STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390100		-	A. BLDG: _ B. WING: _	DPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 02/15/2019				
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801			STREET ADDRESS, CITY, STATE, ZIP CODE: 555 NORTH DUKE STREET LANCASTER, PA 17604						
STATE LICENS	E NOMBER. 120001								
(X4) ID PREFIX TAG	TIX MUST BE PRECEEDED BY FULL REGULATORY O			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
A 0000	INITIAL COMMENT			A 0000					
LABORATORY I	DIRECTOR'S OR PROVIDER/SUPPLI	ER 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/SUPPLIE IDENTIFICATION NUMB 390100				PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 02/15/2019	EY
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801			STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRI	EET		
(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	
A 0000	This report is the result complaint investigation on February 15, 2019. facility was not in com of 42 CFR, Title 42, Participation for Hospi Immediate Jeopardy w 2019, at 3:25 pm due to provide goods and serve physical harm. The fact adequate supervision for who was cognitively in wandered off the unit w Staff failed to develop care plan based on the left the facility after 9:1 without staff's knowled hospital allegedly on for wearing a pair of scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the room and a server of the staff scrub unaware the patient left doing rounds at 11:00 proof in the staff scrub unaware the patient left doing rounds at 11:00 proof in the staff scrub unaware the patient left doing rounds at 11:00 proof in the staff scrub unaware the patient left doing rounds at 11:00 proof in the staff scrub unaware the patient left doing rounds at 1	It was determined the pliance with the request 482-Conditions of tals. as called on Februar to the facility's failure vices necessary to avoid the facility failed to provide or one (1) patient, Monpaired and occasion without staff's knowleand evaluate an indipatient's needs. The poop on October 12 days and traveled to a poot. The patient was as and shoes. Staff with the building until a pun discovered that Northean and the pulled to the patient was staff with the building until a pun discovered that Northean and the pulled to the patient was staff with the building until a pun discovered that Northean and the pulled to the patient was staff with the pulled to the pulled to the patient was staff with	ompleted hat the uirements f y 15, e to oid e IR 1, nally ledge. vidualized patient 2, 2018 nearby s only vas nurse MR1 was	A 0000			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 390100			(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 02/15/2019	ΞY	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801			STREET ADDRESS, 555 NORTH D LANCASTER	OUKE STRI			
(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 CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0000	successful. The facility and procedure, for supercognitively impaired prother patients of the horisk for serious injury, The facility's action plate accepted on February I facility's immediate act of the CNO of all elope on a daily basis; discuss daily Safety Huddle; depatient elopement of coeducation provided to a managers/directors regimplementation of the be developed and implication in the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of the beautified elopement rilearning module for managers/directors regimplementation of	ervision of wanderinatients, placed MR 1 ospital (MR 2 and M harm, and/or death. an to abate the jeopa 15, 2019 at 4:59 pm. tion plan included: nument risks within the sion of all elopement evelopment of a policy impaired pall nursing staff and arding the policy and policy; a tracking to emented to audit/mosks; a computer base itigating risks of elopand development of	rdy was The totification the hospital at risks at the second patients; hospital dol/log will onitor all ed pement and an	A 0000			

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		390100				02/15/2019	
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A 0000	Continued from page 3			A 0000			
A 0043				A 0043			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 390100			A. BLDG: <u>00</u>		(X3) DATE SURVI COMPLETED: 02/15/2019		
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		C, THE	STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRE			
(X4) ID PREFIX TAG	PREFIX MUST BE PRECEEDED BY FULL REGULATORY OF			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0043	Continued from page 4 482.12 GOVERNING BOD There must be an effective gresponsible for the conduct does not have an organized legally responsible for the carry out the functions specthe governing body This REQUIREMENT is not	governing body that is le of the hospital. If a hosp governing body, the per onduct of the hospital m ified in this part that per	pital sons ust	A 0043	The Chief Executive Officer Chief Clinical Officer to propresentation to the Board of Trustees regarding the Octob 2018 elopement of a cognitivi impaired patient, the regulate deficiencies identified, and tocorrective actions being implemented to ensure compwith all CMS Conditions of Participation and Departmen Health state regulation. Compate 3/21/19 The Chief Nursing Officer to provide a presentation to the of Trustees Quality Committed a presentation to the of Trustees Quality Committed and the Cotober 12, 20 elopement of a cognitively in patient, the regulatory deficited identified, and the corrective being implemented to ensure compliance with all CMS Cotof Participation and Departmented the trusted of Participation and Departmented to Participation and Partmented to Participation and Partmented to Part	ovide a ovi	Completion Date: 04/08/2019 Status: APPROVED Date: 03/19/2019

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OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED:	
	390100				02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		555 NORTH D	UKE STRI	EET		
MUST BE PRECEEDE	D BY FULL REGULATORY OF		ID PREFIX TAG	CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETE DATE
Continued from page 5			A 0043			
records, and interviews with Body failed to function effect hospital consistently operated protected the health and saffindings include: The Governing Body failed facility operated in a manneontinued compliance with that promote and protect pasafety as evidenced by the noncompliance over the pasafety as evidenced to ensure that patient abuse and failed to conduct comprehensive investigation abuse were alleged by patients. As a result of the surveys in	th staff, the Governing actively and ensure the sted in a manner that afety of its patients. Ito ensure that the er that ensured the federal regulations patients 'health and hospital's history of est 12 months. From February 2018 ailed to ensure that ared physician ordered review of survey results aled that the facility est were free from the timely and ens when allegations of ents.					
responded with a plan to co	orrect the deficient					
	As a result of the surveys in November, 2018, mentions of the survey	A SPORT SUPPLIER: ER GENERAL HOSPITAL, THE ENUMBER: 120801 SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION) Continued from page 5 Based on review of facility documents and medica 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. Findings include: 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. A review of survey results from February 2018 revealed that the facility failed to ensure that patients consistently received physician ordered	Areview of survey results from February 2018 Areview of survey results from February 2018 Areview of survey results from November 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 consistently received physician ordered respiratory treatments. A review of survey results from November 2018 revealed that the facility failed to ensure that the patients consistently received physician ordered respiratory treatments. A review of survey results from November 2018 revealed that the facility failed to ensure that the patients consistently received physician ordered respiratory treatments. A review of survey results from November 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. As a result of the surveys in February and November, 2018, mentioned above, the facility	A BLDG: 390100 STREET ADDRESS, CITY, STATE, STS NORTH DUKE STRET ADDRESS, CITY, STATE, STS NORTH DUKE STRET LANCASTER, PA 17604 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 5 A 0043 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. Findings include: 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. 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. As a result of the surveys in February and November, 2018, mentioned above, the facility	A BLDG:	IDENTIFICATION NUMBER: 390100 STREET AIDDRESS, CITY, STATE, ZIP CODE SSS NORTH DUKE STREET LANCASTER, PA 17604 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued from page 5 A 0043 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 approtected the health and safety of its patients. Findings include: 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. 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. As a result of the surveys in February and November, 2018, mentioned above, the facility

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PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 02/15/2019			
NAME OF PRO	VIDER OR SUPPLIER:	390100	STREET ADDRESS,			02/10/2019			
	ER GENERAL HOSPITAI	L, THE	555 NORTH DUKE STREET LANCASTER, PA 17604						
STATE LICENS	E NUMBER: 120801		Lanceristen	,111 17001					
(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 CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
A 0043	Continued from page 6			A 0043					
	practices. During each followed determined that the facility plan of correction and had but the period of compliant than a few months. In February, 2019, it was donospital did not have a plan wandering cognitively imporesult, a patient, MR 1, elonight and walked by hersel another hospital. MR1 woo miles taking approximately 49 degree weather wearing and crocs.	y implemented their achieved compliance ce did not last more etermined that the in in place to supervise aired patients and as a sped from the facility at f through town to ald have walked 1.3							
A 0057				A 0057					

