Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number	(X3) Date Survey Completed
	010001	08/02/2021
Name of Provider or Supplier	**Street Address, City, State**	
Southeast Health Medical Center	1108 Ross Clark Circle, Dothan, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0000	An unannounced federal Emergency Medical Treatment & Labor Act (EMTALA) complaint survey, AL41422 and AL41464, was conducted at Southeast Health Medical Center on August 2, 2021, specifically for the review of EMTALA requirements. The Chief Executive Officer, Chief Medical Officer and Director of Quality and Regulatory Programs were notified on September 13, 2021 at 12:15 pm that Immediate Jeopardy (IJ) existed. Based on review of the facility policies and procedures, Medical Staff Bylaws and Rules and Regulations, Southeast Health Medical Center (SH, Hospital A) Medical Record (MR) review, transferring hospital (Hospital C and Hospital D) medical record (MR), receiving hospital (Hospital B) MR, ambulance run report(s), facility Physician Link Transfer Line documentation, Physician Link Transfer Line audio files, Southeast Health Diversionary Status Report, SH Unassigned Emergency Room (ER) Call Roster(s), facility Critical Care Unit (CCU), Family Birth Center (FBC) and Neonatal Intensive Care Unit (NICU) bed census documentation, and interviews with staff it was determined the facility failed to: 1. Identify and approve individual(s) qualified to perform the medical screening examination (MSE) for the Emergency Department (ED) in the facility bylaws or rules and regulations, including Patient Identifier (PI) # 23, PI # 3, PI # 4, PI # 6, PI # 11, PI # 14 and PI # 18. (2) Prevent a patient at risk for suicide from leaving the ED prior to the completion of the MSE, including PI # 15 and PI # 11. (3) Ensure the staff implemented steps to prevent a patient(s) with Suicidal Ideation (SI) from leaving prior to receiving stabilizing treatment, including placement of the patient(s) in a safe environment area, initiation of 1:1 observation and/or constant observation, and documenting every 15 minute observations of the patient(s) behavior per the facility policy, including PI # 11 and PI # 15. (4) Ensure a patient having hallucinations was re-evaluated for the dangerousness of the hallucinations and the family was apprised of the risks and benefits of leaving given the patient's hallucinations, including PI # 18. (5) Accept from referring hospitals (Hospital C and Hospital D) an appropriate transfer, of: (A) PI # 2, who was experiencing a possible ST-Segment Elevation Myocardial Infarction (STEMI), and required SH 's specialized capabilities. SH had the capability and capacity to treat PI # 2, when

	contacted by the transferring hospital (Hospital C) which did not have the capability of treating PI # 2. (B) PI # 22, who was 35 weeks pregnant and in active labor and required SH's specialized capabilities. SH had the capability and capacity to treat PI # 22, when contacted by the transferring hospital (Hospital D) which did not have the capability of treating PI #22. The hospital's failures to provide stabilizing treatment as required, and accept PI #2 and PI #22 requests for transfer posed an immediate and serious threat to patients health and safety and inappropriately delayed treatment for emergency medical conditions. The hospital was found to be not in compliance with the Federal Regulations at 42 CFR 489.20 and CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases. The following is a description of the non-compliance.
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 review of the facility policies and procedures, Medical Staff Bylaws and Rules and Regulations, Southeast Health Medical Center (SH, Hospital A) Medical Record (MR) review, transferring hospital (Hospital C and Hospital D) medical record (MR), receiving hospital (Hospital B) MR, ambulance run report(s), facility Physician Link Transfer Line documentation, Physician Link Transfer Line audio files, Southeast Health Diversionary Status Report, SH Unassigned Emergency Room (ER) Call Roster(s), facility Critical Care Unit (CCU), Family Birth Center (FBC) and Neonatal Intensive Care Unit (NICU) bed census documentation, and interviews with staff it was determined the facility failed to: 1. Identify and approve individual(s) qualified to perform the medical screening examination (MSE) for the Emergency Department (ED) in the facility bylaws or rules and regulations, including Patient Identifier (PI) # 23, PI # 3, PI # 4, PI # 6, PI # 11, PI # 14 and PI # 18. 2. Prevent a patient at risk for suicide from leaving the ED prior to the completion of the MSE, including PI # 15 and PI # 11. 3. Ensure the staff implemented steps to prevent a patient(s) with Suicidal Ideation (SI) from leaving prior to receiving stabilizing treatment, including placement of the patient(s) in a safe environment area, initiation of 1:1 observation and/or constant observation, and documenting every 15 minute observations of the patient(s) behavior per the facility policy, including PI # 11 and PI # 15. 4. Ensure a patient having hallucinations was re-evaluated for the dangerousness of the hallucinations and the family was apprised of the risks and benefits of leaving given the patient's hallucinations, including PI # 18. 5. Accept from referring hospitals (Hospital C and Hospital D) an appropriate transfer, of: A. PI # 2, who was experiencing a possible ST-Segment Elevation Myocardial Infarction (STEMI), and required SH 's specialized capabilities. SH had the capability and capacity to treat PI # 2, when contacted by the transferring hospital (Hospital C) which did not have the capability of treating PI # 2. B. PI # 22, who was 35 weeks pregnant and in active labor and required SH's specialized capabilities. SH had the capability and capacity to treat PI # 22, when contacted by the transferring hospital (Hospital D) which did not have the capability of treating PI #22. Findings Include: Refer to A 2406, A 2407 and A 2411 for findings.
