STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	440091	A. BUILDING _____ B. WING _____	C 06/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HEALTHCARE SYSTEM, INC	**2525 DESALES AVE CHATTANOOGA, TN 37404**

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A 000	INITIAL COMMENTS On June 12, 2012, an investigation of complaint # TN-329876 was conducted. Memorial Healthcare System, Inc. was found out of compliance with Requirements for the Responsibilities of Medicare Participating Hospitals in Emergency Cases 42 CFR Parts 489.20 and 489.24. The failure of the facility to provide adequate "On-Call" services for patient number 3; failure to provide on-call services of an Orthopedic surgeon; and failure to provide an appropriate transfer placed patient number 3 in Immediate Jeopardy. The administrator was notified of the Immediate Jeopardy on April 3, 2013.	A 000		
A2400	489.20(l) COMPLIANCE WITH 489.24 [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on medical record reivew, facility policy review, and interview, the facility failed to ensure patients who are transferred to another facility have been seen by qualified on-call physicians and received stablizing treatment before being transferred to another hospital for one (#3) of thirty patients reviewed: The findings included: Please refer to A-2404 Please refer to A-2409	A2400		
A2404	489.20(r)(2) and 489.24(j)(1-2) ON CALL PHYSICIANS §489.20(r)(2)	A2404		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A2404	Continued From page 1 [The hospital (including both the transferring and receiving hospitals), must maintain] a list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition. §489.24(j)(1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians. §489.24(j)(2)(i) The hospital must have written policies and procedures in place to respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control. §489.24(j)(2)(ii) The hospital must have written policies and procedures in place to provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on call or to permit on-call physicians to have simultaneous on-call duties. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to consult the on-call Orthopedic surgeon for the facility before transferring the patient to another facility.	A2404		

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A2404	Continued From page 2 The findings included: Medical record review revealed patient #3 presented to the Emergency Department (ED) of hospital #1 on May 17, 2012, at 11:07 p.m. with complaints of having jumped twenty feet from a retaining wall to concrete. Continued medical record review revealed the patient complained of pain to the right shin at a level of 10 on a scale of 1-10 with 10 being the worst possible pain. Review of the Physician On-call Schedule for May 17, 2012, revealed there was an Orthopedic surgeon on call. Review of the ED record revealed no documentation the Orthopedic surgeon was consulted about the patient. Telephone interview with the Physician Assistant (PA) on June 12, 2012, at noon in the conference room, revealed the patient was already considered a trauma case. Continued interview revealed the PA would have called the Orthopedic Surgeon on call at hospital #1 if hospital #2 had not agreed to accept the patient. Continued interview revealed it depends upon the case as to whether Orthopedics would be consulted but the PA considered a jump of twenty feet to be a trauma. Further interview revealed hospital #2 accepted the patient immediately so the patient was prepared for transfer and splints were not applied to the lower extremities. Telephone interview with the Medical Director of the ED on June 12, 2012, at 12:10 p.m., revealed the Medical Director had polled ED physician, PA, and Nurse Practitioner staff and 70% said they would have transferred the patient without calling	A2404		

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A2404	Continued From page 3 the on-call Orthopedic Surgeon. Continued interview revealed the Medical Director "...would probably have called the Orthopedic Surgeon on-call to let them know the type of injury and plans to transfer the patient...". Further interview with the Medical Director revealed the patient met orthopedic trauma criteria. Continued interview with the Mdeical Director revealed the physician must consider the mechanism of injury and the physicians felt regardless of having orthopedics facilities at hospital #1, the patient needed a trauma center. Telephone interview with physician #2 on June 14, 2012, at 1:30 p.m., revealed orthopedicas at hospital #1 was not consulted because of the mechanism of injury with the patient falling from twenty feet. Continued interview revealed the physician felt the patient should be evaluated by a trauma surgeon in case there were other injuries. Further interview revealed splints were not applied because the fractures were not unstable and there would have been no threat to the limbs if splints were not applied.	A2404		
A2409	489.24(e)(1)-(2) APPROPRIATE TRANSFER (1) General If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless - (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of	A2409		

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A2409	Continued From page 4 transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer. (B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or (C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based. (2) A transfer to another medical facility will be appropriate only in those cases in which - (i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child; (ii) The receiving facility	A2409		

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A2409	Continued From page 5 (A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment. (iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and (iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer. This STANDARD is not met as evidenced by: Based on medical record review, facility policy review, and interview the facility failed to ensure a patient with multiple orthopedic injuries was adequately stabilized with intravenous access	A2409		

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A2409	Continued From page 6 and splints for orthopedic injuries before transfer to another facility for one (#3) of thirty patients reviewed. The findings included: Medical record review revealed patient #3 presented to the Emergency Department (ED) on May 17, 2012, at 11:07 p.m., with complaints of having jumped twenty feet from a retaining wall to concrete. Continued medical record review revealed the patient complained of pain to the right shin at a level of 10 on a scale of 1-10 with 10 being the worst possible pain. Medical record review revealed the Physician Assistant assessed the patient at 11:31 p.m. and found the patient to have "...left ankle with periauricular swelling and tender to palpation; extension and flexor intact. Range of Movement in ankle limited in ankles bilaterally due to pain. Right ankle with swelling and tender to touch and palpation; extensors and flexors intact. Distal pulses equal and present x4...". Medical record review revealed the patient was assessed at 11:16 p.m., by the Triage Nurse who documented "...pt. (patient) jumped off a ledge onto concrete from 15-20 feet up. Both ankles are swollen and scratched up. Pt. Also complains of pain to right shin...". Medical record review revealed the patient was assessed by nursing at 11:20 p.m. and stated pain was at a level 10 on a scale of 1-10 with 10 being the worst pain. Medical record review revealed the patient had an	A2409		

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A2409	Continued From page 7 IV (intravenous line into vein to administer fluids) started at 12:24 a.m., in the left antecubital area. Continued review revealed the patient received Dilaudid (pain relief) 0.5 mg (milligrams) IV and Zofran (anti-nausea) 4 mg at 12:30 a.m., and another dose of Dilaudid 0.5 mg IV at 12:55 a.m. Medical record review of a medical note written by the Physician Assistant on May 17, 2012, and untimed, revealed "...Discussed and review all x-rays with (named physician #2). We discussed further imaging versus transfer. Agreed to transfer. Spine is non-tender to touch and palpation. (named physician) at hospital #2 accepts transfer of patient per transfer center at 12:46 a.m...". Review of the transfer form dated May 17, 2012 revealed the reason for transfer was "...health care services required are not available at (named hospital #1). The patient has been stabilized within reasonable medical care standards. No further deterioration is likely as a result of the transfer...". Medical record review revealed the patient was transported to hospital #2 on May 18, 2012, at 1:35 a.m., per ambulance. Review of the Emergency Record from hospital #2 dated May 18, 2012, at 1:45 a.m., revealed the statement by the ED physician "...Called (named hospital #1) and spoke with (named physician #2). Told him stable VS (vital signs) and that IV had been removed before transport...". Review of hospital #1s ED policy entitled Standard of Care - Orthopedic Emergencies	A2409		

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A2409	Continued From page 8 (Extremities) ECC - 01025, revealed "...The treatment and management of the patient with an orthopedic emergency to any extremity may include the following: 8. Obtain IV..." Medical record review of a nursing note dated May 18, 2012, at 1:59 a.m., revealed an IV was started in the patient's left hand at hospital #2. Telephone interview with the Physician Assistant (PA) on June 12, 2012, at noon, in the conference room, revealed the patient was already considered a trauma case. Further interview revealed an IV is usually in place when a patient is transferred to another facility. Continued interview revealed "...I believe it is protocol for patients to have IV access with transfer...". Telephone interview with the Medical Director of the ED on June 12, 2012, at 12:10 p.m., revealed most patients have an IV in place when transferred. Continued interview with the Medical Director revealed "...Any patient who goes by ambulance from one facility to another should have an IV...". During interview on June 12, 2012, at 1:30 p.m., in the conference room, the ED Director confirmed the patient did not have IV access present on transfer and all transfer patients are required to have IV access. Telephone interview with physician #2 on June 14, 2012, at 1:30 p.m. revealed splints were not applied because the fractures were not unstable and there would have been no threat to the limbs if splints were not applied.	A2409		

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A2409	Continued From page 9 Continued telephone interview with physician #2 on June 14, 2012, at 1:30 p.m., revealed patients are usually transferred with IV access in place. Continued interview revealed physician #2 was unaware there was no IV access during the transfer and stated "...I would have wanted one..."	A2409		

