Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	670068	06/25/2024
Name of Provider or Supplier	**Street Address, City, State**	
Texas Health Presbyterian Hospital Flower Mound	4400 Long Prairie Road, Flower Mound, TX	

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 on-site unannounced EMTALA complaint survey was conducted beginning on the afternoon of June 24, 2024. An entrance conference was held in a conference room with Texas Health Presbyterian - Flower Mound's administrative staff members on June 24, 2024, at 1315 PM. A survey investigation was conducted to determine the hospital's compliance with the Medicare Conditions of Participation set forth at 42 CFR Part 482 using the applicable survey report form. It was explained that the complaint survey would be conducted according to 42 CFR 489.24 and 42 CFR 489.20 (l), (m), (q), and (r) of the Emergency Medical Treatment and Labor Act, and section 5400, appendix V of the State Operations Manual. . 06/25 /2024: EMTALA Complaint TX00501547 will be referred to CMS Regional Office for final compliance determination. . An exit conference was held with Texas Health Presbyterian - Flower Mound's administrative staff members at 1530 PM and they were informed that CMS would make the final determination for complaint TX00501547. .
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 record review and interview the facility failed to abide by the provider's agreement that required a hospital to comply with 42 CFR 489.24, Special responsibilities of Medicare hospitals in emergency cases. . Based on a record review and interview, Facility A failed to provide a complete and accurate medical screening examination (MSE) for 1 of the 20 (Patient #1) whose records were reviewed. Patient #1 was a 27-year-old male patient with a history of spinal epidural abscess and intravenous drug use who presented with stated complaints of back pain,

	"going cross-eyed" from the back pain medicine he is on, and a dental infection on 04 /05/2023. There was also reported concern for suicide for Patient #1's safety expressed by Patient #1's mother and grandmother. Facility A failed to obtain the needed laboratory screening and radiological screenings to determine if an emergency medical condition (EMC) existed for Patient #1. . Cross refer A2406. .
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 a record review and interview, Facility A failed to provide a complete and

accurate medical screening examination (MSE) for 1 of the 20 (Patient #1) whose records were reviewed. Patient #1 was a 27-year-old male patient with a history of spinal epidural abscess and intravenous drug use who presented with stated complaints of back pain, "going cross-eyed" from the back pain medicine he is on, and a dental infection on 04/05/2023. There was also reported concern for suicide for Patient #1's safety expressed by Patient #1's mother and grandmother. Facility A failed to obtain the needed laboratory screening and radiological screenings to determine if an emergency medical condition (EMC) existed for Patient #1. . Findings: Patient #1 Medical Record Reviews from Facility A from the Primary Complaint: 04/05/2023: 9:21 PM - Patient #1 arrived at the ED with chief complaints documented by Staff #19 (ED RN) of back pain due to chronic back injury, going cross-eyed from the back pain medications, and a dental infection. Assigned an Acuity level of "3-Urgent". . 10:26 - It was documented by Staff #19 that Patient #1's mother called and stated that (Patient #1's) "grandmother dropped him off because he has a broken back and is in a great deal of pain; however, she also states that she is very concerned for his safety as he has told her and his grandmother that he does not want to live and has even vocalized that he wants to commit suicide per pt's mother. Informed (Patient #1's) mother that I (Staff #19) could only verify he has arrived at our facility but that any additional information he would have to give approval for it to be shared. (Patient #1's) mother verbalized understanding while also reiterating that she just wants to make sure staff is aware so he can get appropriate help." . 10:31 PM - Triage initiated by Staff #19. Medical history, allergies, immunizations, surgical history, family history, screenings, height, weight, and medications were all obtained. . 10:32 PM - A Suicide Screening Risk showed "No Risk" during triage assessments. . 10:36 PM - Staff #19 documented, "During triage, (Patient #1) nonstop moving and fidgeting. (Patient #1) unable to sit still in triage chair. (Patient #1) not making eye contact when speaking with triage nurse. (Patient #1) had slight slur when speaking." . 11:08 PM - MSE was initiated by Staff #20, ED physician for the Facility. Notes were as follows: "Medical Problem (Patient #1) here with chief complaint of here for continued back pain, points to the paralumbar region, onset was approximately 8 weeks ago Apparently the patient has been seen in this ED and another facility, several times. The patient has trouble with transport, therefore was not able to see the spine doctor. He has symptoms of spinal stenosis. He does not have any lower extremity weakness or sensory loss. However, he does feel like his legs give out at times, and he feels numbness in his posterior thigh and anterior thigh, right. . He (Patient #1) has had imaging, including CT abdomen pelvis (04/06/2023 at 6:36 AM) which showed right complete ankylosis, sacral iliac, and a MRI as recently as greater than 1 month ago (04/06/2023 at 12:25 AM) which shows spinal stenosis in the lumbar region. There was question of diskitis, however at 1 month ago, images suggest that likely it is more degenerative rather than inflammatory. The patient denies any fevers chills chest pain pressure tightness denies any abdominal pain, nausea, vomiting, or diarrhea. The patient denies any perineal numbness. . He feels like the medications that were given last (Norflex and gabapentin) cause some double vision (Patient #1) has no focal neuro deficits, no lateralizing symptoms like weakness or sensory loss. There was no slurring of speech, facial droop, aphasia. There are no posterior fossa symptoms like ataxia, vertigo without movement of head, clumsiness, visual deficits/diplopia ..." . Patient #1's Triage assessment and histories and medications were reviewed. . The physical exam included: "NECK: Neck supple. No anterior swelling noted. MIDBACK: No ttp (tenderness to palpation) to midline T spine, No ttp (tenderness to palpation) to parathoracic spine. LOW BACK: no ttp (tenderness to palpation) to midline LS spine, + ttp (tenderness to palpation) to paralumbar spine. 5/5 motor and sensory b/l (bilateral) LE w/normal plantar flex b/l (bilateral) feet and normal 2+ patellar reflexes.