A2406	MEDICAL SCREENING EXAM CFR(s): 489.24(a) & 489.24(c)

(a) 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 regulations and who meets the requirements of 482.55 of this chapter concerning emergency services personnel and direction; and (ii) 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)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135 (b)(3) of the Act, sanctions under this section for an inappropriate transfer 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 if the following conditions are met: (A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period. (B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan. (C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay. (D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act. (E) There has been a determination that a waiver of sanctions is necessary. (ii) 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 under 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 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 review of the facility policies and procedures, Medical Staff Bylaws and Rules and Regulations, Medical Record (MR) review and interviews with staff it was determined the facility failed to: 1. Identify and approve individual(s) qualified to perform the medical screening examination (MSE) for the Emergency Department (ED) in the facility bylaws or rules and regulations, including Patient Identifier (PI) # 23, PI # 3, PI # 4, PI # 6, PI # 11, PI # 14 and PI # 18. 2. Prevent a patient at risk for suicide from leaving the Emergency Department (ED) prior to the completion of the MSE, including PI # 15 and PI # 11. This deficient practice affected 8 of 23 MR's reviewed and had the potential to affect all patients treated at this facility.

Findings include: Facility Policy: Emergency Medical Treatment and Labor Act (EMTALA) Administrative Policy Effective Date: 4/1/19 Purpose: To comply with the EMTALA, which requires a Medicare participating hospital with a dedicated ED to provide an appropriate MSE to determine the presence of an Emergency Medical Condition (EMC). Policy Statement: It is the policy of Southeast Health that individuals coming to the ED and who require Emergency Medical Services (EMS) receive an appropriate MSE...as required by the EMTALA law. Scope: EMTALA applies to any individual who presents at a hospital's dedicated ED requesting examination or treatment for a medical condition... Procedure: Patient coming to the ED: 1. Provide an appropriate MSE to any individual who comes to the ED.... ... Procedures by Department:... 2. ED...Patients presenting to the ED seeking acute medical care...given an appropriate MSE by an ED Physician or APP (Advanced Practice Provider) to determine whether the patient has an EMC... Facility Policy: Suicide Precaution Policy Number: None Department: Patient Care Services Effective Date: 10/1/96 Purpose: To provide a safe environment for patients who are a potential for suicide or have a past history of attempted suicide and re-present with Suicidal Ideations (SI) or who have expressed SI. Policy Statement: To provide a safe, secure and structured environment for psychiatric patients who demonstrate suicidal intent, either verbal or non-verbal. These patients will be placed on suicidal precautions. Procedures: Emergency Department: Initiate suicide precautions if the patient has suicidal thoughts. Nursing may initiate 1:1 observation on an emergent basis, but must follow-up with the attending physician, or their delegate, for a physician's order. Never leave the patient alone. 1) Patient will be on constant observation. ...c) If the patient leaves the room, a staff member must accompany him or her, including observation when toileting. 2) A qualified staff member will document the 15 min (minute) observation checks noting patients' behavior.... 1. The facility Medical Staff Bylaws and Rules and Regulations were received from Employee Identifier (EI) # 2, Director of Quality and Regulatory Programs, on 7/27/21. Review of the facility bylaws and rules and regulations on 7/28/21 revealed documentation of "...Assessment and Stabilization (Medical Screening):...For patients who present to the ED proper, by an ED provider..." There was no documentation of who the facility designates as ED providers, a Physician Assistant (PA) and/or a Certified Registered Nurse Practitioner (CRNP) was qualified in the facility bylaws or rules and regulations as qualified to perform the MSE. PI # 23 presented to the facility ED on 1 /28/21 at 6:41 AM with a chief complaint of MVC (Motor Vehicle Collision). Review of the MR documentation revealed the MSE was conducted on 1/28/21 at 7:28 AM by a CRNP and not an ED physician. PI # 3 presented to the facility ED on 2/6/21 at 8:09 AM with a chief complaint of Headache and Request for Recheck of Blood Pressure. Review of the MR documentation revealed the MSE was conducted on 2/6/21 at 9:28 AM by a PA and not an ED physician. PI # 4 presented to the facility ED on 2/12/21 with a chief complaint of Dog Bite. Review of the MR documentation revealed the MSE was conducted on 2/12/21 at 10:06 AM by a PA and not an ED physician. PI # 6 presented to the facility ED on 3/20/21 at 12:37 AM with a chief complaint of a 5 day manic episode, which medications were not helping. Review of the MR documentation revealed the MSE was conducted on 3/20/21 at 3:17 AM by a CRNP and not an ED physician. PI # 11 presented to the facility ED on 5/18/21 at 3:36 PM with a chief complaint of being suicidal and also having right foot pain, on 5/18/21 at 5:47 PM with a chief complaint of not being able to stop singing and suicidal, and on 5 /19/21 at 11:29 AM with a chief complaint of being Suicidal and Right Foot Pain. Review of the MR documentation revealed the MSE was conducted all 3 visits by a PA and not an ED physician. PI # 14 presented to the facility ED on 6/4/21 at 8:30 PM with a chief complaint of Anxiety and Depression. Review of the MR documentation revealed the MSE was conducted on 6/4/21 at 8:35 PM by a PA and