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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:	
		390100		B. WING:		02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		L, THE	555 NORTH I LANCASTER	OUKE STRE			
(X4) ID PREFIX TAG				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 7			A 0057			
	Continued from page 7 482.12(b) CHIEF EXECUTIVE OFFICER The governing body must appoint a chief executive officer who is responsible for managing the hospital. This REQUIREMENT is not met as evidenced by:		officer		The Chief Executive Officer called an emergency executile adership meeting on Sunda February 17, 2019 to discuss immediate jeopardy deficient establish an executive action with timelines for implement The individuals included: 1. CEO 2. EVP and Chief Administr Officer 3. Chief Clinical Officer 4. Chief Financial Officer 5. Chief Human Resources Control of SVP and General Counsel 7. SVP, Hospital Operations 8. SVP, Quality 9. Chief Nursing Officer 10. SVP, Service Lines & Potential Date 2/17/19 The CEO made the decision a Chief Operating and Integrofficer position to oversee a operations. The job description finalized and an agreement wing signed with an executive search	ve ay, so the acy and a plan tation. ative Officer acy and a plan tation.	Completion Date: 03/20/2019 Status: APPROVED Date: 03/19/2019

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	OF DEFICIENCIES AND RECTION (POC)			ΣΥ			
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		L, THE	STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRE	EET		
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A 0057	Continued from page 8			A 0057	to launch a national search. Complete Date 2/20/19 The CEO sent an organization communication to all leaders directing them to curtail all meeting/conference travel of Lancaster to focus on primar responsibilities of protecting patients from potential harm meet all regulatory standards patient safety. Complete Date 2/26/19 The CEO led an Executive Leadership Briefing to discuregulatory deficiencies that r in loss of CMS deemed statut times over the past year. CEO provided clear prioritization need for immediacy in achie organizational compliance we CMS Conditions of Participa Department of Health state regulations. Complete Date 3: The Hospital Regulatory Ste Committee was redesigned wupdated membership, committee was redesigned wupdated membership.	utside of ry g our and s for te uss the resulted us three O and eving vith all ation and 3/7/19 eering with	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
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LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAL E NUMBER: 120801	L, THE	STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRI	EET		
(X4) ID PREFIX TAG	MUST BE PRECEEDI	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)				OULD BE	(X5) COMPLETE DATE
A 0057	Continued from page 9			A 0057	charter, and implementation monthly meetings for the nemonths. Regulatory and CM chapter leads began meeting on 3/8/19 to clarify standard identify potential gaps in compliance, and implement corrective actions. In additio 3/8/19 a hospital lawyer was dedicated to the regulatory rehospital policies to ensure the complaint with CMS, DOH, regulatory requirements. The Quality and SVP, Legal Couthe responsible leaders proviously oversight of the regulatory reand improvements. Complet 3/20/19	xt 6 S s, weekly s, on, on s fully eview of ney were and TJC e SVP of unsel are iding eview	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER 390100			(X2) MULTI A. BLDG: _ B. WING: _		(X3) DATE SURVE COMPLETED: 02/15/2019	ΞY	
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A 0057	Based on a review of the history, it was determine executive officer did not oversight necessary to provided the necessary by the patients. Findings include: Based on a review of the deficiency reports for the February 2018 to February 2018 t	ned that the facility' of provide the supervensure staff consister care and treatment of the past 12 months from the past 12 m	ealth com that the ce in these for mely and ditient y impaired eep them y had ection	A 0057			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390100		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED: 02/15/2019	
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A 0057	Continued from page 11			A 0057			
A 0115				A 0115			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBER 390100			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 02/15/2019		
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A 0115	Continued from page 12 482.13 PATIENT RIGHTS A hospital must protect and This REQUIREMENT is no	promote each patient's i	rights.	A 0115	Effective immediately, the C created a process to ensure the was notified on a daily basis patient that would be conside elopement risk to ensure that appropriate resources and interventions were in place the prevent a potential patient elopement. This process will continue until a formal police procedures are established, implemented, and audited to demonstrate compliance to expatient safety. Complete Date 2/15/19 The CNO provided education high priority departments (so nursing supervisors, nursing directors, and ED leadership immediate actions that needed take place to keep patients we cognitive deficiencies safe file elopement. Complete Date 2 An Elopement Screening To adopted and a process development on arrive nursing unit within the hospital patients.	hat she to of any ered an t oo I ty and ensure te on to ecurity, o) and the ed to with rom 2/18/19 eol was oped to ral to a	Completion Date: 04/15/2019 Status: APPROVED Date: 03/19/2019

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
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A 0115	Continued from page 13			A 0115	positive for risk of elopement status will continue for the dof the patient's hospitalization unless it is determined by an interdisciplinary care team the patient is no longer an eloper risk. Patients who screen negfor risk for elopement will be rescreened upon transfer of locare or change in condition. CNO is responsible for the implement and daily tracking of compliating the screening and will ensure any lack of compliance will identified, analyzed and corrections implemented. Compliance implements in the Elopement Screening To built in the Epic medical receive the Director of Business Interist the responsible person for ensuring daily reports of screening daily reports of screening daily reports of screening tool compliance are provided CNO and nursing managers. Visual (red/green) cue was be Epic to alert the nurse if the screening tool was complete	duration on hat the ment gative e level of The ntation ance to e that be rective lete Date ool was ord and elligence eening d to the A uilt into	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
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A 0115	Continued from page 14			А 0115			
					admission. Complete Date 3/	/8/19	
					An Epic report was created to identify any patient that was admitted prior to the admissive elopement screening implement. The nursing directors rounded the clinical units and complete Elopement Screening Tool of patients. Complete Date 3/11 The CNO led a taskforce that developed and implemented for "Elopement Risk Intervention Patients Who Are Cognitive Complete Cognitive	tentation. ed on sted the n those 1/19 t a Policy ntions	
					Impaired". The policy includ assessment frequency; interv for patients at risk; collabora with patient and family; the resecurity; and documentation requirements. Education was provided to nursing staff and hospital managers/ directors regarding the policy prior to implementation. Complete D 3/8/19	led: ventions tion role of	
					A computer-based learning (module for mitigating risks of		

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		(XI) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER 390100	ER: A. BLDG: _		PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 02/15/2019	ΞY
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		STREET ADDRESS, 555 NORTH D LANCASTER	OUKE STRE				
(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 15			A 0115	elopement was developed an implemented by the Director Nursing Professional Develo It is mandatory for all staff to complete the CBL by April 1 (unless on extended leave). A noncompliance will be address through the employee discip process. Complete Date 3/4/ The CNO created a tracking monitor cognitively impaired patients identified at risk for elopement and audit complia screening, interventions implemented, documentation the medical record, and complete to the policy. The CNO will any deviations, identify any opportunities for improveme implement corrective actions Complete Date 3/18/19 The CNO (or her delegate) we provide a monthly elopement compliance update at the Pat Safety Committee until there three consecutive months of compliance with the policy.	r of opment. o 1, 2019 Any essed linary 19 log to d ance with n within pliance review ent, and s. vill tt tient e are full	

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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:	
		390100				02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI	EET			
(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	
A 0115	Continued from page 16			A 0115	Patient Safety Committee mi approved at the Board Qualit Committee Meeting and the Trustees Meeting. Complete 4/15/19	ty Board of	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER	I * *		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		390100		_	<u></u>	02/15/2019	
LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAI SE NUMBER: 120801	L, THE	STREET ADDRESS, 555 NORTH D LANCASTER	OUKE STRI			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
A 0115	Continued from page 17			A 0115			
	Based on the facility's failu						
	impaired ambulatory patie						
	consistent and appropriate						
	was determined that cogni						
	ambulatory patients (MR 2 at risk for harm. Findings i						
	Medical record review on						
	MR 1 was transferred by ar						
	emergency department or						
	patient's refusal to take me						
	to harm staff and other par						
	MR 1 lived. Nursing docun	•					
	following admission to the						
	1 began to wander in and o						
	unit. Based on a review of						
	medical record, the hospita	al failed to have a					
	system in place which prot	ected the wandering					
	patient and implemented a	a plan of care that met					
	the patient 's needs. This f	failure placed MR1, and					
	other cognitively impaired	patients (MR 2 and MR					
	3), at risk for harm if they l	eft their room, unit, or					
	building without staff 's kn	nowledge or assistance.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	ΣΥ		
		390100		B. WING: 02/15/2019				
LANCAST	NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRE	EET			
(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 CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
A 0115	Continued from page 18			A 0115				
A 0144				A 0144				

