Centers for Medicare and Medicaid Services: Hospital Surveys with 2567 Statement of Deficiencies - 2024 Q2
Microsoft Excel file with investigation data and description available here.

The following was copied from the document's "deficiency text" column, edited only for formatting:

36003

Based on review of facility policy, medical record review, and interviews the facility failed to perform an appropriate medical screening exam (MSE) to rule out sepsis (life threatening infection) in a timely manner and assess fetal heart tones for fetal well-being for 1 patient (Patient #20) who presented to the Emergency Department (ED) of 20 ED patients reviewed.

The findings include:

Review of Facility A's policy "Documentation and nursing care of the patient in the Emergency Department" revised 1/2020 showed "...Triage Assessment [assessment to determine the urgency for treatment and type of treatment needed]: Registered Nurse or Provider will complete a triage assessment and triage classification on all patients who present to the Emergency Department. The nature of illnesses and injuries of these patients will govern the classification to assign priorities for a patient's treatment...The Emergency Severity Index (ESI) [a 5 level system used to categorize Emergency Department patients] triage system will be used to prioritize patients presenting to the Emergency Department seeking care...Goals of Triage...A triage assessment completed by a Registered Nurse or Provider as soon after their arrival as is possible...Determination of the urgency of need for care...The most critically ill patients take priority over other patients...Assist in the flow of patients through the emergency department...Triage Class...All patients will be assigned a triage classification based on the ESI triage system, upon completion of the triage assessment. The classification is documented as Level 1 through 5, depending on the patient's presenting complaint as well as other subjective and objective data obtained during triage...The following triage classification description will be used...Level 2...Stable, but high risk situation, newly confused, lethargic, or disoriented, or severe pain/distress, time sensitive conditions. Potentially life-threatening illness. Patient could

easily deteriorate if left to wait. Patient is physiologically stable but should not wait..."

Review of Facility A's policy "Emergency Medical Treatment & Active Labor Act (EMTALA) Guidelines" last reviewed 10/2022 showed "...Medical screening examination (MSE)-is defined as the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an emergency medical condition (EMC) or not. An MSE is an ongoing process that begins with triage...Triage-refers to the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital in order to prioritize when the individual will be seen by a physician or other qualified medical personnel (QMP) for completion of the Medical Screening Examination...Each designated emergency department will follow their normal triage and evaluation/treatment policy and procedures, perform the emergency medical screening examination, and initially stabilize the patient within the Emergency Department's capabilities..."

Review of Facility A's Severe Sepsis Clinical Criteria showed:

Patient must have 2 or more SIRS (Systemic Inflammatory Response Syndrome)

*Temperature > (greater than) 100.9 F or < (less than) 96.8 F

*Heart rate > 90 beats per minute

*Respirations > 20 breaths per minute

*WBC>12,000 or <4,000, or >10% bands

Organ Dysfunction

*Systolic blood pressure <90mmHg or mean arterial pressure <65

*Acute Respiratory failure-new need for invasive or non-invasive mechanical

Ventilation (breathing machine)

*Creatinine >2.0

*Urine Output <0.5 milliliters/kilogram/hour for 2 consecutive hours

*Total Bilirubin >2

*Platelet Count <100,000

*INR >1.5 or a PTT >60 (If no anticoagulant-blood thinner)

*Lactate >2

Review of Facility A's ED Nursing Suspected Sepsis Standing Orders showed "...Initiate ED Nursing Suspected Sepsis Standing Order...ED Cardiac Monitoring...ED Continuous Pulse Oximetry...Peripheral IV and IV Site Care...Sepsis CBC w/ Automated Differential...Sepsis Comprehensive Metabolic Panel...Sepsis Prothrombin Time and INR...Lactic Acid with Reflex...ED Lactic POC with Reflex...Sepsis Urinalysis with Culture/Microscopic, if indicated...Sepsis Blood Culture...from 2 different peripheral sites...15 minutes apart...XR Chest 1 View Portable..."

Medical record review of Patient #20's Face sheet/Encounter Information for Facility A showed Patient #20 registered in the ED on 4/3/2023 at 10:50 PM.

Medical record review of an ED sign-in sheet for Facility A dated 4/3/2023 showed Patient #20's reason for the ED visit was "...Sudden temp [fever], chills, 29 wk [weeks-7 months] pregnant, ? [possible] PICC line [peripherally inserted central catheter used to administer long term antibiotics, nutrition] infection..."