not an ED physician. PI # 18 presented to the facility ED on 7/8/21 at 9:07 PM with a chief complaint of Psychiatric Evaluation due to auditory and visual hallucinations. Review of the MR documentation revealed the MSE was conducted on 7/9/21 at 12: 11 AM by a PA and not an ED physician. An interview was conducted with EI # 2, on 7/30/21 at 8:18 AM who confirmed PA's and CRNP's do conduct the MSE in the facility ED. EI # 2 was asked if the facility identified a PA and/or CRNP in the Medical Staff Bylaws or Rules and Regulation as being qualified to perform the MSE. EI # 2 stated, "It says ED provider, so that would include them." 2. PI # 15 presented to the facility ED on 5/13/21 at 8:38 PM with an arrival complaint of SI and attempt. Review of the MR revealed documentation the patient was called for triage at 8:48 PM and again at 8:57 PM. The patient did not respond to either call and was documented as LWBS (Left without being seen) at 8:57 PM. There was no documentation the patient was placed under observation upon arrival to the ED with a complaint of SI and attempt and was allowed to elope from the ED prior to the completion of the MSE. An interview was conducted on 8/2/21 at 8:32 AM with EI # 5, Performance Improvement Coordinator, Emergency Department, who verbalized the facility staff member who took the arrival complaint was a registration clerk and the patient eloped prior to being seen by a clinical person. EI # 5 also verbalized the facility protocol for a patient presenting with a SI and attempt complaint would have been for the registration clerk to place the patient information in the system and notify a nurse. EI # 5 confirmed there was no documentation a nurse was notified of the patient's arrival and complaint. 41624 3. PI # 11 presented to the ED 4 times within a 24 hours timeframe. PI # 11 first presented to the ED on 5/18/21 at 3:36 PM with a chief complaint of, "I am suicidal, I want to jump off a bridge. I'm also having right foot pain." Review of the triage assessment dated 5/18/21 at 3:37 PM revealed documentation of "Neurological ...Within Defined Limits...Psychiatric evaluation...I am suicidal, I want to jump off a bridge. I'm also having right foot pain." Review of the Physician Assistant (PA) assessment dated 5/18/21 at 3:43 PM revealed documentation, " ...Psychiatric/Behavioral...positive for dysphoric mood, hallucinations and suicidal ideas, negative for confusion...Neurological...Mental Status...alert and oriented to person, place and time...Psychiatric...Attention normal... Does not perceive auditory or visual hallucinations...Mood and Affect... normal,... Speech...normal, Behavior...cooperative,...Thought Content...Is not paranoid. Does not include homicidal or suicidal ideation." Review of the Q (every) 15 (minute) Safety Precautions Form revealed the following documentation: At 3:45 PM, PI # 11's behavior was calm At 4:00 PM, PI # 11's behavior was calm At 4: 15 PM, PI #11's behavior was bizarre. At 4:30 PM, PI # 11's behavior was bizarre and demanding. At 4:34 PM. documentation revealed "patient walked out." There was no documentation of the type of bizarre behavior PI # 11 displayed and the ED provider was notified of PI # 11's bizarre and demanding behavior. Review of the Columbia Suicide Severity Risk Assessment dated 5/18/21 at 4:19 PM revealed documentation of a risk score of .... low risk. Review of the PA documentation dated 5/18/21 at 5:25 PM revealed, "Patient left the ED without completing the entire evaluation." There was no documentation of a Psychiatric Consult. PI # 11 was allowed to leave from the ED prior to the completion of the MSE. PI # 11 presented a second time to the ED on 5/18/21 at 5:47 PM, with a chief complaint of, "I can't stop singing and I am suicidal." Review of the triage assessment dated 5/18/21 at 5:58 PM revealed documentation of " Neurological ..." Within Defined Limits"... Psychiatric evaluation..."I can't stop singing and I am suicidal." Review of the PA assessment on 5/18/21 at 5:59 PM documented, "States (he/she) took some ecstasy today...Review of Systems... Psychiatric /Behavioral...Positive for confusion, the patient is nervous/anxious...Neurological... Mental status alert...Psychiatric...Mood and Affect..."Mood is elated, Affect is

	inappropriate...Thought Content...Delusional...Cognition and Memory...Cognition is impaired." Review of the nursing notes dated 5/18/21 at 7:42 PM revealed documentation of "Called Pt (Patient) and received no answer." The documented disposition was AMA (against medical advice) at 8:02 PM. There was no documentation of a Psychiatric Consult, or that the patient was placed under observation upon arrival to the ED with a complaint of SI, and PI # 11 was allowed to leave from the ED prior to the completion of the MSE. PI # 11 presented a third time to the ED on 5/19/21 at 3:13 AM with a chief complaint of suicide attempt. The triage assessment on 5/19/21 at 3:17 AM documented the patient stated, "I caught my boyfriend having f***** my mom. I'm suicidal and want to kill myself. I walked out in front of a car about 20 minutes ago." Review of the nursing notes dated 5/19/21 at 3:52 AM revealed documentation of..."Pt has left ER (emergency room) 3 times now. (He/She) states, "Nevermind I'm fine. I don't want to be seen." Review of the nursing notes dated 5/19/21 at 5:32 AM revealed documentation of ..."Disposition was set to LWBS (left without being seen) after triage. There was no documentation of a Psychiatric Consult, the patient was placed under observation upon arrival to the ED with a complaint of SI and was allowed to leave from the ED prior to the completion of the MSE. PI # 11 presented to the ED a fourth time on 5/19 /21 at 11:29 AM with a chief complaint of Suicidal and Foot Pain. Suicide safety measures were implemented, a psychiatric hold was initiated, and the patient was admitted to the inpatient psychiatric unit under the care of a psychiatrist with diagnosis Psychotic Disorder, R/O (rule out) Schizophrenia, Cannabis Use Disorder. An interview was conducted on 7/30/21 at 1:07 PM with EI # 4, Director of Emergency Services, regarding PI # 11's third ED visit on 5/19/21 at 3:13 AM. EI # 4 was asked if the physician, PA, or the CRNP on duty was notified of the patient's three attempts to leave as documented by the nurse at 3:52 AM after voicing SI/attempted suicide? EI # 4 answered there was nothing documented the nurse got the physician or midlevel to do the MSE. EI # 4 was also asked if the patient was placed on 1:1 observation and a suicide risk assessment performed? EI # 4 stated, "Not on this visit. On suicide attempts we try to get them in a room as soon as possible, then 1:1 is put into place. We do have a policy for 1:1 observation once placed in a room." EI # 4 was asked if any ED staff witnessed the patient leaving? EI # 4 stated, "It's not clear based on charting. Don't know if witnessed or not. We had the AMA form ready to sign." In a second email interview conducted 8/6 /21 at 1:07 PM for the patient visits on 5/18/21, EI # 5 was asked if the attending ED provider was notified that the patient's behavior had changed from calm, to bizarre and demanding by ED staff on visit 5/18/21 at 3:36 PM? EI # 5 answered no. EI # 5 also confirmed there was a Psychiatrist on call 5/18/21, but the patient left before completing treatment on both visits to determine if one needed to be consulted. EI # 5 was also asked if the patient was placed in a safe environment on visit 5/18/21? EI # 5 stated the patient was never placed in a room.