		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390100		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		L, THE	STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRE			
(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
A 0144	Continued from page 19 482.13(c)(2) PATIENT RIC The patient has the right to This REQUIREMENT is no	receive care in a safe set		A 0144	The Director of Security and Director of Safety will devel implement an Elopement Re Plan within the Emergency Management Plan. Education provided to all departments impacted. A debriefing will after each activation of the elopement response plan or opportunities for improvement identified. Complete Date 4/ The CNO developed a bedsite Standard of Work document bedside nurses regarding the procedure for screening and launching the interventions of patients who screen positive of elopement. The leader State Work document that is used daily quality rounds by the unmanager/facilitator was modinclude daily auditing of conto the elopement policy and standard work. Complete Data 3/8/19 Creating and modifying the individualized "interdiscipling interdiscipling individualized "interdiscipling interdiscipling i	op and sponse on will be occur drill and ent (18/10) de for for risk andard of for mit diffied to impliance ate	Completion Date: 04/18/2019 Status: APPROVED Date: 03/19/2019

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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:	
		390100			<u>ou</u>	02/15/2019	
LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAI E NUMBER: 120801	L, THE	STREET ADDRESS, 555 NORTH D LANCASTER	OUKE STRE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0144	Continued from page 20			A 0144	of care" is an expectation as in the Policy for Interdiscipli Documentation and Charting CNO implemented a process nursing directors (including nursing supervisor on duty dweekends/holidays) to review care plan on a daily basis, fo patient screened positive for elopement, with the nurse mand the bedside nurse to proceoaching/education on the wconsider for an individualize care. Once the daily review is consistently compliant at 100 daily review of the care plan completed by the nurse managers/facilitators and documented in the leaders St of Work document utilized datheir daily quality rounds. Opportunities for improvement actions implemented through collaboration between the nurdirectors to ensure consistent across the hospital (Duke Str. Hospital and Women and Bat Hospital). Complete Date 3/1	inary g. The s for the hospital luring w each r each risk of anager vide that to d plan of is 0%, the s will be tandard during ent will ent n ursing cy reet ubies	

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PLAN OF CORRECTION (POC) IDENTIFICATION		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			00	(X3) DATE SURVEY COMPLETED: 02/15/2019	
NAME OF DRO	VIDER OR SUPPLIER:	390100	STREET ADDRESS,			02/15/2019	
LANCAST	ER GENERAL HOSPITAI	., тне	555 NORTH D	UKE STRI	EET		
STATE LICENS	E NUMBER: 120801						
(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	
A 0144	Continued from page 21			A 0144			
					The policy for Interdisciplina Documentation and Charting revised with more specific instructions on how and whe individualize the Interdiscipl Plan of Care documentation. CNO is the owner of the policy will oversee the revision of t policy. Complete Date 4/18/	en to inary The icy and he	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER 390100				PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 02/15/2019	ΞY	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRI	EET			
(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 CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
A 0144	Continued from page 22			A 0144			
	Based on the review of me facility documents, and state determined that the facility patient received the superson their assessed needs. Tognitively impaired ambut and other patients with sin and MR 3), at risk for harm According to the medical rewas transferred to the facility is locked had a diagnosis of acute ervascular dementia with beland a history of bipolar and disorder. On 9/20/18, at 4 brought to the emergency to take medications and at patients and staff. Assessing room by the physician on 9 pm, revealed that MR 1 was pacing in the room intermil. Nursing documentation sitter and a bed alarm were patient was in the emergent the patient is behaviors at	off interviews, it was by failed to ensure each vision necessary based in failure placed a latory patient (MR 1) milar diagnoses (MR 2 notes). Findings include: ecord, on 9/20/18, MR1 lity from another and dementia unit. MR 1 notephalopathy and havioral disturbances dischizoaffective 4:44 pm, MR 1 was room due to the refusal tempts to harm other ment in the emergency 9/20/18 signed at 11:01 as "adamantly agitated ittently" and "restless indicated that both a le utilized while the noty department due to	I				

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(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390100	A. BLDG: <u>0</u>	LE CONSTRUCTION:	(X3) DATE SURVI COMPLETED: 02/15/2019	EY
THE 555 No.	ORTH DUKE STRE			
F DEFICIENCIES (EACH DEFICIENCY BY FULL REGULATORY OR LSC 'ING INFORMATION)	Y ID PREFIX TAG	CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETE DATE
d that case and recommended at. e written on 9/20/18 at was going to be get the patient back on elp with the sing documentation 8:39 pm, the patient out the assistance or itional nursing 8 through 10/12/18, empted to and/or attended without staff ' ccasions. According to all record and and EMP 3), the facility eep MR 1 safe. Further erventions to stop MR it unattended were d and/or R 2 on 2/15/19, as admitted on	A 0144			
	THE STREET 555 N LANC THE F DEFICIENCIES (EACH DEFICIENCY BY FULL REGULATORY OR LSC TING INFORMATION) d that case and recommended t. was going to be get the patient back on all with the sing documentation 8:39 pm, the patient but the assistance or ational nursing 8 through 10/12/18, empted to and/or ttended without staff ' ccasions. According to all record and and EMP 3), the facility eep MR 1 safe. Further erventions to stop MR it unattended were d and/or R 2 on 2/15/19,	A. BLDG: _0 B. WING:	390100 A. BLDG: B. WING: STREET ADDRESS, CITY, STATE, ZIP CODE: 555 NORTH DUKE STREET LANCASTER, PA 17604 F DEFICIENCIES (EACH DEFICIENCY BY FULL REGULATORY OR LSC 'ING INFORMATION) A. 0144 d that case and recommended t	A BLDG:00

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 390100				PLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED: 02/15/2019	ΞY				
LANCAST	VIDER OR SUPPLIER: YER GENERAL HOSPITAL SE NUMBER: 120801	L, THE	STREET ADDRESS, CITY, STATE, ZIP CODE: 555 NORTH DUKE STREET LANCASTER, PA 17604							
(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 CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE			
A 0144	Continued from page 24			A 0144						
	included: behavioral disturencephalopathy, heroin abdysfunction-falling at home non-compliance. Accordin 4 on 2/15/19, MR 2 was to because the patient was so Nursing documentation in ambulated around the roo but was considered a high and combative behaviors, doctors' order and the rest discontinued when the behatient was assessed as condelirium and visual hallucing notes written in a psych compatient was assessed as an according psychiatric medical Based on MR 2's condition patient was assessed as an according to staff, EMP 4, oweak to get out ". Staff in concerned that when MR 2 the patient may try to elop failed to develop an individed.	e, and medication g to interview with EMF have a constant sitter weak and unsteady. dicated that the patient m and to the restroom fall risk. Due to agitated MR 2 was restrained per raints were to be naviors improved. The gnitively impaired with nations according to nsult and that some of rium were associated multiple medications rations. and past history, the elopement risk but on 2/15/19, " she is too dicated that they were et's condition improves, we from the unit. Staff	d r							

