became combative and threw the dinner tray and then slipped on the liquid that had spilled on the floor from the food tray. Later that same day, nursing notes indicated that MR 1 was noted to be impulsive and attempted to leave the unit. On 9/23/18, it was documented in the nursing notes at 11:01 pm, that MR 1 said, "I want to go home." The | A 0145 | | |

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| A 0145 | Continued from page 30<br><br>following day, 9/24/18, on 12:42 am, nursing notes indicated that alarms were being used and the sitter would be used only as needed. At 7:45 pm that evening, nursing notes indicated the patient was turning off the chair alarm and wondering in the room. On 9/25/18, at 5:55 am, nursing documentation indicated that staff were "occasionally finding patient attempting and successfully turning off safety alarm. " Although staff documented MR 1 was confused to the situation, they reminded the patient to ring the call bell if assistance was needed. On 9/26/18, at 5:34 am, nursing notes indicated that the patient was an elopement and safety risk and further documentation over the next four (4) days, revealed MR 1 continued to ambulate in the room and in the hall refusing to use the bed alarm. On 9/30/18, a note written by the physician at 6:15 pm, indicated that MR 1 left " the floor without permission for a walk " and " just wanted to get out of the room a bit. I think it may help to have planned walks off the floor with a staff member ". The physician wrote an order for the patient to be taken off the floor by a staff member for walks. Review of MR 1 ' s record on 2/15/19, indicated | A 0145 | | |

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| A 0145 | Continued from page 31<br><br>there was no evidence that this order was followed. Nursing documentation on 9/30/18 at 6:45 pm, revealed that MR 1 left the floor earlier that day without staff ' s knowledge and was found in the emergency room. As of 10/1/18, nursing staff began to document that MR 1 was on elopement precautions. Interview with staff EMP 2 and EMP 3 on 2/15/19, revealed the facility had not defined " elopement precautions " and there was no policy or protocol for staff to follow if they had a patient like MR 1 who attempted to elope. Based on a review of the medical record documentation for MR 1 and this interview, there was no evidence that the interventions used to supervise MR 1 to ensure safety were being evaluated and changed if needed when the episodes of attempted elopement continued. Nursing documentation from 10/2/18 through 10/11/18, indicated that MR 1 remained an elopement risk and attempted to or successfully elope on six (6) occasions and on two (2) of those elopements, MR1 was found in the emergency room or in radiology.<br>Nursing documentation written on 10/13/18 at 2:53 am revealed that MR 1 was seen by security at 10:00 pm on 10/12/18, standing alone outside on | A 0145 | | |

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| A 0145 | Continued from page 32<br><br>the emergency room ramp, wearing a pair of staff ' s scrubs. When security approached MR 1, security inquired if the patient was an employee. MR 1 said yes. Because security did not see an armband on the patient, security called the emergency room to see if any of their patients were missing. When the emergency room said no, security spoke again to MR 1 telling the patient to have a good evening. Two hours later, security was notified that a patient, MR 1, was missing. Nursing documentation indicated that staff had gone into MR 1 ' s room at 9:30 pm to check on the patient but when staff returned for their two (2) hour check at 11:30 pm, MR 1 was missing. Nursing notified security of the missing patient and security realized that the individual they observed earlier on the emergency room ramp, was most likely MR 1. Calls were made to local hospitals to notify them of the missing patient. Another hospital responded indicating that the patient was on their property. This hospital is 1.3 miles away and the evening of the elopement, the air temperature was 49 degrees. Nursing documentation written on 10/13/18 at 5:36 am, indicated that when MR 1 was returned to the hospital around 2:00 am, | A 0145 | | |

