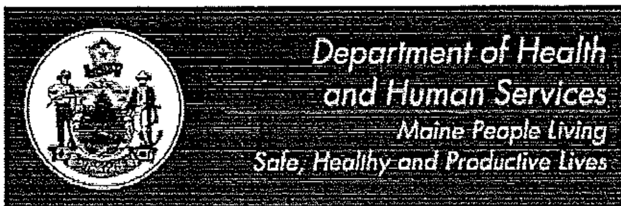

Paul R. LePage, Governor   Ricker Hamilton, Commissioner

Department of Health and Human Services
Licensing and Certification
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-9300; Fax: (207) 287-9307
Toll Free (800) 791-4080; TTY Users: Dial 711 (Maine Relay)

August 7, 2018

David Tupponce, Administrator
Central Maine Medical Center
300 Main Street
Lewiston, ME 04240

Dear Mr. Tupponce:

The revised Plan of Correction for the complaint survey, completed on May 21, 2018, for Central Maine Medical Center has been received in our office.

Upon review, your revised Plan of Correction received on August 3, 2018 was found to be acceptable as submitted.

If you have any questions, please feel free to call Marcia Smith at (207) 287-9259 or by email at Marcia.Smith@maine.gov.

Sincerely,

Marcia Smith RN BSN

Elizabeth Church, RN, BSN
Manager of Acute Care and Long Term Care
Division of Licensing and Certification

cc: Nancy Hannah, CMS - Boston Regional Office

Complaint # 27864

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200024	A. BUILDING ____ B. WING ____	C 05/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MAINE MEDICAL CENTER	300 MAIN STREET LEWISTON, ME 04240

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A 000	INITIAL COMMENTS EMTALA Complaint #27864 Survey Dates: May 14, 2018 - May 21, 2018 Central Maine Medical Center is not in compliance with 42 Code of Federal Regulation Part 489 Responsibilities of Medicare Participating Hospitals in Emergency Cases. The following requirements have not been met:	A 000		
A2400	COMPLIANCE WITH 489.24 CFR(s): 489.20(l) [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 hospital policy review and medical record review, the hospital failed to comply with 42 CFR 489.24. The findings include: Central Maine Healthcare, Administrative Policy No.: HC-ED, SUBJECT: Emergency Medical Treatment and Active Labor Act (EMTALA) stated: -"POLICY: To ensure that all patients presenting to a CMH's hospital requesting emergency services receive an appropriate medical screening examination within Hospital's capability to determine whether or not an emergency medical condition exists. If a patient is determined to have an emergency medical condition, then Hospital will either stabilize and/or transfer the patient in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA)."	A2400		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: President CMMC (X6) DATE: August 3, 2018

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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A2400	Continued From page 1 -Comes to the Emergency Department: Is defined as the individual (not yet a patient): Presents at the Hospital's Emergency Department or on hospital property and examination or treatment for a medical condition is requested or it can reasonably be inferred that the individual needs evaluation or treatment for a medical condition; Patient #1 presented at the hospital's Emergency Department (ED) on October 28, 2017 at approximately 10:08 AM, seeking care. A hospital security log and a police report indicated that Patient #1 completed the ED registration process and remained seated at the ED registration desk. Documentation obtained indicated that Patient #1 became uncooperative prior to being triaged (assessed for level of illness/injury), and was eventually removed from the ED by security and placed under arrest by the police. The registration log entry was deleted from the ED log, causing this patient encounter to not be seen in the Emergency Department Log. Additionally, the hospital failed to provide a medical screening examination for an individual presenting to a CMH's hospital requesting emergency services.	A2400		
A2402	POSTING OF SIGNS CFR(s): 489.20(q) [The provider agrees,] in the case of a hospital as defined in §489.24(b), to post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance,	A2402		

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A2402	Continued From page 2	A2402		

admitting area, waiting room, treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital (e.g., critical access hospital) participates in the Medicaid program under a State plan approved under Title XIX.

This STANDARD is not met as evidenced by:
Based on Emergency Department observations, the hospital failed to ensure required signage was posted conspicuously.

