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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	048-548	A. BUILDING B. WING	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLSTAR DOUGLAS HOSPITAL	**8954 HOSPITAL DRIVE DOUGLASVILLE, GA 30134**

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A 000	INITIAL COMMENTS An EMTALA complaint survey was performed on August 20, 2021. The Hospital President, the Director of Patient Safety and Quality, Director of Acute Care Manager for the Georgia Department of Community Health, Executive Director of Accreditation and Licensure, Vice President for Safety & Accreditation for the Health System, and the Medical Director of the Emergency Department were notified on December 14, 2021 at 2:11 P.M., that Immediate Jeopardy (IJ) existed. Based on record reviews, video surveillance footage, and interviews, the hospital failed to provide an adequate continuous medical screening examination and stabilizing treatment prior to discharging an individual (Patient #1) who presented to the Emergency Department on 7/28/2021 with chief complaints of weakness, syncope (fainting), Dehydration and COVID 19. The patient was not stabilized prior to discharge as evidenced by an abnormal Electrocardiogram in the setting of syncope, he was not acting himself, unable to stand on his own prior to discharge, and required multiple persons to assist with getting him into his parents' car status post discharge. Patient #1's family took him to another acute care hospital where he presented having seizures and was emergently intubated. The patient was admitted to the Intensive Care Unit, and died 4 days later. The facility's failure to provide an appropriate medical screening examination and stabilizing treatment prior to discharge on 7/28/2021 posed an immediate and serious threat to Patient #1's health and safety and inappropriately delayed treatment for his emergency medical condition. An Emergency Medical Treatment & Labor Act (EMTALA) complaint survey GA00216697, was conducted at WellStar Douglas Hospital on August 16, 2021 through August 20,2021. The facility is not in compliance with Emergency Medical Treatment & Labor Act (EMTALA)	A 000		

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	requirements for Acute Care Hospitals at 489.24(d)(1-3) and (e)(1)-(2) and the related requirements at 489.20 (l): Responsibilities of Medicare Participating Hospitals in Emergency Cases. Deficiencies cited. Please refer to findings at A2400, A2407, and A2409.			
A 2400	489.20(l) COMPLIANCE WITH 489.24 [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This REQUIREMENT is not met as evidenced by: Based on medical record reviews, Policy and procedure review, physician on-call schedule review, and interviews the facility failed to ensure that an appropriate medical screening examination was provided within the capability of the hospital ' s emergency department including ancillary services routinely available to the ED to determine whether or not an emergency medical condition existed for 1 (#1) of 20 sampled patients who presented to the ED for a second visit via ambulance with complaints of syncope, unable to stand on his own, barely speaking, positive for COVID 19 and hypotensive. Refer to findings at Tag A-2406. Based on review of video recordings, review of medical records, review of ambulance report, review of Medical Staff Rules and Regulations, review of policies and procedures and interviews, it was determined that the facility failed to provide stabilizing treatment as required, that was within the capabilities of the staff and facilities available at the hospital for one (Patient #1) of 20 sampled patients who was not stabilized prior to discharge. Refer to findings at Tag -2407.	A 2400		

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A 2406	489.24(a) & 489.24(c) MEDICAL SCREENING EXAM (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.	A 2406		

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	(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 REQUIREMENT is not met as evidenced by: Based on medical record reviews, Policy and procedure review, physician on-call schedule			

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	review, and interviews the facility failed to ensure that an appropriate medical screening examination was provided within the capability of the hospital ' s emergency department including ancillary services routinely available to the ED to determine whether or not an emergency medical condition existed for 1 (#1) of 20 sampled patients who presented to the ED for a second visit via ambulance with complaints of syncope, unable to stand on his own, barely speaking, positive for COVID 19 and hypotensive. Findings: A review of P #1's medical record (first visit) revealed that P#1 arrived to Facility 1's (Wellstar Douglas Hospital) ED via family car and was admitted to the facility's ED on 7/25/21 at 10:15 a.m., with chief complaints of fatigue and dizziness. The medical record further noted that P#1 tested positive for COVID -19 (An infectious disease caused by the SARS (severe acute respiratory syndrome)-CoV (Carona Virus -2 virus) days prior to arriving at the facility's ED, positive cough, lightheadedness and decreased appetite. The record revealed that P#1 was initially triaged (refers to sorting sick people according to their need for emergency medical attention) at 10:16 a.m., and revealed P#1 presented with the following vital signs: Blood Pressure (BP): not recorded, Heart Rate (HR): 106 (normal 60-100), Respiration: 16 (normal 12-16), Temperature (Temp) 98.6 (normal 97.4 - 99.6), and Oxygen Saturation (SaO2): 94% (97%-100%). A review of P #1's record revealed the facility placed P#1 in one of the ED rooms at 10:31 a.m., and P#1's Emergency Severity Index (ESI is a five-level ED triage numbers that provide clinically relevant information about the acuity and resources needed to treat a patient with 1 (one) as the most urgent, and 5 (five) the least urgent) was a level 3 (Stable with multiple types of resources needed for treatment). At 10:44 a.m., a secondary triage was completed, and P #1's BP			