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| A 0145 | Continued from page 33<br><br>nursing management indicated that the " patient should be changed into a hospital gown. Pt now has a 1:1 sitter in the room " .<br>On 2/15/19, interview with facility staff (EMP 2 and EMP 4), confirmed that: the facility failed to develop a plan to keep a known wanderer safe; have evidence that included the interventions that were used to prevent elopement and if they were effective; failed to demonstrate follow-up and reevaluation of the interventions if they were not effective; failed to utilize established tools the hospital had created including the complex care meeting which brought together multiple disciplines to discuss complex cases and make recommendations; and failed to define elopement precautions and create a policy and procedure, so staff knew what to do if they had a patient who was at risk for elopement.<br>A review of facility documentation and interview with EMP 1, revealed that the hospital staff met on 10/25/18 to discuss the circumstances around the incident of 10/12/18. Staff presented their findings of the incident to the hospital ' s Patient Safety Committee on 11/19/18. A taskforce began to meet to further develop and implement | A 0145 | | |

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| A 0145 | Continued from page 34<br><br>interventions on January 1, 2019, 82 days after the elopement. At the time of this survey, 2/15/19, four (4) months after MR 1 eloped, the hospital had not implemented a policy and plan designed to protect patients like MR 1 who were at risk for serious harm, injury, or death.<br>Medical record review on 2/15/19, revealed that MR 2 and MR 3 were both assessed as potential elopement risks. Both patients were ambulatory and cogently impaired. Staff felt that although the patients had not attempted to elope from the facility, their inability to make sound decisions and the psychiatric diagnoses that they were suffering from, put the two (2) patients at risk for harm should they leave the facility themselves. | A 0145 | | |

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| P 0000 | INITIAL COMMENT<br><br>This report is the result of an unannounced onsite complaint investigation (CHL19C064H) completed on February 15, 2019, at Lancaster General Hospital. It was determined that the facility was not in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Hospitals, 28 PA Code, Part IV, Subparts A and B, November 1987, as amended June 1998. | P 0000 | | |
| P 0301 | | P 0301 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

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| P 0301 | Continued from page 1<br><br>103.1 GENERAL PROVISIONS - PRINCIPLE<br><br>103.1 Principle<br><br>There shall be an organized governing body or designated person vested with ownership who shall assume the full legal authority and responsibility for the conduct of the hospital.<br><br>This REGULATION is not met as evidenced by: | P 0301 | The Chief Executive Officer and Chief Clinical Officer to provide a presentation to the Board of Trustees regarding the October 12, 2018 elopement of a cognitively impaired patient, the regulatory deficiencies identified, and the corrective actions being implemented to ensure compliance with all CMS Conditions of Participation and Department of Health state regulation. Complete Date 3/21/19<br><br>The Chief Nursing Officer to provide a presentation to the Board of Trustees Quality Committee regarding the October 12, 2018 elopement of a cognitively impaired patient, the regulatory deficiencies identified, and the corrective actions being implemented to ensure compliance with all CMS Conditions of Participation and Department of Health state regulations. 4/8/19 | Completion Date: **04/08/2019** Status: **APPROVED** Date: **03/19/2019** |

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| P 0301 | Continued from page 2<br><br>Based on review of facility documents and medical records, and interviews with staff, the Governing Body failed to function effectively and ensure the hospital consistently operated in a manner that protected the health and safety of its patients.<br>Findings include:<br>The Governing Body failed to ensure that the facility operated in a manner that ensured continued compliance with the federal regulations that promote and protect patients ' health and safety as evidenced by the hospital's history of noncompliance over the past 12 months.<br>A review of survey results from February 2018 revealed that the facility failed to ensure that patients consistently received physician ordered respiratory treatments. A review of survey results from November 2018 revealed that the facility failed to ensure that patients were free from abuse and failed to conduct timely and comprehensive investigations when allegations of abuse were alleged by patients.<br><br>As a result of the surveys in February and November, 2018, mentioned above, the facility | P 0301 | | |

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| P 0301 | Continued from page 3<br><br>responded with a plan to correct the deficient practices. During each follow up survey, it was determined that the facility implemented their plan of correction and had achieved compliance but the period of compliance did not last more than a few months.<br><br>In February, 2019, it was determined that the hospital did not have a plan in place to supervise wandering cognitively impaired patients and as a result, a patient, MR 1, eloped from the facility at night and walked by herself through town to another hospital. MR1 would have walked 1.3 miles taking approximately 23 minutes to arrive in 49 degree weather wearing only hospital scrubs and crocs. | P 0301 | | |
| P 0315 | | P 0315 | | |

