Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	530033	01/02/2018
Name of Provider or Supplier	**Street Address, City, State**	
Mountain View Regional Hospital	6550 East 2nd Street, Casper, WY	

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	A complaint health survey for compliance with Emergency Medical Treatment and Labor Act (EMTALA) 42 CFR Part 489.20 Basic Section Commitments Relevant to Section 1867 Responsibilities and 42 CFR Part 489.24 Special Responsibilities of Medicare Hospitals in Emergency Cases was conducted from 12/20/17 through 1/2 /18. Based on the findings of the survey team, Mountain View Regional Hospital was found not in compliance with the requirement for A2400 and A2406.
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 interviews with staff, law enforcement, and DFS (Division of Family Services), and review of policies and procedures, police report, and event report, the facility failed to ensure a policy was developed to address a situation in which local law enforcement was called by the facility as an intervention for 1 of 1 confused family member. The findings were Refer to A2406 for details concerning facility failure to perform a Medical Screening Exam for a patient's family member who was in the waiting room and appeared confused. In addition, the facility lacked a policy for notification of law enforcement for this type of situation that did not include an unlawful act.
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 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 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 interviews with staff, law enforcement, and DFS (Division of Family Services), and review of policies and procedures, police report, and event report, the facility failed to ensure a medical screening examination was completed for 1 of 1 family member who was confused and identified as needing continuous supervision due to cognitive impairment. In addition the facility failed to develop policies and procedures regarding notification of law enforcement; this failure resulted in the facility utilizing law enforcement to address the family member's condition; and medical and nursing interventions were lacking. The findings were: Review of the facility's Safety/Security Event Report, dated 11/6/17, showed a patient left a family member in the waiting room while s/he received surgery on 11/6/17 at 7:30 AM. Further review revealed the following information: the pre-operative nurse told admissions clerk #1 the family member had "Alzheimer's, so to look out for" him/her and s/he "was getting a ride from someone at some point". Admissions clerks #1 and #2 ..."looked out for [the family member] until 8:30 AM", when the family member asked admissions clerk #1 to call his/her "ride"; and later asked the admissions clerks to call the police take him/her home. The admissions clerks called the listed contact number on the patient's admission form 3 times and did not received a response. The family member had a pamphlet with a DFS case manager's name and number. The admissions clerks called the DFS case manager who told them she could not come to get the family member. The family member was adamant about leaving and "threatened to leave 3 more times" before the

local law enforcement was called. The family member left the building and was redirected back to the waiting room area. At that time s/he was "pretty agitated." After a discussion between the officer and the emergency department (ED) manager, the officer transported the family member to the ED at another hospital. Interview on 1/2 /18 at 11:30 AM with the DFS case manager revealed the following information: The patient's family member arrived at the patient's home from another state a few weeks prior to 11/6/17. The patient talked with the DFS case manager about finding placement for the family member due to severe dementia. The patient was scheduled to have surgery and inpatient admission on 11/6/17. At that time, the patient had not completed the required forms to receive assistance from DFS. On the day of surgery the patient arrived with the family member who had a small suitcase with him/her. At 6:45 AM the patient called the DFS case manager from the hospital and asked the DFS case manager to come to the hospital to pick up the family member. The DFS case manager told the patient this was not possible. Later, the DFS case manager received multiple calls from the hospital staff and each time she told them she could not come to get the family member. Staff told her, their facility could not keep the family member, and the DFS case manager repeated she was unable to do what they asked. Interview on 12/20/17 at 1:10 PM with the ED manager revealed the following information: The officer would not allow the facility more time to make additional contacts to get someone to come to get the family member. The ED manager told the officer the family member should be seen in the facility's ED, the officer said he was taking the family member to another hospital. After the officer departed with the family member the ED manager called the receiving hospital and told them about the family member who was enroute. The ED manager acknowledge the lack of documentation regarding the transport because the family member was not a patient and therefore no medical record had been developed. Interview on 12/20/17 at 1:20 PM with admissions clerk #1 revealed the family member was confused, not aggressive, and repeated,"Call the police they are supposed to come get me". Admissions clerk #2 further stated there were discussions about contacting someone to come to get the family member, but she was not aware of any discussions about having a physician examine the family member. Interview on 12/20/17 at 4:20 PM with admissions clerk #2 revealed she called the DFS case manager and was told DFS could not help because the patient had not followed through with the process for finding placement for the family member. Admissions clerk #2 stated she called law enforcement so they could come and take the family member home. She further stated the officer told her the expectation was to transport the family member to another hospital. Interview on 12/20/17 at 4:30 PM with admissions clerk #3 revealed the family member had a suitcase and was in the waiting area when admissions clerk #3 arrived at work at 9:30 AM. She further stated the officer was present; and the family member was confused and expressed a desire to go home. Interview on 12/21/17 at 12: 50 AM with the pain management manager revealed when she arrived at the waiting area the admissions clerks were upset and weren't sure about what they should do. The pain management manager stated she called the ED manager and social worker; the admissions clerk had already called law enforcement. She stated the ED manager told the officer that this facility had an ED, but the officer stated he planned to take the family member to another hospital because that is what he usually did. Interview on 12/21/17 at 9:20 AM with the social worker/case manager revealed she talked with the family member in the waiting area and noted s/he was confused, smiling and talking about getting a ride home. The social worker/case manager further stated the officer told her he was called to come to get the family member. Interview on 12/21/17 at 10 AM with the maintenance technician revealed he received instructions from the admissions clerk to bring the family member back into the building when s/he went outside due to confusion. He further stated he asked the

	security staff to assist with monitoring the family member. Interview on 12/21/17 at 10:24 PM with the ED manager revealed he wasn't sure why law enforcement had been called. He stated the family member needed to be safe and keeping him/her in the waiting area for hours might not have been the safest place for him/her. He further stated notification of law enforcement could have been handled differently; and the facility needed to make changes in their process for addressing this type of situation. Interview on 12/21/17 at 8 PM with the law enforcement officer revealed the following information: He arrived at the facility on 11/6/17 at 9:20 AM. He was unable to get any information from the family member due to his/her confused state. The hospital administrative staff arrived and talked with him about issuing a legal hold. This was not an option because the family member was not a threat to self or others. The staff talked about other options, including the expense of keeping the family member at the facility, then told the officer there was nothing they could do for the family member. The officer was directed to transport the family member to another hospital. Review of the police report revealed the officer understood the facility wanted him to transport the family member to another hospital and he did. Review of the policies and procedures provided by the facility revealed none addressed a process, system, or guidelines for notification of law enforcement for lawful acts. Interview on 12/21/17 at 11:10 AM with the chief nursing officer revealed the patient did not tell the staff about the family member until the nurses were wheeling him/her into the operating room. She stated if staff had known prior to the day of surgery they could have helped the patient with placement for the family member. She verified a medical screening examination was not provided prior to law enforcement's arrival or afterwards. She stated the facility policies and procedures about notifying law enforcement specifically addressed reporting unlawful acts. However, she was unable to provide the surveyors with any policy and procedure or established guidelines for notification of law enforcement for lawful acts. Interview on 1/3/17 at 9 AM with the director of quality and regulatory at the receiving hospital revealed the family member arrived at the ED on 11/6/17 at 10:54 AM (this was over 4 hours after the family member arrived at the hospital with the patient). She further stated the family member was admitted after the medical screening examination was completed.