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A 000	INITIAL COMMENTS On August 21 -23, 2012 an investigation of complaint # TN-30311 was conducted. Memorial Healthcare System, Inc. was found out of compliance with Requirements for the Responsibilities of Medicare Participating Hospitals in Emergency Cases 42 CFR Parts 489.20 and 489.24. The failure of the facility to provide adequate Medical Screening, and Stabilization of ED patient number 9; failure to provide on-call services of a neurology MD; and failing to provide an appropriate transfer placed patient number 9 in Immediate Jeopardy. The administrator was notified of the Immediate Jeopardy on April 3, 2013.	A 000		
A2400	489.20(l) COMPLIANCE WITH 489.24 [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on medical record review, facility policy and protocol review, review of on-call schedules, and interview, the facility failed to maintain a list of on-call physicians, failed to provide stabilizing treatment, and failed to provide appropriate transfer for one patient (#9) of twenty sampled patients reviewed. The findings included: Please refer to A-2404 for failing to maintain a physician on-call list Please refer to A-2407 for failing to provide stabilizing treatment Please refer to A-2409 for failing to provide apporpriate transfer	A2400		
A2404	489.20(r)(2) and 489.24(j)(1-2) ON CALL	A2404		

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A2404	Continued From page 1 PHYSICIANS §489.20(r)(2) [The hospital (including both the transferring and receiving hospitals), must maintain] a list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition. §489.24(j)(1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians. §489.24(j)(2)(i) The hospital must have written policies and procedures in place to respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control. §489.24(j)(2)(ii) The hospital must have written policies and procedures in place to provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on call or to permit on-call physicians to have simultaneous on-call duties. This STANDARD is not met as evidenced by: Based on review of facility policy, review of	A2404		

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A2404	Continued From page 2 Emergency Room On-Call Schedules, observation, and interview, the facility failed to maintain a list of on-call neurologists. The findings included: Review of facility Policy Number PC-07179 most recently reviewed and/or revised in September 2009, and titled "EMTALA (Emergency Medical Treatment and Labor Act) Guidelines - Treatment and Transfer of Individuals in Need of Emergency Medical Services revealed, "...The Hospital shall maintain an on-call list of physicians, including specialists and sub-specialists who are available to examine and treat an individual with an emergency medical condition...The Medical Staff Office, on a monthly basis, creates the Emergency Department ("ED") on-call Roster...the ED will maintain the on-call rosters...The on-call roster is divided into categories of medical specialties...specialties include but are not limited to...Neurology..." Review of Emergency Room On-Call Schedules dated January-July 2012, revealed no documentation regarding on-call neurologists. Observation on August 21, 2012, at 4:47 p.m. at an Emergency Room nurse's station, revealed a list of on-call physicians that identified the specialty, and included a physician's name and telephone number. Continued review revealed the specialties included neurology with a telephone number, and no documentation regarding identification of an on-call neurologist. Telephone interview with Registered Nurse (RN) #1 on August 23, 2012, at 2:40 p.m., revealed the	A2404		

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A2404	Continued From page 3 On-Call Schedule for August 23, 2012, included a phone number to call when neurology was required. RN #1 stated, "...If (a) patient (is) under the care of a neurologist we call their neurologist, otherwise we just call this answering service..."	A2404		
A2407	489.24(d)(1-3) STABILIZING TREATMENT (1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either- (i) within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition. (ii) For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section. (2) Exception: Application to inpatients. (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual (ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment. (iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.	A2407		

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A2407	Continued From page 4 (3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both. This STANDARD is not met as evidenced by: Based on review of facility policy and protocol, medical record review and interview, the facility failed to provide stabilizing treatment for one patient (#9) of twenty sampled patients. The findings included: Review of facility Policy Number PC-07179 most recently reviewed and/or revised in September 2009, and titled "EMTALA (Emergency Medical Treatment and Labor Act) Guidelines - Treatment and Transfer of Individuals in Need of Emergency Medical Services revealed, "...The Hospital will provide an individual with an emergency medical condition such further examination and treatment	A2407		

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A2407	Continued From page 5 as required to stablize the emergency medical condition, within the capability of the Hospital...To stabilize...mean...the patient is provided such medical treatment of the condition as is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient..." Review of facility Policy Number ECC-01070 and most recently reviewed and/or revised in January 2010, revealed, "...Title Standard of Care - CVA (Cerebrovascular Accident) or Stroke...Outcome: To establish guidelines in the treatment of a CVA/Stroke patient...A patient who arrives at the Emergency Center with CVA or stroke may receive the following care...Notify Emergency physician to determine if patient meets criteria for thrombolytic (dissolution of blood clots) therapy..." Review of an Emergency Center Protocol For t-PA (tissue plasminogen activator - dissolves clots and restores blood flow) In Acute Stroke dated August, 2006, revealed, "...NOTIFY on call Neurologist of potential t-PA candidate...Review the following exclusion criteria...Are the patient's stroke symptoms greater than 3 hours old? (IV(intravenous) t-PA must be given within 3 hours of onset of stroke symptoms...Does the CT (Computerized Tomography) brain demonstrate intracranial bleed or mass effect...Screening ER (Emergency Room) Physician Signature If the answer to any of the above questions is 'YES', the patient is not a candidate for t-PA...If the answer to all the above questions is 'NO', the patient may be a candidate for t-PA...NOTIFY Neurologist that patient IS a t-PA candidate..."	A2407		

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A2407	Continued From page 6 Patient #9 presented to Hospital #1's Emergency Department on March 26, 2012. Medical record review of Patient Information revealed, "...Arrival Date/Time: 1213 (12:13 p.m.)...Stated Complaint: Neurologic Symptoms/Deficits..." Medical record review of a Triage Assessment dated March 26, 2012, at 12:23 pm., revealed, "Stated Complaint: Possible Stroke...onset SOB (shortness of breath) after walking to surgery waiting...family reports slurred speech...High Risk Situation..." Medical record review of a nurse's note dated March 26, 2012, at 12:47 p.m., revealed, "...reassessed in triage. Noted to have reoccurence of slurred speech. Equal grip strengths. L (left) side facial droop." Medical record review of a nurse's note dated March 26, 2012, at 12:51 p.m., revealed, "...taken to room... (Medical Doctor - MD #1) notified of pt (patient) change in status." Medical record review of an untimed Emergency Department Physical History and Assessment dated March 26, 2012, revealed, "Chief complaint: slurring...duration less than one hour...with L facial droop that has waxed and waned...decreased blink on Left..." Medical record review of a CT (computerized tomography) scan of the brain without contrast dated March 26, 2012, at 2:33 p.m., revealed, "...Impression...No acute intracranial abnormality..."	A2407		

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A2407	Continued From page 7 Medical record review of a nurse's note dated March 26, 2012, at 4:02 p.m., revealed, "Dramatic neuro (neurological) changes noted...increased slurred speech and left sided weakness...(M.D. #1) notified, (M.D. #1) to bedside @ (at) (4:03 p.m.)..." Medical record review of the Physical History and Assessment dated March 26, 2012, revealed, "...Disposition Discussed with pt and family. Pt dysarthria seems more prounounced and I am uncertain of Bell's Palsy...Discussed with (neurologist) who requests MRI. If negative D/C (discharge) with steroids)...(4:00 p.m.)...densely hemiplegic on L. Call (neurologist)...onset greater than 3 hours. Recommended (Hospital #2)..." Medical record review revealed no documentation regarding an ER Center Protocol for t-PA in Acute Stroke for Patient #9. Medical record review revealed no documentation regarding assessment by a neurologist. Medical record review of a Certificate of Transfer dated March 26, 2012, revealed, "...Diagnosis: Neurological deficits with L side neglect...The patient has been stabilized within reasonable medical care standards. No further deterioration is likely as a result of transfer..." Medical record review of a CT scan of the brain with and without contrast dated March 26, 2012, at 5:05 p.m., revealed, "...Comparison is made with previous...exam (examination) of the brain dated 3/26/2012...There is a questionable minimal developing infarct in the anterior limb of the right internal capsule...Impression...Occlusion	A2407		

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A2407	Continued From page 8 of the right internal carotid artery and proximal portion of the right middle cerebral artery...Questionable minimal infarct in the anterior limb of the right internal capsule..." Medical record review revealed the patient was transferred to Hospital #2 on March 26, 2012. Medical record review of an Emergency Room Record (Hospital #2) dated March 26, 2012, revealed, "...Triage (6:19 p.m.)...presented to ed (Emergency Department) with complaints of stroke like symptoms transfer from (Hospital #1)...onset of new symptoms app (approximately) 45 minutes...Arrived via (Hospital #1's) EMS (emergency medical service)...(6:38 p.m.)...Historian: History obtained from patient, records from transferring facility. Time course: Onset of symptoms reported as sudden..." Medical record review of a physician's progress note dated March 26, 2012, at 6:52 p.m., revealed, "...Patient's status is critical." Medical record review of a physician's progress note dated March 26, 2012, at 6:52 p.m., revealed, "...pt had neg Head CT for acute bleed, no surgery, no head bleed per pt. reviewed risk and benefits pt wants to go with tPa. Spoke with (M.D. #2) ok to give tPA..." Medical record review of a physician's progress note dated March 26, 2012, at 6:54 p.m., revealed, "Review of transfer records..." Medical record review of a physician's progress note dated March 26, 2012, at 7:11p.m., revealed, "...pt unchanged. will continue with tPA waiting for neuro eval (evaluation)." Medical record review of a physician's progress note dated March 26, 2012, at 7:27 p.m.,	A2407		

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A2407	Continued From page 9	A2407		

revealed, "spoke with (M.D. #2)...states after talking with family, stroke started this am (a.m.). I spoke with patient who said symptoms started at 5 pm (p.m.) and EMS hand over indicated that symptoms started at 4 pm. Family was not here yet so that is the information I went with. tPA was stopped..."