No redness to midline back. Normal but bent forward/shopping cart type gait ... EXTREMITIES: Normal appearing, 2+ pulses b/l (bilateral) radial ... NEUROLOGIC: Cranial nerves 2-12 intact. Muscle strength 5/5 throughout. Sensation grossly intact ..." . 11:10 PM - Documentation by Staff #20 "Reviewed prior imaging: CT: "Lower chest: The imaged lung bases are clear. The heart is normal in size. No pleural or pericardial effusion. Liver: Within normal limits. Gallbladder: Within normal limits. Bile ducts: Within normal limits. Spleen: Within normal limits. Pancreas: Within normal limits. Adrenal glands: Within normal limits. Kidneys and ureters: Within normal limits. Bowel: No evidence of bowel obstruction or abnormal bowel wall thickening. Normal appendix. Vasculature: The abdominal aorta and IVC are normal in course and caliber. Prominent vasculature in the left inguinal canal, asymmetric when compared to the right. Lymph nodes: No pathologically enlarged mesenteric, retroperitoneal, or pelvic lymph nodes within the limits of a noncontrast exam. Peritoneum and retroperitoneum: No free air or free fluid. No organized fluid collection. Bladder: Within normal limits. Reproductive structures: The prostate gland is not enlarged. Soft tissues: No hernia or subcutaneous mass. Bones: Mild levoconvex curvature of the lumbar spine. There is thoracolumbar spondylosis. At T12-L1 there is endplate irregularity on both sides of disc space which may be degenerative although underlying age-indeterminate discitis /osteomyelitis not excluded. No paraspinal inflammatory fat stranding is present suggest. There is complete ankylosis of the right sacroiliac joint. The left sacroiliac joint grossly images within normal limits. No suspicious lytic or blastic lesion is identified." . CT of the Lumbar Spine: "IMPRESSION: 1. No acute abnormality of the abdomen or pelvis. 2. Thoracolumbar spondylosis present. There is endplate irregularity on both sides of the T12-L1 disc which may be degenerative although underlying age indeterminate discitis/osteomyelitis difficult to entirely exclude. No surrounding inflammatory soft tissue changes are seen in the paraspinal soft tissues. Recommend correlation with patient's symptoms and history. 3. Ankylosis of the right sacroiliac joint. 4. Prominent vasculature in the left inguinal canal, asymmetric compared to the right. This is nonspecific but can be seen with an underlying varicocele. 5. Mild levoconvex curvature of the lumbar spine. . 11:11 PM - Staff #20 reviewed the subsequent MRI from 03/06/2023: No discitis. IMPRESSION: Degenerative changes in the lumbar spine, most severe at L3-L4 where there is moderate to severe canal stenosis. Mild endplate edema at T10-T11 is felt to be degenerative in nature and mild enhancement. No evidence of active discitis or osteomyelitis. No epidural abscess. Findings are advanced for patient's age, center etiologies for age advanced spinal degenerative changes, such as various spondyloarthropathies. Chronic and left L5 pars defect" . 11:15 PM - A consult to Behavioral Health was initiated by Staff #20 (ED physician) due to a call from Patient #1's mother but was discontinued on 04/06/2023 at 4:03 as Patient #1 denied suicidal thoughts on several assessments by Staff. . 11:15 PM - A urinalysis with conditional microscopic exam was ordered. A CT of the head without IV contrast was ordered. An MRI of the lumbar spine was ordered. . 11:17 PM - "NIH STROKE SCALE SCORE "No upper extremity drift 10 seconds no lower extremity drift 5 seconds able to walk, no ataxia Visual inspection of flanks unremarkable, no paralumbar redness rash or crepitus No percussive tenderness along midline spine, thoracic and lumbar Range of motion preserved right hip right knee right ankle No swelling noted to bilateral legs 2+ PT pulse noted Patient denies any suicidal thoughts depressive thoughts or sadness Denies any thoughts of harming self" . An MRI, which did not show any acute change, also a CT of the head was obtained, unremarkable. The patient says he does not do well with steroids and or muscle relaxants, so these were not prescribed." . On 04/06/2023 the visit continued: 12:36 AM - A CT of the Head, without IV Contrast was obtained. The findings included: " ...IMPRESSION:

No acute intracranial abnormalities ..." . 12:36 AM - An MRI Spine Lumbar without Contrast was obtained. "IMPRESSION: 1. Substantially limited exam due to motion artifact. 2. Spondylotic changes of the lumbar spine without substantial change since the prior exam. Stable high-grade spinal canal narrowing at L3-L4." . 12:49 AM - Discharge orders written by Staff #20. The documented clinical impression was for sciatica of the right side and spinal stenosis, unspecified spinal region. Instructions included follow-up with Orthopedic Surgery "Schedule an appointment as soon as possible for a visit." . 12:55 AM - Notes by Staff #20: "Rounded on patient, advised of stable MRI findings, no signs of infection, the patient is not febrile, mom at bedside, aware, appreciative of plan of care, agrees that the patient needs to follow-up with spine, return to ER precautions given especially if lower extremity weakness sensory deficits occur, or if the patient has a fever. . I also asked the patient again if he has any suicidal thoughts, depression, suicidal plans, he said no, mom was present at this time." . 1:03 AM - Patient #1 departed the ED with discharge instructions to follow-up with an orthopedic surgeon and with prescriptions for Hydrocodone-acetaminophen tablets, Lidocaine patches, Naproxen sodium tablets, and Protonix tablets. . Meds given in the ED: 1. Ondansetron ODT (Zofran ODT) tablet (4 mg Tablet orally) Given on 04/05/2023 at 11:28 PM 2. Diphenhydramine (Benadryl) solution (25 mg intramuscularly) Given on 04/05/2023 at 11:28 PM 3. Oxycodone-acetaminophen (Percocet) 5-325 mg tablet (2 Tablets orally) Given on 04/06/2023 at 12:44 AM . Facility A failed to assess the dental complaint. Patient #1 has a medical history of prior spinal abscesses. Patient #1 had presenting complaints of back pain and reported concerns for suicidal ideation. Facility A did not rule out all potential emergency medical conditions (EMCs). There were no labs obtained to look for evidence of infection or inflammation. . While a CT was obtained of the lumbar spine was obtained, it was non-diagnostic. Nothing was done to rule out a recurrence of a spinal epidural abscess. . 04/08/2024 - Note that this ED visit at Facility B: 11:12 AM - Arrived via EMS (emergency medical services) to the Emergency Department (ED) with chief complaints of chronic back pain and blood in his urine. The EMS run sheet was signed by Staff #10, (ED RN). 1115 AM - Triage was initiated by Staff #10. Medical history, allergies, immunizations, surgical history, family history, screenings, height, weight, and medications were all obtained. 1123 AM - Medical Screening Exam was initiated by Staff #7 (ED physician) for the Facility. Notes included: "Patient is a 26-year-old male past medical history of IV drug use, chronic back pain, fracture of spine in 2018 after skateboarding accident presents to the ED with chief complaint of back pain, worsening difficulty moving his lower extremities, paresthesia to both lower extremities, blood in his urine. Patient states he has been having difficulty ambulating the last 3 days, was seen at an outside facility (Facility C) yesterday and had a Foley catheter placed. Patient is a poor historian; states he does not know what the diagnosis was yesterday. Denies any abdominal pain, denies any nausea vomiting diarrhea constipation ..." - of note, Patient #1's drug history was documented on 06/01/2020 and his last use was documented as "a week ago" for marijuana and 05/29/2020 for heroin. . " ...Review of Systems: Musculoskeletal: Positive for back pain. Neurological: Positive for weakness. All other systems reviewed and are negative ..." . " ...Physical Exam: Musculoskeletal: General: No deformity. Cervical back: Neck supple ..." . " ...Neurological: Mental Status: He is alert and oriented to person, place, and time. Cranial Nerves: Cranial nerves 2-12 are intact. Comments: 3/5 strength while L2-Patient able to abduct thighs L3-extend knee, dorsiflex ankle L4-dorsiflex ankle L5-dorsiflex great toe 51-flex knee 52-plantar flex toes S3-S4 S5-normal sensation to the groin and perianal region ..." . 11:29 AM - EKG obtained and reviewed by Staff #7. The EKG showed tachycardia with sinus rhythm. 11:46 AM - Abnormal lab findings: Result: Value: Reference Range: White blood cells 13.9 k/uL (high) 3.9 - 10.9 K/uL (indicative for infection)