The findings include:

While conducting observations of the Emergency Department and areas in which patients may enter or be waiting to be seen by the emergency department providers between May 14, 2018 and May 15, 2018, it was noted that the signage in place was not conspicuous.

Upon entering the emergency department (ED) walk in entrance adjacent to the security entrance, there was one sign noted that stated "Emergency Department Notices" which was obstructed and not in an area likely to be noticed by patients entering for ED services as there was a sign immediately in front of it stating: "MRI registration and waiting area."

On the side of the ED registration window was a small 8.5 x 11 inch piece of paper which had wording stating, "IT'S THE LAW" in 4 different languages, but it was not of sufficient size or

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A2402	Continued From page 3 location to be seen or noticed by all entering. Within the ambulance entrance area was a small 8.5 x 11 inch piece of paper which had wording stating, "IT'S THE LAW" in 4 different languages, but it was not of sufficient size or location to be seen or noticed by all entering. This paper was covered in plastic and located directly above the heating control and on the wall between the emergency department entrance wall and a large glass encased bulletin board on the wall. In an interview conducted with several Emergency Medical Services (EMS) staff on the dates of observation, the surveyor was informed that approximately 70% of the patients they bring into the hospital are seated upright and able to look forward as they enter the emergency department. None of the EMS staff could read the posted signage standing next to their stretchers and one stated "it would be next to impossible for someone on a stretcher to read the sign as posted.	A2402		
A2405	EMERGENCY ROOM LOG CFR(s): 489.20(r)(3) [The provider agrees,] in the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain a central log on each individual who comes to the emergency department, as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged. §489.24 The provisions of this regulation apply to all hospitals that participate in Medicare and	A2405		

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A2405	Continued From page 4	A2405		

provide emergency services.

This STANDARD is not met as evidenced by:
Based on record review, the facility failed to register all individuals in a central log who came to the emergency department seeking care, in 1 of 16 Emergency Department (ED) patients (Patient #1).

Findings include:

The Emergency Department log was received on 5/14/18 at approximately 5:18 PM. This log failed to identify an entry for Patient #1's name on October 28, 2017.

A review of the Emergency Department security log provided on May 16, 2018 at approximately 1:40 PM, indicated entry 17-5156; that Patient #1 arrived at the hospital Emergency Department on October 28, 2017 at approximately 10:08 AM. Security log entry stated: "[Patient #1] JUST PRESENTED TO THE ER ...ADVISED THAT IF [HE/SHE] NEEDED TO BE SEEN TO REGISTER ... PT REFUSES TO COOPERATE AND IS ESCALATING. ESCORTED OUT OF ER @1020 BY [security]. LPD [police department] CALLED @ 1021. SUBJECT PLACED UNDER ARREST @ 1039."

Document titled "LPD Statement Related to IR 17-5156" was provided on May 21, 2018 at approximately 2:45 PM. This document included a photograph of a police statement, dated October 28, 2017 at 10:45 AM, completed by RN #8. The police statement indicated: "[Patient #1] arrived to the Central Maine Medical center waiting room at approximately 10:15 AM. Upon registration [his/her] chief complaint was to

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A2405	Continued From page 5 demand an MRI exam for self reported brain cancer. [Patient #1] refused to proceed with the triage process and refused to self ambulate to an exam room for medical examination ... [Patient #1] has been medically evaluated for similar complaint recently and has been deemed mentally competent with most recent consultation of October 25, 2017. [Patient #1] has been told that if [he/she] can comply with the medical evaluation process [he/she] will be evaluated at any time. [He/She] is denying intent to self harm at this time." Document titled "Canceled Registration 2017.10.28" was provided on May 21, 2018 at approximately 2:45 PM. This document demonstrated that Patient #1 was registered to the Emergency Department on October 28, 2017 at 10:15 AM, although the ED log failed to show that patient registered on that date and time.	A2405		
A2406	MEDICAL SCREENING EXAM CFR(s): 489.24(a) & 489.24(c) Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must (i) provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and	A2406		