Medical record review of the medical records sent by Hospital #1 to Hospital #2 revealed no documentation regarding the final report of the CT scan of the brain dated March 26, 2012, at 2:33 p.m. or the CT scan of the brain dated March 26, 2012, at 5:05 p.m.

Medical record review of a Consultation dated March 26, 2012, revealed, "...was visiting (spouse)...at (Hospital #1)...Per the family, who were present at the time of onset, which was around 11 or 11:30 a.m...started staggering...happened while (Patient #9) was in (Hospital #1)...was immediately taken to the emergency room...apparently had a CT angiogram of head done at (Hospital #1), which showed a distal...occlusion on the right side, and around 5:30 pm...was transferred to us for further management. Because the records from (Hospital #1) indicated that the time of onset was 5:00 p.m...thought to be within the window for...TPA...I stopped the TPA infusion...Assessment...Acute ischemic stroke secondary to internal carotid artery occlusion....Left hemiplegia left hemi neglect, secondary to stroke...Admit to ICU (intensive care unit)..."

Medical record review of a History and Physical dated March 26, 2012, revealed, "...basically had

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A2407	Continued From page 10 started a TPA infusion and then later discovered...time of onset was different than originally reported, and so that was stopped....has a continued dense left hemiplegia and neglect...continues in ICU (Intensive Care Unit) after receiving part of the TPA dose. Also with a large stroke and risk of hemorrhage..." Interview with M.D. #1 on August 22, 2012, at 10:28 a.m. in an Emergency Room office in Hospital #1, revealed M.D. #1 was prepared to discharge the patient after consultation with a neurologist and negative findings from a CT of the brain. Continued interview revealed the nursing staff informed M.D. #1 of a decline in the patient's condition, the neurologist was reconsulted and recommended a CT scan of the brain with contrast, and M.D. #1 stated, "...was past the three hour window (a specific timeframe for administration in relation to onset of symptoms) for t-PA and that's why (neurologist) wanted me to call (Hospital #2)." Interview with the ER Nurse Manager on August 22, 2012, at 11:30 a.m., in a conference room, revealed the ER Nurse Manager was unaware the facility had a stroke protocol. The ER Nurse Manager stated, "...just if we know we're getting a possible stroke we just get them to CT scan right away." The facility failed to follow their stroke protocols, and failed to treat and stabilize the patient. The patient was misdiagnosed with Bells Palsy and was not evaluated for stroke in a timely manner. C/O: #30311	A2407		
A2409	489.24(e)(1)-(2) APPROPRIATE TRANSFER	A2409		

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A2409	Continued From page 11 (1) General If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless - (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer. (B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or (C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1)	A2409		

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A2409	Continued From page 12 of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based. (2) A transfer to another medical facility will be appropriate only in those cases in which - (i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child; (ii) The receiving facility (A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment. (iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after	A2409		

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A2409	Continued From page 13 transfer; and (iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer. This STANDARD is not met as evidenced by: Based on review of facility policy, medical record review and interview, the facility failed to ensure an appropriate transfer for one patient (#9) of twenty sampled patients. The findings included: Review of facility Policy Number PC-07179 most recently reviewed and/or revised in September 2009, and titled "EMTALA (Emergency Medical Treatment and Labor Act) Guidelines - Treatment and Transfer of Individuals in Need of Emergency Medical Services revealed, "...The Hospital will provide an individual with an emergency medical condition such further examination and treatment...or arrange for transfer of an individual to another medical facility in accordance with the procedures set forth below...'Stable for transfer' means...The physician...determines...that the receiving facility has the capability to manage the emergency medical condition..." Patient #9 presented to Hospital #1's Emergency Department on March 26, 2012. Medical record review of Patient Information revealed, "...Arrival Date/Time: 1213 (12:13	A2409		

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A2409	Continued From page 14 p.m.)...Stated Complaint: Neurologic Symptoms/Deficits..." Medical record review of a Triage Assessment dated March 26, 2012, at 12:23 pm., revealed, "Stated Complaint: Possible Stroke...onset SOB (shortness of breath) after walking to surgery waiting...family reports slurred speech...High Risk Situation..." Medical record review of a nurse's note dated March 26, 2012, at 12:47 p.m., revealed, "...reassessed in triage. Noted to have reoccurence of slurred speech. Equal grip strengths. L side facial droop." Medical record review of a nurse's note dated March 26, 2012, at 12:51 p.m., revealed, "...taken to room...(Medical Doctor - MD #1) notified of pt (patient) change in status." Medical record review of an untimed Emergency Department Physical History and Assessment dated March 26, 2012, revealed, "Chief complaint: slurring...duration less than one hour...with L (left) facial droop that has waxed and waned...decreased blink on Left..." Medical record review of a CT (computerized tomography) scan of the brain without contrast dated March 26, 2012, at 2:33 p.m., revealed, "...Impression...No acute intracranial abnormality..." Medical record review of a nurse's note dated March 26, 2012, at 4:02 p.m., revealed, "Dramatic neuro (neurological) changes noted...increased slurred speech and left sided weakness...(M.D. #1) notified, (M.D. #1) to	A2409		

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A2409	Continued From page 15 bedside @ (at) (4:03 p.m.)..." Medical record review of the Physical History and Assessment dated March 26, 2012, revealed, "...Disposition Discussed with pt (patient) and family pt dysarthria seems more prounounced and I am uncertain of Bell's Palsy...Discussed with (neurologist) who requests MRI. If negative D/C (discharge) with steroids)...(4:00 p.m.)...densely hemiplegic on L. Call (neurologist)...onset greater than 3 hours. Recommended (Hospital #2)..." Continued review revealed no documentation regarding communication with a receiving physician or (Hospital #2). Medical record review of a Certificate of Transfer dated March 26, 2012, revealed no documentation regarding an authorizing person at (Hospital #2; appropriate medical information sent with the patient; or a Registered Nurse (Hospital #2) to whom report was given. Continued review revealed specific benefits and risks regarding transfer were not documented and included, "...Diagnosis: Neurological deficits with L side neglect...The patient has been stabilized within reasonable medical care standards. No further deterioration is likely as a result of transfer...Date/Time 3/26/12/(4:13 p.m.)...Consent to Transfer...to the service of (M.D. #2) at (Hospital #2)..." Medical record review of a CT scan of the brain with and without contrast dated March 26, 2012, at 5:05 p.m., revealed, "...Comparison is made with previous...exam (examination) of the brain dated 3/26/2012...There is a questionable minimal developing infarct in the anterior limb of	A2409		

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A2409	Continued From page 16 the right internal capsule...Impression...Occlusion of the right internal carotid artery and proximal portion of the right middle cerebral artery...Questionable minimal infarct in the anterior limb of the right internal capsule..." Medical record review of a nurse's note dated March 26, 2012, at 5:34 p.m., revealed, "...Will prepare pt. for Transfer." Medical record review revealed no documentation regarding the time or condition of the patient at the time of transfer. Medical record review of an Emergency Room Record (Hospital #2) dated March 26, 2012, revealed, "...Triage (6:19 p.m.)...presented to ed (Emergency Department) with complaints of stroke like symptoms transfer from (Hospital #1)...onset of new symptoms app (approximately) 45 minutes...Arrived via (Hospital #1's) EMS (emergency medical service)...(6:38 p.m.)...Historian: History obtained from patient, records from transferring facility. Time course: Onset of symptoms reported as sudden..." Medical record review of a physician's progress note dated March 26, 2012, at 6:52 p.m., revealed, "...Patient's status is critical." Medical record review of a physician's progress note dated March 26, 2012, at 6:52 p.m., revealed, "...pt had neg Head CT for acute bleed, no surgery, no head bleed per pt. reviewed risk and benefits pt wants to go with tPa (tissue plasminogen activator - dissolves clots and restores blood flow). Spoke with (M.D. #2) ok to give tPA..." Medical record review of a physician's progress note dated March 26, 2012, at 6:54	A2409		