Glucose 117 mg/dl (high) 6 - 20 mg/dl Creatinine 0.8 mg/dl (low) 0.9 - 1.3 mg/dl Sodium 131 mmol/L (low) 136 - 145 mmol/L Chloride 93 mmol/L 98 - 107 mmol/L Albumin 2.80 g/dL (low) 3.50 - 5.20 g/dL Globulins 5.4 g/dL (high) 2.0 - 4.0 g/dL A /G Ratio 0.5 (low) 0.8 - 2.0 Alk Phos 129 U/L (high) 25 - 100 U/L Bilirubin, total 1.4 mg/dL (high) 0.3 - 1.2 mg/dL Osmolality calculated 274 mOsm/Kg (low) 275 - 295 mOsm/Kg C Reactive Protein 53.4 mg/dL (high) <= 0.5 mg/dL (indicative for infection) . A urinalysis was positive for moderate bilirubin, ketones, moderate blood, protein, and nitrates and contained moderate bacteria (indicative for a urinary tract infection (UTI) and a Sedimentation rate of 75 mm/h (high) (reference range is 0 - 15 mm/h) (indicative of inflammation). . A urine drug screening showed: Positive for benzodiazepines, opiates (some are prescribed), and cannabinoids. . 12:14 PM - CT of the abdomen and pelvis without contrast results: "IMPRESSION: There are no appreciable obstructing renal or ureteral stones. No hydronephrosis. Bladder is decompressed by Foley catheter and cannot be evaluated Bibasilar atelectasis. No evidence of abscess, free air, or mechanical obstruction." 12:21 PM - Per nursing notes by Staff #11, Patient #1 stated that he was unable to tolerate an MRI, the physician (Staff #7) was notified, and he (Staff #7) spoke to Patient #1 and Patient #1 agreed to continue with the MRI. 1:15 PM - A consult to spinal surgery by Staff #7 took place. They recommended transferring to Facility B or (another facility) given the fluid collection/edema and possible concern for transfer myelitis. 2:05 PM - The transfer process was initiated by Staff #7 and IV antibiotics were started. 2:18 PM - Staff #11 noted that she spoke to Patient #1's mother and grandmother on air transfer. 2:37 PM - Facility B's ED accepted Patient #1 pending acceptance from Neurosurgery. 3:00 PM - Neurosurgery at Facility B accepted Patient #1 for transfer. 3:19 PM - Staff #7 spoke to Patient #1's mother and given his history of IV drug use, broad spectrum antibiotics including Vancomycin were started. 3:50 PM - Staff #7 spoke with the radiologist who states that MRI looks more like an infectious process, findings concerning with septic joint as well as possibly osteomyelitis. 4:22 PM - Repeat Exam documented, "3/5 strength and abduction of the thighs, flexion of the knees, dorsiflexion, and plantar flexion of the foot. Able to discriminate sharp to dull. Upper extremities 5/5 strength. No sensory deficits." . 4:25 PM - MRI of the Lumbar Spine results: " ...IMPRESSION: 1 . Diffuse subarachnoid enhancement suggests meningitis. 2. Upper and lower thoracic dorsal epidural phlegmon. 3. T8 suspected right dorsal subdural empyema. 4. T10-11 and f 11-12 right facet joint septic arthritis. 5. L1-2 suspected ventral subdural empyema. 6. L3-4 bilateral facet joint septic arthritis. . MRI of the Lumbar Spine Final Results: IMPRESSION: Multilevel lumbar spondylosis with severe thecal sac narrowing at L3-4 . MRI of the Thoracic spine: IMPRESSION: l . Diffuse subarachnoid enhancement suggests meningitis. 2. Upper and lower thoracic dorsal epidural phlegmon. 3. T8 suspected right dorsal subdural empyema. 4.I10-11 and l1-12 right facet joint septic arthritis. 5. L1-2 suspected ventral subdural empyema. 6. L34 bilateral facet joint septic arthritis. . MRI of the Thoracic spine Final Impression: IMPRESSION: 1. Extensive thoracic cord abnormal signal. Differential considerations include infection and infarct. 2. Multilevel thoracic dorsal epidural fluid collections concerning for infection. 3. Multilevel thoracic facet joint abnormal signal concerning for septic arthritis. Critical Result: Cord edema ..." . 4:57 PM - Attempting to transfer Patient #1 by air. . ED physician Notes (no time indicated), Staff #7: "DIFFERENTIAL DIAGNOSIS: An extensive differential diagnosis was considered. Rather than list the full complement of potential causes of the patients' symptoms and signs today, the following MDM is intended to give a general overview of some of the evaluation and thought process used to develop our diagnostic and treatment plan. CONCERN FOR: Cauda equina syndrome, thoracolumbar pathology DOUBT: Bowel obstruction, renal colic" . 5:19 PM - Staff #10 noted that the air crew for transport had arrived and

was at the bedside of Patient #1. . Medications given: 1. Piperacillin-tazobactam (Zosyn) 3.375 g in sodium chloride 0.9 % 100 mL (via IV piggyback) infusion Completed on 04/08/2023 at 3:09 PM 2. Normal Saline (NS) 1,000 mL IV bolus infusion (Completed on 04/08/2023 at 2:19 PM) 3. Acetaminophen (Ofirmev) intravenous solution IV infusion (Completed on 04/08/2023 at 11:55 AM) 4. Dexamethasone sodium phosphate PF (Decadron) solution 10 mg IV (Given on 04/08 /2023 at 2:03 PM) 5. NS 1,000 mL IV bolus (New Bag/Vial on 04/08/2023 at 2:19 PM) 6. Vancomycin 1,000 mg in NS 250 mL given via IV piggyback (New Bag/Vial on 04/08/2023 at 3:06 PM) 7. Gadoterate meglumine (Dotarem) 0.5 mmol/mL (376.9 mg/mL) solution, 20 mL IV (Given on 04/08/2023 at 3:42 PM) . Medications ordered but not given: 1. Hydromorphone (Dilaudid) solution (Held on 04/08/2023 3:00 PM) 2. Ondansetron (Zofran) solution (Held on 04/08/2023 3:00 PM) 3. Ceftriaxone (Rocephin) 2g in sodium chloride 0.9 % 100 mL . 