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER. 390100			IPLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED: 02/15/2019	ΞY
LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAI E NUMBER: 120801	L, THE	STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI	EET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0144	addressed the need to proso that patient would not less taff or staff's knowledge of whereabouts. Medical record review for I revealed the patient was at the patient's need for psyctreatment. The patient was which was facilitated by the aware and concerned about patient was making. The pland the delirium that was placed upon admission the patient's impaired cogrammy be an elopement risidevelop an individualized pensure that the patient did facility and potentially suffer	eave the facility without of the patient's MR 3 on 2/15/19, dmitted in 1/19 due to hiatric assessment and is admitted from home e spouse who was ut the decisions that the latient was ambulatory present at home to the facility. Due to hition, staff felt that MR k. Staff failed to blan of care for MR 3 to land form the	t ·	A 0144			
A 0145				A 0145			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER 390100			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 02/15/2019		
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		L, THE	STREET ADDRESS 555 NORTH I LANCASTER	DUKE STRE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFIC MUST BE PRECEEDED BY FULL REGULATORY OR I IDENTIFYING INFORMATION)			ID PREFIX TAG			(X5) COMPLETE DATE
A 0145	Continued from page 26 482.13(c)(3) PATIENT RICABUSE/HARASSMENT The patient has the right to or harassment. This REQUIREMENT is not seem to be a	be free from all forms of	fabuse	A 0145	A workforce strategy was er reduce lag time between a st vacancy occurring and the ti the position. Human Resource reate "evergreen requisition Workday that will allow the recruitment of skilled staff continually throughout the y rather than waiting until a vaccurs. The evergreen requisivill be created based on hist trends of turnover and organizational needs. The V President of Human Resource responsible party for communand implementing this strate will help to ensure that there adequate staffing to meeting needs of the patients. 4/18/11 Compliance to Active Nursing Orders for all patients identifies for elopement will be audially by the nursing manage facilitator in association with responsible for the patient. Eidentified in the workflow or orders will be identified and escalated to the nursing directions.	affing me to fill ces will as" in ear acancy sitions orical ice ses is the unicating gy that is the 9 ng fied at adited r and/or n the RN Barriers f nursing	Completion Date: 04/18/2019 Status: APPROVED Date: 03/19/2019

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390100		A. BLDG: _	IPLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 02/15/2019	ΞY
LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAL ENUMBER: 120801	L, THE	STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRI	EET		
(X4) ID PREFIX TAG	MUST BE PRECEED!	OF DEFICIENCIES (EACH DE FED 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 27			A 0145	and CNO for resolution. Noncompliance by the staff of the addressed through coaching the bedside by the manager at utilizing as Human Resource disciplinary process if indicated 3/18/19 Nursing department policy for "Chart Check Procedure" wire reviewed and modified to encurrent practice and policy a consistent with best practice regulatory standards. The CN the owner of the policy and it responsible for completion or review and revisions. Completion of the policy and it responsible for completion of the policy and its responsible for completion of th	and and es ated. For daily ill be asure and NO is is of the	

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTI A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	ΞY
		390100		B. WING: 02/15/2019			
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		_, THE	STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI	EET		
(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 SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0145	Continued from page 28			A 0145			
	Based on the facility's failur implement a plan of supervisafety of cognitively impair patients at risk for serious in Three patients were identified ue to their impaired cognistatus, MR 1, MR2, and MR Findings include: Medical record review on 2 MR 1 was brought to the indepartment on 9/20/18, for facility where the patient lift dementia unit. According to the hospital emergency room MR 1 had been refusing me exhibiting behaviors some wharmed others. In addition MR1 had been pounding on yelling to be let out of the lift Medical record review reveassessed by the physician in at 1901 pm. The assessments	vision to ensure the ed patients, placed the injury, harm, and death fied as being in jeopardy ition and ambulatory at 3. 2/15/19 revealed that ospital's emergency om another healthcare ved on a locked to documentation from om record on 9/20/18, edications and was of which could have an the walls daily and locked unit. ealed that MR1 was an the emergency room	,				
	at 9:01 pm. The assessmen schizoaffective disorder and	· · · · · · · · · · · · · · · · · · ·	l,				
	the physician documented						
	Acute metabolic encephalo	ppathy. The physician					

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00		(X3) DATE SURVEY COMPLETED:	
		390100			<u></u>	02/15/2019	
LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAI	, THE	STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI	EET		
STATE LICENS	e number: 120801						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0145	Continued from page 29			A 0145			
	wrote that the patient requ	uired inpatient					
	admission due to the diagn						
	patient could not be treate	d safely as an					
	outpatient.						
	Medical record review reve	ealed that MR 1 was					
	admitted to the hospital or	9/20/18 and a consult					
	with a psychiatrist the follo	wing day, 9/21/18, at					
	8:51 am, revealed an addit	· ·					
	vascular dementia with bel		d				
	a note that indicated that N	_					
	capacity was compromised						
	behaviors at the the prior f						
	documentation indicated the		_				
	would continue since the p		a				
	danger to others at the factorior to admission.	inty the patient lived					
	Medical record review reve	valed that two (2) days					
	following admission, on 9/2						
	combative and threw the d						
	slipped on the liquid that h	·					
	from the food tray. Later th	·					
	notes indicated that MR 1						
	impulsive and attempted to	leave the unit. On					
	9/23/18, it was documente		at				
	11:01 pm, that MR 1 said,	"I want to go home." T	he				

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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:		
		390100 A. BLDG:00_ B. WING: 02/15/2019							
LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAI E NUMBER: 120801	C, THE	STREET ADDRESS, CITY, STATE, ZIP CODE: 555 NORTH DUKE STREET LANCASTER, PA 17604						
giiii ziczii	ENOMBER: 12001								
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY O FYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE		
A 0145	Continued from page 30			A 0145					
	6 11 1 0 0 0 1 1 0								
	following day, 9/24/18, on	_	S						
	indicated that alarms were sitter would be used only a	_							
	that evening, nursing notes								
	was turning off the chair al	·							
	the room. On 9/25/18, at 5	_							
	documentation indicated the								
	"occasionally finding patier	nt attempting and							
	successfully turning off safe	ety alarm. " Although							
	staff documented MR 1 wa	s confused to the							
	situation, they reminded th	ne patient to ring the ca	II						
	bell if assistance was neede	ed. On 9/26/18, at 5:34	4						
	am, nursing notes indicated	d that the patient was a	n						
	elopement and safety risk a								
	documentation over the ne	ext four (4) days,							
	revealed MR 1 continued to								
	and in the hall refusing to u								
	9/30/18, a note written by		m,						
	indicated that MR 1 left " t								
	permission for a walk " and	•							
	out of the room a bit. I thin								
	planned walks off the floor								
	The physician wrote an ord	•							
	taken off the floor by a staf								
	Review of MR 1 's record o	m z/15/19, maicated							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BLDG:	PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		390100			<u></u>	02/15/2019	
LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAL E NUMBER: 120801	C, THE	STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRI	EET	L	
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
A 0145	Continued from page 31			A 0145			
	4 h a	k Abia andanaa					
	there was no evidence that followed. Nursing docume						
	6:45 pm, revealed that MR						
	that day without staff 's kn		d				
	in the emergency room. As						
	began to document that M	R 1 was on elopement					
	precautions. Interview wit	h staff EMP 2 and EMP	3				
	on 2/15/19, revealed the fa	acility had not defined	"				
	elopement precautions " a	and there was no policy					
	or protocol for staff to follo	ow if they had a patient					
	like MR 1 who attempted to	o elope. Based on a					
	review of the medical reco	rd documentation for					
	MR 1 and this interview, th	iere was no evidence					
	that the interventions used	to supervise MR 1 to					
	ensure safety were being e	valuated and changed i	f				
	needed when the episodes						
	elopement continued. Nur	_					
	from 10/2/18 through 10/1		R 1				
	remained an elopement ris						
	successfully elope on six (6						
	(2) of those elopements, M						
	emergency room or in radio						
	Nursing documentation wr		53				
	am revealed that MR 1 was						
	10:00 pm on 10/12/18, sta	naing alone outside on					