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| P 0315 | Continued from page 4<br><br>103.4 (1) FUNCTIONS<br><br>103.4 Functions<br>The governing body, with technical assistance and advice from the hospital staff, shall do the following:<br>(1) Provide appropriate physical resources and personnel required to meet the needs of the patients and participate in planning to meet the health needs of the patients and health needs of the community. A quality control mechanism should be established which includes as an integral part thereof a risk management component and an infection control program.<br><br>This REGULATION is not met as evidenced by: | P 0315 | A workforce strategy was created to reduce lag time between a staffing vacancy occurring and the time to fill the position. Human Resources will create "evergreen requisitions" in Workday that will allow the recruitment of skilled staff continually throughout the year rather than waiting until a vacancy occurs. The evergreen requisitions will be created based on historical trends of turnover and organizational needs. The Vice President of Human Resources is the responsible party for communicating and implementing this strategy that will help to ensure that there is adequate staffing to meeting the needs of the patients. 4/18/19<br><br>Compliance to Active Nursing Orders for all patients identified at risk for elopement will be audited daily by the nursing manager and/or facilitator in association with the RN responsible for the patient. Barriers identified in the workflow of nursing orders will be identified and escalated to the nursing directors | Completion Date: **04/18/2019**<br>Status: **APPROVED**<br>Date: **03/19/2019** |

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| P 0315 | Continued from page 5 | P 0315 | and CNO for resolution. Noncompliance by the staff RN will be addressed through coaching at the bedside by the manager and utilizing as Human Resources disciplinary process if indicated. Complete Date 3/18/19<br><br>Nursing department policy for daily "Chart Check Procedure" will be reviewed and modified to ensure current practice and policy are consistent with best practice and regulatory standards. The CNO is the owner of the policy and is responsible for completion of the review and revisions. Complete Date 4/18/19 | |
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| P 0315 | Continued from page 6<br><br>Based on the facility's failure to develop and implement a plan of supervision to ensure the safety of cognitively impaired patients, placed the patients at risk for serious injury, harm, and death. Three patients were identified as being in jeopardy due to their impaired cognition and ambulatory status, MR 1, MR2, and MR 3.<br><br>Findings include:<br><br>Medical record review on 2/15/19 revealed that MR 1 was brought to the hospital's emergency department on 9/20/18, from another healthcare facility where the patient lived on a locked dementia unit. According to documentation from the hospital emergency room record on 9/20/18, MR 1 had been refusing medications and was exhibiting behaviors some of which could have harmed others. In addition, the record stated that MR1 had been pounding on the walls daily and yelling to be let out of the locked unit.<br>Medical record review revealed that MR1 was assessed by the physician in the emergency room at 9:01 pm. The assessment revealed a history of schizoaffective disorder and dementia. In addition, | P 0315 | | |

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| P 0315 | Continued from page 7<br><br>the physician documented the "ED diagnosis" was Acute metabolic encephalopathy. The physician wrote that the patient required inpatient admission due to the diagnoses and that the patient could not be treated safely as an outpatient.<br><br>Medical record review revealed that MR 1 was admitted to the hospital on 9/20/18 and a consult with a psychiatrist the following day, 9/21/18, at 8:51 am, revealed an additional diagnosis of vascular dementia with behavioral disturbance and a note that indicated that MR 1's decision making capacity was compromised with no recollection of behaviors at the the prior facility. Nursing documentation indicated that the use of a sitter would continue since the patient, MR 1, had been a danger to others at the facility the patient lived prior to admission.<br><br>Medical record review revealed that two (2) days following admission, on 9/22/18, MR 1 became combative and threw the dinner tray and then slipped on the liquid that had spilled on the floor from the food tray. Later that same day, nursing | P 0315 | | |