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	was 141/83 (Normal systolic 90-120, and Diastolic 50-80). A further review of P #1's medical record revealed at 10:56 a.m., a Medical Screening Examination (MSE) was performed and revealed confirmation for fatigue, dizziness, lightheadedness, and COVID-19. Physical Examination revealed the following vital signs: BP 122/67, Pulse: 98, Temp: 100.1, Respiration:18, Sat O2: 97%. The ED physician ordered a portable chest X-ray (1 view). The clinical indication for the study was COVID-19 positive, and cough. The x-ray findings revealed P#1 had pneumonia (an inflammatory disease of the lungs). While being treated in the ED, the Registered Nurse administered 8mg of dexamethasone (this medication can be used treat breathing problems) via left hand IV (intravenous) line at 1:05 p.m. Additionally, Respiratory administered 3 mL Ipratropium-Albuterol (medication used to treat and prevent wheezing and shortness of breath) via inhalation therapy at 1:10 p.m. At 1:24 p.m. an order for an Incentive Spirometer (IS -a device used to help expand the lungs via deep breathing), for P#1 to take home. P#1's vital signs at 1:48 p.m. were the following: BP: 131/74, Temp: 100.1 (normal average is 98.6), Respiration: 18, Heart Rate: 95, and SaO2: 91%. The ED physician ordered the following laboratory tests at 2:04 p.m.- Basic Metabolic Panel, Blood Cultures, Complete Blood Count with Differential, Procalcitonin, and lactic acid level (elevated blood level indicates infection or sepsis). Further review of the medical record revealed that at 2:14 p.m., the ED physician had discontinued all labs for the patient. P#1's vital signs were recorded as BP: 122/67, Heart Rate: 98, Respiration: 18, SaO2: 97%. The ED physician listed the patient ' s final diagnosis as "Pneumonia due to Covid-19 virus". At 2:25			

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	p.m., P#1 received 975 mg of Tylenol by mouth. Further review revealed the ED physician placed an order for Pt#1 to be discharged home. The discharge medications list contained: Albuterol (medication that opens the airway) 90 mcg, inhale two puffs every four hours as needed, Azithromycin (antibiotic) 250 mg tab to take one tablet by mouth for five days (take two tabs on day one), Dexamethasone (Decadron) 2 mg tab to take one tablet by mouth two times a day for ten days. The medical record review revealed P #1 was discharged on 7/25/21 at 3:22 p.m., in stable condition via wheelchair. Review of the medical record for Patient #1, revealed the patient returned to Facility #1's ED (second visit) on 7/28/21 at 7:59 p.m. by ambulance. The patient was placed in an ED room at 8:08 p.m. The medical record revealed an ED physician had his first contact with P#1 at 8:08 p.m. and evaluated patient #1 at 8:13 p.m. P#1's ED physician initial assessment revealed that P#1's chief complaint was Syncope (a temporary loss in consciousness caused by a fall in blood pressure). P#1's mother reported him as being weak due to poor appetite, nausea, with associated symptoms of malaise, fatigue, and shortness of breath. P#1 was also positive for COVID-19. The Physical Examination section the ED physician completed and documented in part, "Musculoskeletal: General: No swelling, tenderness, deformity or signs of injury Normal Range of Motion." Further review of the medical record revealed the ED physician ordered lab work, including CBC, chest X-ray, 12-lead EKG (electrocardiogram, a test that records electrical activities in the heart), and one liter of normal saline IV. On 7/28/21 at 8:20 p.m., the chest portable X-ray was taken in the ED room. P#1's chest x-ray revealed the lungs were hypoaerated (lung			

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	volume is abnormally increased) and the findings were worrisome for pneumonia in the appropriate clinical setting. The Physician Note revealed that P#1's chest x-ray was improved from the previous films. The diagnosis was COVID-19, and pneumonia. P#1's Pulse Ox (blood oxygen was 98% on room air (RA). At 8:24 p.m., P#1's vital signs were the following: BP: 145/85, Heart Rate (HR): 82, Respiration: 18, Temperature: 98.0, O2 saturation (Sat O2) 98% on room air. P#1's ESI (triage) level was 3. At 8:41 p.m., the order for chest X-ray and blood work was completed. Further review of P#1's lab result revealed a White Blood Cell Count, (WBC)- 5.21, Red Blood Cell count 8.61, Hemoglobin 18.0 (a protein in the blood that carries Oxygen), Hematocrit- 42.8, Platelets 316 (a type of blood cell that favors blood clot), Sodium of 143, Potassium Level, 4.5, and Carbon dioxide-22 (blood gas produced and expelled in respiration)- all of these laboratory results were within normal limits. The other labs listed below were Chloride of 109 (normal is 98-107), Glucose of 151 (normal is 70-99), Creatinine (a blood protein produced by normal body metabolism) of 0.67 (normal is 07-1.2), Total Calcium of 8.5 (normal is 8.6-10). Review of the ED orders dated 7/28/2021 at 8:14 p.m. revealed that a stat EKG was ordered by the ED physician for patient #1. The reason for the examination was listed as "non-specific abnormal EKG. The 12-lead Electrocardiogram (EKG) stat was performed at 8:47 p.m., and the impression indicated the EKG was abnormal. Review of the EKG report revealed a prolonged QTc (an abnormally long or short QTc interval is associated with an increased risk of developing abnormal heart rate and sudden cardiac death). Further review revealed that on 7/28/2021 at 9:21 p.m., the ED physician interpreted the EKG as" Rhythm as Sinus rhythm, Ectopy comments: none, Rate: normal, QRS axis- normal, ST segments: ST segment normal, T waves: T			