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A2409	Continued From page 17 p.m., revealed, "Review of transfer records..." Medical record review of a physician's progress note dated March 26, 2012, at 7:11p.m., revealed, "...pt unchanged. will continue with tPA waiting for neuro eval (evaluation)." Medical record review of a physician's progress note dated March 26, 2012, at 7:27 p.m., revealed, "spoke with (M.D. #2)...states after talking with family, stroke started this am (a.m.). I spoke with patient who said symptoms started at 5 pm (p.m.) and EMS hand over indicated that symptoms started at 4 pm. Family was not here yet so that is the information I went with. tPA was stopped..." Medical record review of the medical records sent by Hospital #1 to Hospital #2 revealed no documentation regarding the final report of the CT scan of the brain dated March 26, 2012, at 2:33 p.m. or the CT scan of the brain dated March 26, 2012, at 5:05 p.m. Medical record review of a Consultation dated March 26, 2012, revealed, "...was visiting (spouse)...at (Hospital #1)...Per the family, who were present at the time of onset, which was around 11 or 11:30 a.m...started staggering...happened while (Patient #9) was in (Hospital #1)...was immediately taken to the emergency room...apparently had a CT angiogram of head done at (Hospital #1), which showed a distal...occlusion on the right side, and around 5:30 pm...was transferred to us for further management. Because the records from (Hospital #1) indicated that the time of onset was 5:00 p.m...thought to be within the window for...TPA...I stopped the TPA	A2409		

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A2409	Continued From page 18 infusion...Assessment...Acute ischemic stroke secondary to internal carotid artery occlusion....Left hemiplegia left hemi neglect, secondary to stroke...Admit to ICU (intensive care unit)..." Medical record review of a History and Physical dated March 26, 2012, revealed, "...basically had started a TPA infusion and then later discovered...time of onset was different than originally reported, and so that was stopped....has a continued dense left hemiplegia and neglect...continues in ICU (Intensive Care Unit) after receiving part of the TPA dose. Also with a large stroke and risk of hemorrhage..." Interview with M.D. #1 on August 22, 2012, at 10:28 a.m. in an Emergency Room office in Hospital #1, revealed M.D. #1 was prepared to discharge the patient after consultation with a neurologist and negative findings from a CT of the brain. Continued interview revealed the nursing staff informed M.D. #1 of a decline in the patient's condition, the neurologist was reconsulted and recommended a CT scan of the brain with contrast, and M.D. #1 stated, "...was past the three hour window (a specific timeframe for administration in relation to onset of symptoms) for PTA and that's why (neurologist) wanted me to call (Hospital #2)." Continued interview revealed M.D. #1 did not recall communication with Hospital #2 regarding the care of Patient #9 and M.D. #1's communication with an accepting facility was usually documented in the Physical History and Assessment. Continued interview revealed M.D. #1 called the facility's tranfer center (to arrange transfer) and confirmed the facility failed to provide an	A2409		

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A 000	INITIAL COMMENTS On June 12, 2012, an investigation of complaint # TN-329876 was conducted. Memorial Healthcare System, Inc. was found out of compliance with Requirements for the Responsibilities of Medicare Participating Hospitals in Emergency Cases 42 CFR Parts 489.20 and 489.24. The failure of the facility to provide adequate "On-Call" services for patient number 3; failure to provide on-call services of an Orthopedic surgeon; and failure to provide an appropriate transfer placed patient number 3 in Immediate Jeopardy. The administrator was notified of the Immediate Jeopardy on April 3, 2013.	A 000	Tag A 000 This Plan of Correction is submitted to provide credible evidence of correction of any alleged EMTALA deficiency so that CMS may determine that there is no immediate threat to the health and safety of any individual, and that CMS may rescind the proposed termination of the Hospital's provider agreement. This Plan of Correction is not an admission that the alleged deficiencies exist, and may not be used in any other context or for any purpose, other than as set forth below..	4/12/13
A2400	489.20(l) COMPLIANCE WITH 489.24 [The provider agrees,] In the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on medical record relvew, facility policy review, and interview, the facility failed to ensure patients who are transferred to another facility have been seen by qualified on-call physicians and received stabilizing treatment before being transferred to another hospital for one (#3) of thirty patients reviewed: The findings included: Please refer to A-2404 Please refer to A-2409	A2400		
A2404	489.20(r)(2) and 489.24(j)(1-2) ON CALL PHYSICIANS §489.20(r)(2)	A2404		

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

James M Hobson / Em Loder | President & CEO / VP Quality | 4/17/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A2404	Continued From page 1 [The hospital (including both the transferring and receiving hospitals), must maintain] a list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition. §489.24(j)(1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians. §489.24(j)(2)(i) The hospital must have written policies and procedures in place to respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control. §489.24(j)(2)(ii) The hospital must have written policies and procedures in place to provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on call or to permit on-call physicians to have simultaneous on-call duties. This STANDARD is not met as evidenced by: Based on medical record review and interview, the facility failed to consult the on-call Orthopedic surgeon for the facility before transferring the patient to another facility.	A2404	ED Leadership monitors all ED transfers for on call notification and response. Data reflects 100% compliance for three months, therefore monitoring concluded September 30, 2012.. Appendix 3. Monitoring: ED Director will provide data trends on physician certification for all transfers to ED CQI Committee quarterly and ultimately to Medical Executive Committee and Quality Committee of the Board. Documentation omissions will be reviewed with involved staff. Responsible Person: ED Director/CNO Completion Date: 9/30/12 At the direction of ED CQI, 100% of ED transfers are peer reviewed for compliance beginning February 1, 2013. Appendix 5. Per ED CQI, transfer case peer review outliers are trended and medical staff action will be taken as appropriate to ensure compliance. Responsible Person: Director, Medical Affairs Completion Date: February 1, 2013, monitoring ongoing	9/30/12 2/1/13

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A2404	Continued From page 2 The findings included: Medical record review revealed patient #3 presented to the Emergency Department (ED) of hospital #1 on May 17, 2012, at 11:07 p.m. with complaints of having jumped twenty feet from a retaining wall to concrete. Continued medical record review revealed the patient complained of pain to the right shin at a level of 10 on a scale of 1-10 with 10 being the worst possible pain. Review of the Physician On-call Schedule for May 17, 2012, revealed there was an Orthopedic surgeon on call. Review of the ED record revealed no documentation the Orthopedic surgeon was consulted about the patient. Telephone interview with the PhysicianAssistant (PA) on June 12, 2012, at noon in the conference room, revealed the patient was already considered a trauma case. Continued interview revealed the PA would have called the Orthopedic Surgeon on call at hospital #1 if hospital #2 had not agreed to accept the patient. Continued interview revealed it depends upon the case as to whether Orthopedics would be consulted but the PA considered a jump of twenty feet to be a trauma. Further interview revealed hospital #2 accepted the patient immediately so the patient was prepared for transfer and splints were not applied to the lower extremities. Telephone interview with the Medical Director of the ED on June 12, 2012, at 12:10 p.m., revealed the Medical Director had polled ED physician, PA, and Nurse Practitioner staff and 70% said they would have transferred the patient without calling	A2404		

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A2404	Continued From page 3 the on-call Orthopedic Surgeon. Continued interview revealed the Medical Director "...would probably have called the Orthopedic Surgeon on-call to let them know the type of injury and plans to transfer the patient...". Further interview with the Medical Director revealed the patient met orthopedic trauma criteria. Continued interview with the Mdeical Director revealed the physician must consider the mechanism of injury and the physicians felt regardless of having orthopedics facilities at hospital #1, the patient needed a trauma center. Telephone interview with physician #2 on June 14, 2012, at 1:30 p.m., revealed orthopedicas at hospital #1 was not consulted because of the mechanism of injury with the patient falling from twenty feet. Continued interview revealed the physician felt the patient should be evaluated by a trauma surgeon in case there were other injuries. Further interview revealed splints were not applied because the fractures were not unstable and there would have been no threat to the limbs if splints were not applied.	A2404		
A2409	489.24(e)(1)-(2) APPROPRIATE TRANSFER (1) General If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless - (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of	A2409	Plan begins on page 7	

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A2409	Continued From page 4 transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer. (B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or (C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based. (2) A transfer to another medical facility will be appropriate only in those cases in which - (i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child; (ii) The receiving facility	A2409	Plan begins on page 7	

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A2409	Continued From page 5 (A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment. (iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and (iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer. This STANDARD is not met as evidenced by: Based on medical record review, facility policy review, and interview the facility failed to ensure a patient with multiple orthopedic injuries was adequately stabilized with intravenous access	A2409	Plan begins on page 7	