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| P 0315 | Continued from page 8<br><br>notes indicated that MR 1 was noted to be impulsive and attempted to leave the unit. On 9/23/18, it was documented in the nursing notes at 11:01 pm, that MR 1 said, "I want to go home." The following day, 9/24/18, on 12:42 am, nursing notes indicated that alarms were being used and the sitter would be used only as needed. At 7:45 pm that evening, nursing notes indicated the patient was turning off the chair alarm and wandering in the room. On 9/25/18, at 5:55 am, nursing documentation indicated that staff were "occasionally finding patient attempting and successfully turning off safety alarm. " Although staff documented MR 1 was confused to the situation, they reminded the patient to ring the call bell if assistance was needed. On 9/26/18, at 5:34 am, nursing notes indicated that the patient was an elopement and safety risk and further documentation over the next four (4) days, revealed MR 1 continued to ambulate in the room and in the hall refusing to use the bed alarm. On 9/30/18, a note written by the physician at 6:15 pm, indicated that MR 1 left " the floor without permission for a walk " and " just wanted to get out of the room a bit. I think it may help to have | P 0315 | | |

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| P 0315 | Continued from page 9<br><br>planned walks off the floor with a staff member ". The physician wrote an order for the patient to be taken off the floor by a staff member for walks. Review of MR 1 ' s record on 2/15/19, indicated there was no evidence that this order was followed. Nursing documentation on 9/30/18 at 6:45 pm, revealed that MR 1 left the floor earlier that day without staff ' s knowledge and was found in the emergency room. As of 10/1/18, nursing staff began to document that MR 1 was on elopement precautions. Interview with staff EMP 2 and EMP 3 on 2/15/19, revealed the facility had not defined " elopement precautions " and there was no policy or protocol for staff to follow if they had a patient like MR 1 who attempted to elope. Based on a review of the medical record documentation for MR 1 and this interview, there was no evidence that the interventions used to supervise MR 1 to ensure safety were being evaluated and changed if needed when the episodes of attempted elopement continued. Nursing documentation from 10/2/18 through 10/11/18, indicated that MR 1 remained an elopement risk and attempted to or successfully elope on six (6) occasions and on two (2) of those elopements, MR1 was found in the | P 0315 | | |

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| P 0315 | Continued from page 10<br><br>emergency room or in radiology.<br><br>Nursing documentation written on 10/13/18 at 2:53 am revealed that MR 1 was seen by security at 10:00 pm on 10/12/18, standing alone outside on the emergency room ramp, wearing a pair of staff ' s scrubs. When security approached MR 1, security inquired if the patient was an employee. MR 1 said yes. Because security did not see an armband on the patient, security called the emergency room to see if any of their patients were missing. When the emergency room said no, security spoke again to MR 1 telling the patient to have a good evening. Two hours later, security was notified that a patient, MR 1, was missing. Nursing documentation indicated that staff had gone into MR 1 ' s room at 9:30 pm to check on the patient but when staff returned for their two (2) hour check at 11:30 pm, MR 1 was missing. Nursing notified security of the missing patient and security realized that the individual they observed earlier on the emergency room ramp, was most likely MR 1. Calls were made to local hospitals to notify them of the missing patient. Another hospital responded indicating that the patient was on their | P 0315 | | |

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| P 0315 | Continued from page 11<br><br>property. This hospital is 1.3 miles away and the evening of the elopement, the air temperature was 49 degrees. Nursing documentation written on 10/13/18 at 5:36 am, indicated that when MR 1 was returned to the hospital around 2:00 am, nursing management indicated that the " patient should be changed into a hospital gown. Pt now has a 1:1 sitter in the room " .<br><br>On 2/15/19, interview with facility staff (EMP 2 and EMP 4), confirmed that: the facility failed to develop a plan to keep a known wanderer safe; have evidence that included the interventions that were used to prevent elopement and if they were effective; failed to demonstrate follow-up and reevaluation of the interventions if they were not effective; failed to utilize established tools the hospital had created including the complex care meeting which brought together multiple disciplines to discuss complex cases and make recommendations; and failed to define elopement precautions and create a policy and procedure, so staff knew what to do if they had a patient who was at risk for elopement.<br>A review of facility documentation and interview | P 0315 | | |