6:13 PM - Patient #1 was documented to have departed the ED of Facility A to transfer to Facility B (note - Facility B is the sister facility to Facility A). The MOT was reviewed and noted to have been filled out as needed. . The transfer diagnoses at discharge were: Septic arthritis of the thoracic spine Spinal meningitis Spinal epidural abscess Tachycardia Weakness of both lower extremities . Medical Record Review for Patient #1 at Facility C: 04/07/2023: 7:20 PM - Arrived at the Emergency Department (ED) as a walk-in patient with the stated complaint, "legs paralyzed", assigned a Priority 2. . 7: 22 PM- Medical Screening Exam was initiated by Staff #7 (ED mid-level provider) for the Facility. Notes included: "Patient is a 26-year-old male with a history of lumbar fracture, had a laminectomy to repair the fracture in 2018, however states that he refractured his back approximately 1.5 months ago. Has been seen both here and at (Facility A) with complaint of increasing lower back pain. Patient states that he has a follow-up appointment with a surgeon on Tuesday however over the last 2 days his condition has acutely worsened. States that he is unable to urinate at all, has no function of his lower legs, and states that they are tingly, and he is unable to walk." Triage notes were reviewed. . "Physical Assessment: Neck Atraumatic, Supple, Full range of motion, No midline vertebral tenderness Abdomen/GI Atraumatic, Soft Tenderness/Guarding/Rebound Tender suprapubic. MS Back Flank/Spine/Paraspinal Lumbar spine tender. Neurologic Oriented X3, Speech NL Focal Weakness Lower extremity R, Lower extremity L. Sensory Deficit Lower extremity R, Lower extremity L." 7:28 PM - The initial documented reason for the visit by Staff #15 (ED RN) was "back pain ongoing for years, inability to urinate x2 days, both legs are completely numb since yesterday." . 7:33 PM - Triage initiated by Staff #8 (ED RN). Patient #1's medical history, allergies, immunizations, surgical history, family history, screenings, height, weight, and medications were all obtained during triage. 7:40 PM - Staff # 5 (ED Physician) reviewed the patient chart. 7:40 PM - Staff #7 ordered a complete blood count (CBC) with differential and a urinalysis (UA) with culture if indicated. 7:55 PM - Staff #7 ordered an MRI of the lumbar spine due to a history of a lumbar fracture, being post laminectomy in 2018 and now having urinary retention and weakness of the legs. . 8:00 PM - Labs reviewed by Staff #7: Result: Value: Reference Range: White blood cells 13.1 k/uL (high) 3.9 - 10.9 K/uL (indicative for infection) Hematocrit 38.8 % 41 - 53% Glucose 100 mg/dl 6 - 20 mg/dL Creatinine 0.76 mg/dl (low) 0.9 - 1.3 mg/dL Sodium 132 mmol/L (low) 136 - 145 mmol/L Chloride 95 mmol/L 98 - 107 mmol/L BUN 20 mg/dL (high) 7 - 18 mg/dL . A urinalysis was positive for ketones and contained trace bacteria (indicative for a urinary tract infection (UTI). . 8:03 PM - A bladder scan was obtained by Staff #16 (ED RN) showing 337 ml of urine retained in the urinary bladder. 8:03 PM - Morphine 4mg IV, Zofran 4mg IV, and a Lidocaine patch were ordered by Staff #7. 8: 33 PM - A foley catheter was placed by Staff # 17 (ED RN) due to "Acute retention /obstruction." . 8:48 PM - Valium 10mg oral was ordered by Staff #5. . 9:50 PM -

Staff # 7 documented: "discussed case with MRI tech who reports the patient started the MRI but is now refusing the scan and made her take him off the table and bring him back to the ER. I discussed this with the patient (Patient #1) and he is refusing MRI now. I discussed that at this time if he does not want further evaluation then we would have him sign out AGAINST MEDICAL ADVICE. I discussed risks and benefits of staying versus leaving including but not limited to worsening neurologic condition, worsening strength or sensation, and total lower extremity paralysis. He understands and says he just wanted help with his pain and will follow up with the spine doctor on Tuesday as planned. I tried asking him if there is anything I can do to change his mind and he says no. He is okay leaving the Foley in with a leg bag and I discussed supportive care for that. He does have meds that were prescribed from the previous hospital but I will add a muscle relaxer and steroid pack but discussed with them that if he does have significant spinal lesions that this would not help and he would continue to worsen. I discussed that he needs to definitely follow-up as planned, but I encouraged with strict return precautions reasons to come back. He understands and says he will sign out AMA." . 