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A2409	Continued From page 6 and splints for orthopedic injuries before transfer to another facility for one (#3) of thirty patients reviewed. The findings included: Medical record review revealed patient #3 presented to the Emergency Department (ED) on May 17, 2012, at 11:07 p.m., with complaints of having jumped twenty feet from a retaining wall to concrete. Continued medical record review revealed the patient complained of pain to the right shin at a level of 10 on a scale of 1-10 with 10 being the worst possible pain. Medical record review revealed the Physician Assistant assessed the patient at 11:31 p.m. and found the patient to have "...left ankle with periauricular swelling and tender to palpation; extension and flexor intact. Range of Movement in ankle limited in ankles bilaterally due to pain. Right ankle with swelling and tender to touch and palpation; extensors and flexors intact. Distal pulses equal and present x4...". Medical record review revealed the patient was assessed at 11:16 p.m., by the Triage Nurse who documented "...pt. (patient) jumped off a ledge onto concrete from 15-20 feet up. Both ankles are swollen and scratched up. Pt. Also complains of pain to right shin...". Medical record review revealed the patient was assessed by nursing at 11:20 p.m. and stated pain was at a level 10 on a scale of 1-10 with 10 being the worst pain. Medical record review revealed the patient had an	A2409	**Tag 2409 489.24(e)(1)(2)** The Hospital revised its comprehensive EMTALA policy to ensure compliance with all EMTALA requirements so as to provide a more comprehensive policy that accurately and fully provides direction to all emergency department staff on the procedures necessary for compliance. A copy of the revised Policy is attached to this Plan of Correction at Appendix 1. The revised policy was accepted by the Medical Executive Committee and was approved by the Board of Directors on June 25, 2012. Monitoring: The Hospital Policy is reviewed and revised annually, and as needed, to ensure compliance. Responsible Person: Associate Corporate Responsibility Officer Completion Date: June 25, 2012	6/25/12

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A2409	Continued From page 7 IV (intravenous line into vein to administer fluids) started at 12:24 a.m., in the left antecubital area. Continued review revealed the patient received Dilaudid (pain relief) 0.5 mg (milligrams) IV and Zofran (anti-nausea) 4 mg at 12:30 a.m., and another dose of Dilaudid 0.5 mg IV at 12:55 a.m. Medical record review of a medical note written by the Physician Assistant on May 17, 2012, and untimed, revealed "...Discussed and review all x-rays with (named physician #2). We discussed further imaging versus transfer. Agreed to transfer. Spine is non-tender to touch and palpation. (named physician) at hospital #2 accepts transfer of patient per transfer center at 12:46 a.m...". Review of the transfer form dated May 17, 2012 revealed the reason for transfer was "...health care services required are not available at (named hospital #1). The patient has been stabilized within reasonable medical care standards. No further deterioration is likely as a result of the transfer...". Medical record review revealed the patient was transported to hospital #2 on May 18, 2012, at 1:35 a.m., per ambulance. Review of the Emergency Record from hospital #2 dated May 18, 2012, at 1:45 a.m., revealed the statement by the ED physician "...Called (named hospital #1) and spoke with (named physician #2). Told him stable VS (vital signs) and that IV had been removed before transport...". Review of hospital #1s ED policy entitled Standard of Care - Orthopedic Emergencies	A2409	The Hospital implemented the revised EMTALA policy and provided training to all emergency department medical staff and ED staff related to the changes to the EMTALA policy. The revised draft policy was presented to ED medical staff and ED staff during training staff meetings and re-training sessions. EMTALA education was provided to all ED medical staff and ED staff to review EMTALA requirements for medical stabilization and documentation prior to transfer to another facility. Twelve 60 minute mandatory EMTALA education sessions were scheduled for 06-07-12 through 06-11-12, and were attended by all Hixson ED and Chattanooga Emergency Medicine staff and ED staff. Classes were led by the Corporate Responsibility Officer, Emergency Department Nurse Manager at Hixson and the Emergency Department Director. Hospital also implemented an eLEARN module requirement for all	6/30/12

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A2409	Continued From page 8 (Extremities) ECC - 01025, revealed "...The treatment and management of the patient with an orthopedic emergency to any extremity may include the following: 8. Obtain IV..." Medical record review of a nursing note dated May 18, 2012, at 1:59 a.m., revealed an IV was started in the patient's left hand at hospital #2. Telephone interview with the Physician Assistant (PA) on June 12, 2012, at noon, in the conference room, revealed the patient was already considered a trauma case. Further interview revealed an IV is usually in place when a patient is transferred to another facility. Continued interview revealed "...I believe it is protocol for patients to have IV access with transfer...". Telephone interview with the Medical Director of the ED on June 12, 2012, at 12:10 p.m., revealed most patients have an IV in place when transferred. Continued interview with the Medical Director revealed "...Any patient who goes by ambulance from one facility to another should have an IV...". During interview on June 12, 2012, at 1:30 p.m., in the conference room, the ED Director confirmed the patient did not have IV access present on transfer and all transfer patients are required to have IV access. Telephone interview with physician #2 on June 14, 2012, at 1:30 p.m. revealed splints were not applied because the fractures were not unstable and there would have been no threat to the limbs if splints were not applied.	A2409	ED medical staff (physicians, nurse practitioners and physician assistants) and ED staff. Email sent to eLEARN administrator by ED Director requesting EMTALA assignment on 05-31-12. The LEARN module requirement addressed, without limitation, EMTALA basics, the obligations of On-Call physicians and Emergency Department physicians, including timely in-person response, medical screening examinations, stabilizing treatment including awareness of and requirement for IV access, appropriate transfers, escalation and chain of command (in the event the On-Call physician cannot respond) and documentation. (In addition, annual EMTALA training is provided for all hospital staff as an eLEARN module. New staff are oriented to EMTALA guidelines and policy.)	

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A2409	Continued From page 9 Continued telephone interview with physician#2 on June 14, 2012, at 1:30 p.m., revealed patients are usually transferred with IV access in place. Continued interview revealed physician#2 was unaware there was no IV access during the transfer and stated "...I would have wanted one..."	A2409	Monitoring: The Hospital monitors EMTALA education through the use of eLEARN documentation, sign in sheets, and attestations signed by the Medical Staff members and staff. The completion rosters of eLearn modules are tracked to ensure all staff complete the required courses. Responsible Person: Associate Corporate Responsibility Officer Completion Date: June 30, 2012 Appendix 2, CRO focused training, Appendix 6 LEARN annual module The hospital implemented an expanded checklist for staff floating to the ED May 25, 2012. Subsequent monitoring for IV access was done. Monitoring: FY13 Quarter 1 – IV access continued through transfer; the Hospital reviewed 100% of transfers (37) Responsible Person: ED Director / CNO Completion Date: September 30, 2012 Results – 100% compliance (37/37) Appendix 3. Certificate of Transfer document Appendix 4.	9/30/12

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A 000	INITIAL COMMENTS On August 21 -23, 2012 an investigation of complaint # TN-30311 was conducted. Memorial Healthcare System, Inc. was found out of compliance with Requirements for the Responsibilities of Medicare Participating Hospitals in Emergency Cases 42 CFR Parts 489.20 and 489.24. The failure of the facility to provide adequate Medical Screening, and Stabilization of ED patient number 9; failure to provide on-call services of a neurology MD; and failing to provide an appropriate transfer placed patient number 9 in Immediate Jeopardy. The administrator was notified of the immediate Jeopardy on April 3, 2013.	A 000	Tag A 000 This Plan of Correction is submitted to provide credible evidence of correction of any alleged EMTALA deficiency so that CMS may determine that there is no immediate threat to the health and safety of any individual, and that CMS may rescind the proposed termination of the Hospital's provider agreement. This Plan of Correction is not an admission that the alleged deficiencies exist, and may not be used in any other context or for any purpose, other than as set forth below.	
A2400	489.20(l) COMPLIANCE WITH 489.24 [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on medical record review, facility policy and protocol review, review of on-call schedules, and interview, the facility failed to maintain a list of on-call physicians, failed to provide stabilizing treatment, and failed to provide appropriate transfer for one patient (#9) of twenty sampled patients reviewed. The findings included: Please refer to A-2404 for failing to maintain a physician on-call list Please refer to A-2407 for failing to provide stabilizing treatment Please refer to A-2409 for failing to provide appropriate transfer	A2400	Tag A 2400 Please see plan of correction under A-2404, A-2407 and A-2409.	
A2404	489.20(r)(2) and 489.24(j)(1-2) ON CALL	A2404	Tag A 2404 The Hospital complies with 489.20(r), and 489.24(j)(1) and (2) by maintaining an On-Call roster, and adopting and enforcing the On-Call Policy and the EMTALA Policy, and providing period education.	