A2407	STABILIZING TREATMENT CFR(s): 489.24(d)(1-3) (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. (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 policies and procedures, medical records (MR), and interview with staff, it was determined the facility failed to ensure: 1. The staff implemented steps to prevent a patient(s) with Suicidal Ideation (SI) from leaving prior to receiving stabilizing treatment, including placement of the patient(s) in a safe environment area, initiation of 1:1 observation and/or constant observation, and documenting every 15 minute observations of the patient(s) behavior per the facility policy, including Patient Identifier (PI) # 11 and PI # 15 2. A patient having hallucinations was re-evaluated for the dangerousness of the hallucinations and the family was apprised of the risks and benefits of leaving given the patient's hallucinations, including PI # 18. This deficient practice affected 3 of 23 MR's reviewed and had the potential to affect all patients treated at this facility. Findings include: Facility Policy: Suicide Precaution Policy Number: None Department: Patient Care Services Effective Date: 10/1/96 Purpose: To provide a safe environment for patients who are a potential for suicide or have a past history of attempted suicide and re-present with SI or who have expressed SI. Policy Statement: To provide a safe, secure and structured environment for psychiatric patients who demonstrate suicidal intent, either verbal or non-verbal. These patients will be placed on suicidal precautions. Procedures: Emergency Department (ED): Initiate suicide precautions if the patient has suicidal thoughts. Nursing may initiate 1:1 observation on an emergent basis, but must follow-up with the attending physician, or their delegate, for a physician's order. Never leave the patient alone. 1) Patient will be on constant observation. ...c) If the patient leaves the room, a staff member must accompany him or her, including observation when toileting. 2) A qualified staff member will document the 15 min (minute) observation checks noting patients' behavior. Facility Policy: Emergency Medical Treatment and Labor Act (EMTALA) Administrative Policy Effective Date: 4/1/19 Purpose: To comply with the EMTALA.... Policy Statement: It is the policy of Southeast Health that individuals coming to the emergency department and who require emergency medical services receive an appropriate medical screening examination (MSE) and stabilization of any emergency medical condition (EMC) ... Procedure: Patients coming to the Emergency Department (ED): ...2. Provide necessary stabilizing treatment to an individual with

an EMC or an individual in active labor. 1. PI # 11 presented to the ED 4 times within a 24 hours timeframe. PI # 11 first presented to the ED on 5/18/21 at 3:36 PM with a chief complaint of, "I am suicidal, I want to jump off a bridge. I'm also having right foot pain." Review of the triage assessment dated 5/18/21 at 3:37 PM revealed documentation of "Neurological ...Within Defined Limits...Psychiatric evaluation...I am suicidal, I want to jump off a bridge. I'm also having right foot pain." Review of the Physician Assistant (PA) assessment dated 5/18/21 at 3:43 PM revealed documentation, " ...Psychiatric/Behavioral...positive for dysphoric mood, hallucinations and suicidal ideas, negative for confusion...Neurological...Mental Status...alert and oriented to person, place and time...Psychiatric...Attention normal... Does not perceive auditory or visual hallucinations...Mood and Affect... normal,... Speech...normal, Behavior...cooperative,...Thought Content...Is not paranoid. Does not include homicidal or suicidal ideation." Review of the Q (every) 15 (minute) Safety Precautions Form revealed the following documentation: At 3:45 PM, PI # 11's behavior was calm At 4:00 PM, PI # 11's behavior was calm At 4: 15 PM, PI #11's behavior was bizarre. At 4:30 PM, PI # 11's behavior was bizarre and demanding. At 4:34 PM. documentation revealed "patient walked out." There was no documentation of the type of bizarre behavior PI # 11 displayed and the ED provider was notified of PI # 11's bizarre and demanding behavior. Review of the Columbia Suicide Severity Risk Assessment dated 5/18/21 at 4:19 PM revealed documentation of a risk score of .... low risk. Review of the PA documentation dated 5/18/21 at 5:25 PM revealed, "Patient left the ED without completing the entire evaluation." PI # 11 presented a second time to the ED on 5/18 /21 at 5:47 PM, with a chief complaint of, "I can't stop singing and I am suicidal." Review of the triage assessment dated 5/18/21 at 5:58 PM revealed documentation of " Neurological ..."Within Defined Limits"... Psychiatric evaluation..."I can't stop singing and I am suicidal." Review of the PA assessment on 5/18/21 at 5:59 PM documented, "States (he/she) took some ectasy (ecstasy) today...Review of Systems... Psychiatric/Behavioral...Positive for confusion, the patient is nervous/anxious...Neurological...Mental status alert...Psychiatric...Mood and Affect..."Mood is elated, Affect is inappropriate...Thought Content...Delusional... Cognition and Memory...Cognition is impaired." Review of the nursing notes dated 5 /18/21 at 7:42 PM revealed documentation of "Called Pt (Patient) and received no answer." The documented disposition was AMA (against medical advice) at 8:02 PM. There was no documentation the patient was placed on suicide precautions including a safe environment area, 1:1 observation and/or constant observation initiated and the patients behavior documented every 15 minutes per the facility policy. There was no documentation of a Columbia Suicide Severity Risk Assessment being