10:15 PM - Documentation shows that Patient #1 physically left the ED. 10:18 PM - Patient #1 signed an AMA form. 11:22 PM - Staff #8 documented that Patient #1 left AMA from the ED. It is documented that Patient #1 was ambulatory at the time he left the ED. . Medications Given in the ED: 1. Lidocaine patch Given on 04/07/2023 at 8:11 PM 2. Diazepam 10 mg oral Given on 04/07/2023 at 8:54 PM 3. Morphine Sulfate 4mg IV Given on 04/07/2023 at 8:10 PM 4. Zofran 4mg IV Given on 04/07/2023 at 8:11 PM 5. Contrast for MRI Given on 04/07/2023 at 8:55 PM . Medical Record Review for Patient #1 at Facility B: 04/08/2023: 6:15 PM - Arrived at Facility B's ED. 6:15 PM - Triage initiated by Staff #22 (ED RN). Notes: "Pt (Patient #1) arrived via (Company Name) air #10 from (Facility A). Pt (Patient #1) was seen at (Facility C) hospital 2 days ago for anuria, back pain and leg weakness. Per EMS, pt (Patient #1) had an MRI at that time that was negative. Pt (Patient #1) presented at (Facility A) today with worsening weakness in legs, hematuria and numbness to BLE. Pt (Patient #1) states sensation feels like "shocks" to BLE (bilateral lower extremities). Pt (Patient #1) unable to lift legs off the bed, weak strength to BLE CM placed. NAD noted, call light within reach. Awaiting MD eval." . Medical history, allergies, immunizations, surgical history, family history, screenings, height, weight, and medications were all obtained. . 6:18 PM - ED Triage Vitals: BP 131/81, Pulse 123, Respirations 26, Temperature (oral) 98.8 F (37.1C), Oxygen saturation 96 % on room air, and Pain Level 3/10. . 6: 34 PM - Medical Screening Exam (MSE) was initiated by Staff #21 (ED Physician). Notes included: "Referral Pt (Patient #1) transferred from (Facility A) for spinal abscess and spinal meningitis anuria 2 days and tingling BLE (bilateral lower extremities) ... ...(Patient #1) a 26 y.o. male with a h/o prior spine fracture presents with 3 days of increasing back pain and difficulty urinating. He was seen at (Facility A) and discovered to have an epidural abscess versus hematoma. He was sent here for neurosurgical evaluation. Patient (#1) reports some continued weakness of his bilateral lower extremities ... Physical Exam Cardiovascular: Rate and Rhythm: Regular rhythm. Tachycardia present. Heart sounds: Normal heart sounds. Comments: Heart rate 120s Musculoskeletal: General: Normal range of motion. Cervical back: Normal range of motion and neck supple. Neurological: Comments: Patient (#1) alert and oriented, answers questions and follows commands without difficulty. Patient (#1) is somnolent but arousable secondary to medications given for pain.. Patient (#1) exhibit some mild weakness of his bilateral lower extremities ..." . Labs and radiology findings from Facility A were reviewed. . 9:39 PM - Bedside Glucose, 136 mg/dL (high), reference range 65 - 100 mg/dL . This ED Visit continued into 04/08/2023: 4: 39 AM - Abnormal lab findings: Result: ---------- Value: ---------- Reference Range: Neutrophil # ----- 8.55 k/uL (high) --- 1.50 - 7.00 k/uL Lymphocyte # ---- 0.46 k/uL

(low) ---- 0.85 - 3.20 k/uL Monocyte # ------ 0.87 k/uL (high) ----- 0.20 - 0.80 k/uL Calcium --------- 8.0 mg/dL (low) --- 8.4 - 10.2 mg/dL Glucose --------- 137 mg/dL (high) --- 70 - 100 mg/dL Creatinine --------- 0.64 mg/dL (low) --- 0.72 - 1.25 mg/dL White Blood Cells -- 9.99 k/uL (high) --- 3.98 - 9.57 k/uL Red Blood Cells --- 3.74 M /uL (low) --- 4.20 - 5.60 M/uL Hemoglobin ------ 10.8 g/dL (low) ---- 13.0 - 17.0 g/dL Hematocrit ----- 31.6 (low) --------- 39.0 - 51.0 % . 5:07 PM - Additional lab findings: Result: ---------- Value: ---------- Reference Range: Hepatitis B Surface Antigen - Non-reactive ------ Non-reactive Hepatitis B Core IgM ------ Non-reactive ------ Non-reactive Hepatitis A Antibody IgM --- Non-reactive ------ Non-reactive Hepatitis C Antibody ----- Non-reactive ------ Non-reactive HIV 1 & 2 Antibody ----- Non-reactive ------ Non-reactive Total Protein ---------- 5.5 g/dL (low) ---- 6.0 - 8.3 g/dL Albumin ---------- 1.9 g/dL (low) ----- 3.3 - 5.0 g/dL A/G Ratio ---------- 0.5 g/dL (low) ----- 1.1 - 1.8 g/dL Vitamin D 25-Hydroxy --- 18.8 ng /mL (low) --- 30.0 - 80.0 ng/mL . ED Medication Administration from 04/08/2023 at 6:13 PM to 04/08/2023 at 9:36 PM None . 