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| P 0315 | Continued from page 12<br><br>with EMP 1, revealed that the hospital staff met on 10/25/18 to discuss the circumstances around the incident of 10/12/18. Staff presented their findings of the incident to the hospital ' s Patient Safety Committee on 11/19/18. A taskforce began to meet to further develop and implement interventions on January 1, 2019, 82 days after the elopement. At the time of this survey, 2/15/19, four (4) months after MR 1 eloped, the hospital had not implemented a policy and plan designed to protect patients like MR 1 who were at risk for serious harm, injury, or death.<br>Medical record review on 2/15/19, revealed that MR 2 and MR 3 were both assessed as potential elopement risks. Both patients were ambulatory and cognitively. Staff felt that although the patients had not attempted to elope from the facility, their inability to make sound decisions and the psychiatric diagnoses that they were suffering from, put the two (2) patients at risk for harm should they leave the facility themselves. | P 0315 | | |

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| P 0344 | | P 0344 | | |

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| P 0344 | Continued from page 14<br><br>103.21 PATIENT'S BILL OF RIGHTS<br><br>103.21 Principle<br>It is the purpose of these 103.21 - 103.24 to promote the interests and well being of the patients and residents of hospitals subject to this subpart even in those instances where the interests of the patients may be in opposition to the interests of the hospital. It is declared to be the public policy of the Department that the interests of the patients be protected by a Patient's Bill of Rights. Nothing in these 103.21 - 103.24 is intended to serve as evidence of a standard of reasonable conduct for the purpose of determining civil liability between providers and consumers of health services. The hospital has the right to expect the patient to fulfill patient responsibilities as may be stated in the hospital's rules affecting patient care and conduct.<br><br>This REGULATION is not met as evidenced by: | P 0344 | Effective immediately, the CNO created a process to ensure that she was notified on a daily basis of any patient that would be considered an elopement risk to ensure that appropriate resources and interventions were in place to prevent a potential patient elopement. This process will continue until a formal policy and procedures are established, implemented, and audited to demonstrate compliance to ensure patient safety. Complete Date 2/15/19<br><br>The CNO provided education to high priority departments (security, nursing supervisors, nursing directors, and ED leadership) and the immediate actions that needed to take place to keep patients with cognitive deficiencies safe from elopement. Complete Date 2/18/19<br><br>An Elopement Screening Tool was adopted and a process developed to screen every patient on arrival to a nursing unit within the hospital. If | Completion Date: **04/15/2019**<br>Status: **APPROVED**<br>Date: **03/19/2019** |

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| P 0344 | Continued from page 15 | P 0344 | positive for risk of elopement, the status will continue for the duration of the patient's hospitalization unless it is determined by an interdisciplinary care team that the patient is no longer an elopement risk. Patients who screen negative for risk for elopement will be rescreened upon transfer of level of care or change in condition. The CNO is responsible for the implementation and daily tracking of compliance to the screening and will ensure that any lack of compliance will be identified, analyzed and corrective actions implemented. Complete Date 3/8/19<br><br>The Elopement Screening Tool was built in the Epic medical record and the Director of Business Intelligence is the responsible person for ensuring daily reports of screening tool compliance are provided to the CNO and nursing managers. A visual (red/green) cue was built into Epic to alert the nurse if the screening tool was completed on admission. Complete Date 3/8/19 | |

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| P 0344 | Continued from page 16 | P 0344 | An Epic report was created to identify any patient that was admitted prior to the admission elopement screening implementation. The nursing directors rounded on the clinical units and completed the Elopement Screening Tool on those patients. Complete Date 3/11/19<br><br>The CNO led a taskforce that developed and implemented a Policy for "Elopement Risk Interventions for Patients Who Are Cognitively Impaired". The policy included: assessment frequency; interventions for patients at risk; collaboration with patient and family; the role of security; and documentation requirements. Education was provided to nursing staff and hospital managers/directors regarding the policy prior to implementation. Complete Date 3/8/19<br><br>A computer-based learning (CBL) module for mitigating risks of elopement was developed and | |