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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:	
		390100		B. WING:		02/15/2019	
LANCAST	DVIDER OR SUPPLIER: FER GENERAL HOSPITAI SE NUMBER: 120801	, THE	STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRE			
(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 CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
A 0145	Continued from page 32			A 0145			
	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 be 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		cy d				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIEF IDENTIFICATION NUMBER				PLE CONSTRUCTION:	(X3) DATE SURVI COMPLETED:	EY	
		390100		B. WING:			
LANCAST	OVIDER OR SUPPLIER: FER GENERAL HOSPITAI SE NUMBER: 120801	C, THE	STREET ADDRESS, 555 NORTH D LANCASTER	OUKE STRI			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	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	Continued from page 33			A 0145			
	nursing management indices should be changed into a has a 1:1 sitter in the room On 2/15/19, interview with EMP 4), confirmed that: the develop a plan to keep a known have evidence that include that were used to prevent were effective; failed to deand reevaluation of the interview most and read include the most effective; failed to utilize hospital had created include meeting which brought toget disciplines to discuss comparecommendations; and fail precautions and create a pestaff knew what to do if the was at risk for elopement. A review of facility docume with EMP 1, revealed that 10/25/18 to discuss the circincident of 10/12/18. Staff of the incident to the hosp Committee on 11/19/18. A meet to further develop are	in facility staff (EMP 2 and in a facility failed to an	in				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER 390100			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 02/15/2019		
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801			STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI			
(X4) ID PREFIX TAG	MUST BE PRECEEDE	OF DEFICIENCIES (EACH DE ED BY FULL REGULATORY OF FYING INFORMATION)		ID PREFIX TAG			
A 0145	interventions on January 1 elopement. At the time of four (4) months after MR 1 not implemented a policy a protect patients like MR 1 serious harm, injury, or de Medical record review on 2 MR 2 and MR 3 were both elopement risks. Both patients had not attempted facility, their inability to mathe psychiatric diagnoses to from, put the two (2) paties should they leave the facility.	this survey, 2/15/19, eloped, the hospital had and plan designed to who were at risk for eath. 2/15/19, revealed that assessed as potential ents were ambulatory off felt that although the date of the elope from the eake sound decisions and that they were suffering ints at risk for harm	d	A 0145			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:				
		390100	A. BLDG:00_ B. WING:			02/15/2019			
	vider or supplier: ER GENERAL HOSPITAI	L, THE	STREET ADDRESS, CITY, STATE, ZIP CODE: 555 NORTH DUKE STREET LANCASTER, PA 17604						
STATE LICENS	E NUMBER: 120801		Liki (Ci KST Lik	,111 17004					
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION SHOULD			(X5) COMPLETE DATE			
P 0000	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.		ompleted I was not s and rt IV,	P 0000					
P 0301				P 0301					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNA			ATURE		TITLE:	(X6) DATE:			

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* * * * * * * * * * * * * * * * * * * *		` '	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
		390100			02/15/2019			
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRI	EET				
(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	
P 0301	Continued from page 1 103.1 GENERAL PROVISION 103.1 Principle There shall be an organized governing body or designate vested with ownership who the full legal authority and responsibility for the conduction hospital. This REGULATION is not	l ed person shall assume ct of the		P 0301	The Chief Executive Officer Chief Clinical Officer to propresentation to the Board of Trustees regarding the October 2018 elopement of a cognitive impaired patient, the regulated deficiencies identified, and the corrective actions being implemented to ensure composite with all CMS Conditions of Participation and Department Health state regulation. Composite 3/21/19 The Chief Nursing Officer to a presentation to the Board of Trustees Quality Committee regarding the October 12, 20 elopement of a cognitively in patient, the regulatory deficited identified, and the corrective being implemented to ensure compliance with all CMS Coof Participation and Department Health state regulations. 4/8/	vide a per 12, vely ory he pliance at of plete provide of 118 mpaired encies e actions conditions ment of	Completion Date: 04/08/2019 Status: APPROVED Date: 03/19/2019	
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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:	
	390100				<u></u>	02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI	EET			
(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 0301	Continued from page 2 Based on review of facility records, and interviews wit Body failed to function effe	h staff, the Governing	I	P 0301			
	hospital consistently opera protected the health and so Findings include: The Governing Body failed						
	facility operated in a mann continued compliance with that promote and protect p safety as evidenced by the	er that ensured I the federal regulations patients 'health and hospital's history of	i				
	noncompliance over the past 12 months. 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.						
	As a result of the surveys in November, 2018, mentioned	•					

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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:	
	390100				<u>vv.</u>	02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 0301	responded with a plan to copractices. During each followed determined that the facility plan of correction and had but the period of compliant than a few months. In February, 2019, it was donospital did not have a plan wandering cognitively imporesult, a patient, MR 1, elonight and walked by hersel another hospital. MR1 wou miles taking approximately 49 degree weather wearing and crocs.	ow up survey, it was y implemented their achieved compliance ce did not last more etermined that the in in place to supervise aired patients and as a sped from the facility at f through town to ald have walked 1.3 23 minutes to arrive in		P 0301			
P 0315				P 0315			

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STATEMENT OF DEF PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	II) PROVIDER/SUPPLIER/CLIA SENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
		390100			<u></u>	02/15/2019		
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801			STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY OF IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		OULD BE	(X5) COMPLETE DATE	
103.4 The assis hosp follo (1) I resou meet partii healt healt quali estab integ mana contri	4 (1) FUNCTIONS 4 Functions 2 governing body, with to stance and advice from to ital staff, shall do the owing: Provide appropriate phy urces and personnel required the needs of the patients at the needs of the patients at the needs of the community control mechanism shished which includes a gral part thereof a risk agement component and rol program.	he sical uired to ts and eet the and ity. A hould be as an		P 0315	A workforce strategy was created reduce lag time between a stavacancy occurring and the time the position. Human Resource create "evergreen requisition. Workday that will allow the recruitment of skilled staff continually throughout the year their than waiting until a vaccurs. The evergreen requision will be created based on histotrends of turnover and organizational needs. The Vi President of Human Resource responsible party for communand implementing this strategical will help to ensure that there adequate staffing to meeting needs of the patients. 4/18/19. Compliance to Active Nursin Orders for all patients identified in the workflow of orders will be identified and	affing me to fill ees will s" in ear cancy itions orical ce es is the nicating gy that is the o ng fied at dited a and/or a the RN earriers	Completion Date: 04/18/2019 Status: APPROVED Date: 03/19/2019	

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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:	
		390100				02/15/2019		
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI	EET				
(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 0315	Continued from page 5			P 0315	and CNO for resolution. Noncompliance by the staff of the addressed through coaching the bedside by the manager at utilizing as Human Resource disciplinary process if indicated Complete Date 3/18/19 Nursing department policy for "Chart Check Procedure" with reviewed and modified to encurrent practice and policy acconsistent with best practice regulatory standards. The CN the owner of the policy and it responsible for completion or review and revisions. Completion of the policy and it responsible for completion or review and revisions. Completion of the policy and it responsible for completion or review and revisions. Completion of the policy and it responsible for completion or review and revisions. Completion of the policy and it responsible for completion or review and revisions. Completion of the policy and it responsible for completion or review and revisions.	ng at and es ted. or daily ll be sure re and NO is s		

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00_		(X3) DATE SURVEY COMPLETED:	
	390100			1	<u> </u>	02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801			STREET ADDRESS, 555 NORTH I LANCASTER	UKE STRI	EET		
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P 0315	Continued from page 6			P 0315			
	Based on the facility's failu implement a plan of supersafety of cognitively impair patients at risk for serious. Three patients were identified ue to their impaired cognistatus, MR 1, MR2, and MR Findings include: Medical record review on 2 MR 1 was brought to the hidepartment on 9/20/18, for facility where the patient lidementia unit. According the hospital emergency room MR 1 had been refusing mexhibiting behaviors some harmed others. In addition MR1 had been pounding on yelling to be let out of the Medical record review reveassessed by the physician is at 9:01 pm. The assessments schizoaffective disorder and	vision to ensure the red patients, placed the injury, harm, and death fied as being in jeopardy ition and ambulatory R 3. 2/15/19 revealed that ospital's emergency om another healthcare ved on a locked to documentation from om record on 9/20/18, edications and was of which could have in the walls daily and locked unit. ealed that MR1 was in the emergency room int revealed a history of	/				