9:36 PM - Transferred from the ED to Neuro Critical Care and admitted. "Disposition Condition Comment The condition of the patient at this time is: serious" . FACILITY B EVENTS: 04/11/2023 - Blood Cultures were obtained on 04/09/2023. Findings were for MSSA (methicillin susceptible staphylococcus aureus. . 04/14/2023 - MRI of the thoracic spine showed diffuse subarachnoid enhancement suggesting meningitis, upper and lower thoracic dorsal epidural phlegmon, T8 suspected right dorsal subdural empyema (puss in the lung), T10-T11 and T11-12 right facet joint septic arthritis, L1-L2 suspected ventral subdural empyema, L3-L4 bilateral facet joint septic arthritis. . 04/08/2023 - Patient #1 had a TEE (Transesophageal echocardiogram) completed. Findings: "-Left Ventricle (LV): Normal systolic function with estimated EF (ejection fraction) of 60-65%. Normal LV wall motion. Left Ventricle size is normal. Increased wall thickening. Unable to assess diastolic function due to sinus tachycardia. -Aortic Valve: No vegetation present. -Mitral Valve: No vegetation present. -Tricuspid Valve: No vegetation present. -Pulmonic Valve: No vegetation present. -Aorta: No significant aortic atherosclerotic (Hardening) plaque." . 04/15/2023: MRI of the cervical spine, impression: "shallow disc bulge at C 6-7. No extradural fluid collection over the cervical segment." . 04/16/2023: MRI of the thoracic spine findings: "Severe facet degenerative changes at T 9-10, likely representing septic arthritis. Dorsal extradural fluid collection extending from T 8 - T 10, essentially unchanged. Shallow Spondylotic features T 9 - 10 and T 10 - 11. Questionable disc space infection changes at T 10 - 11. Similar features demonstrated before. Periarticular fluid collection in paraspinous muscle compartment at the T 4 - 5 level. Abnormal signal within the T 4 - 5 facet joints, right more so than left. Findings likely reflect septic arthritis and periarticular reactive changes. Similar features present before. Enlargement of the spinal cord contour from T 7 to the conus with central cord edema from T 7 inferiorly. Similar features demonstrated before. No pathologic enhancement of the cord. Impression: 1. Findings consistent with septic arthritis T 4 - 5 and T 9 - 10. See discussion above. 2. Probable disc space infection T 10 - 11. 3.Spinal cord enlargement and edema from mid T 7 inferiorly, similar to prior features." . MRI of the lumbar spine: "Interval laminectomy and medial facetectomy at L 3 - 4. Fluid collection extends from the dorsal epidural space into the subcutaneous tissues. Differential diagnosis would include seroma and psuedomeningocele. Present or absence of infection cannot be inferred. There is no mass effect on the dural sac by the fluid collection. Impression: Status post laminectomy and medial facetectomy L 3 - 4. Fluid collection extending from the dorsal epidural space into the subcutaneous tissues. No mass effect on the dural sac." . 04/18/2023 - Ultrasound guided aspiration, L3/4 by Interventional Radiology (IR). Findings: Cloudy pink fluid aspirated from lumbar spine subcutaneous tissues extending to region of L 3.4 laminectomy; 20

milliliter(s) removed and sent for cell count and micro. . 04/24/2023 - Thoracentesis . 04/28/2023 - Thoracentesis ('350 mLs of dark bloody pleural fluid was removed') . 05/03/2023 - Patient #1 had an XI Robotic Thoracoscopy with decortication on the lung (right side). Intercostal nerve block levels 2 through 10 with exparel. Pleural biopsy (Surgical Findings: Retained hemothorax with lung entrapment). . 05/07/2023 - Chest x-ray: "Lungs and pleura: Reticular opacities of tight lung base are unchanged. The lungs are otherwise grossly clear. No pneumothorax is visible. There is no large pleural fluid collection. Additional comments: Right chest wall emphysema, unchanged." . 05/15/2023 - MRI lumbar - thoracic spine: "1. Diffuse contrast enhancement within the epidural space from T 1 to S 1 consistent with epidural phlegmon. Previously seen subdural empyema/abscesses are no longer identified. There is extensive T 2/STIR hyperintense signal within the thoracic and lumbar spinal cord. The extent of the spinal cord signal abnormality has increased with not reaches the T 2 level. Enhancement of the nerve roots of the cauda equina, somewhat improved since prior studies. The findings are nonspecific but may represent infectious arachnoiditis/neuritis. 