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| P 0344 | Continued from page 17 | P 0344 | implemented by the Director of Nursing Professional Development. It is mandatory for all staff to complete the CBL by April 1, 2019 (unless on extended leave). Any noncompliance will be addressed through the employee disciplinary process. Complete Date 3/4/19<br><br>The CNO created a tracking log to monitor cognitively impaired patients identified at risk for elopement and audit compliance with screening, interventions implemented, documentation within the medical record, and compliance to the policy. The CNO will review any deviations, identify any opportunities for improvement, and implement corrective actions. Complete Date 3/18/19<br><br>The CNO (or her delegate) will provide a monthly elopement compliance update at the Patient Safety Committee until there are three consecutive months of full compliance with the policy. The Patient Safety Committee minutes are | |

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| P 0344 | Continued from page 18 | P 0344 | approved at the Board Quality Committee Meeting and the Board of Trustees Meeting. Complete Date 4/15/19 | |

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| P 0344 | Continued from page 19<br><br>Based on the facility's failure to ensure cognitively impaired ambulatory patients were provided with consistent and appropriate supervision (MR 1), it was determined that cognitively impaired ambulatory patients (MR 1, MR 2, and MR 3) were at risk for harm.<br><br>Findings include:<br><br>Medical record review on 2/15/19 revealed that MR 1 was transferred by ambulance to the emergency department on 9/20/18, due to the patient's refusal to take medications and attempts to harm staff and other patients at the facility that MR 1 lived. Nursing documentation indicated that following admission to the hospital on 9/20/18, MR 1 began to wander in and out of the room and the unit. Based on a review of documentation in the medical record, the hospital failed to have a system in place which protected the wandering patient or implemented a plan of care that met the patient ' s needs. This failure placed MR1, and other cognitively impaired patients (MR 2 and MR 3), at risk for harm if they left their room, unit, or | P 0344 | | |

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| P 0344 | Continued from page 20<br><br>building without staff ' s knowledge or assistance. | P 0344 | | |
| P 0352 | | P 0352 | | |

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| P 0352 | Continued from page 21<br><br>103.22 (b)(7) IMPLEMENTATION<br><br>(7) The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.<br><br>This REGULATION is not met as evidenced by: | P 0352 | The Director of Security and the Director of Safety will develop and implement an Elopement Response Plan within the Emergency Management Plan. Education will be provided to all departments impacted. A debriefing will occur after each activation of the elopement response plan or drill and opportunities for improvement identified. Complete Date 4/18/19<br><br>The CNO developed a bedside Standard of Work document for bedside nurses regarding the procedure for screening and launching the interventions for patients who screen positive for risk of elopement. The leader Standard of Work document that is used for daily quality rounds by the unit manager/facilitator was modified to include daily auditing of compliance to the elopement policy and standard work. Complete Date 3/8/19<br><br>Creating and modifying the patients' individualized "interdisciplinary plan of care" is an expectation as outlined | Completion Date: **04/18/2019**<br>Status: **APPROVED**<br>Date: **03/19/2019** |

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| P 0352 | Continued from page 22 | P 0352 | in the Policy for Interdisciplinary Documentation and Charting. The CNO implemented a process for the nursing directors (including hospital nursing supervisor on duty during weekends/holidays) to review each care plan on a daily basis, for each patient screened positive for risk of elopement, with the nurse manager and the bedside nurse to provide coaching/education on the what to consider for an individualized plan of care. Once the daily review is consistently compliant at 100%, the daily review of the care plans will be completed by the nurse managers/facilitators and documented in the leaders Standard of Work document utilized during their daily quality rounds. Opportunities for improvement will be identified and improvement actions implemented through collaboration between the nursing directors to ensure consistency across the hospital (Duke Street Hospital and Women and Babies Hospital). Complete Date 3/18/19<br>The policy for Interdisciplinary | |

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| P 0352 | Continued from page 23 | P 0352 | Documentation and Charting will be revised with more specific instructions on how and when to individualize the Interdisciplinary Plan of Care documentation. The CNO is the owner of the policy and will oversee the revision of the policy. Complete Date 4/18/19 | |