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	waves normal ...Other findings: prolonged QTc interval, Clinical Impression: Abnormal ECG." Medical Record review revealed that no consult orders placed with this encounter (hospital visit). Further review of the record revealed that on 7/30/2021 at 8:10 am. The final result of the status of the EKG was read/interpreted by another physician with recommendations. His final impression of the results was listed as normal sinus rhythm, Prolonged QT, and abnormal EKG. "Recommend follow-up with a Wellstar pediatric cardiology. The facility failed to ensure that ancillary services was utilized to assist with determining whether or not patient #1 had an emergency medical condition related to Patient #1 ' s abnormal EKG (prolonged QTc) and diagnosis of syncope. Medical review revealed that P#1 received 1Liter of sodium chloride via IV at 8:14 p.m. and 9:19 p.m. Additionally, P#1 received 4 mg of ondansetron (a medication to treat nausea and vomiting) by mouth. Review of the ED provider notes dated 7/28/2021 at 9:22 p.m., the ED physician documented "Pt. workup complete and there is no further need for emergent diagnostics of treatment. Pt is stable, nontoxic without concerns ... the patient is ready for discharge." Review of the ED notes the RN documented on 7/28/2021 at 9:48 p.m., P#1's family requested possible admission for the patient. The ED RN documented in part, "Discussed with Physician and had made decision due to patient (#1) not meeting admittable criteria for COVID at this time he feels safe to discharge patient." Further review of the ED Notes revealed that at 9:53 p.m., P#1 complained of chest and head pain, the ED physician was made aware of P#1's complaints. The ED physician ordered Tylenol for P#1, and the patient refused to take the Tylenol and spat it out. ED notes revealed P #1 was discharged on 7/28/21 at 10:50 p.m. with			

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	the following vital signs: Blood Pressure: 145/85, Pulse:82, Temperature: 98.0 C, Respiration: 18, and Oxygen Saturation 98%. Review of the ED notes revealed that on 7/28/2021 at 10:59 p.m., the ED RN documented, "Pt. brought to car in the wheelchair with help of RN x2. Patient aided to stand and get into car. Pt. stood and had steady gait and then fell forward with controlled movement into car. RN ' s tried to aid the patient with getting into car with no success. Pt. family member helping to get patient #1 into car with security assistance. Pt. Had purposeful movement throughout visit." Patient #1 was discharged from the ED via wheelchair with the assist of 2 Registered Nurses. The ED Nurse documented in the medical record that patient #1 fell into the car. There was no documentation in the medical record to indicate that the RN ' s notified the ED physician that patient #1 was experiencing difficulty with the ability to walk on his own, and the amount of assistance it required to get the patient into his parents' vehicle prior to discharge. The hospital ' s ED Physician On-call schedule "Week 30 of 2021 was reviewed. The schedule revealed that on 7/28/2021 a Cardiologist (ancillary services) was on-call. A review of policy #LD-108, Emergency Medical Treatment and Labor Act (EMTALA), review date 11/4/2020, revealed a policy to comply with Federal interpretive guidelines and State Regulations. The policy indicated that the facility would provide an appropriate Medical Screening Exam (MSE) within the capability of the facility ' s Dedicated Emergency Department to determine if an emergency medical condition exists. The facility will provide further medical examination and treatment required to stabilize the emergency medical condition... The policy addressed that the facility must maintain a Physician on-call list of physicians who are on-call for duty, who will, after the medical screening examination, provide further			

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	evaluation or treatment necessary to stabilize an individual with an emergency medical condition. During an interview with emergency department (ED) Medical Director (MD) EE, on 8/17/21, at 12:05 p.m., in the office of ED Director, MD EE revealed that the criteria for discharge from the ED depended on the extent of the disease. He continued to say that other items to consider were patient vital signs, comorbidities (presence of two or more diseases or medical conditions in a patient), how the patient was responding to treatment, and home support. MD EE further stated that pediatric patients tend to have lower comorbidities than older patients. He revealed that the expectation of his ED staff was to talk to the patient and or patient 's family in person if they had concerns with being discharged from the ED. He continued to state that the expectations of his ED staff would be to assess and reassess any new changes in a patient ' s mental or physical status before leaving the facility. During a second interview with MD EE on 8/18/2021 at 2:00 P.M, stated that the Oxygen Saturation was not always the determining factor they looked at in the ED to admit a patient with Covid. MD EE said the Incentive Spirometer (IS) was a device they gave to any patient with difficulty breathing and that they gave it to the patient to encourage lungs exercise. The device he said, was not specific for Covid patients. They gave it to patient after surgery, any condition that required the lungs to get some type of rehabilitation. The goal of using the IS was to avoid pneumonia by encouraging patients to take deep breaths. MD EE said the facility provided wheelchair service to all patients, not because the patient could not walk but they offered such service to avoid potential fall. MD EE stated again there was no set of criteria to admit a patient with COVID. As a board-certified physician, it is it was up to the physician to make that decision. Such decision was based heavily on the patients past medical history. MD EE stated that COVID-19 manifested itself differently in different			

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	population and then because of that it was at the physician's discretion to admit or to discharge a patient with COVID-19. MD EE stated that an abnormal EKG would be the cause for further investigation not a cause for automatic admission.MD EE stated if a patient had an abnormal EKG with ST elevation with Myocardial Infarction (STMI) that would be more an emergency and that would prompt the patient to the Catheterization lab.MD EE said there were two times that you must see a patient as a physician (at least); MD EE said he saw patient in the ED during the initial assessment or Medical Screening Exam (MSE) and he saw the patient again at discharge for discussion on decision to admit or transfer. MD EE said if a patient ' s lactic acid level was over 4, he considered Intensive Care for the patient. MD EE said if the first lactic acid was normal, there was no need to continue to investigate the lactic acid.; however, if above 2, he repeated it. During a phone interview with Radiologist (MD) CC on 8/17/21 at 3:26 p.m., MD CC stated that he was a Radiologist and he read patient ' s chest Xray. MD CC said Opacity in a patient ' s lungs was not specific for anything, it could be due to some inflammatory process, or any other pathologic process. MD CC said he worded the report in such a way for the treating clinician to decide what it could be that caused the opacity in the lungs. MD CC said if for instance the treating clinician suspected pneumonia before the reading result, therefore it was pneumonia. He added it was up to the clinician to decide on the cause of the lung ' s opacity. An interview with the Director of Quality and Patient Safety (DQPS) (LL) on 8/18/21 at 12:10 p.m. in the conference room revealed that a patient would be transported from the Emergency Department (ED) via wheelchair if the patient is at a high fall risk. DQPS LL reported that from a safety perspective, this is what we do for patients. DQPS LL stated that our primary focus is to prevent falls. DQPS LL			