2. Postoperative changes of posterior decompression at L 3 - 4, L 4 - 5, and L 5 - S 1. There is a nonspecific postoperative fluid collection within the laminectomy defect at L 3 - 4 with mild to moderate thecal sac narrowing. The sterility of the collection is indeterminate. [Fluid collection (4 x 2 x 1.5 cm) within the laminectomy defect is not significantly produce mass effect upon the thecal sac. The fluid collection has a thick rind of contrast enhancement. Mild posterior disc bulge. Mild to moderate thecal sac narrowing.] 3. Probable changes of discitis at T 10 - 11, nonspecific. There are changes since prior study. 4. Changes of septic arthritis at T 4 - 5 and T 5 - 6 have significantly improved. There has been improvement of the septic arthritis changes at T 10 - 11." . 05/23/2023 - Pathology from Parietal Pleural Biopsy: Acute and chronic fibrinous pleuritis overlying mature adipose tissue. No malignancy identified. . Patient #1 remained at Facility B for IV antibiotics and continued care until he was discharged on 05/30/2023 at 8:33 AM. . Policy Review: Facility A's Medical Screening Examinations and Patient Transfers policy, last reviewed and implemented on 10/07/2022, stated on page 5 of 25: " ...4.1.5 Evaluating the patient and performing a Medical Screening Examination. a. Evaluation. Each patient who arrives at the Hospital ED or Labor and Delivery will be evaluated by a physician or Qualified Medical Personnel (in the ED or Labor and Delivery as applicable) or evaluated by a physician on the medical staff who is on call and: 1) is physically able to reach the patient within a reasonable time, not to exceed 30 minutes, after being informed that a patient is present at Hospital and who requires immediate medical attention; or 2) is available by direct telephone or radio communication within 30 minutes with authorized personnel at Hospital under orders to assess and report the person's condition to the physician ..." . And on page 6 of 25: " ...3) The physician will determine if an Emergency Medical Condition exists and, if so, initiate necessary stabilizing treatment or arrange for a transfer to another hospital as appropriate ..." . And on page 10 of 25: " ...5) If based upon the screening physician's evaluation, the physician determines that additional specialist services are needed to further assess the patient and these specialists are routinely available to the ED, these services must be utilized. The screening physician shall call the specialist physician on call for the particular medical condition and shall ask him /her to see the patient. Hospital medical staff rules and regulations require the specialist physician to respond ..." And on page 21 of 25: " ...5.6 Emergency Medical Condition - Means a medical condition exhibited by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: 5.6.1 placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 5.6.2 serious impairment to bodily functions, or 5.6.3 serious

	dysfunction of any bodily organ or part; ..." . And page 22 of 25: " ...5.10 Medical Screening Examination - Means the process to determine, with reasonable clinical confidence, whether the patient is suffering from an Emergency Medical Condition. Depending on the individual's presenting symptoms, the Medical Screening Examination represents a spectrum ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as lumbar punctures, clinical laboratory tests, CT scans, and/or diagnostic tests or procedures. A medical screening exam is not an isolated event, but an ongoing process ... .5.11 Qualified Medical Personnel or Qualified Medical Person 5.11.7 Emergency Department. In the Emergency Department, "Qualified Medical Personnel" means a physician on the medical staff or advanced practice professionals on the allied health staff of Hospital. . 5.11.3 Behavioral Health. ln the Behavioral Health environment, "Qualified Medical Personnel" means either a member of the medical staff of Hospital or other licensed members of the behavioral health team to include Psychologists (Ph.D., PsyD), Registered Nurses, Master's prepared Social Workers (LCSW, LMSW), Licensed Professional Counselor (LPC, LPC lntern), and Licensed Marriage and Family Therapist (LMFT, LMFTA). Each Psychologist, Registered Nurse, Social Worker, Licensed Professional Counselor, or Licensed Marriage and Family Therapist who serves as Qualified Medical Personnel shall have received training on what constitutes an appropriate Medical Screening Exam ..." . Interviews: On the afternoon of June 24 and June 25, 2024, the Facility's Quality Director (Staff #2) was interviewed. After reviewing the medical record for Patient #1, Staff #2 felt that Facility A had provided a complete MSE and necessary treatments. .