performed. PI # 11 presented a third time to the ED on 5/19/21 at 3:13 AM with a chief complaint of suicide attempt. The triage assessment on 5/19/21 at 3:17 AM documented the patient stated, "I caught my boyfriend having f***** my mom. I'm suicidal and want to kill myself. I walked out in front of a car about 20 minutes ago." Review of the nursing notes dated 5/19/21 at 3:52 AM revealed documentation of..."Pt has left ER (emergency room) 3 times now. (He/She) states, "Nevermind I'm fine. I don't want to be seen." Review of the nursing notes dated 5/19/21 at 5:32 AM revealed documentation of ..."Disposition was set to LWBS (left without being seen) after triage. There was no documentation the patient was placed on suicide precautions including a safe environment area, 1:1 observation and/or constant observation initiated and the patients behavior documented every 15 minutes per the facility policy. There was no documentation of a Columbia Suicide Severity Risk Assessment being performed. PI # 11 presented to the ED a fourth time on 5/19/21 at 11:29 AM with a chief complaint of Suicidal and Foot Pain. Suicide safety measures were implemented, a psychiatric hold was initiated, and the patient was admitted to

the inpatient psychiatric unit under the care of a psychiatrist with diagnosis Psychotic Disorder, R/O (rule out) Schizophrenia, Cannabis Use Disorder. An interview was conducted on 7/30/21 at 1:07 PM with Employee Identifier (EI) # 4, Director of Emergency Services, regarding PI # 11's third ED visit on 5/19/21 at 3:13 AM. EI # 4 was asked if the physician, PA, or NP (Nurse Practitioner) on duty was notified of the patient's three attempts to leave as documented by the nurse at 3:52 AM after voicing SI/attempted suicide? EI # 4 answered there was nothing documented the nurse got the physician or midlevel to do the medical screening exam. EI # 4 was also asked if the patient was placed on 1:1 observation and a suicide risk assessment performed? EI # 4 stated, "Not on this visit. On suicide attempts we try to get them in a room as soon as possible, then 1:1 is put into place. We do have a policy for 1:1 observation once placed in a room." EI # 4 was asked if any ED staff witnessed the patient leaving? EI # 4 stated, "It's not clear based on charting. Don't know if witnessed or not. We had the AMA form ready to sign." In a second email interview conducted 8/6/21 at 1:07 PM for the patient visits on 5/18/21, EI # 5, ED Performance Improvement Coordinator, was asked if the attending ED provider was notified that the patient's behavior had changed from calm, to bizarre and demanding by ED staff on visit 5/18/21 at 3:36 PM? EI # 5 answered no. EI # 5 also confirmed there was a Psychiatrist on call 5/18/21, but the patient left before completing treatment on both visits to determine if one needed to be consulted. EI # 5 was also asked if the patient was placed in a safe environment on visit 5/18/21? EI # 5 stated the patient was never placed in a room. 40119 2. PI # 15 presented to the facility ED on 5/13/21 at 8:38 PM with an arrival complaint of SI and attempt. Review of the MR revealed documentation the patient was called for triage at 8:48 PM and again at 8:57 PM. The patient did not respond to either call and was documented as LWBS at 8:57 PM. There was no documentation the patient was placed in a safe environment area, 1:1 observation and/or constant observation was initiated and the patients behavior was documented every 15 minutes per the facility policy. An interview was conducted on 8/2/21 at 8:32 AM with EI # 5, Performance Improvement Coordinator, Emergency Department, who verbalized the facility staff member who took the arrival complaint was a registration clerk and the patient eloped prior to being seen by a clinical person. EI # 5 also verbalized the facility protocol for a patient presenting with a SI and attempt complaint would have been for the registration clerk to place the patient information in the system and notify a nurse. EI # 5 confirmed there was no documentation of the above suicide precautions per the facility policy. 3. PI # 18 presented to the facility ED on 7/8/21 at 9:07 PM with an arrival complaint of "Psych (Psychiatric) Problem - Seeing People." Review of the Triage note dated 7/8/21 at 9:16 PM revealed documentation of the chief complaint as "Psychiatric Evaluation (Auditory and visual hallucinations). Review of the Physician Assistant (PA) note dated 7/9/21 at 12:11 AM revealed documentation PI # 18 "... presents...with (his/her) parents with a chief complaint of '(he/she) is seeing stuff and talking to (himself/herself).'...Over the past few weeks patient has had worsening hallucinations. Patient is seeing people and talking to people that are not present according to the (parent identified). The patient agrees that (he/she) has been seeing and hearing people that are not present. Patient reports that the people are trying to get (him/her) and kill (him/her). Patient...does feel paranoid towards the hallucinations...would like the patient transferred to a pediatric facility to assist with psychiatric care as (he/she) reports that the hallucinations are getting worse... Psychiatric: Attention and Perception...inattentive. Mood and Affect: Mood is anxious. Affect is flat... Thought Content:...paranoid..." Review of the nursing note dated 7/9/21 at 5:37 PM revealed documentation the patient was hearing voices that wanted to kill an cut him/her. Review of the PA note dated 7/9/21 at 6:00 PM revealed documentation of "patient remains in the ED with auditory hallucination