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

James M Hobson / [illegible] President + CEO / VP Quality — 4/17/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A2404	Continued From page 1 PHYSICIANS §489.20(r)(2) [The hospital (including both the transferring and receiving hospitals), must maintain] a list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition. §489.24(j)(1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians. §489.24(j)(2)(i) The hospital must have written policies and procedures in place to respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control. §489.24(j)(2)(ii) The hospital must have written policies and procedures in place to provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on call or to permit on-call physicians to have simultaneous on-call duties. This STANDARD is not met as evidenced by: Based on review of facility policy, review of	A2404	The Hospital revised its Emergency Room On-Call Schedule template on 04/01/2013 to require individual physician names (not physician group names), by specialty, including neurology.. The April, 2013 Emergency Room On-Call Schedule includes the on-call neurologists by individual physician name . Appendix _1_ Emergency Room On-call Schedule April 1, 2013. The Hospital hired a hospital-based neurologists 11/12 to share on-call coverage and promote overall stroke management. Monitoring: Medical Staff Office Coordinator to review Emergency Room On-Call schedule prior to the beginning of the next month for individual physician names and contact information; any deficiencies will be immediately addressed. Will continue monthly posting. Responsible Person: Director Medical Affairs Completion Date: April 1, 2013. Monitoring is ongoing.	4/1/13

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A2404	Continued From page 2 Emergency Room On-Call Schedules, observation, and interview, the facility failed to maintain a list of on-call neurologists. The findings included: Review of facility Policy Number PC-07179 most recently reviewed and/or revised in September 2009, and titled "EMTALA (Emergency Medical Treatment and Labor Act) Guidelines - Treatment and Transfer of Individuals in Need of Emergency Medical Services revealed, "...The Hospital shall maintain an on-call list of physicians, including specialists and sub-specialists who are available to examine and treat an individual with an emergency medical condition...The Medical Staff Office, on a monthly basis, creates the Emergency Department ("ED") on-call Roster...the ED will maintain the on-call rosters...The on-call roster is divided into categories of medical specialties...specialties include but are not limited to...Neurology..." Review of Emergency Room On-Call Schedules dated January-July 2012, revealed no documentation regarding on-call neurologists. Observation on August 21, 2012, at 4:47 p.m. at an Emergency Room nurse's station, revealed a list of on-call physicians that identified the specialty, and included a physician's name and telephone number. Continued review revealed the specialties included neurology with a telephone number, and no documentation regarding identification of an on-call neurologist. Telephone interview with Registered Nurse (RN) #1 on August 23, 2012, at 2:40 p.m., revealed the	A2404	ED Leadership monitors all ED transfers for on call notification and response. Data reflects 100% compliance for three months, therefore monitoring concluded. Appendix 3. At the direction of ED CQI, 100% of ED transfers are peer reviewed beginning February 1, 2013. Appendix 5. Monitoring: Per ED CQI, transfer case peer review outliers are trended and medical staff action will be taken as appropriate to ensure compliance. Responsible Person: Associate Corporate Responsibility Officer Completion Date: June 25, 2012	6/25/12

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A2404	Continued From page 3 On-Call Schedule for August 23, 2012, included a phone number to call when neurology was required. RN #1 stated, "...If (a) patient (is) under the care of a neurologist we call their neurologist, otherwise we just call this answering service..."	A2404		
A2407	489.24(d)(1-3) STABILIZING TREATMENT (1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either- (i) within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition. (ii) For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section. (2) Exception: Application to inpatients. (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual (ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment. (iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.	A2407	Tag 2407 489.24(d)(1-3) The Hospital complies with 489.24(1-3) by ensuring the hospital provides appropriate stabilizing treatment within the hospital's capacity and capabilities to all patients who present to the Emergency Department with an emergency medical condition, or an appropriate transfer. All ED staff (including physicians and nurses) were provided re-training on current stroke protocol, to promote use of the stroke guidelines for t-PA administration where appropriate based on the patient's condition, as a form of stabilizing treatment under EMTALA within the Hospital's capabilities. Appendix _2_ Didactic t-PA and protocol training content. Appendix 12 Emergency Center Protocol for t-PA in Acute Stroke. Training and education plan includes ensuring all new staff and physicians as well as staff and physicians on leave receive training. The Hospital also hired a hospital-based neurologists	4/18/13

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A2407	Continued From page 4 (3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both. This STANDARD is not met as evidenced by: Based on review of facility policy and protocol, medical record review and interview, the facility failed to provide stabilizing treatment for one patient (#9) of twenty sampled patients. The findings included: Review of facility Policy Number PC-07179 most recently reviewed and/or revised in September 2009, and titled "EMTALA (Emergency Medical Treatment and Labor Act) Guidelines - Treatment and Transfer of Individuals in Need of Emergency Medical Services revealed, "...The Hospital will provide an individual with an emergency medical condition such further examination and treatment	A2407	11/12 and hired a stroke coordinator 2/13 to promote appropriate stroke management. Monitoring: ED Director to track compliance for completion of training; Appendix _3_ Training completion reports Responsible Person: ED Director/CNO Completion Date: April 18, 2013. Monitoring is ongoing. ED physicians were provided retraining on EMTALA, including the physician certification requirements for an appropriate transfer, including the requirement that the physician's certification be specific enough to give a complete picture of the benefits to be expected from appropriate care at the receiving (recipient) facility and the specific risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer. Appendix _4 Monitoring: Hospital monitors training on new policies and procedures by maintaining sign in sheets and attestations signed by the Medical Staff	6/25/12

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A2407	Continued From page 5 as required to stabilize the emergency medical condition, within the capability of the Hospital...To stabilize...mean...the patient is provided such medical treatment of the condition as is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient..." Review of facility Policy Number ECC-01070 and most recently reviewed and/or revised in January 2010, revealed, "...Title Standard of Care - CVA (Cerebrovascular Accident) or Stroke...Outcome: To establish guidelines in the treatment of a CVA/Stroke patient...A patient who arrives at the Emergency Center with CVA or stroke may receive the following care...Notify Emergency physician to determine if patient meets criteria for thrombolytic (dissolution of blood clots) therapy..." Review of an Emergency Center Protocol For t-PA (tissue plasminogen activator - dissolves clots and restores blood flow) in Acute Stroke dated August, 2006, revealed, "...NOTIFY on call Neurologist of potential t-PA candidate...Review the following exclusion criteria...Are the patient's stroke symptoms greater than 3 hours old? (IV(intravenous) t-PA must be given within 3 hours of onset of stroke symptoms...Does the CT (Computerized Tomography) brain demonstrate intracranial bleed or mass effect...Screening ER (Emergency Room) Physician Signature If the answer to any of the above questions is 'YES', the patient is not a candidate for t-PA...If the answer to all the above questions is 'NO', the patient may be a candidate for t-PA...NOTIFY Neurologist that patient IS a t-PA candidate..."	A2407	members and staff. Responsible Person: Corporate Responsibility Officer Completion Date: June 25, 2012. Monitoring is ongoing.	

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A2407	Continued From page 6 Patient #9 presented to Hospital #1's Emergency Department on March 26, 2012. Medical record review of Patient Information revealed, "...Arrival Date/Time: 1213 (12:13 p.m.)...Stated Complaint: Neurologic Symptoms/Deficits..." Medical record review of a Triage Assessment dated March 26, 2012, at 12:23 pm., revealed, "Stated Complaint: Possible Stroke...onset SOB (shortness of breath) after walking to surgery waiting...family reports slurred speech...High Risk Situation..." Medical record review of a nurse's note dated March 26, 2012, at 12:47 p.m., revealed, "...reassessed in triage. Noted to have reoccurence of slurred speech. Equal grip strengths. L (left) side facial droop." Medical record review of a nurse's note dated March 26, 2012, at 12:51 p.m., revealed, "...taken to room... (Medical Doctor - MD #1) notified of pt (patient) change in status." Medical record review of an untimed Emergency Department Physical History and Assessment dated March 26, 2012, revealed, "Chief complaint: slurring...duration less than one hour...with L facial droop that has waxed and waned...decreased blink on Left..." Medical record review of a CT (computerized tomography) scan of the brain without contrast dated March 26, 2012, at 2:33 p.m., revealed, "...Impression...No acute intracranial abnormality..."	A2407		

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A2407	Continued From page 7 Medical record review of a nurse's note dated March 26, 2012, at 4:02 p.m., revealed, "Dramatic neuro (neurological) changes noted...increased slurred speech and left sided weakness...(M.D. #1) notified, (M.D. #1) to bedside @ (at) (4:03 p.m.)..." Medical record review of the Physical History and Assessment dated March 26, 2012, revealed, "...Disposition Discussed with pt and family. Pt dysarthria seems more prounounced and I am uncertain of Bell's Palsy...Discussed with (neurologist) who requests MRI. If negative D/C (discharge) with steroids)...(4:00 p.m.)...densely hemiplegic on L. Call (neurologist)...onset greater than 3 hours. Recommended (Hospital #2)..." Medical record review revealed no documentation regarding an ER Center Protocol for t-PA in Acute Stroke for Patient #9. Medical record review revealed no documentation regarding assessment by a neurologist. Medical record review of a Certificate of Transfer dated March 26, 2012, revealed, "...Diagnosis: Neurological deficits with L side neglect...The patient has been stabilized within reasonable medical care standards. No further deterioration is likely as a result of transfer..." Medical record review of a CT scan of the brain with and without contrast dated March 26, 2012, at 5:05 p.m., revealed, "...Comparison is made with previous...exam (examination) of the brain dated 3/26/2012...There is a questionable minimal developing infarct in the anterior limb of the right internal capsule...Impression...Occlusion	A2407		