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	said that there was not a policy for using a wheelchair to escort patients from the facility to their vehicle. DQPS LL stated as a clinician; you assess the patient to be aware of a need for a wheelchair. DQPS LL reported that if a patient came in with a walker, they would be offered a wheelchair for transport. DQPS LL stated the facility would try to accommodate the patients according to their needs. A phone interview with the family of P#1 on 8/18/21 at 12:18 p.m. revealed P#1 first arrived into the facility's ED on 7/25/21. The family of P#1 stated that P#1 developed a runny nose and congestion. P#1 attempted to clear the congestion by coughing, but the cough was not productive. P#1 was diagnosed with COVID-19 on 7/23/21. The family of P#1 stated P#1 was taken to the facility's ED on 7/25/21. The family of P#1 confirmed after P#1's evaluation at the ED, the physician revealed P#1 had pneumonia in both lungs and that the ED physician prescribed an inhaler, antibiotics, and steroids. P#1's family stated P#1 felt better. The family of P#1 revealed that on the evening of 7/28/21, P#1 complained of a headache. The family stated they told P#1 to get up and shower to go to the ED. The family stated when P#1 stood up, he fell back, and they called 911. The family stated paramedics arrived, started fluids on P#1, and transported him to the hospital. The family of P#1 explained that P#1 was slow to respond, and then P#1 did not respond. The family of P#1 confirmed the facility relayed that P#1's diagnosis was COVID-19 and dehydration. The family stated the nurse that cared for P#1 indicated that P#1 would feel better after receiving fluids. The family member of P#1 stated she told the nurses that she did not want P#1 discharged because P#1 could not walk. The family of P#1 reported she begged the hospital to keep P#1 at the facility. The family confirmed that P#1 was given Tylenol in a cup, but P#1 dropped it after it was placed in his hand. The family of P#1 stated they helped P#1 place the Tylenol in P#1's mouth. Family of P#1			

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	stated she requested that P#1 receive liquid Tylenol because P#1 could not swallow the pills. The family of P#1 requested the patient be kept at the facility and asked if P#1 could be sent to a children's hospital (facility #2) because P#1 was not himself. A phone interview was conducted with the ED physician (MD) BB on 8/19/21 at 9:00 a.m., as he cared for Patient #1 on 7/28/2021. MD BB said in the case of P #1, he was not tachypneic (a rapid and shallow breathing), P #1 was not in respiratory distress, P #1's pulse was between 95-96, the breathing treatment administered in the ED worked. He continued to state that P#1 was already put on steroid, and his chest X-ray was improving. He stated that P #1 ' s chief complaint was dehydration, and they gave him IV fluids, vital signs were normal, and P #1 improved with fluid administration. He stated that he was sitting in the bed and talking to the patient. MD BB said because the patient was stable, and P #1 ' s complaint of headache and chest pain did not worry him, MD BB said P #1 with dehydration had body aches. MD BB said P #1 ' s labs were "benign " and P #1 ' s vital signs were stable on discharge. During a second phone interview with ED Physician, MD BB on 8/20/21 at 10:10 a.m. MD BB was asked about the abnormal EKG reading for P #1. MD BB said the Prolonged QT observed in P #1 ' s EKG was common finding; and that the EKG was abnormal because of the prolonged QT but that was not something dangerous. MD BB stated such finding was common in all age groups and the finding did not have a whole lot of clinical significance. MD BB said in the case of P #1 the prolonged QT did not require further investigation. MD BB said the chest pain in a 17-year-old patient P #1 was just body ache. MD BB stated that there was no difference in treatment for a vaccinated versus an unvaccinated patient infected with Covid; it was just the same. MD BB said that treatment still consisted of fluid therapy and steroid. MD BB said the last time he saw P #1, he was alert, oriented, and stable and that he was not made			

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	aware of any change in P #1 ' s condition. During a phone interview with the emergency department (ED) Registered Nurse (RN) DD on 8/19/21, at 2:15 p.m. in the facility conference room, RN DD stated that he had worked as an ED nurse for three years. He further said that he worked the 3:00 p.m. to 3:00 a.m. shift. RN DD stated that he remembered P#1 because he came to the ED after he had passed out in the shower at home. He further explained that he recalled that P#1 was positive for COVID-19 and was dehydrated. He stated that P#1 was given two liters of intravenous (IV) fluids and discharged. RN DD stated that he recalled P#1 complaining of a headache and chest tightness before discharge. He said that he informed MD BB, and an EKG was ordered, and Tylenol was administered. When RN DD proceeded to administer the Tylenol to P#1, he could not swallow it. RN DD recalled that P#1's family member stated that P#1 had difficulty swallowing pills. RN DD continued to say that he broke the tablet up and tried to administer it to P#1 with water, but he spit it back out. RN DD stated that after several attempts, P#1 could swallow some of the Tylenol. RN DD said he would ask the patient if they would rather have liquid but was unsure why he did not do this for P#1. RN DD did not recall P#1 ' s family member asking for the Tylenol liquid form. RN DD stated that he further observed MD BB walking into P#1 ' s room after RN DD had administered the Tylenol. RN DD continued to say that he was not in P#1 ' s room when MD BB entered. RN DD stated that he recalled that P#1' s family member had asked that he be admitted to the hospital. He said that he informed MD BB of her request, but it was not approved because P#1 did not meet the admitting criteria for COVID. He further explained that the admitting criteria would have been related to whether patients could have sustained their oxygenation levels.			