	telling (him/her) they are going to kill (him/her)....no acute distress and currently boarded in the ED awaiting transfer/placement...Patient reports voices telling (him /her) they are going to kill (him/her). Family does not feel comfortable taking patient home. (He/She) will remain in the ED until placement can be facilitated...no acute distress with family at bedside..." Review of the PA note dated 7/10/21 at 1:21 PM revealed documentation of "patient remains in the ED with auditory hallucination telling (him/her) they are going to kill (him/her)....no acute distress and currently boarded in the ED awaiting transfer/placement...Patient reports voices telling (him /her) they are going to kill (him/her). Family does not feel comfortable taking patient home. (He/She) will remain in the ED until placement can be facilitated...no acute distress with family at bedside..." Review of the nursing note dated 7/10/21 at 7:15 PM revealed documentation the patient had no change in condition and the family verbalized the patient was still hearing voices that are threatening to cut and kill him /her. Review of the nursing note dated 7/10/21 at 8:10 revealed documentation the PA was at the bedside with the patient's parent who had decided to have the patient discharged and would seek help for the patient on an outpatient basis. Review of the PA note dated 7/10/21 at 8:25 PM revealed documentation of "patient remains in the ED with auditory hallucination telling (him/her) they are going to kill (him/her)....no acute distress and currently boarded in the ED awaiting transfer/placement...Patient reports voices telling (him/her) they are going to kill (him/her). Family does not feel comfortable taking patient home. (He/She) will remain in the ED until placement can be facilitated... No bed placement was facilitated. (Parent Identified) desires to take patient home and follow up outpatient. Return precautions given. (Parent Identified) ok (okay) with plan. There was no documentation the patient was re-evaluated for dangerousness of the hallucinations and the patient's family was apprised of the risks and benefits of leaving given the patient's auditory and visual hallucinations. Review of the Discharge Information revealed the patient was discharge home on 7/10/21 at 8:54 PM. There was no documentation PI # 18 was stabilized prior to being discharged home, PI # 18 was re-evaluated for dangerousness of the auditory and visual hallucinations and the family was apprised of the risks and benefits of leaving given the patient's auditory and visual hallucinations. An interview was conducted on 8/2/21 at 8:36 PM with EI # 5, who confirmed there was no documentation the patient was re-evaluated prior to discharging home for the dangerousness of the auditory and visual hallucinations and the family was apprised of the risks and benefits of leaving given the patient's auditory and visual hallucinations.
A2411	RECIPIENT HOSPITAL RESPONSIBILITIES CFR(s): 489.24(f) A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers, which, for purposes of this subpart, means hospitals meeting the requirements of referral centers found at 412. 96 of this chapter) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. This requirement applies to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department. This STANDARD is not met as evidenced by:

Based on review of the facility policy and procedure, Southeast Health Medical Center (SH, Hospital A) Medical Record (MR) review, transferring hospital (Hospital C and Hospital D) MR, receiving hospital (Hospital B) MR, ambulance run report(s), facility Physician Link Transfer Line documentation, Physician Link Transfer Line audio files, Southeast Health Diversionary Status Report, SH Unassigned Emergency Room (ER) Call Roster(s), facility Critical Care Unit (CCU), Family Birth Center (FBC) and Neonatal Intensive Care Unit (NICU) bed census documentation, and interviews, it was determined Southeast Health Medical Center (SH, Hospital A) refused to accept from referring hospitals (Hospital C and Hospital D) an appropriate transfer, of: 1. Patient Identifier (PI) # 2, who was experiencing a possible ST-Segment Elevation Myocardial Infarction (STEMI), and required SH 's specialized capabilities. SH had the capability and capacity to treat PI # 2, when contacted by the transferring hospital (Hospital C) which did not have the capability of treating PI # 2. 2. PI # 22, who was 35 weeks pregnant and in active labor and required SH's specialized capabilities. SH had the capability and capacity to treat PI # 22, when contacted by the transferring hospital (Hospital D) which did not have the capability of treating PI #22. This deficient practice affected 2 of 2 emergency transfer requests reviewed, who were appropriate for transfer to the facility and, which SH had the capability and capacity to treat. This did affect PI # 2 and PI # 22, and had the potential to affect all patients with a request for transfer to SH. Findings include: Facility Policy: Emergency Medical Treatment and Labor Act (EMTALA) Administrative Policy Effective Date: 4/1/19 Purpose: To comply with the EMTALA... ...Procedure: ...Recipient Hospital Responsibilities ...Further, any participating Medicare hospital is required to accept appropriate transfers of individuals with emergency medical conditions if the hospital has the specialized capabilities not available at the transferring hospital and has the capacity to treat those individuals. 1. Hospital C (transferring hospital) documentation: PI # 2 presented to Hospital C's emergency department (ED) on 7/14/21 at 7:01 PM with a chief complaint of Chest Pain. Review of the Triage note dated 7/14/21 at 7:01 PM revealed the following documentation: "pt (patient) c/o (complaint of) left sided pressure-like chest pain for 1 day. Pt has history of MI (Myocardial Infarction), CABG (Coronary Artery Bypass Graft), Pacer/Defibrillator, and Cardiac Stents..." with vital signs documented as: Blood pressure 134/69, Pulse 74, Respirations 19, Oxygen Saturation 94 % on room air and pain 10 on a 1-10 scale. Review of the EKG 12 Lead dated 7/14/21 at 7:14 PM revealed impression documentation of "ST Elevation (STEMI) Myocardial Infarction of Unspecified Site..." Review of the ED Physician assessment dated 7/14/21 at 7:29 PM revealed documentation of "...presents with extensive cardiac history presents with sudden onset left-sided chest pain since last night after coughing. Patient reported having intermittent chest pain today. Reported the pain was 10 out of 10 (0-10 scale). Reported having history of CAD (Coronary Artery Disease) with open heart surgery, recent cardiac catheterizations about 6 months ago leading to a 10 stent placement. Patient appeared in no acute distress...EKG (Electrocardiogram) demonstrated marked ST elevations to the anterior leads without reciprocal changes. Patient does have a pacemaker but compared to EKG from January of this year ST changes are now present....Provided with a full dose Aspirin...Call placed to Southeast Medical (SH) but wasn't (was on) critical care admission (diversion). (Hospital B, Receiving Hospital) was then contacted...accepted transfer..." Review of the Nursing Treatment Notes dated 7/14/21 at 7:41 PM revealed documentation of "called SH Transfer line...who states they are on Critical Care diversion..." Review of the Laboratory (lab) test completed on 7/14/21 at 7:59 PM revealed a Troponin level of 7.84 (Normal range from 0.02 to 0.10). Review of the Disposition documentation revealed PI # 2 was transferred to Hospital B on 7/14/21 at 8:12 PM via ambulance. Hospital A, Southeast Health (SH) Medical Center: Review of the facility Physician

Link Transfer Line Log documentation on 7/28/21 revealed no documentation of a transfer request from Hospital C on 7/14/21 at 7:41 PM. An interview was conducted on 7/28/21 at 3:19 PM with Employee Identifier (EI) # 3, Director of Patient Placement, who verbalized the facility Physician Link Transfer Line does not fill out the a Physician Line Transfer Line Form on patient's when the facility does not have beds and so the transfer request would not be on the facility log. EI # 3 verbalized the call on 7/14/21 at 7:41 PM from Hospital C did offer the diagnosis of the patient but no other information. Review of the Physician Link Transfer Line audio file and transcript dated 7/14/21 at 7:41 PM revealed the facility received a call from Hospital C requesting a transfer for a "...patient here in the ER (Emergency Room) that...may be having a STEMI and...wanting to talk with someone about (him /her) please." Hospital C was then told by SH Physician Link Transfer Line staff, "we are on Critical Care diversion..." There was no documentation an on-call physician and /or ED Physician was notified of the transfer request and provided clinical information on the patient to determine where the patient would need to be evaluated and treated. Review of the SH Diversionary Status Report revealed no documentation the facility was on Critical Care (CCU) diversion on 7/14/21 at 7:41 PM. Review of the CCU bed census for 7/14/21 at 7:41 PM revealed documentation the CCU had 1 bed available. Review of the SH Unassigned ER Call Roster for 7/14/21 revealed documentation the facility had an on-call Cardiologist and Cardiothoracic Surgeon. An interview was conducted on 7/29/21 at 9:44 AM with EI # 3, who verbalized PI # 2 would have been transferred to CCU if the transfer request would have been accepted. An interview was conducted on 8/2/21 at 4:16 PM with EI # 7, Director of Critical Care, who confirmed the facility CCU did have 1 available bed and adequate staffing on 7/14/21 at 7:41 PM. The facility failed to ensure that their policy and procedure was followed as evidenced by refusing to accept an appropriate transfer of PI #2 on 7/14/21, who had an identified emergency medical condition, as SH had the capability and capacity to treat PI # 2. 2. Hospital A, Southeast Health (SH) documentation: Review of the facility Physician Link Transfer Line Log documentation dated 4/4/21 revealed documentation of a transfer request from Hospital C, Transferring Hospital, at 11:44 PM for a patient who was "...35 weeks active labor..." with a "Non-Admit Reason... Other - See Comments...(EI # 8, SH on-call Obstetrics and Gynecology (OB/GYN) physician identified) suggested pt (patient) go to closer facility for evaluation d/t (due to) high risk pregnancy..." Review of the Physician Link Transfer Line audio file and transcript dated 7/14/21 at 7:41 PM revealed the following information: Hospital D, ED called the Physician Link Transfer Line and stated, "...I have a...35 weeks pregnant...in active labor, 5 minutes apart... and we don't want to deliver a baby, especially not a preterm, so I needed to speak to somebody either to do an ER to ER transfer or something." SH obtained the patient information and then connected the call to EI # 8. EI # 8 was provided the following information on PI # 22 by Hospital D's, ED Provider, "...patient that came in, just came in through the ER door that was um, she is traveling through....She is 35 weeks, high risk, both her other children, this is her third child, both of her other ones were delivered between 35 and 36 weeks and she is having contractions 5 minutes apart that last about a minute and I needed to see if I could transfer her ER to ER or something cause I certainly don't need to have her in my ER." EI # 8 then asked if the ED provider was able to check PI # 22's cervix. The ED Provider stated, "....I was afraid to. her water hasn't broken. She is having difficulty even laying back on the stretcher and so it is just kind of like, I am 45 minutes away from any place that I send her...but I don't mind checking it." EI # 8 then verbalized "it would just be helpful...I don't know how far your town is from where we are, but she is certainly better off delivering there than she would be in the ambulance on the way here...if that is not something in your wheelhouse, no worries, I just didn't know if it was a