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A2407	Continued From page 8 of the right internal carotid artery and proximal portion of the right middle cerebral artery...Questionable minimal infarct in the anterior limb of the right internal capsule..." Medical record review revealed the patient was transferred to Hospital #2 on March 26, 2012. Medical record review of an Emergency Room Record (Hospital #2) dated March 26, 2012, revealed, "...Triage (6:19 p.m.)...presented to ed (Emergency Department) with complaints of stroke like symptoms transfer from (Hospital #1)...onset of new symptoms app (approximately) 45 minutes...Arrived via (Hospital #1's) EMS (emergency medical service)...(6:38 p.m.)...Historian: History obtained from patient, records from transferring facility. Time course: Onset of symptoms reported as sudden..." Medical record review of a physician's progress note dated March 26, 2012, at 6:52 p.m., revealed, "...Patient's status is critical." Medical record review of a physician's progress note dated March 26, 2012, at 6:52 p.m., revealed, "...pt had neg Head CT for acute bleed, no surgery, no head bleed per pt. reviewed risk and benefits pt wants to go with tPa. Spoke with (M.D. #2) ok to give tPA..." Medical record review of a physician's progress note dated March 26, 2012, at 6:54 p.m., revealed, "Review of transfer records..." Medical record review of a physician's progress note dated March 26, 2012, at 7:11p.m., revealed, "...pt unchanged. will continue with tPA waiting for neuro eval (evaluation)." Medical record review of a physician's progress note dated March 26, 2012, at 7:27 p.m.,	A2407		

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A2407	Continued From page 9 revealed, "spoke with (M.D. #2)...states after talking with family, stroke started this am (a.m.). I spoke with patient who said symptoms started at 5 pm (p.m.) and EMS hand over indicated that symptoms started at 4 pm. Family was not here yet so that is the information I went with. tPA was stopped..." Medical record review of the medical records sent by Hospital #1 to Hospital #2 revealed no documentation regarding the final report of the CT scan of the brain dated March 26, 2012, at 2:33 p.m. or the CT scan of the brain dated March 26, 2012, at 5:05 p.m. Medical record review of a Consultation dated March 26, 2012, revealed, "...was visiting (spouse)...at (Hospital #1)...Per the family, who were present at the time of onset, which was around 11 or 11:30 a.m...started staggering...happened while (Patient #9) was in (Hospital #1)...was immediately taken to the emergency room...apparently had a CT angiogram of head done at (Hospital #1), which showed a distal...occlusion on the right side, and around 5:30 pm...was transferred to us for further management. Because the records from (Hospital #1) indicated that the time of onset was 5:00 p.m...thought to be within the window for...TPA...I stopped the TPA infusion...Assessment...Acute ischemic stroke secondary to internal carotid artery occlusion....Left hemiplegia left hemi neglect, secondary to stroke...Admit to ICU (intensive care unit)..." Medical record review of a History and Physical dated March 26, 2012, revealed, "...basically had	A2407		

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A2407	Continued From page 10 started a TPA infusion and then later discovered...time of onset was different than originally reported, and so that was stopped....has a continued dense left hemiplegia and neglect...continues in ICU (Intensive Care Unit) after receiving part of the TPA dose. Also with a large stroke and risk of hemorrhage..." Interview with M.D. #1 on August 22, 2012, at 10:28 a.m. in an Emergency Room office in Hospital #1, revealed M.D. #1 was prepared to discharge the patient after consultation with a neurologist and negative findings from a CT of the brain. Continued interview revealed the nursing staff informed M.D. #1 of a decline in the patient's condition, the neurologist was reconsulted and recommended a CT scan of the brain with contrast, and M.D. #1 stated, "...was past the three hour window (a specific timeframe for administration in relation to onset of symptoms) for t-PA and that's why (neurologist) wanted me to call (Hospital #2)." Interview with the ER Nurse Manager on August 22, 2012, at 11:30 a.m., in a conference room, revealed the ER Nurse Manager was unaware the facility had a stroke protocol. The ER Nurse Manager stated, "...just if we know we're getting a possible stroke we just get them to CT scan right away." The facility failed to follow their stroke protocols, and failed to treat and stabilize the patient. The patient was misdiagnosed with Bells Palsy and was not evaluated for stroke in a timely manner. C/O: #30311	A2407		
A2409	489.24(e)(1)-(2) APPROPRIATE TRANSFER	A2409		

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A2409	Continued From page 11 (1) General If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless - (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer. (B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or (C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1)	A2409	The Hospital complies with 489.24(e)(1) and (2) by ensuring patients who present to the ED with emergency medical conditions receive appropriate stabilizing treatment within it capability and capacity prior to transfer, and that each transfer meets the elements of an "appropriate transfer." The Hospital revised its EMTALA policy to ensure compliance with all EMTALA requirements and to provide more accurate and complete direction to all staff on the procedures necessary for EMTALA compliance. A copy of the revised Policy is attached to this Plan of Correction at Appendix _5_ The revised policy was accepted by the Medical Executive Committee and was approved by the Board of Directors on 6/25/12. Monitoring: The EMTALA Policy is reviewed and revised annually, and as needed, to ensure compliance Responsible Person: Associate Corporate Responsibility Officer Completion Date: June 25, 2012	6/25/12

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A2409	Continued From page 12 of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based. (2) A transfer to another medical facility will be appropriate only in those cases in which - (i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child; (ii) The receiving facility (A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment. (iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after	A2409	The Hospital Certificate of Transfer form includes fields for documentation of report called to RN / Name at receiving facility. The receiving facility (authorized person) Transfer Center RN receives report and relays to transfer unit. Appendix _6_ Certificate of Transfer 08/2012 Monitoring: ED Director reviews 100% of neuro and stroke transfers for documentation of report called to RN / Name and reports to ED CQI Committee quarterly and ultimately to Medical Executive Committee and Quality Committee of the Board. Documentation omissions will be reviewed with involved staff. Appendix _7_ Transfers with diagnosis of neuro or trauma FY 13. Deficiencies will be reviewed with involved staff; any identified trends will be reviewed in staff meetings and ED Leadership Appendix _8_ Process Change Alert for documentation of RN to RN report on Certificate of Transfer April 2013 Responsible Person: ED Director with CNO provision of oversight assurance and process continuation Completion Date: April 11, 2013. Monitoring is ongoing	4/11/13

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A2409	Continued From page 13 transfer; and (iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer. This STANDARD is not met as evidenced by: Based on review of facility policy, medical record review and interview, the facility failed to ensure an appropriate transfer for one patient (#9) of twenty sampled patients. The findings included: Review of facility Policy Number PC-07179 most recently reviewed and/or revised in September 2009, and titled "EMTALA (Emergency Medical Treatment and Labor Act) Guidelines - Treatment and Transfer of Individuals in Need of Emergency Medical Services revealed, "...The Hospital will provide an individual with an emergency medical condition such further examination and treatment...or arrange for transfer of an individual to another medical facility in accordance with the procedures set forth below...'Stable for transfer' means...The physician...determines...that the receiving facility has the capability to manage the emergency medical condition..." Patient #9 presented to Hospital #1's Emergency Department on March 26, 2012. Medical record review of Patient Information revealed, "...Arrival Date/Time: 1213 (12:13	A2409	The Hospital Certificate of Transfer form is revised to include additional fields for the certifying physician's documentation to promote EMTALA compliance, including the requirement that the physician's certification be specific enough to give a complete picture of the benefits to be expected from appropriate care at the receiving (recipient) facility and the specific risks associated with the transfer, including the time away from an acute care setting necessary to effect the transfer **Appendix _9_ Certificate of Transfer 4/12/2013** Monitoring: ED Director will provide data trends on physician certification for all transfers to ED CQI Committee quarterly and ultimately to Medical Executive Committee and Quality Committee of the Board. Documentation omissions will be reviewed with involved staff. **Appendix _10_ EMTALA Summary (FY 2013)** Responsible Person: ED Director with CNO provision of oversight assurance and process continuation Completion Date: April 30, 2013. Monitoring is ongoing	4/30/13