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A2406	Continued From page 6 regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (b) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section. (2) Nonapplicability of provisions of this section. Sanctions under this section for inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act. (c) Use of Dedicated Emergency Department for Nonemergency Services If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request	A2406		

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A2406	Continued From page 7 makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition. This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide a screening examination to a patient who came to the emergency department seeking care in 1 of 16 (Patient #1) Emergency Department (ED) patient records reviewed. The finding includes: Patient #1 presented to the ED on October 28, 2017 at approximately 10:08 AM seeking emergency care. The patient reportedly was seeking an examination to rule out brain cancer. The patient was registered as an ED patient, however; was described as uncooperative with the nursing triage process and was removed from the ED by security and police prior to receiving a medical screening examination. Documentation provided by the hospital indicated that Patient #1 was arrested and removed from the hospital property. (See Tag A-2405).	A2406		

Revised Plan of Correction --CMS Statement of Deficiencies Dated 6/29/18

Introduction

Central Maine Medical Center ("CMMC") is committed to complying with all requirements under EMTALA and serving all individuals who need or request emergency services or otherwise come to the CMMC Emergency Department ("ED"). Consistent with this commitment, our corrective action plan consists of the following areas of focus, each of which is described in more detail below:

1. **A root cause analysis of the October 28, 2017, patient incident described in the CMS Statement of Deficiencies dated June 29, 2018.** We have evaluated the factors that may have contributed to the incident and identified corrective actions, including an improved workflow for addressing individuals who come to the ED and request treatment but who exhibit disruptive and/or non-cooperative behavior in the ED waiting room.

2. **A detailed review of the CMMC EMTALA policy.** This is the policy on which all CMMC staff members, clinicians and security guards who may encounter individuals who come to CMMC in need of or requesting emergency services are educated and trained on their obligations under EMTALA.

3. **Enhancing our systems and processes to monitor and assess on a systematic basis our workforce's understanding of and compliance with all elements of our EMTALA policy.** This includes using our Quality Assurance and Performance Improvement ("QAPI") program to (a) monitor and track staff compliance with EMTALA obligations and education requirements and (b) ensure that senior leadership receives reports on EMTALA compliance on a regular basis.

4. **Enhancing our commitment to workforce education, including by engaging The Greeley Company ("Greeley") to carry out supplemental EMTALA-related education sessions** during the month of August 2018 for certain CMMC staff, and to help us assess whether to improve our regular onboarding and annual EMTALA-related educational curricula.

The CMMC President and the Central Maine Healthcare ("CMH") Director of Quality shall be responsible for the overall execution of this Plan of Correction. In connection with this responsibility, the Director of Quality shall have day-to-day responsibility for ensuring that all elements of the Plan of Correction are being carried out effectively, and shall work together with the other members of the CMMC leadership team tasked with responsibility over particular corrective action items, as described below. The President shall review on a bi-weekly basis the status of each element of the Plan of Correction with the Director of Quality.

Part A: Finding A2400

1. Summary of Finding and Corrective Action

The State Surveyors determined, in Tag A2400 in the Statement of Deficiencies, that CMMC failed to comply with the EMTALA regulations at 42 C.F.R. 489.24 in connection with a person that presented to the ED on October 28, 2017. The State Surveyors found that CMMC failed to provide a medical screening examination to this individual and that the registration log entry relating to this patient encounter was cancelled from the ED central log.

CMMC undertook an investigation to understand the factors contributing to the incident and to develop corrective measures to prevent re-occurrence. As detailed below, the corrective action consists of (a) a root cause analysis and implementation of a new process for managing patients in the ED waiting room based on that analysis, (b) review of the CMMC EMTALA policy to evaluate whether any revisions are needed to provide further guidance regarding compliance with EMTALA requirements, (c) engagement of Greeley to provide EMTALA education to certain CMMC personnel, and to enhance CMMC's EMTALA on-boarding and annual education, if Greeley, in consultation with CMMC, determines such improvements are necessary, and (d) development of enhanced controls for monitoring EMTALA compliance and reporting on the status of compliance to senior management and the CMMC board (through a standing committee of the board). This corrective action will be completed by August 13, 2018.