Medical record review an ED Triage note showed Patient #20 was triaged on 4/3/2023 at 11:48 PM (58 minutes after arrival) with an ESI score of 2 (emergent-a life-threatening situation wherein the patient could suffer significant harm without rapid or immediate therapeutic and/or diagnostic intervention). The patient reported she felt like she was septic from her PICC line which had been placed on 2/16/2023 due to excessive vomiting during pregnancy. Patient #20 was 29 weeks pregnant. The patient's oral (under tongue) temperature was 99.3 Fahrenheit (98.6 considered normal), heart rate 113 (reference range 60-100), respiratory rate 24 (reference range 14-20), and blood pressure was 111/72 (systolic/top reference range 90-140 and diastolic/bottom 60-110). Her oxygen saturation (amount of oxygen in blood) was 95% (normal 95-100%) in room air. Patient #20's triage assessment (respiratory rate and heart rate) prompted a sepsis alert in the documentation system which was acknowledged by the triage nurse.

Medical record review showed Patient #20 was placed in an ED treatment room on 4/4/2023 at 12:09 AM (1 hour 9 minutes after arrival).

Medical record review of Patient #20's physician orders showed diagnostic laboratory tests were not ordered until 4/4/2023 at 5:24 AM (6 hours 34 minutes after arrival and 5 hours 36 minutes after triage).

Medical record review of an ED Provider Patient Seen note showed Patient #20 was not seen by an ED physician and a MSE was not initiated until 4/4/2023 at 7:30 AM (8 hours 40 minutes after arrival and 7 hours 42 minutes after triage).

Medical record review of an electronic medication administration record showed Patient #20 did not receive IV fluids or medications for nausea and vomiting until 4/4/2023 at 8:43 AM (9 hours 53 minutes after arrival).

Medical record review of an ED Physician note dated 4/4/2023 at 12:10 PM showed Patient #20 presented to the ED with a history of Severe Hyperemesis Gravida (extreme, persistent nausea and vomiting during pregnancy). The patient had a PICC line, and she administered 2 liters of IV (intravenous) fluids to herself daily. She reported she began having chills late in the evening on 4/3/2023 and her temperature had been as high as 103.2 Fahrenheit (F). The patient complained of body aches and muscle aches. She denied abdominal pain and reported no unusual discharge. Her physical exam showed the patient was in "...Mild-to-moderate distress, cooperative, conversant..." Patient #20's diagnoses included Nausea and Vomiting, Hyperemesis Gravidarum, Viral Gastroenteritis, Hypokalemia, and Pregnancy.

Medical record review of Discharge Instructions showed Patient #20 was discharged from Facility A to home on 4/4/2023 at 1:20 PM.

During a telephone interview on 8/21/2023 at 1:40 PM, Patient #20 stated she presented to Facility A's ED sometime between 4/1/2023-4/3/2023 around 10:30 PM. Patient #20 stated she waited in the ED lobby for a while before she was taken to triage. In triage, she explained that she had a PICC line and that she was afraid she was septic from the line. The triage nurse told her she was a sepsis alert, and she was taken to an ED room pretty quickly. The patient reported a nurse told her the ED physician said he would do the blood work but that was it. Patient #20 stated she was not evaluated by an ED physician, Nurse Practitioner (NP), or Physician Assistant (PA) until the following morning after the next shift arrived. Patient #20 stated her major concern was the ED physician making the decision to wait until morning, after the next shift arrived without evaluating her. After she was discharged, Patient #20 went to Facility B's ED where it was

determined she had an infection in her PICC line. Her PICC line was replaced, she was hospitalized for a week, and had to have an additional week of IV antibiotics after she was discharged from Facility B.

During a telephone interview on 8/22/203 at 3:20 PM, Registered Nurse (RN) #1 stated Patient #20 was frustrated because she had not been seen by a physician. RN #1 was not sure why there had been a delay in obtaining Patient #20's blood for labs.

During an interview on 8/22/2023 at 2:35 PM, in the conference room, the Chief Nursing Officer (CNO) stated if a patient was a "...true sepsis...the goal is to get fluids in..." An increased heart rate and respiratory rate should have prompted the nurse to have a conversation with the physician. The CNO agreed the medical record documentation showed there was a delay in a MSE and laboratory tests for Patient #20. In a second interview on 8/22/2023 at 4:15 PM, the CNO stated "...I cannot disagree..." that there was a long length of time for Patient #20's labs and MSE to be performed.

During a telephone interview on 8/22/2023 at 4:20 PM, Physician #1 stated he recalled the staff talking about the patient, trying to figure out what was going on with the patient "...I remember thinking this could be a number of issues..." Physician #1 stated he did not recall physically seeing the patient and asked if his name was on the patient's record. Physician #1 could not recall why he had not seen/evaluated Patient #20 during her ED visit.

Medical record review showed no documentation to indicate fetal heart tones were assessed or an exam of the PICC line or the skin tissue around it.