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A2409	Continued From page 14 p.m.)...Stated Complaint: Neurologic Symptoms/Deficits..." Medical record review of a Triage Assessment dated March 26, 2012, at 12:23 pm., revealed, "Stated Complaint: Possible Stroke...onset SOB (shortness of breath) after walking to surgery waiting...family reports slurred speech...High Risk Situation..." Medical record review of a nurse's note dated March 26, 2012, at 12:47 p.m., revealed, "...reassessed in triage. Noted to have reoccurence of slurred speech. Equal grip strengths. L side facial droop." Medical record review of a nurse's note dated March 26, 2012, at 12:51 p.m., revealed, "...taken to room...(Medical Doctor - MD #1) notified of pt (patient) change in status." Medical record review of an untimed Emergency Department Physical History and Assessment dated March 26, 2012, revealed, "Chief complaint: slurring...duration less than one hour...with L (left) facial droop that has waxed and waned...decreased blink on Left..." Medical record review of a CT (computerized tomography) scan of the brain without contrast dated March 26, 2012, at 2:33 p.m., revealed, "...Impression...No acute intracranial abnormality..." Medical record review of a nurse's note dated March 26, 2012, at 4:02 p.m., revealed, "Dramatic neuro (neurological) changes noted...increased slurred speech and left sided weakness...(M.D. #1) notified, (M.D. #1) to	A2409	The Hospital implemented the revised EMTALA policy and provided training to all emergency department medical staff and ED staff related to the changes to the EMTALA policy. The revised draft policy was presented to ED medical staff and ED staff during training staff meetings and re-training sessions. EMTALA education was provided to all ED medical staff and ED staff to review EMTALA requirements for medical stabilization and/ documentation prior to transfer to another facility. Twelve 60 minute mandatory EMTALA education sessions were scheduled for 06-07-12 through 06-11-12, and were attended by all Hixson ED and Chattanooga Emergency Medicine staff and ED staff. Classes were led by the Corporate Responsibility Officer, Emergency Department Nurse Manager at Hixson and the Emergency Department Director. Hospital also implemented an eLEARN module requirement for all ED medical staff (physicians, nurse practitioners and physician assistants) and ED staff. Email sent to eLEARN administrator by ED Director requesting EMTALA assignment on 05-31-12. The LEARN module requirement addressed,	6/30/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A2409	Continued From page 15 bedside @ (at) (4:03 p.m.)..." Medical record review of the Physical History and Assessment dated March 26, 2012, revealed, "...Disposition Discussed with pt (patient) and family pt dysarthria seems more pronounced and I am uncertain of Bell's Palsy...Discussed with (neurologist) who requests MRI. If negative D/C (discharge) with steroids)...(4:00 p.m.)...densely hemiplegic on L. Call (neurologist)...onset greater than 3 hours. Recommended (Hospital #2)..." Continued review revealed no documentation regarding communication with a receiving physician or (Hospital #2). Medical record review of a Certificate of Transfer dated March 26, 2012, revealed no documentation regarding an authorizing person at (Hospital #2; appropriate medical information sent with the patient; or a Registered Nurse (Hospital #2) to whom report was given. Continued review revealed specific benefits and risks regarding transfer were not documented and included, "...Diagnosis: Neurological deficits with L side neglect...The patient has been stabilized within reasonable medical care standards. No further deterioration is likely as a result of transfer...Date/Time 3/26/12/(4:13 p.m.)...Consent to Transfer...to the service of (M.D. #2) at (Hospital #2)..." Medical record review of a CT scan of the brain with and without contrast dated March 26, 2012, at 5:05 p.m., revealed, "...Comparison is made with previous...exam (examination) of the brain dated 3/26/2012...There is a questionable minimal developing infarct in the anterior limb of	A2409	without limitation, EMTALA basics, the obligations of On-Call physicians and Emergency Department physicians, including timely in-person response, medical screening examinations, stabilizing treatment including awareness of and requirement for IV access, appropriate transfers, escalation and chain of command (in the event the On-Call physician cannot respond) and documentation. (In addition, annual EMTALA training is provided for all hospital staff as an eLEARN module. New staff is oriented to EMTALA guidelines and policy.) Monitoring: The Hospital monitors EMTALA education through the use of eLEARN documentation, sign in sheets, and attestations signed by the Medical Staff members and staff. The completion rosters of eLearn modules are tracked to ensure all staff complete the required courses. Appendix 11 Responsible Person: Associate Corporate Responsibility Officer Completion Date: June 30, 2012.	

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A2409	Continued From page 16 the right internal capsule...Impression...Occlusion of the right internal carotid artery and proximal portion of the right middle cerebral artery...Questionable minimal infarct in the anterior limb of the right internal capsule..." Medical record review of a nurse's note dated March 26, 2012, at 5:34 p.m., revealed, "...Will prepare pt. for Transfer." Medical record review revealed no documentation regarding the time or condition of the patient at the time of transfer. Medical record review of an Emergency Room Record (Hospital #2) dated March 26, 2012, revealed, "...Triage (6:19 p.m.)...presented to ed (Emergency Department) with complaints of stroke like symptoms transfer from (Hospital #1)...onset of new symptoms app (approximately) 45 minutes...Arrived via (Hospital #1's) EMS (emergency medical service)...(6:38 p.m.)...Historian: History obtained from patient, records from transferring facility. Time course: Onset of symptoms reported as sudden..." Medical record review of a physician's progress note dated March 26, 2012, at 6:52 p.m., revealed, "...Patient's status is critical." Medical record review of a physician's progress note dated March 26, 2012, at 6:52 p.m., revealed, "...pt had neg Head CT for acute bleed, no surgery, no head bleed per pt. reviewed risk and benefits pt wants to go with tPa (tissue plasminogen activator - dissolves clots and restores blood flow). Spoke with (M.D. #2) ok to give tPA..." Medical record review of a physician's progress note dated March 26, 2012, at 6:54	A2409		

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A2409	Continued From page 17 p.m., revealed, "Review of transfer records..." Medical record review of a physician's progress note dated March 26, 2012, at 7:11p.m., revealed, "...pt unchanged. will continue with tPA waiting for neuro eval (evaluation)." Medical record review of a physician's progress note dated March 26, 2012, at 7:27 p.m., revealed, "spoke with (M.D. #2)...states after talking with family, stroke started this am (a.m.). I spoke with patient who said symptoms started at 5 pm (p.m.) and EMS hand over indicated that symptoms started at 4 pm. Family was not here yet so that is the information I went with. tPA was stopped..." Medical record review of the medical records sent by Hospital #1 to Hospital #2 revealed no documentation regarding the final report of the CT scan of the brain dated March 26, 2012, at 2:33 p.m. or the CT scan of the brain dated March 26, 2012, at 5:05 p.m. Medical record review of a Consultation dated March 26, 2012, revealed, "...was visiting (spouse)...at (Hospital #1)...Per the family, who were present at the time of onset, which was around 11 or 11:30 a.m...started staggering...happened while (Patient #9) was in (Hospital #1)...was immediately taken to the emergency room...apparently had a CT angiogram of head done at (Hospital #1), which showed a distal...occlusion on the right side, and around 5:30 pm...was transferred to us for further management. Because the records from (Hospital #1) indicated that the time of onset was 5:00 p.m...thought to be within the window for...TPA...I stopped the TPA	A2409		

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A2409	Continued From page 18 infusion...Assessment...Acute ischemic stroke secondary to internal carotid artery occlusion....Left hemiplegia left hemi neglect, secondary to stroke...Admit to ICU (intensive care unit)..." Medical record review of a History and Physical dated March 26, 2012, revealed, "...basically had started a TPA infusion and then later discovered...time of onset was different than originally reported, and so that was stopped....has a continued dense left hemiplegia and neglect...continues in ICU (Intensive Care Unit) after receiving part of the TPA dose. Also with a large stroke and risk of hemorrhage..." Interview with M.D. #1 on August 22, 2012, at 10:28 a.m. in an Emergency Room office in Hospital #1, revealed M.D. #1 was prepared to discharge the patient after consultation with a neurologist and negative findings from a CT of the brain. Continued interview revealed the nursing staff informed M.D. #1 of a decline in the patient's condition, the neurologist was reconsulted and recommended a CT scan of the brain with contrast, and M.D. #1 stated, "...was past the three hour window (a specific timeframe for administration in relation to onset of symptoms) for PTA and that's why (neurologist) wanted me to call (Hospital #2)." Continued interview revealed M.D. #1 did not recall communication with Hospital #2 regarding the care of Patient #9 and M.D. #1's communication with an accepting facility was usually documented in the Physical History and Assessment. Continued interview revealed M.D. #1 called the facility's tranfer center (to arrange transfer) and confirmed the facility failed to provide an	A2409		

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A2409	Continued From page 19 appropriate transfer for Patient #9. The transfer was not timely for the diagnosis of CVA and it appeared that the facility had the capability to treat the patient. As a result, the patient arrived at Hospital 2 too late for definitive treatment for stroke. C/O: #30311	A2409		