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| P 0352 | Continued from page 24<br><br>Based on the review of medical records and facility documents, and staff interviews, it was determined that the facility failed to ensure each patient received the supervision necessary based on their assessed needs. This failure placed a cognitively impaired ambulatory patient (MR 1) and other patients with similar diagnoses (MR 2 and MR 3), at risk for harm. Findings include:<br>According to the medical record, on 9/20/18, MR1 was transferred to the facility from another healthcare facility ' s locked dementia unit. MR 1 had a diagnosis of acute encephalopathy and vascular dementia with behavioral disturbances and a history of bipolar and schizoaffective disorder. On 9/20/18, at 4:44 pm, MR 1 was brought to the emergency room due to the refusal to take medications and attempts to harm other patients and staff. Assessment in the emergency room by the physician on 9/20/18 signed at 11:01 pm, revealed that MR 1 was " adamantly agitated pacing in the room intermittently " and " restless ". Nursing documentation indicated that both a sitter and a bed alarm were utilized while the patient was in the emergency department due to the patient ' s behaviors at the other facility. | P 0352 | | |

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| P 0352 | Continued from page 25<br><br>Documentation also revealed that case management was involved and recommended hospitalization for placement.<br><br>The admitting physician note written on 9/20/18 at 7:31 pm indicated that MR 1 was going to be admitted to the hospital to get the patient back on medications which would help with the problematic behaviors. Nursing documentation revealed that on 9/22/18 at 8:39 pm, the patient tried to leave the floor without the assistance or knowledge of the staff. Additional nursing documentation from 9/22/18 through 10/12/18, revealed that the patient attempted to and/or successfully left the unit unattended without staff ' s knowledge, on seven (7) occasions. According to documentation in the medical record and interview with staff (EMP 2 and EMP 3), the facility failed to develop a plan to keep MR 1 safe. Further interview confirmed that interventions to stop MR 1 from wandering off the unit unattended were not consistently documented and/or implemented.<br><br>Medical record review for MR 2 on 2/15/19, | P 0352 | | |

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| P 0352 | Continued from page 26<br><br>indicated that the patient was admitted on 1/22/19. The patient had diagnoses which included: behavioral disturbances, encephalopathy, heroin abuse, ambulatory dysfunction-falling at home, and medication non-compliance. According to interview with EMP 4 on 2/15/19, MR 2 was to have a constant sitter because the patient was so weak and unsteady. Nursing documentation indicated that the patient ambulated around the room and to the restroom but was considered a high fall risk. Due to agitated and combative behaviors, MR 2 was restrained per doctors' order and the restraints were to be discontinued when the behaviors improved. The patient was assessed as cognitively impaired with delirium and visual hallucinations according to notes written in a psych consult and that some of MR 2's behaviors and delirium were associated with self-medicating with multiple medications including psychiatric medications.<br><br>Based on MR 2's condition and past history, the patient was assessed as an elopement risk but according to staff, EMP 4, on 2/15/19, " she is too weak to get out ". Staff indicated that they were | P 0352 | | |

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| P 0352 | Continued from page 27<br><br>concerned that when MR 2's condition improves, the patient may try to elope from the unit. Staff failed to develop an individualized care plan that addressed the need to provide supervision to MR 2 so that patient would not leave the facility without staff or staff's knowledge of the patient's whereabouts.<br><br>Medical record review for MR 3 on 2/15/19, revealed the patient was admitted in 1/19 due to the patient's need for psychiatric assessment and treatment. The patient was admitted from home which was facilitated by the spouse who was aware and concerned about the decisions that the patient was making. The patient was ambulatory and the delirium that was present at home continued upon admission to the facility. Due to the patient's impaired cognition, staff felt that MR 3 may be an elopement risk. Staff failed to develop an individualized plan of care for MR 3 to ensure that the patient did not elope from the facility and potentially suffer harm. | P 0352 | | |