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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:	
		390100		B. WING:		02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRE				
(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 0315	the physician documented Acute metabolic encephalo wrote that the patient requadmission due to the diagn patient could not be treate outpatient. Medical record review reveadmitted to the hospital or with a psychiatrist the follo 8:51 am, revealed an additivascular dementia with bela note that indicated that Nacapacity was compromised behaviors at the the prior f documentation indicated the would continue since the patients of	ppathy. The physician aired inpatient poses and that the disafely as an ealed that MR 1 was a 9/20/18 and a consult wing day, 9/21/18, at ional diagnosis of mavioral disturbance and MR 1's decision making with no recollection of acility. Nursing that the use of a sitter attent, MR 1, had been	d	P 0315			
	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						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BLDG:	IPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
	390100			B. WING: _		02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		L, THE	STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRI	EET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DI MUST BE PRECEEDED BY FULL REGULATORY (IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SE CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETE DATE
P 0315	Continued from page 8			P 0315			
	notes indicated that MR 1 impulsive and attempted to 9/23/18, it was documented 11:01 pm, that MR 1 said, following day, 9/24/18, on indicated that alarms were sitter would be used only at that evening, nursing note was turning off the chair all the room. On 9/25/18, at documentation indicated to "occasionally finding paties successfully turning off saff staff documented MR 1 was situation, they reminded to bell if assistance was need am, nursing notes indicate elopement and safety risk documentation over the nerevealed MR 1 continued to and in the hall refusing to 9/30/18, a note written by indicated that MR 1 left "repermission for a walk" and out of the room a bit. I thin	o leave the unit. On ed in the nursing notes a "I want to go home." T 12:42 am, nursing notes a being used and the as needed. At 7:45 pm is indicated the patient darm and wandering in 5:55 am, nursing hat staff were int attempting and ety alarm. " Although as confused to the he patient to ring the called. On 9/26/18, at 5:30 d that the patient was a land further ext four (4) days, o ambulate in the room use the bed alarm. On the physician at 6:15 pithe floor without d " just wanted to get	ihe s				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390100		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 02/15/2019	
LANCAST	OVIDER OR SUPPLIER: FER GENERAL HOSPITAI SE NUMBER: 120801	<u> </u>	STREET ADDRESS, 555 NORTH D LANCASTER	OUKE STRI	EET		
(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	HOULD BE	(X5) COMPLETE DATE
P 0315	Continued from page 9			P 0315			
	planned walks off the floor The physician wrote an ord taken off the floor by a star Review of MR 1's record of there was no evidence that followed. Nursing docume 6:45 pm, revealed that MR that day without staff's kr in the emergency room. As began to document that M precautions. Interview wit on 2/15/19, revealed the fr elopement precautions are or protocol for staff to follo like MR 1 who attempted to review of the medical record MR 1 and this interview, the that the interventions used ensure safety were being eneeded when the episodes elopement continued. Nur from 10/2/18 through 10/2 remained an elopement ris successfully elope on six (6) (2) of those elopements, N	der for the patient to be if member for walks. On 2/15/19, indicated this order was entation on 9/30/18 at a 1 left the floor earlier nowledge and was found for 10/1/18, nursing states at 1 was on elopement the staff EMP 2 and EMP accility had not defined and there was no policy ow if they had a patient to elope. Based on a ard documentation for here was no evidence at to supervise MR 1 to evaluated and changed it is of attempted arising documentation 11/18, indicated that Misk and attempted to or is occasions and on two	d iff 3 "				

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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:	
		390100		B. WING:		02/15/2019	
LANCAST	OVIDER OR SUPPLIER: FER GENERAL HOSPITAI SE NUMBER: 120801	L, THE	STREET ADDRESS, 555 NORTH D LANCASTER	OUKE STRI	EET		
(X4) ID PREFIX TAG	MUST BE PRECEEDE	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
P 0315	Continued from page 10			P 0315			
	emergency room or in radiology.						
	Nursing documentation wr	ritten on 10/13/18 at 2:	53				
	am revealed that MR 1 was	s seen by security at					
	10:00 pm on 10/12/18, sta	nding alone outside on					
	the emergency room ramp	, wearing a pair of staf	f'				
	s scrubs. When security ap	proached MR 1, securi	ty				
	inquired if the patient was	an employee. MR 1 sa	id				
	yes. Because security did n	ot see an armband on					
	the patient, security called	the emergency room to	0				
	see if any of their patients	were missing. When					
	the emergency room said r	no, security spoke again	1				
	to MR 1 telling the patient	to have a good evening	g.				
	Two hours later, security w	as notified that a					
	patient, MR 1, was missing	. Nursing					
	documentation indicated t	hat staff had gone into					
	MR 1 's room at 9:30 pm t	o check on the patient l	but				
	when staff returned for the	eir two (2) hour check a	at				
	11:30 pm, MR 1 was missir	ng. Nursing notified					
	security of the missing pati	ient and security					
	realized that the individual	they observed earlier					
	on the emergency room ra	mp, was most likely MF	}				
	1. Calls were made to loca	l hospitals to notify					
	them of the missing patien	t. Another hospital					
	responded indicating that t	the patient was on thei	r				

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
390100		390100				02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801			STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI	EET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDE IDENTII		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE	
P 0315		the air temperature documentation written dicated that when MR 2 al around 2:00 am, ated that the " patient	1	P 0315			
	nursing management indicated that the "patient should be changed into a hospital gown. Pt now has a 1:1 sitter in the room". 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.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390100		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 02/15/2019	
LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAI ENUMBER: 120801	L, THE	STREET ADDRESS, 555 NORTH I LANCASTER	UKE STRI	EET		
(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 CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	IOULD BE	(X5) COMPLETE DATE
P 0315	with EMP 1, revealed that 10/25/18 to discuss the cir incident of 10/12/18. Staff of the incident to the hosp Committee on 11/19/18. Meet to further develop ar interventions on January 1 elopement. At the time of four (4) months after MR 1 not implemented a policy a protect patients like MR 1 serious harm, injury, or de Medical record review on 2 MR 2 and MR 3 were both elopement risks. Both patiand cognitively. Staff felt to patients had not attempted facility, their inability to mather psychiatric diagnoses to from, put the two (2) paties should they leave the facility.	rcumstances around the f presented their finding ital 's Patient Safety A taskforce began to and implement, 2019, 82 days after the this survey, 2/15/19, a eloped, the hospital had and plan designed to who were at risk for ath. 2/15/19, revealed that a assessed as potential ients were ambulatory that although the d to elope from the ake sound decisions and hat they were suffering ents at risk for harm	gs ad	P 0315			

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PLAN OF COR	OF DEFICIENCIES AND RECTION (POC) VIDER OR SUPPLIER:	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390100		A. BLDG: _ B. WING: _	PLE CONSTRUCTION: 00 IIP CODE:	(X3) DATE SURVE COMPLETED: 02/15/2019	EY
LANCAST	ER GENERAL HOSPITAI	L, THE	555 NORTH D				
STATE LICENSE NUMBER: 120801		LANCASTER	, PA 17604				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DE MUST BE PRECEEDED BY FULL REGULATORY O IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SH CROSS-REFERENCED TO THE	OULD BE	(X5) COMPLETE DATE
P 0344				P 0344			

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PLAN OF CORRECTION (POC) IDENTIFICATION NUM 390100		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390100		A. BLDG: _ B. WING: _	PLE CONSTRUCTION: 00	(X3) DATE SURVEY COMPLETED: 02/15/2019	
LANCAST	ivider or supplier: T ER GENERAL HOSPITA Se number: 120801	L, THE	STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF MUST BE PRECEEDED BY FULL REGULATORY OR IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		OULD BE	(X5) COMPLETE DATE
P 0344	Continued from page 14 103.21 PATIENT'S BILL Continued It is the purpose of these 10 103.24 to promote the interwell being of the patients are residents of hospitals subject subpart even in those instant the interests of the patients in opposition to the interest hospital. It is declared to be public policy of the Departre the interests of the patients protected by a Patient's Bill Rights. Nothing in these 10 103.24 is intended to serve evidence of a standard of reconduct for the purpose of civil liability between proviconsumers of health service hospital has the right to expand patient to fulfill patient responsibilities as may be steen thospital's rules affecting care and conduct. This REGULATION is not	ossistand and bet to this aces where may be so of the the ment that be of 3.21 - as asonable determining ders and bes. The leet the tated in g patient		P 0344	Effective immediately, the Coreated a process to ensure it was notified on a daily basis patient that would be considelopement risk to ensure that appropriate resources and interventions were in place to prevent a potential patient elopement. This process will continue until a formal policiprocedures are established, implemented, and audited to demonstrate compliance to expatient safety. Complete Date 2/15/19 The CNO provided education high priority departments (so nursing supervisors, nursing directors, and ED leadership immediate actions that needs take place to keep patients we cognitive deficiencies safe file elopement. Complete Date 2 An Elopement Screening To adopted and a process development on arrivenursing unit within the hosping the same process.	hat she of any ered an t o I y and ensure te n to ecurity,) and the ed to with rom 1/18/19 eol was oped to al to a	Completion Date: 04/15/2019 Status: APPROVED Date: 03/19/2019

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		EY
		390100		B. WING:		02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		STREET ADDRESS, 555 NORTH D LANCASTER	OUKE STRE				
(X4) ID PREFIX TAG	SUMMARY STATEMENT MUST BE PRECEEDI IDENTI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE	
P 0344	Continued from page 15			P 0344	positive for risk of elopement status will continue for the dof the patient's hospitalization unless it is determined by an interdisciplinary care team the patient is no longer an eloper risk. Patients who screen negfor risk for elopement will be rescreened upon transfer of heart care or change in condition. CNO is responsible for the implementation and daily tracompliance to the screening ensure that any lack of compatible be identified, analyzed a corrective actions implement Complete Date 3/8/19 The Elopement Screening To built in the Epic medical receive the Director of Business Interist he responsible person for ensuring daily reports of screening daily reports of screening tool compliance are provided CNO and nursing managers. visual (red/green) cue was be Epic to alert the nurse if the screening tool was complete admission. Complete Date 3.6	duration on that the ment gative e level of The acking of and will oliance and ted. ool was ord and elligence eening d to the A uilt into	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390100		PLE CONSTRUCTION: 00	(X3) DATE SURVE COMPLETED: 02/15/2019	ΞY
LANCAST	STREET ADDRESS, CITY, STATE, ZIP CODE: STREET		EET			
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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 admissi elopement screening implem The nursing directors rounde the clinical units and comple Elopement Screening Tool or patients. Complete Date 3/11 The CNO led a taskforce that developed and implemented for "Elopement Risk Interver for Patients Who Are Cognitively Impaired". The princluded: assessment frequer interventions for patients at recollaboration with patient and family; the role of security; a documentation requirements. Education was provided to managers/directors regarding policy prior to implementation Complete Date 3/8/19 A computer-based learning of module for mitigating risks of elopement was developed and	t a Policy notions policy not; risk; d and	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
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P 0344	Continued from page 17			P 0344	implemented by the Director Nursing Professional Develor It is mandatory for all staff to complete the CBL by April 1 (unless on extended leave). A noncompliance will be address through the employee discip process. Complete Date 3/4/ The CNO created a tracking monitor cognitively impaired patients identified at risk for elopement and audit complia screening, interventions implemented, documentation the medical record, and come to the policy. The CNO will any deviations, identify any opportunities for improveme implement corrective actions Complete Date 3/18/19 The CNO (or her delegate) we provide a monthly elopement compliance update at the Pat Safety Committee until there three consecutive months of compliance with the policy. Patient Safety Committee medical resorts and saf	opment. o 1, 2019 Any essed linary 19 log to d ance with n within pliance review ent, and s. vill at tient e are full The	

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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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NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		-, THE	STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI	EET		
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P 0344	Continued from page 18			P 0344	approved at the Board Quality Committee Meeting and the Trustees Meeting. Complete 4/15/19	Board of	

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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:	
		390100		B. WING: 02/15/2019				
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		L, THE	STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI	EET			
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P 0344	Based on the facility's failurimpaired ambulatory patieconsistent and appropriate was determined that cognitambulatory patients (MR 1 at risk for harm. Findings include: Medical record review on MR 1 was transferred by an emergency department or patient's refusal to take meto harm staff and other patient's refusal to take meto harm staff and other patient's refusal to take meto harm staff and other patient's nedecompatient of the 1 began to wander in and counit. Based on a review of medical record, the hospitative system in place which protopatient or implemented a patient's needs. This failure	nts were provided with supervision (MR 1), it tively impaired I., MR 2, and MR 3) were 2/15/19 revealed that imbulance to the edications and attempts dients at the facility that inentation indicated that hospital on 9/20/18, Mout of the room and the documentation in the all failed to have a sected the wandering olan of care that met the re placed MR1, and	e R	P 0344				
	other cognitively impaired 3), at risk for harm if they lead							

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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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P 0344	Continued from page 20 building without staff's kn	owledge or assistance.		P 0344				
P 0352				P 0352				

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* * * * * * * * * * * * * * * * * * * *		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
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TAG		FYING INFORMATION)	K LSC	FREFIX TAG	CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE A		DATE	
P 0352	Continued from page 21 103.22 (b)(7) IMPLEMENT (7) The patient has the righ good quality care and high professional standards that a continually maintained and This REGULATION is not	t to are reviewed.		P 0352	The Director of Security and Director of Safety will devel implement an Elopement Re Plan within the Emergency Management Plan. Education provided to all departments impacted. A debriefing will after each activation of the elopement response plan or opportunities for improveme identified. Complete Date 4/ The CNO developed a bedsic Standard of Work document bedside nurses regarding the procedure for screening and launching the interventions of patients who screen positive of elopement. The leader State Work document that is used daily quality rounds by the umanager/facilitator was modinclude daily auditing of conto the elopement policy and standard work. Complete Date Creating and modifying the individualized "interdiscipling of care" is an expectation as	op and sponse n will be occur drill and ent 18/19 de for for risk endard of for nit iffied to enpliance tte 3/8/19 patients' eary plan	Completion Date: 04/18/2019 Status: APPROVED Date: 03/19/2019	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:			PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED:	EY
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P 0352	Continued from page 22			P 0352	in the Policy for Interdisciplic Documentation and Charting CNO implemented a process nursing directors (including nursing supervisor on duty dweekends/holidays) to review care plan on a daily basis, for patient screened positive for elopement, with the nurse mand the bedside nurse to proceoaching/education on the wconsider for an individualize care. Once the daily review is consistently compliant at 100 daily review of the care plan completed by the nurse managers/facilitators and documented in the leaders Strof Work document utilized of their daily quality rounds. Opportunities for improvement in the leaders of the identified and improvement actions implemented through collaboration between the nurse directors to ensure consistent across the hospital (Duke Str. Hospital). Complete Date 3/The policy for Interdiscipling the control of the process of the complete date of the policy for Interdiscipling the control of the policy for Interdiscipling the control of the process of the policy for Interdiscipling the control of the process of the policy for Interdiscipling the control of the process of the policy for Interdiscipling the process of the process of the policy for Interdiscipling the process of th	g. The s for the hospital during w each r each risk of anager vide that to d plan of is 0%, the s will be tandard during ent will ent n ursing cy reet abies 18/19	

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	OF DEFICIENCIES AND RECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390100		A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 02/15/2019	ΞY
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		C, THE	STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRE			
(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 0352	Continued from page 23			P 0352	Documentation and Charting revised with more specific instructions on how and whe individualize the Interdiscipl Plan of Care documentation. CNO is the owner of the poli will oversee the revision of t policy. Complete Date 4/18/	en to inary The icy and he	

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	OF DEFICIENCIES AND RRECTION (POC)	(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			IPLE CONSTRUCTION: 00	(X3) DATE SURVE COMPLETED:	EY
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LANCAST	OVIDER OR SUPPLIER: TER GENERAL HOSPITAI SE NUMBER: 120801	L, THE	STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRI	EET		
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P 0352	Continued from page 24			P 0352			
	Based on the review of me						
	facility documents, and sta						
	determined that the facilit						
	patient received the super						
	on their assessed needs. T	·					
	cognitively impaired ambu						
	and other patients with sir						
	and MR 3), at risk for harm	•					
	According to the medical r		•				
	was transferred to the facil	•					
	healthcare facility's locke						
	had a diagnosis of acute er						
	vascular dementia with be						
	and a history of bipolar and						
	disorder. On 9/20/18, at 4 brought to the emergency		1				
	to take medications and at						
	patients and staff. Assess	·					
	room by the physician on S						
	pm, revealed that MR 1 wa	_					
	pacing in the room intermi	· -					
	". Nursing documentation	•					
	sitter and a bed alarm were						
	patient was in the emerger						
	the patient 's behaviors at	the other facility.					