2. Root Cause Analysis

A Root Cause Analysis was undertaken by the Quality Department regarding the October 28, 2017 ED incident to determine why the individual involved in that incident was not provided a medical screening examination and was not included in the ED patient log. Several root causes underlying this incident were identified, including: (a) de-escalation by security was attempted without collaboration from clinical personnel; (b) there was no consideration of an alternative process to complete the medical screening, such as seeking immediate support from clinical personnel; and (c) after the individual left the premises, the registration was cancelled from the ED log. Post-RCA action planning has led CMMC to engage Greeley to provide education regarding EMTALA obligations and to undertake a focused review of the EMTALA policy. The findings in the root cause analysis form the basis of the remaining corrective action items described below.

3. EMTALA Policy

In June 2018, CMH Risk Management, with the assistance of outside counsel, commenced a review of the CMMC EMTALA policy to evaluate whether the policy was consistent with EMTALA regulations and/or could be revised to provide clarifying guidance regarding CMMC's EMTALA obligations and the role of CMMC staff and clinicians in supporting these obligations. Outside counsel concluded that the EMTALA policy was consistent with EMTALA regulations and the CMS State Operations Manual but provided recommendations for revisions that would furnish CMMC personnel with clearer and more detailed guidance as to CMMC's obligations under EMTALA. Counsel's recommendations include: (1) additional emphasis on the fact that

CMMC may follow its reasonable registration and triage processes for individuals presenting at the ED and requesting emergency treatment, but that these processes must be conducted so as to not discourage patients from remaining for further evaluation; (2) further clarity within the EMTALA policy on the need to maintain an ED log of all patients who present to CMMC and request emergency treatment.

CMMC has engaged Greeley to conduct a further review of the suggested revisions. Greeley will review and provide its findings to CMMC by August 7, 2018. Thereafter, CMMC will revise the EMTALA policy as necessary and obtain approval of any revisions to the policy by August 13, 2018. Because CMMC's counsel's proposed revisions are in the nature of clarifications to a policy which already is EMTALA compliant, Greeley's education sessions will incorporate all necessary policy education.

Compliance with the EMTALA policy is monitored on an ongoing basis by the Director of Quality through the processes described in more detail below. Until June 30, 2019, all findings relating to the CMMC EMTALA policy shall be included in CMMC's QAPI, with trends reported quarterly to the CMMC President and then to the CVHC Committee as described in more detail below.

4. Education

Engagement of Greeley and Development of Enhanced Education Program

CMMC has engaged Greeley, a regulatory consulting firm, to carry out immediate EMTALA-related compliance education for certain CMMC personnel and to work with CMMC to enhance our new hire and annual refresher education materials, if necessary, based on Greeley's review of CMMC's existing EMTALA education programs.

Greeley employees will commence EMTALA-related compliance education during the week of August 6, 2018 to August 10, 2018. The education sessions will be conducted via live webinar, with each session consisting of approximately 60 minutes of presentation by Greeley employees followed by 30 minutes of a live question and answer session. The education program will cover all elements of EMTALA compliance, including the fundamental obligations under EMTALA and special points of emphasis on: (i) the obligation to conduct a medical screening examination for all individuals that "come to the ED"; (ii) the obligation to maintain a complete and accurate central log and appropriate documentation in the medical record; and (iii) the obligation to maintain clear and conscipuous EMTALA compliant signage.

As recommended by Greeley, the following groups of CMMC staff will be required to participate in these live webinars: all ED clinical and non-clinical staff; all Security Officers; all nursing House Supervisors; and all other members of CMMC leadership who fill the role of Administrator-on-Call.

At the conclusion of each session of the live webinar, Greeley will administer a competency evaluation, which is designed to assess each staff member's comprehension and retention of the material presented during the course of the educational program. Greeley will record one of the live webinar sessions and make it available for viewing through the CMMC intranet, to accommodate staff members who are unable to attend one of the live sessions. The Regulatory

Compliance Coordinator, in collaboration with the Director of Capacity Management, will administer the competency evaluation for the recorded version of the education session.

Staff members who do not achieve a passing score on the competency evaluation will be required to retake the webinar through the CMMC intranet, and retake the competency evaluation, within ten days of the initial webinar. If the employee fails to achieve a passing score on the second competency evaluation, such employee will have a meeting scheduled with the Regulatory Compliance Coordinator, who will conduct additional remediation until the employee passes the competency evaluation.

Monitoring and Evaluation of Compliance with Supplemental Education

The CMMC Regulatory Compliance Coordinator, in collaboration with Director of Capacity Management, will be responsible for ensuring compliance with the Greeley education initiative. These senior administrators will require all categories of personnel listed above to complete one of the education sessions offered by Greeley. Course completion will be tracked through the collection of the competency evaluations administered at the end of each education session, which will include a signature line that each staff member must execute certifying that he or she participated in the educational session (whether live or taped).

CMMC has set a goal of having 75% of staff, who are required to participate in the Greeley education program, complete the training and pass the competency examination by August 13, 2018; it aims to achieve 100% completion no later than August 31, 2018. The CMMC Regulatory Compliance Coordinator and Director of Capacity Management will meet with the Chief Quality Officer on a weekly basis during August and September of 2018 to monitor compliance with the above-described education requirements through the CMMC QAPI. They will report on the status of the Greeley education initiative to senior leadership on August 13, 2017 and again on August 31, 2018 and will notify the QVCH Committee on the same dates.

Development of Additional Educational Content

Following the above-described supplemental education initiative, Greeley will work with the CMMC Regulatory Compliance Coordinator, Director of Capacity Management, and other members of CMMC leadership to evaluate whether new or supplemental education materials would help enhance CMMC's new hire education and annual education programs. All new education materials, if necessary based on this evaluation, will be developed, finalized, and approved by the Chief Quality Officer and QVCH Committee no later than August 13, 2018.

Monitoring of Compliance with Ongoing Education Requirements

Consistent with current practice, the Nurse Leader of each department at CMMC will be responsible for tracking, on an ongoing basis, new hire education and annual education completion information. Issues of non-compliance with required education will be addressed through the Human Resources Counseling, Warning, Discipline, and Termination Actions Policy.

Part B: Finding A2402

1. Summary of Finding and Corrective Action

The State Surveyors further determined, in Tag A2402 in the Statement of Deficiencies, that CMMC failed to comply with its obligation to post signage specifying the rights of individuals to receive examination and treatment for emergency medical conditions consistent with the standards described under 42 C.F.R. 489.20(q).

CMMC has implemented an action to correct this deficiency. As detailed below, as of August 3, 2018, CMMC ordered approximately 70 new EMTALA-compliant signs. In the interim, CMMC will resize and reposition the existing signage to ensure that individuals are notified of their right to receive examination and treatment for emergency medical conditions consistent with the standards described under 42 C.F.R. 489.20(q). Additionally, we have developed enhanced ongoing systematic monitoring and tracking to ensure that EMTALA-compliant signage is maintained across the CMMC campus moving forward. Finally, consistent with the more detailed discussion above regarding educational initiatives, additional education regarding the signage requirements under EMTALA will be provided by Greeley in connection with its August 2018 sessions.

2. Discussion Regarding Corrective Action

In July 2018, the CMMC Regulatory Compliance Coordinator, in collaboration with the CMMC Director of Plant Operations and Director of Capacity Management, reviewed the CMMC campus to evaluate signage for compliance with EMTALA, looking to ensure that all signage was appropriately sized and conspicuously posted in the CMMC ED and other places likely to be noticed by all individuals entering the ED, as well as by those individuals waiting for examination and treatment in areas other than the ED (including the entrance, admitting area, waiting room and treatment areas). On July 27, 2018, these personnel engaged in planning to order and prepare new signage with designated size and verbiage designed to ensure such signage is likely to be noticed by individuals consistent with the above-described EMTALA requirements. On August 3, 2018, the signage was ordered. The CMMC Regulatory Compliance Coordinator, in collaboration with the CMMC Director of Plant Operations and Director of Capacity Management, will oversee the installation of this new signage across the CMMC campus. All new permanent signage will be installed by August 13, 2018, if timely received, and as soon as possible thereafter, if not received by then, and no later than August 30, 2018. As an interim measure, on August 3, 2018, CMMC took the existing signs to a copy center to have them resized. It will then reposition the signs throughout CMMC where they will hang until the permanent signage is received. The existing re-sized signs will be rehung by August 10, 2018 and in the interim, the current signs will be repositioned so as to be visible and noticeable. Compliance with EMTALA signage requirements also will be improved through the supplemental education to be provided by Greeley. Greeley's education will emphasize EMTALA's "posted conspicuously" standard as well as the requirement that CMMC staff ensure that such signage is never blocked or obscured.

The Regulatory Compliance Coordinator will monitor compliance of the EMTALA signage requirements on a monthly basis through use of a tracer tool. Any non-compliance will be noted

and corrected immediately. A summary of the monthly audit of signage will be reported to the CMMC Environment of Care Committee and to the Director of Quality for inclusion on CMMC's QAPI. On a semi-annual basis, the Regulatory Compliance Coordinator will report to the Director of Quality who will report the QAPI results related to signage to the QVCH Committee.

Part C: Finding A2405

1. Summary of Finding and Corrective Action

The State Surveyors further determined, in Tag A2405 in the Statement of Deficiencies, that CMMC failed to maintain a central log of each individual who comes to the emergency department consistent with the standards described under 42 C.F.R. 489.20(r)(3).

CMMC has implemented a corrective action to correct this deficiency. As detailed below, this corrective action focuses on implementation of an electronic barrier to prevent cancellations of patient encounter entries in the ED registration log, and a regular monitoring program to evaluate compliance with ED registration log requirements. The corrective action will be completed by August 13, 2018. Additionally, consistent with the more detailed discussion above regarding educational initiatives, Greeley will provide additional education regarding the ED registration log requirements in its August 2018 sessions.

2. Discussion Regarding Corrective Action

By August 13, 2018, CMMC will implement the following process improvement initiative: (a) any individual presenting to the ED must be entered into the ED registration log; (b) to ensure compliance with the above process and requirement that no entry in the ED registration log be cancelled, activation of an electronic barrier will be implemented to prevent cancellation in the registration log of any ED encounter; (c) to monitor accuracy of this barrier and staff compliance with the requirement to enter all individuals presenting to the ED into the registration log, a weekly cross-walk between the ED registration log and ED encounter log will be completed by the Supervisor of Patient Access.

On August 1 and 2, 2018, ED registration staff members participated in an education session on EMTALA compliance, which included emphasis on the requirements surrounding the ED central log. Further, the education sessions to be conducted by Greeley during the week of August 6, 2018 to August 10, 2018 will include additional content regarding the requirement to maintain a comprehensive central ED registration log and the prohibition on cancelling entries from the log. The education sessions will also emphasize that ED registration staff should seek to follow CMMC's standard processes for patient registration wherever possible, but that such processes must not unduly discourage individuals seeking emergency treatment or screening from obtaining such treatment or screening.

An electronic barrier has been added to CMMC's ED registration software such that no entry in the ED registration log may be cancelled. To monitor accuracy of this barrier and staff compliance with the requirement to enter all individuals presenting to the ED into the registration log, a weekly cross-walk between the ED registration log and ED encounter log will be completed by the

Supervisor of Patient Access. The Supervisor of Patient Access shall compare the weekly ED registration and encounter logs to ensure that the ED registration log is complete. The Supervisor of Patient Access will conduct a focused review of any potential problems observed during this weekly cross-walk of the ED registration and encounter logs and will report incidents of noncompliance to CMMC ED leadership at the weekly ED leadership meeting. No earlier than April 1, 2019, the Supervisor of Patient Access and the Director of Quality will evaluate whether to transition the auditing program from weekly comprehensive auditing reviews of the ED registration log and ED encounters report to quarterly randomized auditing reviews. Under whichever auditing schedule is in effect (weekly, comprehensive auditing or quarterly, randomized auditing), the Supervisor of Patient Access will summarize her findings from the auditing log on a quarterly basis through the QAPI program to the Director of Quality and QVCH Committee.

Part D: Finding A2406

1. Summary of Finding and Corrective Action

The State Surveyors further determined, in Tag A2406 in the Statement of Deficiencies, that CMMC failed to provide a screening examination to a patient who came to the emergency department seeking care consistent with 42 C.F.R. 489.24(a) and 489.24(c).

CMMC has implemented a corrective action to correct this deficiency. As detailed below, this corrective action will be completed by August 13, 2018, through institution of a new workflow for managing patients that exhibit disruptive behavior and through the enhanced process for review and monitoring of the central log described above with respect to Tag A2405, through which potential instances of noncompliance with the screening examination will be identified, evaluated, and reported. Additionally, consistent with the more detailed discussion above regarding educational initiatives, additional education regarding the EMTALA requirement to conduct a medical screening examination will be provided by Greeley in August 2018.

2. Discussion Regarding Corrective Action

Through the root cause analysis summarized above with respect to Tag A2400, the Director of Quality recommended implementation of a new workflow for individuals who present to the ED seeking emergent treatment but who exhibit non-cooperative or disruptive behavior. This workflow entails the provision of a clinical team to provide an immediate response to support individuals who seek emergent treatment in the ED but who exhibit non-cooperative or disruptive behavior. This team includes the ED Team Leader, the ED Nurse Leader, the House Nursing Supervisor, an ED provider, and a Security Officer, as needed, with a goal of properly addressing individuals who exhibit disruptive or uncooperative behavior through de-escalation efforts. If de-escalation efforts are successful, the individual will proceed through the triage process; if unsuccessful, the ED provider will be engaged to complete an expedited medical screening. Upon receipt of the medical screening examination, disposition will occur as the individual's condition warrants. The workflow will be instituted by August 13, 2018, through the adoption of this workflow into the CMMC Triage and Categorization of Patients policy. Greeley will be providing education regarding this workflow as part of the webinars it will be conducting in August 2018.

The ED Nurse Leader will facilitate a post-event debrief with the clinical personnel and Security Officers involved in any event in which this workflow was utilized to evaluate the process. Post –event debriefs will be reported on weekly basis through ED Leadership weekly meetings with review of outcomes and identification of process improvement initiatives. ED Nurse Leader will enter a Midas Event report with reporting of results to CMMC's Chief Nursing Officer/Patient Safety Officer and Director of Quality and to the QAPI on a monthly basis. On a quarterly basis, the QAPI results related to this workflow will be reported by the Director of Quality to the QVCH Committee

Further, the auditing of the ED registration log described with respect to Tag A2405, above, will serve as another important tool to monitor compliance with the requirement that all individuals who come to the ED must be provided with a medical screening examination. Specifically, through that process, the ED Medical Quality Specialist must report to ED leadership at the weekly ED leadership meeting, any instances in which a patient listed in the ED registration log refused to be treated, was denied treatment, was transferred, or otherwise did not receive a complete medical screening examination. The ED Medical Quality Specialist will then report findings from this process on a monthly basis to the ED Medical Director who will assist the Director of Quality in presenting the results through the QAPI program to the QVCH Committee. To the extent that the ED Medical Quality Specialist finds any non-compliance, the ED Medical Director will follow up with the appropriate medical staff.

Additionally, the Greeley education initiative is an essential component of our efforts to ensure that all individuals who come to the ED are provided with an appropriate medical screening examination. The webinars to be carried out by Greeley in August 2018 will include content with a detailed focus on the requirement under EMTALA and CMMC's EMTALA policy to provide an appropriate screening for all individuals who come to the ED. These sessions will further emphasize that the obligation to provide appropriate screening extends to any location on the CMMC "campus," as that term is used under EMTALA and in CMMC's EMTALA policy. Greeley will also assist us in evaluating whether to revise our existing new employee and annual education materials to include emphasis on these issues.