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| P 0374 | | P 0374 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 390100 | A. BLDG: 00<br>B. WING: | 02/15/2019 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **LANCASTER GENERAL HOSPITAL, THE**<br>STATE LICENSE NUMBER: **120801** | **555 NORTH DUKE STREET**<br>**LANCASTER, PA 17604** |

| (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 0374 | Continued from page 29<br><br>103.31 CHIEF EXECUTIVE OFFICER<br><br>103.31 The chief executive officer<br><br>The governing body shall appoint a chief executive officer whose qualifications, authority, responsibilities, and duties shall be defined in a written statement adopted by the governing body. The chief executive officer shall be responsible for the application and implementation of established policies in the operation of the hospital and for providing liaison among the governing body, the medical staff, and the departments of the hospital.<br><br>This REGULATION is not met as evidenced by: | P 0374 | The Chief Executive Officer (CEO) called an emergency executive leadership meeting on Sunday, February 17, 2019 to discuss the immediate jeopardy deficiency and establish an executive action plan with timelines for implementation.<br>The individuals included:<br>1. CEO<br>2. EVP and Chief Administrative Officer<br>3. Chief Clinical Officer<br>4. Chief Financial Officer<br>5. Chief Human Resources Officer<br>6. SVP and General Counsel<br>7. SVP, Hospital Operations<br>8. SVP, Quality<br>9. Chief Nursing Officer<br>10. SVP, Service Lines & Population Health<br>11. President, Physician Services<br>Complete Date 2/17/19<br>The CEO made the decision to create a Chief Operating and Integration Officer position to oversee all clinical operations. The job description was finalized and an agreement was signed with an executive search firm to launch a national search. | Completion Date: **03/20/2019**<br>Status: **APPROVED**<br>Date: **03/19/2019** |

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| P 0374 | Continued from page 30 | P 0374 | Complete Date 2/20/19<br>The CEO sent an organization-wide communication to all leaders directing them to curtail all meeting/conference travel outside of Lancaster to focus on primary responsibilities of protecting our patients from potential harm and meet all regulatory standards for patient safety. Complete Date 2/26/19<br>The CEO led an Executive Leadership Briefing to discuss the regulatory deficiencies that resulted in loss of CMS deemed status three times over the past year. CEO provided clear prioritization and need for immediacy in achieving organizational compliance with all CMS Conditions of Participation and Department of Health state regulations. Complete Date 3/7/19<br>The Hospital Regulatory Steering Committee was redesigned with updated membership, committee charter, and implementation of monthly meetings for the next 6 months. Regulatory and CMS chapter leads began meeting weekly | |

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| P 0374 | Continued from page 31 | P 0374 | on 3/8/19 to clarify standards, identify potential gaps in compliance, and implement corrective actions. In addition, on 3/8/19 a hospital lawyer was fully dedicated to the regulatory review of hospital policies to ensure they were complaint with CMS, DOH, and TJC regulatory requirements. The SVP of Quality and SVP, Legal Counsel are the responsible leaders providing oversight of the regulatory review and improvements. Complete Date 3/20/19 | |

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| P 0374 | Continued from page 32<br><br>Based on a review of the facility's compliance history, it was determined that the facility's chief executive officer did not provide the supervision and oversight necessary to ensure staff consistently provided the necessary care and treatment needed by the patients.<br><br>Findings include:<br><br>Based on a review of the Department of Health deficiency reports for the past 12 months from February 2018 to February 2019, revealed that the facility had been cited for its non compliance in these areas: failure to follow physicians' orders for respiratory treatments; failure to conduct timely and comprehensive investigations of alleged patient abuse; and failure to ensure that cognitively impaired patients received adequate supervision to keep them safe. In each of these situations, the facility had developed and implemented a plan of correction however, the facility failed to maintain compliance thus placing patients at risk for harm. | P 0374 | | |

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| P 0374 | Continued from page 33 | P 0374 | | |

# Certified End Page

**LANCASTER GENERAL HOSPITAL, THE**

**STATE LICENSE NUMBER: 120801**

**SURVEY EXIT DATE: 02/15/2019**

**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**

*Susan Coble*
*Deputy Secretary for Quality Assurance*

*Rachel L. Levine, MD*
*Secretary of Health*

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

## PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY