Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203

Northeast Division of Survey & Certification

July 12, 2018

Mr. Peter Holden, President & CEO
St Mary's Regional Medical Center
93 Campus Avenue - PO Box 291
Lewiston, ME 04243

**RE: CMS Certification Number: 200034**
**Survey ID SJWM11, 05/22/2018**
**Initial Notice of Termination**

Dear Mr. Holden:

To participate in the Medicare program, a hospital must meet the requirements established under Title XVIII of the Social Security Act (the Act) and the regulations established by the Secretary of Health and Human Services under the authority contained in §1861(e) of the Act. Medicare-participating hospitals must meet the provisions under § 1867 of the Social Security Act, or the Emergency Medical Treatment and Labor Act (EMTALA), along with the implementing regulations found at 42 C.F.R. § 489.20 and 489.24. Further, §1866(b) of the Act authorizes the Secretary to terminate the Medicare provider agreement of a hospital that fails to meet these provisions.

Your hospital was surveyed on May 22, 2018 by the Department Of Health And Human Services based on an allegation of noncompliance with the requirements of 42 C.F.R. §489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases and/or the related requirements at 42 C.F.R. §489.20. After a careful review of the findings, we have determined that your hospital violated the requirements at 42 C.F.R. §§489.20 and 489.24.

The deficiencies identified are listed on the enclosed Form CMS-2567, Statement of Deficiencies and Plan of Correction.

Under 42 C.F.R. §489.53, a hospital that violates the provisions of 42 C.F.R. §489.20 or 42 C.F.R. §489.24 is subject to termination of its provider agreement. Consequently, we plan to terminate St Mary's Regional Medical Center's participation in the Medicare program. The projected date on which your agreement will terminate is **October 10, 2018**.

You will receive a "Notice of Termination Letter" on or before September 25, 2018. This final notice will be sent to you concurrently with notice to the public, in accordance with 42 C.F.R. §489.53.

You may avoid termination action and notice to the public by correction of the deficiencies, through submission of an acceptable plan of correction and subsequent verification of compliance by the State Survey Agency. An acceptable plan of correction by the hospital requires a resurvey prior to the projected termination date, and must be received by this office as soon as possible, to permit timely resurvey to verify the corrections. If we verify your corrective action and you are in substantial compliance with requirements for hospitals participating in the Medicare program, your planned termination from the Medicare program will be rescinded.

The Form CMS-2567 with your plan of correction, dated and signed by your facility's authorized representative, must be submitted to CMS no later than July 27, 2018. Please indicate your corrective actions on the right side of the Form CMS-2567 in the column labeled "Provider Plan of Correction", keying your responses to the deficiencies on the left. Additionally, indicate your anticipated completion dates in the column labeled "Completion Date". Please send your plan of correction to the *State of Maine, State Survey Agency and the Boston Regional Office:*

*CMS (By Mail)*
Charles Marino
Centers for Medicare & Medicaid Services
Division of Survey & Certification
JFK Federal Building, Room 2350
Boston, MA 02203

An acceptable plan of correction must contain the following elements:

1. The plan for correcting each specific deficiency cited;
2. Efforts to address improving the processes that led to the deficiency cited;
3. The procedure for implementing the acceptable plan of correction for each deficiency cited;
4. A completion date for correction of each deficiency cited (Note: The correction dates on the plan of correction must be no later than 45 calendar days from the date of this letter)
5. Procedures for monitoring and tracking to ensure that the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
6. The title of the person responsible for implementing the acceptable plan of correction.

Copies of the Form CMS-2567, including copies containing the facility's plan of correction, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 C.F.R. § 401.133(a). As such, the plan of correction should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names. It must, however, be specific as to what corrective action the hospital will take to achieve compliance, as indicated above.

If your Medicare agreement is terminated and you do not believe this termination decision is correct, you may request a hearing before an Administrative Law Judge (ALJ) of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in regulations at 42 C.F.R. Part 498. An appeal/request

for hearing must be filed no later than sixty (60) calendar days from the date of receipt of the initial notice of termination.

You must file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov, unless you have received approval from the Civil Remedies Division (CRD) to file in hardcopy. It is important that you also send a copy of your request for hearing to this office to the attention of: Survey Branch, Northeast Consortium Division of Survey & Certification, Centers for Medicare and Medicaid Services (CMS), JFK Federal Building, Room 2275, Government Center, Boston, MA 02203. A request for a hearing should identify the specific issues, the findings of fact and the conclusions of law, if applicable, with which you disagree. You may be represented by counsel at a hearing at your own expense.

If you have any questions concerning this letter, please contact Charles Marino at 617-565-1328.

Sincerely,

Lauren D. Reinersten, M.P.A, Ph.D
Associate Regional Administrator
Northeast Division, Survey & Certification

Enclosure: Form CMS-2567, Statement of Deficiencies

CC: Maine State Agency
DNV GL
QIO
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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 |
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| **ST MARY'S REGIONAL MEDICAL CENTER** | **93 CAMPUS AVENUE - PO BOX 291 LEWISTON, ME 04243** |

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| A 000 | INITIAL COMMENTS<br><br>EMTALA Complaint #27863<br>Survey Dates: 5/14/18 to 5/18/18 and 5/21/18 to 5/22/18<br><br>St. Mary's Regional Medical Center is not in compliance with 42 Code of Federal Regulation Part 489 Responsibilities of Medicare Participating Hospitals in Emergency Cases. The following requirements have not been met: | A 000 | | |
| A2405 | EMERGENCY ROOM LOG<br>CFR(s): 489.20(r)(3)<br><br>[The provider agrees,] in the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain a central log on each individual who comes to the emergency department, as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.<br><br>§489.24 The provisions of this regulation apply to all hospitals that participate in Medicare and provide emergency services.<br><br>This STANDARD is not met as evidenced by:<br>Based on record reviews and interviews, the hospital failed to ensure that the central log contained the name of an individual, who was seeking medical attention, for 1 of 1 identified incidents (November 6, 2017).<br><br>Finding:<br><br>The Division of Licensing and Certification | A2405 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| A2405 | Continued From page 1<br>received information that Individual #2 went to the hospital on three occasions on November 6, 2017 seeking medical treatment. On the third occasion, the individual was not seen by clinicians and was arrested for criminal trespass when he/she went to the hospital's Emergency Department (ED) seeking treatment.<br><br>A review of the emergency central log indicated that Individual #2 presented to the ED on November 6, 2017 at 4:36 PM and at 9:11 PM. There was no evidence on this emergency central log that the individual presented a third time on November 6, 2017.<br><br>The surveyor requested all security documentation for November 6 and November 7, 2017. The surveyor was provided a "Special Project Report", authored on November 7, 2017 at 12:29 AM by Security Officer #1, that had a check mark beside "disorderly conduct arrest" and under the comment section it indicated "[Individual #2's name] taken to jail for Criminal Trespass". No other information was documented on this report.<br><br>On May 21, 2018 between 3:45 PM and 3:53 PM, a surveyor interviewed Security Officer #1 via telephone. He indicated that the only unlocked entrance to the hospital between the hours of 8:00 PM and 5:00 AM was the ED entrance. He also indicated that calls to the police department were documented in the "Special Project" section in the shift log and that documentation would indicate that police were called, the time they were called, and the reason why the call was made. He did not recall calling the police on November 6, 2017 regarding an individual with the first name of Individual #2. | A2405 | | |

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| A2405 | Continued From page 2<br><br>On May 22, 2018, the surveyor was given a "Round Report", dated November 6, 2017 from 7:00 PM to 5:00 AM. This report indicated the following: Individual #2 "was discharged again and is now sitting in the waiting room. I talked to [Charge Nurse's name] who requested that [he/she] be asked to leave. I followed [him/her] and told [him/her] [he/she] needed to leave the property and [he/she] eventually did, but [he/she] came back and tried to get into the hospital again. I blocked [his/her] path and [he/she] became very caustic, so I called LPD [Lewiston Police Department], and they eventually took [him/her] to jail when [he/she] refused to leave. This ordeal took about an hour ..."<br><br>There was no evidence provided by the hospital to indicate that Individual #2 was not entering the building for the purpose of seeking medical treatment at the ED.<br><br>On May 22, 2018 at 9:08 AM, a surveyor reviewed the "Round Report" with the Director of Emergency Services. He stated he "did not believe [he/she] was coming back for treatment." When asked if there was any evidence that the individual was not coming back for treatment, he responded by saying "it doesn't indicate [he/she] was".<br><br>An affidavit, dated November 7, 2017, indicated the following: On November 6, 2017 at 11:25 PM, an Officer responded to St. Mary's Hospital for "a report of a criminal trespass. St. Mary's Security called in the complaint and advised that a [Individual #2's name and birth date] was at the hospital swearing and causing a disturbance. 911 dispatch advised that [individual's first name] had | A2405 | | |

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| A2405 | Continued From page 3<br>already been escorted out of the ER several times and they wanted [him/her] removed from the property." The officer indicated he verified the identity of the individual with the Supervisor of Security. The Supervisor "advised he needed [individual #2's first name] off the property and wanted a Criminal Trespass warning issued to [Individual #2's first name]." Individual #2 was placed under arrest and transported to the local jail. | A2405 | | |
| A2406 | MEDICAL SCREENING EXAM<br>CFR(s): 489.24(a) & 489.24(c)<br><br>Applicability of provisions of this section.<br>(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<br><br>(b) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for | A2406 | | |

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| A2406 | Continued From page 4<br>further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.<br><br>(2) Nonapplicability of provisions of this section. Sanctions under this section for inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.<br><br>(c) Use of Dedicated Emergency Department for Nonemergency Services<br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on record reviews and interviews, the hospital failed to provide an appropriate medical examination for 4 of 31 patient records reviewed | A2406 | | |

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| A2406 | Continued From page 5<br>(Patient record #2C, #3C, #11, and #13).<br><br>Findings:<br><br>1. A review of the hospital medical records for Patient #2 indicated that an Emergency Department (ED) visit occurred on 11/2/17 for a psychiatric condition that warranted admission and inpatient treatment. However, Patient #2 refused inpatient admission and was discharged.<br><br>On 11/5/17, Patient #2 returned with a complaint of abdominal pain, he/she was assessed, and treated. It was noted that the patient was homeless and had been off his/her prescribed psychiatric medications for one week. The patient was discharged with prescriptions for new medications related to his/her complaint and a discharge plan that included instructions to return to the ED if he/she developed suicidal ideation.<br><br>On 11/6/17 at 4:08 PM, Patient #2 returned to the hospital requesting evaluation. The patient was seen by an ED Physician and a Psychiatric Nurse Practitioner (PNP). The patient's ED medical record (2C) indicated the following: the chief complaint was "I need to get back on my meds"; the patient was homeless; he/she had been off his/her medications; he/she had a history of borderline personality disorder, anxiety, and post-traumatic stress disorder; he/she had indicated that he/she had been sick with a cough with yellow phlegm as well as frequent episodes of nausea and vomiting for three days prior to hospital arrival; he/she denied suicidal or homicidal ideations or hallucinations; and the patient had a history of aggressive behavior towards staff and was no longer permitted on the inpatient psychiatric unit at this hospital for this | A2406 | | |

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| A2406 | Continued From page 6 | A2406 | | |

reason.

Documentation, electronically signed by the PNP at 6:23 PM, indicated the following: the patient had a long history of polysubstance abuse, borderline personality disorder, self-injurious behavior, and recent diagnosis of bipolar disorder during his/her most recent hospitalization, as well as lower intellectual functioning; he/she was no longer allowed as an inpatient at this hospital after assaulting staff during his/her last admission in December 2015; he/she had been off all of his/her medication for the past week; and he/she made several conflicting statements about whether he/she had access to his/her medications. The PNP documented that, "there is nothing in his/her presentation that suggests that he/she is experiencing acute withdrawal from substance or mental health crisis and he/she is likely seeing alternative to sleeping outdoors as he/she had been kicked out of local he/shelters".

Documentation indicated the patient departed the hospital on 11/6/18 at 6:36 PM.

On 11/6/18 at 8:36 PM, Patient #2 returned to the ED for complaints of nausea, vomiting, and diarrhea for one week and bilateral leg numbness. He/she was evaluated and documentation indicated the patient departed the hospital on 11/6/18 at 10:18 PM.

On 11/6/17 sometime between departing at 10:18 PM and 11:25 PM, Patient #2 attempted to enter the hospital, via the ED entrance, was prevented from entering by a Security Officer, and subsequently was arrested.

A review of jail records indicated that Patient #2

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| A2406 | Continued From page 7 | A2406 | | |

was booked into jail on 11/7/17 at 12:27 AM for trespassing. Documentation on 11/7/18 indicated Patient #2 was seen by a mental health representative; per the mental health representative, the individual was placed on suicide watch "due to the individual's deteriorating mental stability"; the nurse at the jail assessed Patient #2 at the jail and determined that he/she was "highly delusional and incapable of expressing a lucid thought that was trustworthy"; was cooperative but "completely unaware of [her/his] surroundings or situation"; and yelling that he/she thought the jail was going to burn down. On 11/8/17, documentation indicated that the individual was screaming incoherent thoughts; yelling "that [his/her] back is broken, please help me, I have fallen four floors, I'm dying, please help me"; and was naked and banging. On 11/8/17, a mental examination was court ordered to determine the individual's competency and the individual was committed to a psychiatric hospital for observation, evaluation, and treatment.

Based on the above information, Patient #2's psychiatric condition was not adequately assessed at the hospital and his/her condition was not stabilized before being arrested.

2. On 12/21/17 at 10:25 PM, Patient #3C was brought to the hospital ED after he/she made a statement to police - "I have problems and I want to kill myself. I want to go to St. Mary's."

At 10:33 PM, the triage nurse documented the following: "Officer reports that they have warned [Patient #3C] about behavior expectations in B-ED [Behavioral Emergency Department], that any issues they are called on they come and

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| A2406 | Continued From page 8 | A2406 | | |

arrest for Disorderly Conduct."; the patient was "loud, singing, obnoxiously swearing"; and the patient had an unsteady gait, intermittent cognition, slurred, loud, inappropriate oral expressions, and poor impulse control.

At 10:38 PM, five minutes after the triage nurse's documentation, the ED Physician documented the following: the patient is intoxicated with a hospital breathalyzer reading of 0.197 (results of 0.008 indicating a person is legally to impaired to operate motor vehicles in Maine); the patient had normal gait and speech and denied suicidal thoughts despite police stating that Patient #3C had stated he/she was suicidal to police; the patient "is threatening violence to staff and putting his/her hands on staff and police have been contacted and he/she is arrested."

At 10:58 PM, the nurse documented, in the teaching record section, that the discharge instructions were given and the patient's response was "reinforcement needed, unable to comprehend."

There was no evidence in the medical record to demonstrate that the discrepancies in the nurse and physician assessments were reconciled and no evidence that this patient, with a tested alcohol level exceeding twice the legal limit, was capable of appropriate participation in a comprehensive medical and psychological screening exam related to the statement made to police that he/she wanted to kill himself.

A review of documentation obtained from the jail denoted that Patient #3C was arrested at the hospital for "disorderly conduct, loud unreasonable noise" and that he was heavily

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| A2406 | Continued From page 9<br>intoxicated, depressed and placed on suicide watch.<br><br>3. Documenation in patient #11's record indicated that on 5/2/18 at 1:41 AM, he/she arrived at the hospital, via the police, for "jail clearance".<br><br>The patient's record indicated the following: the patient had a past history of depression; he/she had told people that he/she was going to jump off the bridge; he/she drove his/her car onto a bridge blocking traffic; he/she called 911; and after a two hour search by police the patient was found at a store. The patient indicated that he/she had right rib pain, an abrasion was noted, and he/she was suicidal on a daily basis for many years and he/she was currently suicidal.<br><br>Documentation electronically signed by the ED Physician, on 5/2/18 at 1:54 AM, indicated the following: the patient was "not very communitive on arrival and will not discuss whether [he/she] is truly feeling suicidal or it is was a prank"; he/she was described "uncooperative"; he/she was medically cleared at this time; he/she would be discharged to police custody; 15 minute suicide checks were recommended and an evaluation by mental health professional prior to be being released from jail.<br><br>The patient was discharged to police custody on 5/2/18 at 2:05 AM<br><br>There was no evidence in the patient's record that indicated the patient's mental health status was adequately assessed while at the ED.<br><br>A review of documentation from the jail indicated that Patient #11 had told family and 911 that | A2406 | | |

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| **ST MARY'S REGIONAL MEDICAL CENTER** | **93 CAMPUS AVENUE - PO BOX 291 LEWISTON, ME 04243** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| A2406 | Continued From page 10<br>he/she was going to commit suicide; he/she wrote a suicide letter and staged scene; he/she was thinking of killing himself; he/she recently had experienced a significant loss; he/she was feeling hopeless and had nothing to look forward to; he/she stated that he/she has been hearing voices for a little while now; and the patient was seen by a mental health worker at the jail who indicated that the patient was to remain on suicidal watch and if he/she was released from court he/she should be driven to St. Mary's Hospital. On 5/3/18, the patient was released on his/her own recognizance and the court order indicated the following: the patient was to go to "St. Mary's or whatever placement set by MPT [Maine Pretrial Services]. Def [Defendent] to have psychological evaluation and follow any other restrictions set by Maine Pretrial Services."<br><br>4. On 5/14/18 at 10:10 AM, Patient #13 arrived at the hospital, via Emergency Medical Services, for a medication overdose and suicide attempt.<br><br>The patient's record indicated that he/she received medical testing and diagnostic workups to address the overdose. At 2:41 PM, the ED Physician documented "[He/she] is now medically cleared for further management by Psychiatric Services."<br><br>At 2:47 PM, all cardiac and vital sign monitoring devices were removed and the patient was moved to the secure area of the ED, which was designated by the hospital as the Behavioral ED (BED).<br><br>Between 2:47 PM and 4:28 PM, there was no documentation related to this patient's status. | A2406 | | |

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| A2406 | Continued From page 11<br>At 4:28 PM, the ED Physician documented the patient "became violent and agitated and threw a chair .... Police were called. [He/She] was then arrested and will be taken to jail. [He/She] has no acute medical issues at this time and is medically cleared for treatment in jail."<br><br>On 5/21/18 at 1:09 PM, the PNP, who was working in the BED on 5/14/18, was interviewed. She informed surveyors that Patient #13 had not been seen or evaluated by either herself or the other PNP. The PNP stated that they were aware of this patient, the BED was extremely busy, and they simply had not gotten to Patient #13 before he/she escalated and was arrested.<br><br>Based on the physician documentation that the patient required further management by psychiatric services, no documented evidence that these services were provided, and the interview with the PNP who confirmed the patient did not receive psychiatric services, this patient did not receive an adequate medical screening or treatment before the police were called and the patient being arrested and taken to jail.<br><br>A review of documentation from the jail indicated that Patient #13 was cooperative at the time of arrest and that he/she stated he/she was suicidal and was placed on "hi suicide watch." | A2406 | | |
| A2407 | STABILIZING TREATMENT<br>CFR(s): 489.24(d)(1-3)<br><br>(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 | A2407 | | |

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| A2407 | Continued From page 12<br>condition, the hospital must provide either-<br>(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.<br>(ii) For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section.<br><br>(2) Exception: Application to inpatients.<br>(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<br>(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.<br>(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.<br><br>(3) Refusal to consent to treatment.<br>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 | A2407 | | |

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| A2407 | Continued From page 13 | A2407 | | |

description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

This STANDARD is not met as evidenced by:
Based on record reviews and interviews, the hospital failed to ensure patients received stabilizing treatment for 3 of 4 patients who were arrested at hospital (Patient Record #1C, #2C, and #13).

Findings:

1. Documentation in Patient #1C's medical record indicated that this patient walked into the Emergency Department (ED) on 11/4/17 at 3:36 PM and stated, "I want to find a safe way to kill myself."

A psychiatric consultation was completed on 11/4/17 at 4:34 PM by a Psychiatric Nurse Practitioner (PNP). The documentation, by the PNP, indicated the following: the patient's "affect was irritable and challenging, mood is challenging and extremely irritable. Thought process is tangential and somewhat paranoid, some grandiosity noted. ... Patient endorses SI [suicidal ideation] but refuses to discuss whether she has a plan, makes threats of violence but no overt homicidal ideation." The documentation indicated that patient's principal diagnosis was "bipolar disorder, manic, severe"; an EIC [Emergency Involuntary Criteria] would be

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| A2407 | Continued From page 14<br>initiated for safety; and the hospital's inpatient psychiatric unit was full. Crisis Agency #1 was contacted for disposition.<br><br>On 11/4/17 at 4:49 PM, a Registered Nurse (RN) documented the following: the patient was "immediately agitated upon arriving on the unit ...Pt [patient] was redirected numerous times and [he/she] would not follow staff instructions ...Pt was asked to go to a room voluntary in which she responded, "I have not broken any laws you can't make me do anything." At this time, local police were in the milieu with another patient and they assisted staff in escorting Patient #1C to a room. The patient became more aggressive and was placed on the bed by police and cuffs were placed on the patient. A psychiatric emergency was initiated and Patient #1C was given medications by injection.<br><br>On 11/4/17 at 5:39 PM, Patient #1C was "medically cleared for the BH eval/dispo [Behavior health evaluation/disposition]" by an ED Physician. This meant that the patient would move from the medical side of the ED to the Behavioral ED side of the ED.<br><br>On 11/5/17 at 3:07 AM, a RN documented the patient was hyperverbal in the milieu, agitated, swearing, and not redirectable.<br><br>At 3:15 AM, a RN documented that the patient was causing "severe milieu disruption"; was yelling and swearing at peers and upsetting others; he/she tells staff that he/she will sue the hospital; he/she tells staff that he/she can not go to jail, for he/she is suicidal; and he/she is not redirectable. The local police are called for assistance. The ED physician came to the area | A2407 | | |

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and attempted to deescalate the patient but was unable to. The police arrived and the patient was medically and psychiatrically cleared for incarceration.

Documentation, electronically signed by a different ED Physician on 11/5/17 at 3:50 AM, indicated the following: the patient became disruptive in the milieu; attempts were made to de-escalate; the patient became antagonistic and aggressive towards other patients and staff; he/she threatened physical violence and was verbally assaultive; and the patient was "given the choice of de-escalating returning to locked door or going to jail. [He/she] opted to go to jail." This document also indicated that the primary clinical impression was suicidal ideations.

This patient had been assessed to be in psychiatric crisis and in need of involuntary psychiatric admission, yet the hospital gave him/her a choice of disposition. Giving an individual a choice of disposition when he/she is in need of involuntary psychiatric admission indicates the hospital failed to stabilize the patient's psychiatric condition prior to his/her release. The patient was escorted out of the hospital and on 11/5/17 at 3:30 AM in the custody of law enforcement.

On 11/6/17 at 6:51 PM, Patient #1C was found wandering the streets in a bathrobe and bedroom slippers yelling and was returned to the hospital ED by police.

On 5/17/18 at approximately 3:30 PM an interview was conducted with the ED Physician responsible for Patient #1C's discharge, the Vice President of Emergency Services/Physician A,

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| A2407 | Continued From page 16<br>and the Director of Psychiatric Inpatient Services/Physician B. Although the physician responsible for the discharge of Patient #1C stated that the patient was "not manic at time of discharge," she agreed that she did not document this in the record. In addition, the physicians agreed that 'this was not a positive outcome for this patient."<br><br>2. A review of the hospital medical records for Patient #2 indicated that a ED visit occurred on 11/2/17 for a psychiatric condition that warranted admission and inpatient treatment. However, Patient #2 refused inpatient admission and was discharged.<br><br>On 11/5/17, Patient #2 returned with a complaint of abdominal pain, he/she was assessed and treated. It was noted that the patient was homeless and had been off his/her prescribed psychiatric medications for one week. The patient was discharged with prescriptions for new medications and a discharge plan that included instructions to return to the ED if he/she developed suicidal ideation.<br><br>On 11/6/17 at 4:08 PM, Patient #2 returned to the hospital requesting evaluation. The patient was seen by a ED Physician and a PNP. The ED medical record (2C) indicated the following: the chief complaint was "I need to get back on my meds"; the patient was homeless; he/she been off his/her medications; he/she had a history of borderline personality disorder, anxiety, and post-traumatic stress disorder; he/she had indicated that he/she had been sick with a cough with yellow phlegm as well as frequent episodes of nausea and vomiting for three days prior to hospital arrival; he/she denied suicidal or | A2407 | | |

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| A2407 | Continued From page 17<br>homicidal ideations or hallucinations; and the patient had a history of aggressive behavior towards staff and was no longer permitted on the inpatient psychiatric unit at this hospital for this reason.<br><br>Documentation, electronically signed by the PNP at 6:23 PM, indicated the following: the patient had a long history of polysubstance abuse, borderline personality disorder, self-injurious behavior, and recent diagnosis of bipolar disorder during his/her most recent hospitalization, as well as lower intellectual functioning; he/she was no longer allowed as an inpatient at this hospital after assaulting staff during his/her last admission in December 2015; he/she had been off all of his/her medication for the past week; and he/she made several conflicting statements about whether he/she had access to his/her medications. The PNP documented that, "there is nothing in his/her presentation that suggests that he/she is experiencing acute withdrawal from substance or mental health crisis and he/she is likely seeing alternative to sleeping outdoors as he/she had been kicked out of local he/shelters".<br><br>Documentation indicated the patient departed the hospital on 11/6/18 at 6:36 PM.<br><br>On 11/6/18 at 8:36 PM, Patient #2 returned to the ED for complaints of nausea, vomiting, and diarrhea for one week, and bilateral leg numbness. He/She was evaluated and documentation indicated the patient departed the hospital on 11/6/18 at 10:18 PM.<br><br>On 11/6/17 sometime between departing at 10:18 PM and 11:25 PM, Patient #2 attempted to enter the hospital, via the ED entrance, hs/she was | A2407 | | |

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stopped by security, and was subsequently arrested.

A review of jail records indicated that Patient #2 was booked into jail on 11/7/17 at 12:27 AM for trespassing. Documentation on 11/7/18 indicated Patient #2 was seen by a mental health representative; per the mental health representative, the individual was placed on suicide watch "due to the individual's deteriorating mental stability"; the nurse at the jail assessed Patient #2 at the jail and determined that the he/she was "highly delusional and incapable of expressing a lucid thought that was trustworthy"; was cooperative but "completely unaware of [her/his] surroundings or situation"; and yelling that he/she thought the jail was going to burn down. On 11/8/17, documentation indicated that the individual was screaming incoherent thoughts; yelling "that [his/her] back is broken, please help me, I have fallen four floors, I'm dying, please help me"; and was naked and banging. On 11/8/17, a mental examination was court ordered to determine the individual's competency and the individual was committed to a psychiatric hospital for observation, evaluation and treatment.

Based on the above information, Patient #2's psychiatric condition was not adequately assessed at the hospital and his/her condition was not stabilized before being arrested.

3. On 5/14/18 at 10:10 AM, Patient #13 arrived at the hospital, via Emergency Medical Services, for a medication overdose and suicide attempt.

The patient's record indicated that he/she received medical testing and diagnostic workups

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to address the overdose. At 2:41 PM, the ED Physician documented "[He/she] is now medically cleared for further management by Psychiatric Services."

At 2:47 PM, all cardiac and vital sign monitoring devices were removed and the patient was moved to the secure area of the ED, which was designated by the hospital as the Behavioral ED (BED).

Between 2:47 PM and 4:28 PM, there was no documentation related to this patient's status; therefore, no evidence of continued monitoring during this time.

At 4:28 PM, the ED Physician documented the patient "became violent and agitated and threw a chair .... Police were called. [He/She] was then arrested and will be taken to jail. [He/She] has no acute medical issues at this time and is medically cleared for treatment in jail."

On 5/21/18 at 1:09 PM, the PNP, who was working in the BED on 5/14/18, was interviewed. She informed surveyors that Patient #13 had not been seen or evaluated by either herself or the other PNP. The PNP stated that they were aware of this patient. The BED was extremely busy and they simply had not gotten to Patient #13 before he/she escalated and was arrested.

Based on the physician documentation that the patient required further management by psychiatric services, no documented evidence that these services were provided, and the interview with the PNP who confirmed the patient did not receive psychiatric services, this patient did not receive an adequate medical screening or

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| A2407 | Continued From page 20<br>treatment before the police were called and the patient being arrested and taken to jail.<br><br>A review of documentation from the jail denoted that Patient #13 was cooperative at the time of arrest and that he/she stated he/she was suicidal and was placed on "hi suicide watch." | A2407 | | |