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	RN DD stated that on discharge, P#1 was alert and oriented. He further revealed that P#1 was not talking a lot, but RN DD did feel that he was responding appropriately. P#1 was able to move from the bed to the wheelchair with RN DD ' s assistance. RN DD continued to say that another nurse was assisting by positioning the wheelchair for P#1's transfer from the bed to the wheelchair. RN DD confirmed that P#1 seemed in pain due to P#1's facial grimacing. RN DD stated he wheeled P#1 out of the ED to be transported to P#1 's family's car. RN DD said that P#1 was assisted to a standing position, and P#1 laid down in the back seat on his stomach. He did recall that P#1 was making grunting noises. RN DD said that facility security was there during this time, and they took over helping getting P#1 into the car. RN DD stated he did not stay until P#1 was secured in the vehicle since security was assisting. RN DD did not recall another nurse assisting him when transferring P#1 into the car. An interview with Security Officer (SO) (QQ) on 8/19/21 at 4:15 p.m. in the conference room revealed that he was walking outside the Emergency Department (ED) when he saw another officer standing by a vehicle. Officer QQ noted a patient who could not stand, and he observed that the patient seemed very sick. Officer QQ observed that the patient's dad repeatedly wrapped his arms around P#1 waist to maneuver him into the vehicle. Officer QQ further noted that the patient kept sliding off the seat. Officer QQ went to the other side of the vehicle and helped maneuver the patient into the car. Officer QQ noted that another officer had been on the scene ahead of him. Officer QQ stated that the mother was in and out of the facility; the female was not on the scene when he arrived. Officer QQ noted that the dad had to lift the patient into the vehicle one hundred (100%) percent. Officer QQ revealed that the dad did get the patient in the car by lying him down and sat him upright. Officer QQ reported			

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	that the patient's eyes were open but not moving; he was not talking and did not appear to be responding to his surroundings. Officer QQ said that the nurses had gone back into the hospital. Officer QQ said that he asked the parents if they were sure they did not want to stay. Officer QQ said that the parents were determined to get in the vehicle and go somewhere else.			
A 2407	489.24(d)(1-3) STABILIZING TREATMENT (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.	A 2407		

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	(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 REQUIREMENT is not met as evidenced by: Based on review of video recordings, review of medical records, review of ambulance report, review of Medical Staff Bylaws, Physician on-call schedules review, policies and procedures reviews, video tape review, and interviews, it was determined that the facility failed to provide stabilizing treatment as required, that was within the capabilities of the staff and facilities available at the hospital for one (Patient #1) of 20 sampled patients who was not stabilized prior to discharge. Findings: The Ambulance Report (Patient Care Report) dated 7/28/2021at 11:28 pm was reviewed. The report revealed in part, "responded to call for			

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	syncopal episode upon arrival found a 17 y/o (year/old) male pt. (patient) sitting upright in the floor of his bedroom. Pt. is leaning up against the wall that his dad propped him up against. He was diagnosed with COVID pneumonia ...However he still has been vomiting and has difficulty keeping fluids down. His parents were trying to help her to bathroom to get bathed and when he stood up from his bed he passed out. His Dad was able to catch his fall and lowered him to the floor without injury. Pt. is not responding verbally, but his eyes open and will look around just a little. He tried to squeeze his hands upon commands and will nod head yes or no to questions but will barely speak when spoken to ...Vital signs ...section of PCR (Patient Care Report) with hypotension (low blood pressure). He is lifted to the stair chair and taken down the apartment stairs and loaded on to the stretcher ...Pt. moves his extremities, but he is not able to stand on his own at this time ...Patient is further assessed skin ...warm and diaphoretic ... Vital Signs are further assessed still showing hypotension (low B/P). BGL (Blood glucose level) 134 (normal blood glucose 60-100) ... An 18g (gauge) INT (intermittent access IV line used to administer fluids and medications) is established in Pt. left hand ...Pt. placed on 500 ml of LR (lactated ringers) drip to which improves B/P. He is administered the entire 500 ml LR enroute to the hospital. Pt. is transported to Wellstar Douglas for further evaluation and treatment. Upon arrival of ER (Emergency Room), gave report to ER nurse. The patient's Vital Signs in the ambulance were listed as - 7/28/21 at 1929 - B/P 99/71- Heart Rate 112; 19:43 B/P 70/58 Heart rate 91; 1954 B/P 115/76; Heart rate 76. Review of the medical record for Patient #1, revealed the patient returned to the ED on 7/28/21 at 7:59 p.m. by ambulance. The patient was placed in ED room at 8:08 p.m. The medical record revealed an ED physician had his first contact with P#1 at 8:08 p.m. and evaluated patient #1 at 8:13 p.m. P#1's ED physician initial assessment revealed that P#1's			

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	chief complaint was Syncope (a temporary loss in consciousness caused by a fall in blood pressure). P#1's mother reported him as being weak due to poor appetite, nausea, with associated symptoms of malaise, fatigue, and shortness of breath. P#1 was also positive for COVID-19. The Physical Examination section the ED physician completed and documented in part, "Musculoskeletal: General: No swelling, tenderness, deformity or signs of injury Normal Range of Motion." A further review of the medical record revealed the ED physician ordered lab work, including CBC, chest X-ray, 12-lead EKG (electrocardiogram, a test that records electrical activities in the heart), and one liter of normal saline IV. On 7/28/21 at 8:20 p.m., the chest portable X-ray was taken in the ED room. P#1's chest x-ray revealed the lungs were hypoaerated (lung volume is abnormally increased) and the findings were worrisome for pneumonia in the appropriate clinical setting. The Physician Note revealed that P#1's chest x-ray was improved from the previous films. The diagnosis was COVID-19, and pneumonia. P#1's Pulse Ox (blood oxygen was 98% on room air (RA). At 8:24 p.m., P#1's vital signs were the following: BP: 145/85, Heart Rate (HR): 82, Respiration: 18, Temperature: 98.0, O2 saturation (Sat O2) 98% on room air. P#1's ESI (triage) level was 3. At 8:41 p.m., the order for chest X-ray and blood work was completed. Further review of P#1's lab result revealed a White Blood Cell Count (WBC)- 5.21, Red Blood Cell count 8.61, Hemoglobin 18.0 (a protein in the blood that carries Oxygen), Hematocrit- 42.8, Platelets 316 (a type of blood cell that favors blood clot), Sodium of 143, Potassium Level, 4.5, and Carbon dioxide-22 (blood gas produced and expelled in respiration)- all of these laboratory results were normal. The			

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	other labs listed below were highlighted in the medical record as abnormal: Chloride of 109 (normal is 98-107), Glucose of 151 (normal is 70-99), Creatinine (a blood protein produced by normal body metabolism) of 0.67 (normal is 07-1.2), Total Calcium of 8.5 (normal is 8.6-10). P#1 had a 12-lead Electrocardiogram (EKG) performed at 8:47 p.m., and the impression indicated the EKG was abnormal. Review of the EKG report revealed a prolonged QTc (an abnormally long or short QTc interval is associated with an increased risk of developing abnormal heart rate and sudden cardiac death). Further review revealed that on 7/28/2921 at 9:21 p.m., the ED physician interpreted the EKG as" Rhythm as Sinus rhythm, Ectopy comments: none, Rate: normal, QRS axis- normal, ST segments: ST segment normal, T waves: T waves normal ...Other findings: prolonged QTc interval, Clinical Impression: Abnormal ECG." Review of the facility's on-call schedule verified that on 7/28/2021 that a Cardiologist was on call, once it was determined that patient's EKG was abnormal. There was no documentation in the medical record to indicate the Cardiologist on call was consulted by the ED physician to provide further evaluation and treatment of the abnormal EKG -prolonged QTc and syncope. Review of the ED notes revealed that on 7/28/2021 at 10:59 p.m., the ED RN documented, Pt #1 transported to the car in a wheelchair with the help of two RNs. Patient required assistance to stand and be placed in vehicle. Pt #1 stood and had a steady gait and then fell forward with controlled movement into car. RN's tried to aid into car with no success. Pt. #1's family member helping with getting him into car with the assistance of hospital security. Pt. Had purposeful movement throughout visit. The ED Nurse documented in the medical record that patient #1 fell into the car. There was no documentation in the medical record to			

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	indicate that the RN's notified the ED physician that patient #1 was experiencing difficulty with the ability to walk on his own, and that it required multiple persons to assist with getting the patient into his parents' vehicle. On 7/28/2021 Patient #1 was not stable at time of discharge A review of Emergency Department (ED) video tape dated 7/28/21, time stamped 10:49 p.m., revealed., P#1 was wheeled out of the ED via wheelchair to the family's vehicle by two nurses. At 10:52:39 p.m., one nurse walked away from P#1's vehicle and entered the ED. The same nurse returned carrying an unidentified object at 10:53:10 p.m. Both unidentified nurses walked away from P#1's vehicle at 10:53:25 p.m. A second security officer arrived 10:53:42 p.m. Continued review of the video footage, revealed the family of P#1 walked away from their car at 10:53:50 p.m., and reentered the ED. At 10:54:10 p.m., one unidentified security officer approached P#1's vehicle where he was observed leaning into the vehicle. At 10:54:55 p.m., the second officer walked around to the driver's side and leaned into the back seat of P#1's vehicle. P#1's family returned from the ED with a nurse and tech at 10:55:12 p.m. At 10:55:35 p.m., the security officer stepped away from the driver's side of the vehicle. At 10:55:38 p.m., P#1's family member walked to the vehicle's driver's side. At 10:56:14 p.m., a nurse and tech walked away from P#1's vehicle. At 10:56:18 p.m., the first security officer walked away from P#1's vehicle, followed by the second officer. At 10:56:40 p.m., P#1's family member was observed entering into the backseat of the vehicle. At 10:56:45 p.m. P#1's family was			

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	observed entering into the driver's seat of P#1 vehicle. At 10:56:55 p.m., P#1's family's vehicle was observed driving away from the ED. Patient #1's Death Summary report dated 8/1/2021 from Facility #2, where the patient was taken via privately owned vehicle by his parents on 7/28/2021, after leaving the Facility #1 (30.2 miles) was reviewed. Patient #1 was admitted to Facility #2 on 7/28/2021 at 11:41 p.m. Documentation by the physician revealed in part, "Patient #1 told his mom he was feeling better, but still very fatigue. Mom concerned took him back to the first hospital. On this visit an EKG and CXR (chest x-ray) were obtained. Mom was told everything was, just need to let COVID run its course, encourage fluids, then discharged home. He was lethargic, unable to walk, staff helped him get in the car and he was brought (to this hospital's ED) for further evaluation. Pt#1 was positive for fever and for vomiting." Facility #2's documentation revealed that patient #1 was emergently intubated on arrival to the ER and placed on mechanical ventilation due to his acute respiratory failure. On the initial assessment Patient #1 presented with seizures. The patient was given 1Liter of Normal Saline bolus and loaded with Celebrex and Keppra (medications used to treat seizures), and Ceftriaxone (an antibiotic). The patient was admitted to the hospital's Pediatric Intensive Care Unit for further care management. Infection Control was consulted (positive for Covid 19). Patient #1 received Decadron and Tocilizumab (medication used to treat Covid 19) on 7/29/2021. Hematology (physician who treats disorders of the blood) was consulted and Patient #1 was started on a Heparin Infusion (Blood thinner). Cardiovascular MD was consulted because the patient was on and off Vasopressors due to hypotension (medication used to treat abnormal Blood Pressure)/Shock. Medical record reviewed also revealed in part the following, "Neuro. . . No			

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	048-548	A. BUILDING B. WING	08/20/2021

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	further seizure reported after ICU admission. EEG (Electrocephalogram- test used to evaluate the electrical activity in the brain.) with severe background slowing. Neurology consulted. Stat CT (Computerized Tomography- process used to make detail pictures of internal organs and other structures) performed due to pupillary changes. CT revealed diffuse dural sinus thrombosis, deep venous thrombosis (blood clots) thrombosis of superficial cerebral (brain)veins along with diffused cerebral swelling ...impending herniation (Cerebral Herniation abnormal protrusion of brain tissue through an opening where there is increased intracranial pressure) was noted. Neurosurgery was consulted and placed on EVD (External ventricular Drain-device used to treat intracranial pressure) and ICP (intracranial Pressure) monitor at bedside. Pt. also with Diabetes Insipidus (a condition that results from an imbalance of water in the body, causes extreme thirst and excessive urination). The Summary of Demise revealed that Neurology performed on 7/31/2021 and 8/1/2021, a brain function examination followed by an apnea examination (Examination that requires medical staff to remove the patient from mechanical ventilation to evaluate if the patient can breathe on their own.) performed by critical care. The tests confirmed and demonstrated irreversible cessation of all brain activity in the cerebral (brain) hemispheres and brainstem. The results were discussed with the family. Patient #1 was pronounced dead on 8/1/2021 at 10:35 a.m. A phone interview with the family of P#1 on 8/18/21 at 12:18 p.m. revealed P#1 first arrived into the facility's ED on 7/25/21. The family of P#1 stated that P#1 developed a runny nose and congestion. P#1 attempted to clear the congestion by coughing, but the cough was not productive. P#1 was diagnosed with COVID-19 on 7/23/21. The family of P#1 stated P#1 was			

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	taken to the facility's ED on 7/25/21. The family of P#1 confirmed after P#1's evaluation at the ED, the physician revealed P#1 had pneumonia in both lungs and that the ED physician prescribed an inhaler, antibiotics, and steroids. P#1's family stated P#1 felt better. The family of P#1 revealed that on the evening of 7/26/21, P#1 complained of a headache. The family stated they told P#1 to get up and shower to go to the ED. The family stated when P#1 stood up, he fell back, and they called 911. The family stated paramedics arrived, started fluids on P#1, and transported him to the hospital. The family of P#1 explained that P#1 was slow to respond, and then P#1 did not respond. The family of P#1 confirmed the facility relayed that P#1's diagnosis was COVID-19 and dehydration. The family stated the nurse that cared for P#1 indicated that P#1 would feel better after receiving fluids. The family member of P#1 stated she told the nurses that she did not want P#1 discharged because P#1 could not walk. The family of P#1 reported she begged the hospital to keep P#1 at the facility. The family confirmed that P#1 was given Tylenol in a cup, but P#1 dropped it after it was placed in his hand. The family of P#1 stated they helped P#1 place the Tylenol in P#1's mouth. Family of P#1 stated she requested that P#1 receive liquid Tylenol because P#1 could not swallow the pills. The family of P#1 requested the patient be kept at the facility and asked if P#1 could be sent to a children's hospital because P#1 was not himself. The family of P#1 stated two male nurses assisted P#1 during discharge from facility #1 in placing P#1 into the family vehicle. The family of P#1 stated P#1's body was limp and shaking. The family of P#1 stated that the nurses told P#1 how to help assist himself into the vehicle. The family added that one of the nurses said that he could not hurt himself while he assisted P#1 into the vehicle and that nurse let go of P#1. When the nurse let P#1 go, P#1 fell face-first onto the car seat. The family of P#1 explained that both nurses left and went back			

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	into the facility. They stated they were going to find additional staff to assist P#1. The family of P#1 stated two security guards assisted them, they pulled P#1 into the car, while family of P#1 pulled from the other side. Family of P#1 stated they drove P#1 to a children's hospital from the first facility. Family of P#1 stated it took 25 minutes to arrive at the Facility #2 and that when they arrived with P#1 at the hospital , a nurse saw P#1 and ran back into the facility and returned with a stretcher and a medical team. Family of P#1 stated the nurse knew P#1 was having seizures. Family of P#1 reported P#1 continued seizing, then coded (a hospital code signifying a patient required immediate resuscitation to revive from his heart stopping) and was intubated (insertion of a tube into airway for ventilation) Pt#1 went straight to the Intensive Care Unit (ICU), and remained on a ventilator until P#1 expired on 8/1/21. Family of P#1 stated P#1 had swelling and blood clots on the brain due to Covid-19. During a phone interview with the ED physician (MD) BB on 8/19/21 at 9:00 a.m., MD BB said in the case of P #1, he was not tachypneic (a rapid and shallow breathing), P #1 was not in respiratory distress, P #1 ' s pulse was between 95-96, the breathing treatment administered in the ED worked, P #1 was already put on steroid, P #1 ' s chest X-ray was improving, P #1 ' s chief complaint was dehydration, they gave him IV fluids, P #1 ' s vital signs were normal, P #1 improved with fluid administration, he was sitting in the bed and talking to him. MD BB said because the patient was stable, P #1 ' s complaint of headache and chest pain did not worry him, MD BB said P #1 with dehydration had body aches. MD BB said P #1 ' s labs were "benign " and P #1 ' s vital signs were stable on discharge. During a second phone interview with ED Physician, MD BB on 8/20/21 at 10:10 a.m. MD BB was asked about the abnormal EKG reading for P #1. MD BB said the Prolonged QT observed in P #1 ' s EKG was common finding; and that the EKG was abnormal because of the prolonged QT but that			

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	was not something dangerous. MD BB stated such finding was common in all age groups and the finding did not have a whole lot of clinical significance. MD BB said in the case of P #1 the prolonged QT did not require further investigation. MD BB said the chest pain in a 17-year-old patient P #1 was just body ache. MD BB stated that there was no difference in treatment for a vaccinated versus an unvaccinated patient infected with Covid; it was just the same. MD BB said that treatment was still consisted of fluid therapy and steroid. MD BB said the last time he saw P #1, he was alert, oriented, and stable and that he was not made aware of any change in P #1 ' s condition. During a phone interview with the (ED) Registered Nurse (RN) DD on 8/19/21, at 2:15 p.m. in the facility conference room, RN DD stated he remembered P#1 because he came to the ED after he had passed out in the shower at home. RN DD further explained, he recalled P#1 was positive for COVID-19 and dehydrated. RN DD stated that P#1 was given two liters of intravenous (IV) fluids and discharged. RN DD stated that he recalled P#1 complained of a headache and chest tightness before discharge. RN DD said he informed MD BB. RN DD said MD BB ordered Tylenol. RN DD further stated he proceeded to administer the Tylenol to P#1, and observed P#1 could not swallow it. RN DD recalled that P#1's family member stated that P#1 had difficulty swallowing pills. RN DD further explained that he broke the Tylenol tablet up and tried to administer it to P#1 with water, but P#1 spit the medication back out. RN DD stated that after several attempts, P#1 was able to swallow some of the Tylenol. RN DD said he usually asked a patient if they would prefer the liquid form, but he was unsure why he did not do this for P#1. RN DD did not recall P#1's family member asking for the Tylenol in liquid form. RN DD stated he observed that MD BB walked into P#1's room after RN DD had administered the Tylenol. RN DD stated that he was not in P#1's room when MD BB entered. RN DD stated that he recalled P#1's family			

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	member requested that P#1 be admitted to the hospital. RN DD said that he informed MD BB of the family's request, but the facility did not approve the request because P#1 did not meet the admission criteria for COVID. RN DD further explained the criteria for COVID-19 admission were based on a patient's inability to maintain their oxygenation levels. During an interview with Security Officer (SO) (QQ) on 8/19/21 at 4:15 p.m. in the conference room, SO QQ recalled he walked outside the ED when he saw another officer standing by the vehicle. SO QQ noted that P#1 was not able to stand and appeared very sick. SO QQ observed that the family member was helping P#1 into the car by wrapping his/her arms around P#1's waist to assist with maneuvering patient into the vehicle. SO QQ further observed that P#1 could not sit in the vehicle without sliding off the seat. SO QQ stated he went around to the other side of the vehicle and helped maneuver P#1 into the car. SO QQ stated that he observed that P#1 could not offer any assistance in helping himself into the vehicle. SO QQ added that the family had to lift P#1 into the vehicle. SO QQ explained that after the family of P#1 got him into the vehicle, the family had to place P#1 in an upright position. SO QQ stated he observed that P#1's eyes were open, but were not moving and he was not talking. P#1 did not respond to anything going on around him, and he was alert and oriented. SO QQ said that the nurses had gone back into the hospital. SO QQ explained that he asked P#1's family if they were sure they wanted to leave the facility. The family indicated they were determined to take P#1 to another facility. A review of the facility's Medical Staff Bylaws revealed that organized medical staff was accountable to the Board of Trustees for the safety, quality, and efficiency of patient care. The organized medical staff were to provide patients with safe, high-quality care that met acceptable standards.			

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	A review of the policy # LD-108" Emergency Medical Treatment and Labor Act-EMTALA", reviewed October 2018, revealed the facility, in the case of an individual who was determined to have an emergency medical condition such further medical examination and treatment as was required to "stabilize" the emergency medical condition. Further review of the policy revealed the meaning of "Stabilize or Stabilized" as "with respect to an emergency medical condition, that no material deterioration of the condition was likely, within reasonable medical probability, to result from or occur during the transfer or discharge of the individual from the facility. The facility failed to provide stabilizing treatment as required for patient #1 on 7/28/2021 within the full capabilities of its staff and facility including access to a specialist on-call. By discharging Patient #1 on 7/28/2021 stabilization of his care was delayed.			