possibility...where is (Hospital D's City identified)." The ED Provider then tried to describe the location of where they were located. EI # 8 then asked, "Are there not any town with obstetrical units between here and there?" The ED Provider stated, "There is one but because she is 35 weeks, they would defer. That would be (city of other hospital identified) and it's about 13 miles, but they deferred because she is 35 weeks. She knows she has high risks and so they just deferred and said I need to go to a different facility." EI # 8 then asked how far away the other hospital was from Hospital D and was told by the ED Provider the other hospital was "...about 13 miles." EI # 8 then asked how far away SH was from the facility and was told by the ED Provider about 45 minute drive by car. EI # 8 then verbalized, "...So I mean I am happy to help you of course...I guess it would stand to reason for her to go to a place with an obstetrical unit...for someone to check her cervix and all that kind of stuff if they are 10 minutes away, get stable...and make sure she is able for the drive if she is indeed in labor and needs a place with a NICU (Neonatal Intensive Care Unit) and higher level of obstetrical care then I'm happy to help you...It just seems unwise...in the setting of, I mean...she's in labor, she's had two kids vaginally before and you are walking distance from an obstetrical unit. It would stand to reason for her to go there to get stable and see if our services are required rather than being at a point of being 45 minutes away from anything with a 35 weeker..." The ED Provider verbalized he/she would call them to which EI # 8 responded, "I would, I would, so please know I am happy to help it just seems unwise to drive 45 minutes passed a labor and delivery..." The ED Provider then verbalized he/she would call the other facility and see what they had to say to which EI # 8 responded, "Well I don't think they have a choice you know...I think it is an EMTALA issue...just let me, know we're here...if there is any way we can help..." The call was then ended. Review of the Family Birth Center (FBC, SH Labor and Delivery Unit) bed census for 4/4/21 at 11:44 PM revealed documentation the FBC had 25 beds available. Review of the NICU bed census for 4/4/21 at 11:44 PM revealed documentation the NICU had 6 beds available. Hospital D (transferring hospital) documentation: Review of the triage assessment dated 4/5/21 at 12:38 AM revealed PI # 22 presented to the ED with a chief complaint of "pt (patient) reports being 35 wks (weeks) pregnant and having labor pains every 5 min (minutes)." Review of the ED Provider assessment dated 4/5/21 at 12:54 AM revealed documentation of "The patient presents with abdominal pain during pregnancy...intermittent contractions, 5 minutes apart, lasting 1 minute...Risks factors consist of...high risk pregnancy, traveling. Prior episodes: both children born at 36 weeks...General: alert, appears uncomfortable...Gastrointestinal: pregnat (pregnant) appearing, tense contractions, 2 minutes apart, last 1.5 minutes... The patient is on vacation...She has had contractions late in the day and early evening. They became harder, more regular and lasting longer so she presented to the ER for care. I called SAMC (SH) and spoke with (EI # 8, SH on-call Obstetrics and Gynecology (OB/GYN) physician identified) who is on call for OB. (He/She) stated (he/she) would be glad to accept the mother and child for admission/transfer but wanted her checked by someone who could deliver and manage a preterm baby and handle maternal complications. (He/She) suggested the OB unit at (Receiving Hospital identified) as they are between our facility and (his/her) facility...The visual exam revealed no blood, no fluid, no crowing..." Review of the Disposition documentation revealed the patient was transferred to another facility on 4/5/21 at 1: 30 AM. Interviews: An interview was conducted on 7/29/21 at 9:44 AM with EI # 3, who verbalized PI # 22 would have been transferred to Labor and Delivery if the transfer request would have been accepted. An interview was conducted on 7/30/21 at 12:16 PM with EI # 8, SH on-call OB/GYN, who verbalized PI # 22 was a "35 weeker within 13 miles of care, they can't refuse them. They needed to evaluate and stabilize them. We can take after that." EI # 8 was asked can you tell me about the

	EMTALA laws and when a transfer can be refused? EI # 8 state, "if unable to provide said service." An interview was conducted on 7/30/21 at 4:32 PM with EI # 6, Director of FBC, NICU and Pediatrics, who confirmed FBC had adequate staffing on 4/4/21 at 11:44 PM. An interview was conducted on 8/2/21 at 10:09 AM with EI # 6, who confirmed NICU had 6 available beds and adequate staffing on 4/4/21 at 11:44 PM. An interview was conducted on 8/2/21 at 2:54 PM with EI # 6, who confirmed FBC had 25 available beds on 4/4/21 at 11:44 PM. The facility failed to ensure that their policy and procedure was followed as evidenced by refusing to accept an appropriate transfer of PI #22 on 4/4/21, who had an identified emergency medical condition, as SH had the capability and capacity to treat PI # 22.