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED:	
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		390100				02/13/2017	
	vider or supplier: ER GENERAL HOSPITAI	L, THE	STREET ADDRESS, 555 NORTH I	DUKE STRI	EET		
STATE LICENS	E NUMBER: 120801		LANCASTER	, PA 17604			
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TAG	IDENTI	FYING INFORMATION)			CROSS-REFERENCED TO THE	APPROPRIATE	DATE
P 0352	Continued from page 25			P 0352			
	Danimantettan alaa marraal	lad #ba# aaaa					
	Documentation also reveal management was involved						
	hospitalization for placeme						
	nospitalization for placeme	ent.					
	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 or	1				
	medications which would h	help with the					
	problematic behaviors. Nu	ursing documentation					
	revealed that on 9/22/18 a	at 8:39 pm, the patient					
	tried to leave the floor witl	hout the assistance or					
	knowledge of the staff. Ad	lditional nursing					
	documentation from 9/22/	/18 through 10/12/18,					
	revealed that the patient a	ttempted to and/or					
	successfully left the unit ur						
	s knowledge, on seven (7)	•)				
	documentation in the med						
	interview with staff (EMP 2						
	failed to develop a plan to						
	interview confirmed that in		l				
	1 from wandering off the u						
	not consistently document	ed and/or					
	implemented.						
	Medical record review for l	MR 2 on 2/15/19,					

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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:	
		390100				02/15/2019	
LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAI E NUMBER: 120801	., THE	STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI			
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P 0352	Continued from page 26			P 0352			
	indicated that the patient of 1/22/19. The patient had of included: behavioral disturencephalopathy, heroin abdysfunction-falling at home non-compliance. According 4 on 2/15/19, MR 2 was to because the patient was so Nursing documentation incompliance around the room but was considered a high and combative behaviors, I doctors' order and the rest discontinued when the behaviors written in a psych complete MR 2's behaviors and delir with self-medicating with reincluding psychiatric medicals.	diagnoses which rbances, use, ambulatory e, and medication g to interview with EMF have a constant sitter weak and unsteady. licated that the patient m and to the restroom fall risk. Due to agitated MR 2 was restrained per raints were to be naviors improved. The gnitively impaired with nations according to insult and that some of ium were associated nultiple medications ations.	d				
	patient was assessed as an						
	according to staff, EMP 4, c						
	weak to get out ". Staff in	dicated that they were					

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00		(X3) DATE SURVEY COMPLETED:	
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P 0352	concerned that when MR 2 the patient may try to elop failed to develop an individual respective to the patient would not I staff or staff's knowledge of whereabouts. Medical record review for revealed the patient was a the patient's need for psyctreatment. The patient was which was facilitated by the aware and concerned about patient was making. The pand the delirium that was continued upon admission the patient's impaired cogramming a may be an elopement ris develop an individualized pensure that the patient did facility and potentially suffered.	the from the unit. Staff dualized care plan that vide supervision to MR eave the facility without of the patient's MR 3 on 2/15/19, dmitted in 1/19 due to hiatric assessment and is admitted from home e spouse who was at the decisions that the patient was ambulatory present at home to the facility. Due to hitton, staff felt that MR k. Staff failed to plan of care for MR 3 to I not elope from the		P 0352			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 390100				(X3) DATE SURVEY COMPLETED: 02/15/2019	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801			STREET ADDRESS, 555 NORTH D LANCASTER,	UKE STRE	CET		
(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 0374				P 0374			

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		(XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:	ER:		PLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:	
		390100				02/15/2019	
LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAI SE NUMBER: 120801	L, THE	STREET ADDRESS, 555 NORTH D LANCASTER	OUKE STRE			
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P 0374	Continued from page 29 103.31 CHIEF EXECUTIV 103.31 The chief executive. The governing body shall a chief executive officer whos qualifications, authority, responsibilities, and duties s defined in a written stateme by the governing body. The executive officer shall be refor the application and imploof established policies in the operation of the hospital and providing liaison among the body, the medical staff, and departments of the hospital. This REGULATION is not	officer ppoint a se se shall be nt adopted chief sponsible ementation c I for governing the		P 0374	The Chief Executive Officer called an emergency executive leadership meeting on Sunda February 17, 2019 to discuss immediate jeopardy deficient establish an executive action with timelines for implement The individuals included: 1. CEO 2. EVP and Chief Administration Officer 3. Chief Clinical Officer 4. Chief Financial Officer 5. Chief Human Resources Complete The Nursing Officer 5. SVP, Hospital Operations Structures SVP, Quality 9. Chief Nursing Officer 10. SVP, Service Lines & Pothealth 11. President, Physician Service Complete Date 2/17/19 The CEO made the decision a Chief Operating and Integrofficer position to oversee a operations. The job descriptificalized and an agreement wing signed with an executive sea to launch a national search.	ve ay, so the acy and a plan tation. ative Officer I population vices to create ration II clinical ion was was	Completion Date: 03/20/2019 Status: APPROVED Date: 03/19/2019

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P 0374	Continued from page 30			P 0374	Complete Date 2/20/19 The CEO sent an organization communication to all leaders directing them to curtail all meeting/conference travel on Lancaster to focus on primar responsibilities of protecting patients from potential harm meet all regulatory standards patient safety. Complete Date 2/26/19 The CEO led an Executive Leadership Briefing to discuregulatory deficiencies that in loss of CMS deemed statutimes over the past year. CEO provided clear prioritization need for immediacy in achie organizational compliance we CMS Conditions of Participa Department of Health state regulations. Complete Date of The Hospital Regulatory Ste Committee was redesigned wupdated membership, commicharter, and implementation monthly meetings for the neamonths. Regulatory and CM chapter leads began meeting	utside of ry g our and s for te uss the resulted us three O and eving vith all ation and 3/7/19 eering with ittee of xt 6 S	

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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:	
		390100		B. WING:		02/15/2019	
LANCAST	VIDER OR SUPPLIER: YER GENERAL HOSPITAI SE NUMBER: 120801	L, THE	STREET ADDRESS, 555 NORTH I LANCASTER	OUKE STRE			
(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	
P 0374	Continued from page 31			P 0374	on 3/8/19 to clarify standard identify potential gaps in compliance, and implement corrective actions. In additio 3/8/19 a hospital lawyer was dedicated to the regulatory rehospital policies to ensure the complaint with CMS, DOH, regulatory requirements. The Quality and SVP, Legal Couthe responsible leaders provioversight of the regulatory reand improvements. Complet 3/20/19	on, on of fully eview of ey were and TJC e SVP of unsel are iding eview	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390100		(X2) MULTIPLE CONSTRUCTION: A. BLDG:00 B. WING:		(X3) DATE SURVEY COMPLETED: 02/15/2019	
LANCAST	VIDER OR SUPPLIER: ER GENERAL HOSPITAI SE NUMBER: 120801	C, THE	STREET ADDRESS, 555 NORTH D LANCASTER	UKE STRI	EET		
(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 0374	Based on a review of the history, it was determine executive officer did not oversight necessary to provided the necessary by the patients. Findings include: Based on a review of the deficiency reports for the February 2018 to February 2018 t	ned that the facility' of provide the supervensure staff consiste care and treatment of the past 12 months from the past 12 mo	ealth com that the ce in these for mely and ditient y impaired eep them y had ection	P 0374			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) (XI) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER. 390100			A. BLDG: _	PLE CONSTRUCTION:	(X3) DATE SURVE COMPLETED: 02/15/2019	EY	
NAME OF PROVIDER OR SUPPLIER: LANCASTER GENERAL HOSPITAL, THE STATE LICENSE NUMBER: 120801		STREET ADDRESS, 555 NORTH D LANCASTER.	UKE STRI	EET			
(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 CORREC CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETE DATE
P 0374	Continued from page 33			P 0374			

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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

Susan Cople



Rachel L. Levine, MD

Secretary of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY