

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

PRINTED: 07/06/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>280119</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/14/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>WINNEBAGO IHS HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>HWY 77-75 WINNEBAGO, NE 68071</b>		
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A 000	<p><b>INITIAL COMMENTS</b></p> <p>An entrance conference was conducted with the management staff of the hospital on May 12, 2015. The members of the Federal survey team were introduced including the areas of responsibility for each team members. The purpose of the visit (follow-up survey of all deficiencies cited during the November 6, 2014, survey, a complaint survey and CLIA) was explained.</p> <p>The hospital had the following surveys completed by Federal surveyors from CMS Region VII that cited non-compliance:</p> <ol style="list-style-type: none"> <li>1. A recertification survey on October 14, 2011, and cited non-compliance on nine (9) Conditions of Participation: Governing Body, Patients' Right, Quality Assessment and Performance Improvement, Medical Staff, Nursing Services, Radiological Services, Infection Control, Organ/Tissue/Eye, and Emergency Services.</li> <li>2. A Complaint survey was conducted on April 25, 2014, which resulted in an Immediate Jeopardy citation on the Condition of Participation for Nursing Services.</li> <li>3. A follow-up survey was completed on May 15, 2014, which resulted in a continuing Immediate Jeopardy citation on the Condition of Participation for Nursing Services.</li> <li>4. Another follow-up survey was conducted on July 17, 2014, which resulted in a continuing Immediate Jeopardy citation on the Condition of Participation for Nursing Services.</li> </ol>	A 000			

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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A 000	<p>Continued From page 1</p> <p>5. An EMTALA complaint survey was conducted on August 27, 2014, which resulted in Immediate Jeopardy citation on Medical Screening Examination and Stabilizing Treatment requirements.</p> <p>Survey jurisdiction of this hospital was transferred to Region VI in September 2014.</p> <p>6. Another follow-up survey was conducted on November 6, 2014, which resulted in non-compliance findings of four (4) Conditions of Participation: Governing Body, Nursing Services, Food &amp; Dietetic Services, and Emergency Services.</p> <p>An exit conference was conducted on May 14, 2015. In attendance onsite were the leadership staff of the hospital including Laboratory staff and some Great Plains IHS Area staff, and via telephone conference line were staff from the Great Plains IHS Area office and IHS HQ in Rockville, MD.</p> <p>The general nature of the preliminary findings were presented and 2 specific examples were discussed. The attendees were informed that the finalization of the survey findings will be dependent on when an advisory opinion from the Quality Improvement Organization is recieved on numerous cases.</p> <p>Based on the survey findings, the following Conditions of Participation and EMTALA</p>	A 000			

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A 000	Continued From page 2 requirements were found out of compliance:  42 CFR 482.12 Governing Body 42 CFR 482.23 Nursing Services 42 CFR 482.54 Outpatient Services 42 CFR 482.55 Emergency Services 42 CFR 489.24(a) and (c) Appropriate Medical Screening Examination 42 CFR 489.24(d) Stabilizing Treatment 42 CFR 489.24(e) Appropriate Transfer  The failure of the Governing Body to effectively discharge its oversight responsibilities on the services provided to patients, and the failure of the hospital staff to provide appropriate assessment of patients' condition and/or provide appropriate stabilizing treatments was deemed an IMMEDIATE JEOPARDY situation that exposed all patients of this hospital with the likelihood of serious harm, injury, or death.	A 000			
A 043	482.12 GOVERNING BODY  There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...  This CONDITION is not met as evidenced by: The Governing Body failed to discharge its oversight responsibilities effectively to ensure that patients coming to this hospital were provided appropriate care in accordance with accepted standards of practice. Such failure created a situation of immediate jeopardy to the health and	A 043			

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A 043	<p>Continued From page 3</p> <p>safety of all patients who come to this hospital for medical care.</p> <p>Review of the incident reporting system with hospital staff showed deficient practices and medical errors were reported but, because of the ineffective Governing Body oversight, such practices were allowed to continue that resulted in the likelihood of serious harm, injury and even death</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The Director of Nurses failed to ensure nursing staff have the requisite competency in the care of obstetric patients. The nursing staff did not have the requisite competency to read and/or interpret fetal monitoring, consequently, the nursing staff failed to recognize critical findings. Cross refer to Tag A-397 for details of findings.</li> <li>2. The hospital staff failed to provide appropriate examinations and treatments within the capabilities of this hospital that adequately addressed the presenting symptoms of 10 out of 30 randomly selected patients. Consequently, some patients had multiple presentations in the Emergency Department before the emergent condition was identified, treated, or patient transferred out for definitive care. Cross refer to Tag A-1100 for details of findings.</li> <li>3. The hospital staff failed to provide appropriate medical care management to a critically ill patient</li> </ol>	A 043			

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A 043	Continued From page 4 who had presented to the Emergency Department and the Outpatient Department for back pain. The patient who presented to the Outpatient Department with a complaint of severe pain (rated as 10 on a 0 - 10 pain scale, 10 being the worst pain). The midlevel practitioner who saw the patient found out after the patient had been discharged home, that the laboratory tests done showed critical lab values. However, the midlevel practitioner simply left a message for the patient to return to the hospital in 2 days. Sadly, the patient died at home. Cross refer to Tag A-1076 for details of the findings.  4. The hospital staff failed to provide services in accordance with the EMTALA requirements. Patients that presented to the Emergency Department:  a. were not provided appropriate medical screening examination that adequately addressed the patients' presenting symptoms;  b. were not provided stabilizing treatment within the capabilities of this hospital; and  c. were not transferred to another hospital appropriately.  For details of the findings, see Tags A-2406, A-2407, and A-2409.	A 043			
A 049	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY  [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients.	A 049			

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A 049	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on medical records review, and interview of available and willing staff, the Governing Body failed to ensure that hospital staff provided services to patients in accordance with acceptable standards of care in 10 out of 30 randomly selected patients. Citing Patient # 2, 3, 6, 7, 8, 14, 16, 18, 22 and 28.</p> <p>Findings:</p> <p>1. Patient #2 was a 15-month old child, who was brought by the parents on January 20, 2015, at 23:00, with complaints of "breathing rapidly, uncomfortable, fever, might need breathing treatment." The RN noted that the oxygen saturation level, at 00:10, was 95% with coarse breath sounds; nebulizer treatment was given. Temperature was recorded as 101.2F, was given Ibuprofen 100mg suspension</p> <p>Patient #2 was seen by a physician, at 23:25, who noted that Patient #2 had "tachypnea with accessory muscles of respiration in use." No further assessments were done and/or treatment provided to ensure that the respiratory condition of Patient #2 has been stabilized. Patient #2 was discharged home at 00:45.</p> <p>Patient #2 was brought back to the ED by parents on January 22, 2015, at 09:37. The RN noted that Patient #2 had "grunting and difficulty breathing." The oxygen saturation level was recorded as 95% with a pulse rate of 138 per minute. Patient #2 was examined by a pediatrician who noted that the patient was in "respiratory distress." Diagnostic work-up done. Nebulizer treatments ordered and administered.</p>	A 049			

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A 049	<p>Continued From page 6</p> <p>Pediatrician decided to transfer patient to a hospital in Sioux City, IA for definitive care.</p> <p>The failure of the staff to provide care and services to meet the needs of Patient #2 during the first presentation placed the health and welfare of this patient in serious jeopardy.</p> <p>2. Patient #3 was 60-year old patient, who had multiple presentations to the Emergency Department with the same complaint of acute chest pain but the medical management was not provided in accordance with acceptable standards to address a likely cardiac emergency.</p> <p>Patient #3 presented to the Emergency Department on June 14, 2014, at 02:04, complaining of chest pain on inspiration and rated it as 6 on a 0 - 10 pain scale (10 being the worst pain). Patient #3 stated that he had a cough for the past 3 days prior to presentation.</p> <p>Patient #3 was seen by a physician at 02:30. The physician noted that Patient #3 has a history of COPD (chronic obstructive pulmonary disease) and was "SOB (short of breath) mostly in recumbent position." The physician further noted that the lung fields of Patient #3 were "clear to auscultation bilaterally." However, Patient #3 was treated with Albuterol nebulizer at 03:08. Patient #3 was discharged home at 04:15.</p> <p>No further examination or diagnostic work-up was done to evaluate the acute chest pain. Acute chest pain is an emergency medical condition that may represent ischemia or infarct.</p> <p>Patient #3 presented to the Emergency</p>	A 049			

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A 049	<p>Continued From page 7</p> <p>Department again on July 3, 2014, at 12:12, with similar complaints. Patient #3 was assessed by a Registered Nurse (RN) but no medical evaluation was completed by a physician. Patient #3 was discharged home. The RN was unavailable for interview.</p> <p>Patient #3 presented to the Emergency Department again on July 3, 2014, at 12:49, with complaints of "chest pains/breathing problems." The RN noted that "Pt (patient) c/o (complaint of) difficulty breathing when he tries to lay down, then experiences a burning pain across his upper chest ..... " A Physician Assistant (PA) examined Patient #3 and noted that Patient #3 had "sinus tach (tachycardia)," lung fields were "clear to auscultation bilaterally, normal respiratory effort" and diagnosed the patient with "COPD exacerbation." No physician examined the patient during this presentation. Patient #3 was discharged home at 02:05. The PA was unavailable for interview.</p> <p>No further examination or diagnostic work-up was done to evaluate the acute chest pain. Acute chest pain is an emergency medical condition that may represent ischemia or infarct.</p> <p>Patient #3 presented to the Emergency Department again on July 3, 2014, at 02:58, with similar complaints. The RN noted that "Pt is in car outside ambulance entrance unable to walk per family members." The RN further noted that Patient #3 was "SOB, tearful and grabbing his chest." Patient #3 was examined by a PA at 03:00. No physician examined the patient. PA unavailable for interview.</p> <p>Diagnostic laboratory tests for cardiac enzymes</p>	A 049			



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A 049	<p>Continued From page 8</p> <p>showed elevated levels: CKMB - 5.6 (normal 0 - 3), Troponin I - 0.500 (normal &lt;0.35), Myoglobin - 151.0 (normal 30 - 90), B-Type Natriuretic Peptide - 193.0 (100 - 300 suggest heart failure is present). Patient #3 was seen by a PA and no physician examined the patient.</p> <p>Patient #3 was eventually transferred to a hospital in Sioux City, IA for further evaluation and stabilizing treatment of a likely cardiac emergency. Patient left the hospital at 13:00 by ambulance.</p> <p>The failure of the hospital staff to conduct an appropriate examination and conduct diagnostic tests to evaluate a likely cardiac emergency condition on previous multiple presentations placed the patient in an Immediate Jeopardy situation with the likelihood of serious harm, injury and death.</p> <p>3. Patient #6 was a 6-month old child, who was brought to the Emergency Department on February 13, 2015, at 10:00, by the mother. The mother informed the RN that the child had "bad congestion, phlemy (sic) nose, shallow breathing." Patient #6 was seen by a PA who noted that there was "no wheezing appreciated throughout lung fields, no retractions, no additional work of breathing, no see-saw breathing." No further examination was done and/or any diagnostic work-up. PA unavailable for interview.</p> <p>Patient #6 and mother were escorted to the Outpatient Department of the hospital at 10:30. A pediatrician examined Patient #6 who noted that there was "wheezing HEARD WITHOUT</p>	A 049			

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A 049	<p>Continued From page 9</p> <p>STETHOSCOPE." The pediatrician further noted that there were "wheezes all over lung fields, SUBCOSTAL retractions present." Diagnostic work-up were done at the Outpatient Department and treatment was provided to Patient #6.</p> <p>ED physician on record was interviewed on May 12, 2015, at approximately 13:00. The ED physician essentially told the surveyor that he did not have to do anything for the patient in the Emergency Department.</p> <p>The hospital staff failed to utilize all available resources in the hospital to address the medical condition of the patient that presented in the Emergency Department. The failure of the ED staff to provide appropriate medical examination including diagnostic work-up, and necessary stabilizing treatment within the capability of the hospital placed this patient with the likelihood of serious injury, harm or death.</p> <p>4. Patient #7 was a 30-year old, who presented to the Emergency Department on May 4, 2015, at 12:29, after reportedly drinking for 3 weeks. Patient #7 stated that "his last drink was around 9am." Further, Patient #7 informed the RN that he was "having frequent episodes of emesis whic (sic) is clear phlegm." Blood pressure reading was recorded as 144/91 with a pulse rate of 124 beats per minute.</p> <p>Patient #7 was seen by the ED physician and noted the blood pressure reading as 179/100 with a pulse rate of 144 beats per minute. The blood pressure was rechecked (time not indicated) and the reading was 185/104 with a pulse rate of 131</p>	A 049			

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A 049	<p>Continued From page 10 beats per minute.</p> <p>Intravenous (IV) fluid of Sodium Chloride with 20 mEq of potassium at 250 ml/hour was started at 14:30. The IV was discontinued at 19:25 and Patient #7 was discharged home at 19:30. No further assessment was done and/or treatment provided to ensure that the patient alcohol withdrawal status was resolved prior to discharge.</p> <p>Patient #7 was brought back to the Emergency Room by the family on May 5, 2015, at 15:21, after at least 2 seizure activities at home. The RN noted that the family members stated that Patient #7 was "just shaky." The RN noted that Patient #7 has fever (101.2F), irregular heart rate (144 beats per minute), and high blood pressure (179/100).</p> <p>The ED physician examined Patient #7. Electrocardiogram was done and showed "atrial fibrillation with RVR (Rapid Ventricular Rate)." Laboratory tests were done and showed that Patient #7 was in "high anion-gap metabolic acidosis, hyponatric/hypochloremic dehydration, and alcoholic hepatitis."</p> <p>Based on the diagnostic work-up done during the second presentation at the Emergency Department, a day after Patient #7 initially presented with symptomatology of alcohol withdrawal, Patient #7 was in a state of delirium tremens and autonomic instability that required critical care services. This could have been avoided if appropriate examination was done and treatment was provided within the capabilities of this hospital rather than discharging the patient home when he was in an alcohol withdrawal state.</p>	A 049			

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A 049	<p>Continued From page 11</p> <p>5. Patient #8 was a 28-year old pregnant woman, who was a Gravida 4 and para 3 (Pregnancy 4, delivered 3) with gestational age of 36 weeks.</p> <p>Patient #8 presented to the Emergency Department on May 5, 2015, at 03:38, complaining of contractions since 23:00. The patient indicated that the contractions are about 4 to 5 minutes apart. She described the pain as 8 on a 0 - 10 pain scale (10 being the worst pain). Also, stated the contraction lasted about 2 minutes each.</p> <p>Medical record indicated that at 03:45 , Patient #8 was placed on the uterine fetal monitor and according to the ED staff documentation, the fetal heart rate were at 140's to 150's with "Good variability with no decelerations noted." At 03:55, Patient #8 was assessed by the provider and determined that Patient #8 was 2 centimeter dilated with 50% effacement.</p> <p>Review of the patient fetal monitor strip (monitor fetal heart rate and uterine activity for contraction) revealed:</p> <ol style="list-style-type: none"> <li>1. The date printed in the monitor strip was 05/12/44. The patient was monitored on 05/05/15.</li> <li>2. The nursing staff documented the fetal heart rate had "good variability" but there was no variability present in the monitor strip.</li> <li>3. The nursing staff documented, "no contractions." However, the external tocometer revealed several waves with no reassurance of the location. External uterine contraction monitor</li> </ol>	A 049			

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A 049	<p>Continued From page 12</p> <p>can be affected by patient movements, patient size and location of the monitor. The staff monitoring the patient needs to be present during a contraction and mark the monitor strip to indicate that a contraction started and ended. The staff should always document the frequency of the contraction.</p> <p>4. The external uterine contraction monitor reads on the 70's that can be interpreted as an indication of abruptio placenta. No further evaluation was done. Abruptio placenta occurs when the placenta separates from the wall of the uterus prior to birth of the baby which can result in severe, uncontrollable bleeding. These external monitor readings can often be affected by positioning of the patient, patient size, placement of the tocometer on the uterus. The staff monitoring the patient should manually palpate the abdomen to ensure uterine relaxation. The staff should document intensity of the contraction with palpation of the abdomen.</p> <p>Results of the review of the patient fetal monitor strip above showed that the staff were unable to adequately assess the condition of Patient #8 either due to inadequate training or no training at all. Lack of competency in the care of obstetric patient places the health and welfare of all obstetric patients that come to this hospital in immediate jeopardy.</p> <p>The medical record indicated that Patient #8 was a high risk obstetric patient with possible pre-term rupture of membranes and possible pre-eclampsia.</p> <p>Record review of the patient fetal monitor strip on May 5, 2015, at 04:45, showed that the patient</p>	A 049			

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A 049	<p>Continued From page 13</p> <p>was removed from the external fetal monitor. The entry in the monitor strip by the provider reads "Good variability-no decelerations, no contractions."</p> <p>On May 13, 2015, at 14:20, the hospital DON was interviewed concerning the care for obstetric patients. During the course of the interview, the fetal monitor strip for this patient was presented. The DON stated there was no fetal heart accelerations recorded on the monitor strip. The DON also verified that the uterine tocometer needed to be repositioned or the nurse needed to palpate the uterus to verify contractions.</p> <p>6. Patient #14 was 32-year old, who presented to the Emergency Department on March 16, 2015, at 13:44, with complaints of laceration of left pointer finger and hypertension. The RN noted that the blood pressure (BP) reading was 216/120.</p> <p>Labetalol (anti-hypertensive drug) 20 mg was given intravenously at 14:22. BP was rechecked at 14:30 and recorded as 194/118; at 15:00, BP was 210/105. Labetalol 40 mg was given intravenously at 15:11.</p> <p>Furosemide (diuretic) 40 mg given intravenously (IV) at 16:02, BP was rechecked at 16:15 which was recorded as 180/102.</p> <p>"Nitroglycerin IV 25 mg in 250 mls (milliliter) D5W solution to infuse at 6 mls/hour = 10 mcg/min" was started at 17:14. According to <a href="http://www.dailymed.nlm.nih.gov">www.dailymed.nlm.nih.gov</a>, &lt;<a href="http://www.dailymed.nlm.nih.gov">http://www.dailymed.nlm.nih.gov</a>&gt;, "Nitroglycerin in 5% Dextrose is indicated for treatment of peri-operative hypertension; for</p>	A 049			

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A 049	<p>Continued From page 14</p> <p>control of congestive heart failure in the setting of acute myocardial infarction; for treatment of angina pectoris in patients who have not responded to sublingual nitroglycerin and <math>\beta</math>-blockers; and for induction of intraoperative hypotension." Further, it stated that "severe hypotension and shock may occur with even small doses of nitroglycerin."</p> <p>Medical record showed that the IV was discontinued at 19:31 and patient was discharged home.</p> <p>There was no further observation and/or assessment done to ensure that the hypertensive emergency was resolved. Failure to observe and assess the patient for a reasonable period of time to ensure that the patient did not have severe hypotension from the drugs administered placed the health and welfare of the patient in immediate jeopardy.</p> <p>7. Patient #16 was 74-year old, who presented to the Emergency Department on April 25, 2015, at 08:58, with complaints of "unable to urinate since yesterday, bleeding." The RN noted, on arrival, that Patient #16 had a blood pressure reading of 190/95.</p> <p>ED physician examined Patient #16 and noted "hypertensive disorder." Urine specimen was collected via catheterization which showed a "trace" blood in urine. Blood glucose showed an elevated level, 210.2 (normal range: 65 - 100). Patient #16 was discharged home at 11:27. The</p>	A 049			

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A 049	<p>Continued From page 15</p> <p>ED physician was no longer available for interview.</p> <p>There was no further assessment done on the elevated high blood pressure nor was the elevated blood glucose addressed prior to discharge. No further assessment done and/or treatment given to address the urine retention. There are emergent causes of urinary retention including infections, neurological spinal cord compression, and renal failure.</p> <p>8. Patient #18 was a 28-year old pregnant woman, who presented to the Emergency Department on April 12, 2015 at 00:18, complaining of "bleeding." The RN noted that Patient 18 was "14 weeks gestation" and "several attempts were made to find fetal heart tones, but were unsuccessful." There were no further attempts made to find fetal heart tones or further assessments done to determine the health status of the fetus. Blood pressure reading on presentation was 129/91. The RN further noted that patient's urine was "turbid, light blood tinged appearance."</p> <p>The RN noted, at 00:45, that Patient #18 went to "bathroom and voids 100ml light blood tinged." At 02:10, "Patient voids 200 ml bright red bloody urine with no clots at this time." Physician unavailable for interview.</p> <p>No further examination and/or diagnostic work-up done. Patient #18 was discharged in care of the mother who was instructed to drive Patient #18 to a hospital in Sioux City, IA via the mother's private vehicle.</p>	A 049			



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A 049	<p>Continued From page 16</p> <p>9. Patient #22 was a 30-year old pregnant woman, who was at 25 weeks gestational age. She was a G (gravida) 7, P (para) 6, A (abortions) 0, with a history of premature delivery at 25-weeks.</p> <p>Patient #22 presented to the hospital on May 10, 2015, at 14:20. The RN noted that Patient #22 complained of cramping and vaginal discharge. Patient due date is August 20, 2015. According to medical record, the patient had a history of premature labor with other pregnancies. This pregnancy was number 7.</p> <p>At 14:55, the patient was placed on external monitor (Toco) to monitor uterine contractions and fetal heart rate. Medical record indicated that the doctor conducted a vaginal examination at 15:10.</p> <p>The medical record failed to show fetal heart rate with variability, or the uterine contraction patterns.</p> <p>The patient was discharged home at 15:30.</p> <p>The patient fetal monitor strip done in the Emergency Department showed the fetal heart tone, not reassuring because the heart rate was recording between 60's to 120's. For over one minute, the fetal heart tones recorded on the external toco were not reassuring. A heart rate of 60 is considered alarming in most cases of obstetric emergency. No further evaluation was done to ensure that the health of the fetus was not in jeopardy. Fetal heart tone should be between 120-160's. The uterine contraction toco was not recording any contractions even when the patient said she was cramping. The Emergency Department nurse or doctor did not</p>	A 049		

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A 049	<p>Continued From page 17</p> <p>document anything related to the fetal activity or uterine contractions. The fetal monitor strip completed in the Emergency Department was dated 04/04/44.</p> <p>On May 13, 2015, at 14:00, an interview was conducted with the Emergency Department nurse. During the interview, the nurse stated that he did not realize that the monitor strip dates were wrong. He also stated that it has been years since the hospital provided a fetal monitor training to staff.</p> <p>On May 13, 2015, at 14:00, an interview with the Outpatient Nurse manager was conducted concerning the nurses fetal monitor training. The manager stated that "nobody here knows how to read a fetal monitor strip. The Director of Nurses may know but she don't come and assess the monitor strips from here or the ED. One or two providers may know. When those providers are not here then nobody read the monitor strips, we sent the patient home without an accurate assessment ." The manager also stated that she has been requesting the DON for a fetal monitor training for her staff and the ED staff, but the DON has not provided the training.</p> <p>On May 13, 2015, at 14:20, an interview with the hospital DON was conducted concerning the fetal monitor training for the nurses in the ED and Outpatient Department. The DON stated that a contract family practice group comes to the clinic once a week and they see all obstetric patients including reading the monitor strips for that day. The DON stated that if a patient needs to be monitored, the nurses or doctors should know how to read a monitor strip. When asked if any staff had request training on fetal monitor strip the</p>	A 049			

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A 049	<p>Continued From page 18</p> <p>DON stated, "no." During the same interview, the monitor strip of the patient in question was presented. The DON stated that the patient should have been monitored closely to verify the fetal heart tones and ensure there were no contractions. The DON also stated that the doctor should have written the cervical examination. The DON verified that the monitor had the wrong date. She said, she didn't know how to change the monitor to the correct date but she will call biomed.</p> <p>Review of the Fetal Monitor Training record provided by the DON on May 14, 2015, revealed that the last training was completed on October 2011.</p> <p>Patient #22 was discharged home after an inadequate medical examination in that the staff were unable to recognize the alarming fetal heart rate recorded on the toco because of either inadequate or no training in that aspect of obstetric care. The monitoring machines used were likely not functioning well due to dead batteries and poor biomedical maintenance as suggested by the wrong date recorded.</p> <p>10. Patient #28 was 38-year old, who presented to the Emergency Department on May 4, 2015, at 01:01, with swollen right ankle. Patient was examined by an ED physician who noted that Patient #28 had "right ankle swelling, painful weight bearing." The ED physician ordered x-ray of the right ankle which showed "a long oblique fracture of the right distal fibula. There is approximately 2 - 3 mm posterior and lateral displacement of the distal fracture fragment with little distraction. In addition, the ankle mortise seems widened especially medially, suspect</p>	A 049			

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A 049	Continued From page 19 underlying instability." Patient was discharged home at 02:14.  No further assessment was done and/or treatment provided. The diagnostic examination was not adequate because the initial x-ray findings did not include stress views. The x-ray result showed a widened mortise which represents a potentially unstable fracture that may require surgical repair. Emergency providers typically can reduce and splint such fractures but these were not attempted or done prior to discharge.	A 049			
A 092	482.12(f)(1) EMERGENCY SERVICES  If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55.  This STANDARD is not met as evidenced by: Based on medical records review, and interview of available and willing staff, the hospital staff failed to provide services to patients that came to the Emergency Department that adequately addressed the presenting symptomatology within the capability of this hospital and in accordance with accepted standards of care in 10 Out of 30 randomly selected patients. Citing Patient # 2, 3, 6, 7, 8, 14, 16, 18, 22 and 28.	A 092			
A 385	Cross refer to Tag -1100 for details of findings. 482.23 NURSING SERVICES  The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.	A 385			

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A 385	Continued From page 20 This CONDITION is not met as evidenced by: Based on medical records review, and interview of available and willing staff, the Director of Nurses failed to ensure that nursing staff had the requisite competency in the care of obstetric patients. Obstetric patients were assigned to nursing staff who were unable to provide care that meets the needs and condition of patients in 3 out of 30 randomly selected patients. Citing Patient # 8, 18 and 22.	A 385			
A 397	Cross refer to Tag A-397 for details of findings. 482.23(b)(5) PATIENT CARE ASSIGNMENTS  A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available.  This STANDARD is not met as evidenced by: Based on medical records review, and interview of available and willing staff, the Director of Nurses failed to ensure that patients were assigned to nursing staff according to the staff qualification and competency that meets the nursing care needs and condition of patients in 3 out of 30 randomly selected patients. Citing Patient # 8, 18 and 22.  Findings:  1. Patient #8 was a 28-year old pregnant woman, who was a Gravida 4 and para 3 (Pregnancy 4, delivered 3) with gestational age of 36 weeks.  Patient #8 presented to the Emergency	A 397			

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A 397	<p>Continued From page 21</p> <p>Department on May 5, 2015, at 03:38, complaining of contractions since 23:00. The patient indicated that the contractions are about 4 to 5 minutes apart. She described the pain as 8 on a 0 - 10 pain scale (10 being the worst pain). Also, stated that the contraction lasted about 2 minutes each.</p> <p>Medical record indicated that at 03:45, Patient #8 was placed on the uterine fetal monitor and according to the ED staff documentation, the fetal heart rate were at 140's to 150's with "Good variability with no decelerations noted." At 03:55, Patient #8 was assessed by the provider and determined she was 2 centimeter dilated with 50% effacement.</p> <p>Review of the patient fetal monitor strip (monitor fetal heart rate and uterine activity for contraction) revealed:</p> <ol style="list-style-type: none"> <li>The date printed in the monitor strip was 05/12/44. The patient was monitored on 05/05/15.</li> <li>The nursing staff documented the fetal heart rate had "good variability" but there was no variability present in the monitor strip.</li> <li>The nursing staff documented, "no contractions." However, the external tocometer revealed several waves with no reassurance of the location. External uterine contraction monitor can be affected by patient movements, patient size and location of the monitor. The staff monitoring the patient needs to be present during a contraction and a mark the monitor strip to indicate that a contraction started and ended. The staff should always document the frequency of the contraction.</li> </ol>	A 397			

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A 397	<p>Continued From page 22</p> <p>4. The external uterine contraction monitor read on the 70's that can be interpreted as an indication of abruptio placenta. No further evaluation was done. Abruptio placenta occurs when the placenta separates from the wall of the uterus prior to the birth of the baby which can result in severe, uncontrollable bleeding. These external monitor readings can often be affected by positioning of the patient, patient size, placement of the tocometer in the uterus. The staff monitoring the patient should manually palpate the abdomen to ensure uterine relaxation. The staff should document intensity of the contraction with palpation of the abdomen.</p> <p>Results of the review of the patient fetal monitor strip above showed that the staff were unable to adequately assess the condition of Patient #8 either due to inadequate training or no training at all. Lack of competency in the care of obstetric patient places the health and welfare of all obstetric patients in immediate jeopardy.</p> <p>The medical record indicated that Pt. #8 was a high risk obstetric patient with possible pre-term rupture of membranes and possible pre-eclampsia.</p> <p>Record review of the patient fetal monitor strip showed that on May 5, 2015, at 04:45, the patient was removed from the external fetal monitor. The entry in the monitor strip by the provider read "Good variability-no decelerations, no contractions." The monitor strip contradicts that statement.</p> <p>On May 13, 2015, at 14:20, the hospital DON was interviewed concerning the care for obstetric</p>	A 397			

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A 397	<p>Continued From page 23</p> <p>patients. During the course of the interview, the fetal monitor strip for this patient was presented. The DON stated there was no fetal heart accelerations recorded on the monitor strip. The DON also verified that the uterine tocometer needed to be repositioned or the nurse needed to palpate the uterus to verify contractions.</p> <p>When asked, when was the last time the ED nursing staff and providers got training on fetal heart monitor reading, the DON stated, "in 2011."</p> <p>2. Patient #18 was a 28-year old pregnant woman, who presented to the Emergency Department on April 12, 2015 at 00:18, complaining of "bleeding." The RN noted that Patient 18 was "14 weeks gestation" and "several attempts were made to find fetal heart tones, but were unsuccessful." No further evaluation was done to ensure the health of the fetus.</p> <p>Blood pressure reading on presentation was 129/91. The RN further noted that patient's urine was "turbid, light blood tinged appearance."</p> <p>The RN noted, at 00:45, that Patient #18 went to "bathroom and voids 100ml light blood tinged." At 02:10, "Patient voids 200 ml bright red bloody urine with no clots at this time." Physician unavailable for interview.</p> <p>No further examination and/or diagnostic work-up done. Patient #18 was discharged in care of the mother who was instructed to drive Patient #18 to a hospital in Sioux City, IA via the mother's private vehicle.</p>	A 397			



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A 397	<p>Continued From page 24</p> <p>3. Patient #22 was a 30-year old pregnant woman, at 25 weeks gestational age. She was a G (gravida) 7, P (para) 6, A (abortions) 0, with a history of premature delivery at 25-weeks.</p> <p>Patient #22 presented to the hospital on May 10, 2015 at 14:20. The RN noted that Patient #22 complained of cramping and vaginal discharge. Patient due date is 08/20/2015. According to medical record, the patient had a history of premature labor with other pregnancies. This pregnancy is number 7.</p> <p>At 14:55, the patient was placed on external monitor (Toco) to monitor uterine contractions and fetal heart rate. Medical record indicated that the doctor conducted a vaginal examination at 15:10.</p> <p>The medical record failed to show fetal heart rate with variability, or the uterine contraction patterns.</p> <p>The Emergency Department sent the patient home at 15:30.</p> <p>Review of the patient's fetal monitor strip done in the Emergency Department showed the fetal heart tone, was not reassuring because the heart rate was recording between 60's to 120's. No further evaluation was done. For over one minute, the fetal heart tones recorded on the external toco was not reassuring. A heart rate of 60 is considered alarming in most cases of an obstetric emergency. Fetal heart tone should be between 120-160's. The uterine contraction toco was not recording any contractions even when the patient said she was cramping. The Emergency Department nurse or doctor did not</p>	A 397			

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A 397	<p>Continued From page 25</p> <p>document anything related to the fetus activity or uterine contractions. The fetal monitor strip completed on the Emergency Department was dated 04/04/44.</p> <p>On May 13, 2015, at 14:00, an interview was conducted with the Emergency Department nurse. During the interview, the nurse stated that he did not realize that the monitor strip dates were wrong. He also stated that it has been years since the hospital provided a fetal monitor training to staff.</p> <p>On May 13, 2015, at 14:00, an interview with the Outpatient Nurse manager was conducted concerning the nurses fetal monitor training. The manager stated that, "nobody here knows how to read a fetal monitor strip. The Director of Nurses may know but she don't come and assess the monitor strips from here or the ED. One or two providers may know. When those providers are not here then nobody read the monitor strips, we sent the patient home without an accurate assessment." The manager also stated that she has been requesting the DON for a fetal monitor training for her staff and the ED staff, but the DON has not provided the training.</p> <p>On May 13, 2015, at 14:20, an interview with the hospital DON was conducted concerning the fetal monitor training for the nurses in the ED and Outpatient Department. The DON stated that a contract family practice group comes to the clinic once a week and they see all obstetric patient including reading the monitor strips for that day. The DON stated that if a patient needs to be monitored, the nurses or doctors should know how to read a monitor strip. When asked if any staff had request training on fetal monitor strip the</p>	A 397			

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A 397	<p>Continued From page 26</p> <p>DON stated, "no." During the same interview, the monitor strip of the patient in question was presented. The DON stated that the patient should have been monitored closely to verify the fetal heart tones and ensure there were no contractions. The DON also stated that the doctor should have written the cervical examination. The DON verified that the monitor had the wrong date. She said, she didn't know how to change the monitor to the correct date but she will call biomed.</p> <p>On May 13, 2015, at 16:00, the DON stated that the two batteries in the fetal monitor located in the ED were dead and that biomed will change the batteries.</p> <p>On May 14, 2015, at 9:00, the surveyor visited the ED to ensure that the Fetal Monitor machine batteries were changed as the DON stated the day before. The visit revealed that the batteries were still not changed and the date in the monitor strip paper was still 04/04/44.</p> <p>On May 15, 2015, at 10:00, an interview with the DON was conducted. The DON stated the batteries will be changed today (05/14/2015).</p> <p>Review of the Fetal Monitor Training record provided by the DON on May 14, 2015, revealed that the last training was completed on October 2011.</p> <p>The nursing staff were unable to recognize the alarming fetal heart rate recorded on the toco because of either inadequate or no training in that aspect of obstetric care. The monitoring machines used were likely not functioning well due to dead batteries and poor biomedical</p>	A 397			

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A 397	Continued From page 27 maintenance as suggested by the wrong date recorded. Lack of competency in the care of obstetric patients placed all obstetric patients that come to this hospital in immediate jeopardy with likelihood of serious harm, injury or death.	A 397			
A1076	482.54 OUTPATIENT SERVICES  If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on medical record review, and interview of available and willing staff, the hospital failed to provide services that meet the needs of patient in accordance with accepted standards of care in 1 of 30 randomly selected patients. Citing Pt. #29.  Patient #29 was 59-year old, who had numerous presentations to the Emergency Department and the Outpatient Department due to chronic back pain. Patient #29 presented to the Outpatient Department on December 17, 2014, at 13:40, with complaint of hip and back pain. Patient #29 was examined by a physician who noted that the pain was rated by the patient as an 8 on a 0 - 10 pain scale (10 being the worst pain).  Patient #29 had a history of "vertebral fractures due to what appears to be marked osteoporosis." The RN noted that Patient #29 was seen at the Emergency Department on December 16, 2014, and was "given a shot of Toradol which truly helped his pain. He was also given some Toradol pills which he feels worked better than his Hydrocodone tabs given his last visit."  The physician noted that Patient #29 "had been	A1076			

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A1076	<p>Continued From page 28</p> <p>referred to Ortho for consultation and possible kypoplasty/bone wedge placement; and he was also referred for DEXA-Scan; unfortunately due to lack of resources, these were never completed."</p> <p>Patient #29 presented again to the Outpatient Department on December 20, 2014, at 09:34, with complaints of back pain. Patient #29 rated the pain as a 10 on a 0 - 10 pain scale (10 being the worst pain). The midlevel practitioner who saw Patient #29 noted the Patient #29's "color was grey" and "patient is very guarded with any movement, and using crutches to get up and ambulate." Patient was discharged home.</p> <p>There was no treatment provided or assessment of the pain status which was rated by the patient as a 10 on a 0 - 10 pain scale, where 10 is the worst. The medical condition of the patient during this presentation indicated an emergent condition but the midlevel practitioner failed to consult with a physician or asked a physician to examine the patient. Absent of a medical attention and/or intervention placed the health and life of Patient #29 in immediate jeopardy with the likelihood of serious harm, injury, or death.</p> <p>The midlevel practitioner wrote a note on December 30, 2014, at 13:45 that reads "Left a phone message for patient to not take any NSAIDS or calcium (TUMS) products as his calcium is elevated and his kidneys are shutting down. Return to clinic in 2 days (Jan 2nd) to have blood rechecked. Take in extra PO fluids. midlevel practitioner not available for interview. Unfortunately, Patient #29 died on January 1, 2015, at his sister's house.</p> <p>The family of Patient #29 was interviewed on May</p>	A1076			

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A1076	<p>Continued From page 29</p> <p>13, 2015 at 9:00. According to the family member, she felt that the patient was mistreated by the medical staff in the Emergency Room and the Out Patient Clinic. The family member interviewed said that she tried to have him seen in the Emergency Department but the ED staff sent him to the outpatient clinic. She thought that Patient #29 was too sick for the clinic.</p> <p>In the outpatient clinic, he was seen by a Nurse Practitioner who ordered blood work. The family said that he was in terrible pain, 10/10, and he looked real sick. Was not able to walk, swallow or hardly talk. His skin color was like ashes; his eyes had a dead look to her. She was very surprised that Patient #29 was not admitted to the hospital. Instead, he was sent home. According to the family member the decision was very poor because he was in severe pain. "My brother used a walker to ambulate but this time I was surprised to see him in a wheel chair."</p> <p>The family member stated that after a few hours, the Nurse Practitioner called her and told her that the results of the blood work were "panic value," and the Nurse Practitioner told her that he needed an appointment to be seen in two days. The family said if the laboratory results were "critical," why Patient #29 was not admitted to the hospital.</p> <p>The family member stated that Patient #29 was so sick that he took the van to his sister house, 40 minutes away, the family started crying repeatedly saying "they killed him here, he dies two days later, why he did not get the care he needed?"</p>	A1076			
A1100	482.55 EMERGENCY SERVICES	A1100			

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A1100	<p>Continued From page 30</p> <p>The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.</p> <p>This CONDITION is not met as evidenced by: Based on medical records review, and interview of available and willing staff, the hospital staff failed to provide appropriate examinations and treatments within the capabilities of this hospital in order to meet the emergency needs of 10 Out of 30 randomly selected patients. Citing Patient # 2, 3, 6, 7, 8, 14, 16, 18, 22 and 28.</p> <p>Findings:</p> <p>1. Patient #2 was a 15-month old child, who was brought by the parents on January 20, 2015, at 23:00 with complaints of "breathing rapidly, uncomfortable, fever, might need breathing treatment." The RN noted that the oxygen saturation level, at 00:10, was 95% with coarse breath sounds; nebulizer treatment was given. Temperature was recorded as 101.2F, was given Ibuprofen 100mg suspension</p> <p>Patient #2 was seen by a physician, at 23:25, who noted that Patient #2 had "tachypnea with accessory muscles of respiration in use." No further assessments were done and/or treatment provided to ensure that the respiratory condition of Patient #2 has been stabilized. Patient #2 was discharged home at 00:45.</p> <p>Patient #2 was brought back to the ED by parents on January 22, 2015, at 09:37. The RN noted that Patient #2 had "grunting and difficulty breathing." The oxygen saturation level was recorded as 95% with a pulse rate of 138 per</p>	A1100		

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A1100	<p>Continued From page 31</p> <p>minute. Patient #2 was examined by a pediatrician who noted that the patient was in "respiratory distress." Diagnostic work-up done. Nebulizer treatments ordered and administered. Pediatrician decided to transfer patient to a hospital in Sioux City, IA for definitive care.</p> <p>The failure of the staff to use all available resources in the management of the condition of Patient #2 during the first presentation placed the health and welfare of this patient in immediate jeopardy.</p> <p>2. Patient #3 was 60-year old patient, who had multiple presentations to the Emergency Department with the same complaint of acute chest pain but the medical management was not provided in accordance with acceptable standards of care to address a likely cardiac emergency.</p> <p>Patient #3 presented to the Emergency Department on June 14, 2014, at 02:04, complaining of chest pain on inspiration and rated it as 6 on a 0 - 10 pain scale (10 being the worst pain). Patient #3 stated that he had a cough for the past 3 days prior to presentation.</p> <p>Patient #3 was seen by a physician at 02:30. The physician noted that Patient #3 has a history of COPD (chronic obstructive pulmonary disease) and was "SOB (short of breath) mostly in recumbent position." The physician further noted that the lung fields of Patient #3 were "clear to auscultation bilaterally." However, Patient #3 was treated with Albuterol nebulizer at 03:08. Patient #3 was discharged home at 04:15.</p>	A1100			



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A1100	<p>Continued From page 32</p> <p>No further examination or diagnostic work-up was done to evaluate the acute chest pain. Acute chest pain is an emergency medical condition that may represent ischemia or infarct.</p> <p>Patient #3 presented to the Emergency Department again on July 3, 2014, at 12:12, with similar complaints. Patient #3 was assessed by a Registered Nurse (RN) but no medical screening examination was completed by a Qualified Medical Practitioner. Patient #3 was discharged home. The RN was unavailable for interview.</p> <p>Patient #3 presented to the Emergency Department again on July 3, 2014, at 12:49, with complaints of "chest pains/breathing problems." The RN noted that "Pt (patient) c/o (complaint of) difficulty breathing when he tries to lay down, then experiences a burning pain across his upper chest ... .." A Physician Assistant (PA) examined Patient #3 and noted that Patient #3 had "sinus tach (tachycardia)," lung fields were "clear to auscultation bilaterally, normal respiratory effort" and diagnosed the patient with "COPD exacerbation." No physician examined the patient during this presentation. Patient #3 was discharged home at 02:05. The PA was unavailable for interview.</p> <p>No further examination or diagnostic work-up was done to evaluate the acute chest pain. Acute chest pain is an emergency medical condition that may represent ischemia or infarct.</p> <p>Patient #3 presented to the Emergency Department again on July 3, 2014, at 02:58, with similar complaints. The RN noted that "Pt is in car outside ambulance entrance unable to walk per family members." The RN further noted that</p>	A1100			

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A1100	<p>Continued From page 33</p> <p>Patient #3 was "SOB, tearful and grabbing his chest." Patient #3 was examined by a PA at 03:00. No physician examined the patient. PA unavailable for interview.</p> <p>Diagnostic laboratory tests for cardiac enzymes showed elevated levels: CKMB - 5.6 (normal 0 - 3), Troponin I - 0.500 (normal &lt;0.35), Myoglobin - 151.0 (normal 30 - 90), B-Type Natriuretic Peptide - 193.0 (100 - 300 suggest heart failure is present). Patient #3 was seen by a PA and no physician examined the patient.</p> <p>Patient #3 was eventually transferred to a hospital in Sioux City, IA for stabilizing treatment of the cardiac emergency. Patient left the hospital at 13:00 by ambulance.</p> <p>The failure of the hospital staff to conduct an appropriate examination and conduct diagnostic tests to evaluate a likely cardiac emergency condition on previous multiple presentation placed the patient in an Immediate Jeopardy situation with the likelihood of serious harm, injury and death.</p> <p>3. Patient #6 was a 6-month old child, who was brought to the Emergency Department on February 13, 2015, at 10:00, by the mother. The mother informed the RN that the child had "bad congestion, phlemy (sic) nose, shallow breathing." Patient #6 was seen by a PA who noted that there was "no wheezing appreciated throughout lung fields, no retractions, no additional work of breathing, no see-saw breathing." No further examination was done and/or any diagnostic work-up. PA unavailable for interview.</p>	A1100			

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A1100	<p>Continued From page 34</p> <p>Patient #6 and mother were escorted to the Outpatient Department of the hospital at 10:30. A pediatrician examined Patient #6 who noted that there was "wheezing HEARD WITHOUT STETHOSCOPE." The pediatrician further noted that there were "wheezes all over lung fields, SUBCOSTAL retractions present." Diagnostic work-up was done and treatment was provided to Patient #6 at the Outpatient Department.</p> <p>ED physician on record was interviewed on May 12, 2015, at approximately 13:00. The ED physician was asked if he examined Patient #6 and/or conducted diagnostic work-up to determine whether an emergency medical condition existed. The ED physician stated that the PA examined the patient and there was no indication that he should have to see the patient himself. The ED physician was asked to explain the discrepancy between the PA's finding regarding the patient's respiratory status and the pediatrician's finding of respiratory distress upon the patient's arrival at the Outpatient Department. The ED physician stated that he "did what was required of me by law. I didn't have to do anything else. I understand EMTALA well, and let me tell you about the law ..... "</p> <p>The hospital staff failed to utilize all available resources in the hospital to address the medical condition of the patient that presented in the Emergency Department. The failure of the ED staff to provide appropriate medical examination including diagnostic work-up, and necessary stabilizing treatment within the capability of the hospital placed this patient with the likelihood of serious injury, harm or death.</p>	A1100			

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A1100	<p>Continued From page 35</p> <p>4. Patient #7 was 30-year old, who presented to the Emergency Department on May 4, 2015, at 12:29, after reportedly drinking for 3 weeks. Patient #7 stated that "his last drink was around 9am." Further, Patient #7 informed the RN that he was "having frequent episodes of emesis whic (sic) is clear phlegm." Blood pressure reading was recorded as 144/91 with a pulse rate of 124 beats per minute.</p> <p>Patient #7 was seen by the ED physician and noted the blood pressure reading as 179/100 with a pulse rate of 144 beats per minute. The blood pressure was rechecked (time not indicated) and the reading was 185/104 with a pulse rate of 131 beats per minute.</p> <p>Intravenous (IV) fluid of Sodium Chloride with 20 mEq of potassium at 250 ml/hour was started at 14:30. The IV was discontinued at 19:25 and Patient #7 was discharged home at 19:30. No further assessment was done and/or treatment provided to ensure that the patient's alcohol withdrawal was resolved.</p> <p>Patient #7 was brought back to the Emergency Room by the family on May 5, 2015, at 15:21, after at least 2 seizure activities at home. The RN noted that the family members stated that Patient #7 was "just shaky." The RN noted that Patient #7 has fever (101.2F), irregular heart rate (144 beats per minute), and high blood pressure (179/100).</p> <p>The ED physician examined Patient #7. Electrocardiogram was done and showed "atrial fibrillation with RVR (Rapid Ventricular Rate)."</p>	A1100		

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A1100	<p>Continued From page 36</p> <p>Laboratory tests were done and showed that Patient #7 was in "high anion-gap metabolic acidosis, hyponatric/hypochloremic dehydration, and alcoholic hepatitis."</p> <p>Based on the diagnostic work-up done during the second presentation at the Emergency Department, a day after Patient #7 initially presented with symptomatology of alcohol withdrawal, Patient #7 was in a state of delirium tremens and autonomic instability that required critical care services. This could have been avoidable if appropriate examination was done and treatment was provided within the capabilities of this hospital rather than discharging the patient home when he was in an alcohol withdrawal state.</p> <p>Patient #7 was transferred to a hospital in Sioux City, IA via ambulance to obtain the critical care services that Patient #7 required.</p> <p>5. Patient #8 was a 28-year old pregnant woman, who was a Gravida 4 and para 3 (Pregnancy 4, delivered 3) with gestational age of 36 weeks.</p> <p>Patient #8 presented to the Emergency Department on May 5, 2015, at 03:38, complaining of contractions since 23:00. The patient indicated that the contractions are about 4 to 5 minutes apart. She described the pain as 8 on a scale of 0 - 10 pain scale (10 being the worst pain). Also, stated the contraction lasted about 2 minutes each.</p> <p>Medical record indicated that at 03:45, Patient #8 was placed on the uterine fetal monitor and according to the ED staff documentation, the fetal</p>	A1100			

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A1100	<p>Continued From page 37</p> <p>heart rate were at 140's to 150's with "Good variability with no decelerations noted." At 03:55, Patient #8 was assessed by the provider and determined that Patient #8 was 2 centimeter dilated with 50% effacement.</p> <p>Review of the patient fetal monitor strip (monitor fetal heart rate and uterine activity for contraction) revealed:</p> <ol style="list-style-type: none"> <li>1. The date printed in the monitor strip was 05/12/44. The patient was monitored on 05/05/15.</li> <li>2. The nursing staff documented the fetal heart rate had "good variability but there was no variability present in the monitor strip.</li> <li>3. The nursing staff documented, "no contractions." However, the external tocometer revealed several waves with no reassurance of the location. External uterine contraction monitor can be affected by patient movements, patient size and location of the monitor. The staff monitoring the patient needs to be present during a contraction and a mark the monitor strip to indicate that a contraction started and ended. The staff should always document the frequency of the contraction.</li> <li>4. The external uterine contraction monitor read on the 70's that can be interpreted as an indication of abruptio placenta. No further evaluation was done. Abruptio placenta occurs when the placenta separates from the wall of the uterus prior to the birth of the baby which can result in severe, uncontrollable bleeding. These external monitor readings can often be affected by positioning of the patient, patient size, placement of the tocometer in the uterus. The</li> </ol>	A1100			

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A1100	<p>Continued From page 38</p> <p>staff monitoring the patient should manually palpate the abdomen to ensure uterine relaxation. The staff should document intensity of the contraction with palpation of the abdomen.</p> <p>Results of the review of the patient fetal monitor strip above showed that the staff were unable to adequately assess the condition of Patient #8 either due to inadequate training or no training at all. Lack of competency in the care of obstetric patient places the health and welfare of all obstetric patients that come to this hospital in immediate jeopardy.</p> <p>The medical record indicated that Patient #8 was a high risk obstetric patient with possible pre-term rupture of membranes and possible pre-eclampsia.</p> <p>Record review of the patient fetal monitor strip showed that on May 5, 2015, at 04:45, patient was removed from the external fetal monitor. The entry in the monitor strip by the provider reads "Good variability-no decelerations, no contractions."</p> <p>On May 13, 2015, at 14:20, the hospital DON was interviewed concerning the care for obstetric patients. During the course of the interview, the fetal monitor strip for this patient was presented. The DON stated there was no fetal heart accelerations recorded on the monitor strip. The DON also verified that the uterine tocometer needed to be repositioned or the nurse needed to palpate the uterus to verify contractions.</p> <p>When asked, when was the last time the ED nursing staff and providers got training on fetal heart monitor reading, the DON stated, "in 2011."</p>	A1100			

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A1100	<p>Continued From page 39</p> <p>6. Patient #14 was 32-year old, who presented to the Emergency Department on March 16, 2015, at 13:44, with complaints of laceration of left pointer finger and hypertension. The RN noted that the blood pressure (BP) reading was 216/120.</p> <p>Labetalol (anti-hypertensive drug) 20 mg was given intravenously at 14:22. BP was rechecked at 14:30 and recorded as 194/118; at 15:00, BP was 210/105. Labetalol 40 mg was given intravenously at 15:11.</p> <p>Furosemide (diuretic) 40 mg given intravenously (IV) at 16:02, BP was rechecked at 16:15 which was recorded as 180/102.</p> <p>"Nitroglycerin IV 25 mg in 250 mls (milliliter) D5W solution to infuse at 6 mls/hour = 10 mcg/min" was started at 17:14. According to <a href="http://www.dailymed.nlm.nih.gov">www.dailymed.nlm.nih.gov</a>, <a href="http://www.dailymed.nlm.nih.gov">http://www.dailymed.nlm.nih.gov</a>, "Nitroglycerin in 5% Dextrose is indicated for treatment of peri-operative hypertension; for control of congestive heart failure in the setting of acute myocardial infarction; for treatment of angina pectoris in patients who have not responded to sublingual nitroglycerin and <math>\beta</math>-blockers; and for induction of intraoperative hypotension." Further, it stated that "severe hypotension and shock may occur with even small doses of nitroglycerin."</p> <p>Blood pressure readings after the initiation of the Nitroglycerine IV were recorded as: 17:45 - 155/99 18:00 - 152/87 18:11 - 191/108</p>	A1100			



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A1100	<p>Continued From page 40 19:00 - 155/90 19:10 - 167/99</p> <p>Medical record showed that the IV was discontinued at 19:31 and patient was discharged home.</p> <p>There was no further observation and/or assessment done to ensure that the hypertensive emergency was resolved. Failure to observe and assess the patient for a reasonable period of time to ensure that the patient did not have severe hypotension from the drugs administered placed the health and welfare of the patient in immediate jeopardy.</p> <p>7. Patient #16 was 74-year old, who presented to the Emergency Department on April 25, 2015, at 08:58, with complaints of "unable to urinate since yesterday, bleeding." The RN noted, on arrival, that Patient #16 had a blood pressure reading of 190/95.</p> <p>ED physician examined Patient #16 and noted "hypertensive disorder." Urine specimen was collected via catheterization which showed a "trace" blood in urine. Blood glucose showed an elevated level, 210.2 (normal range: 65 - 100). Patient #16 was discharged home at 11:27. The ED physician was no longer available for interview.</p> <p>There was no further assessment was done on the elevated high blood pressure nor was the elevated blood glucose addressed prior to discharge. No further assessment was done and/or treatment given to address the urine</p>	A1100			

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A1100	<p>Continued From page 41</p> <p>retention. There are emergent causes of urinary retention including infections, neurological spinal cord compression, and renal failure.</p> <p>8. Patient #18 was a 28-year old pregnant woman, who presented to the Emergency Department on April 12, 2015 at 00:18, complaining of "bleeding." The RN noted that Patient 18 was "14 weeks gestation" and "several attempts were made to find fetal heart tones, but were unsuccessful." No further assessments were done to determine the health status of the fetus. Blood pressure reading on presentation was 129/91. The RN further noted that patient's urine was "turbid, light blood tinged appearance. "</p> <p>The RN noted, at 00:45, that Patient #18 went to "bathroom and voids 100ml light blood tinged." At 02:10, "Patient voids 200 ml bright red bloody urine with no clots at this time." Physician unavailable for interview.</p> <p>No further examination and/or diagnostic work-up done. Patient #18 was discharged in care of the mother who was instructed to drive Patient #18 to a hospital in Sioux City, IA via the mother's private vehicle.</p> <p>9. Patient #22 was a 30-year old pregnant woman, who was at 25 weeks gestational age. She was a G (gravida) 7, P (para) 6, A (abortions) 0, with a history of premature delivery at 25-weeks.</p> <p>Patient #22 presented to the hospital on May 10, 2015 at 14:20. The RN noted that Patient #22 complained of cramping and vaginal discharge.</p>	A1100			

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A1100	<p>Continued From page 42</p> <p>Patient due date is 08/20/2015. According to medical record, the patient had a history of premature labor with other pregnancies. This pregnancy was number 7.</p> <p>At 14:55, the patient was placed on external monitor (Toco) to monitor uterine contractions and fetal heart rate. Medical record indicated that the doctor conducted a vaginal examination at 15:10.</p> <p>The medical record failed to show fetal heart rate with variability, or the uterine contraction patterns.</p> <p>The patient was discharged home at 15:30.</p> <p>The patient fetal monitor strip done in the Emergency Department showed the fetal heart tone, was not reassuring because the heart rate was recording between 60's to 120's. No further evaluation was done. For over one minute, the fetal heart tones recorded on the external toco was not reassuring. A heart rate of 60 is considered alarming in most cases of an obstetric emergency. Fetal heart tone should be between 120-160's. The uterine contraction toco was not recording any contractions even when the patient said she was cramping. The Emergency Department nurse or doctor did not document anything related to the fetal activity or uterine contractions. The fetal monitor strip completed on the Emergency Department was dated 04/04/44.</p> <p>On May 13, 2015, at 14:00, an interview was conducted with the Emergency Department nurse. During the interview, the nurse stated that he did not realize that the monitor strip dates were wrong. He also stated that it has been</p>	A1100			

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A1100	<p>Continued From page 43</p> <p>years since the hospital provided a fetal monitor training to staff.</p> <p>On May 13, 2015, at 14:00, an interview with the Outpatient Nurse manager was conducted concerning the nurses fetal monitor training. The manager stated that "nobody here knows how to read a fetal monitor strip. The Director of Nurses may know but she don't come and assess the monitor strips from here or the ED. One or two providers may know. When those providers are not here then nobody read the monitor strips, we sent the patient home without an accurate assessment." The manager also stated that she has been requesting the DON for a fetal monitor training for her staff and the ED staff, but the DON has not provided the training.</p> <p>On May 13, 2015, at 14:20, an interview with the hospital DON was conducted concerning the fetal monitor training for the nurses in the ED and Outpatient Department. The DON stated that a contract family practice group comes to the clinic once a week and they see all obstetric patient including reading the monitor strips for that day. The DON stated that if a patient needs to be monitored, the nurses or doctors should know how to read a monitor strip. When asked if any staff had request training on fetal monitor strip the DON stated, "no." During the same interview, the monitor strip of the patient in question was presented. The DON stated that the patient should have been monitored closely to verify the fetal heart tones and ensure there were no contractions. The DON also stated that the doctor should have written the cervical examination. The DON verified that the monitor had the wrong date. She said, she didn't know how to change the monitor to the correct date but</p>	A1100			

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A1100	<p>Continued From page 44 she will call biomed.</p> <p>On May 13, 2015, at 16:00, the DON stated that the two batteries in the fetal monitor located in the ED were dead and that biomed will change the batteries.</p> <p>On May 14, 2015, at 9:00, the surveyor visited the ED to ensure that the Fetal Monitor machine batteries were changed as the DON stated the day before. The visit revealed that the batteries were still not changed and the date in the monitor strip paper was 04/04/44.</p> <p>On May 15, 2015, at 10:00, an interview with the DON was conducted. The DON stated the batteries will be changed today (05/14/2015).</p> <p>Review of the Fetal Monitor Training record provided by the DON on May 14, 2015, revealed that the last training was completed on October 2011.</p> <p>Patient #22 was discharged home after an inadequate medical examination in that the staff were unable to recognize the alarming fetal heart rate recorded on the toco because of either inadequate or no training in that aspect of obstetric care. The monitoring machines used were likely not functioning well due to dead batteries and poor biomedical maintenance as suggested by the wrong date recorded.</p> <p>10. Patient #28 was 38-year old, who presented to the Emergency Department on May 4, 2015, at 01:01, with swollen right ankle. Patient was examined by an ED physician who noted that</p>	A1100			

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A1100	Continued From page 45 Patient #28 had "right ankle swelling, painful weight bearing." The ED physician ordered x-ray of the right ankle which showed "a long oblique fracture of the right distal fibula. There is approximately 2 - 3 mm posterior and lateral displacement of the distal fracture fragment with little distraction. In addition, the ankle mortise seems widened especially medially, suspect underlying instability." Patient was discharged home at 02:14.  No further assessment done and/or treatment provided. The diagnostic examination was not adequate because the initial x-ray findings did not include stress views. The x-ray result showed a widened mortise which represents a potentially unstable fracture that may require surgical repair. Emergency providers typically can reduce and splint such fractures but these were not attempted or done prior to discharge.	A1100			
A2406	489.24(a) & 489.24(c) MEDICAL SCREENING EXAM  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	A2406			

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A2406	<p>Continued From page 46</p> <p>regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and</p> <p>(b) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.</p> <p>(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.</p> <p>(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</p>	A2406			

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A2406	<p>Continued From page 47</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on medical records review, and interview of available and willing staff, the hospital staff failed to provide medical screening examination that were within the capabilities of this hospital and appropriate to the presenting symptoms of 8 out of 30 randomly selected patients. Citing Patient # 2, 3, 6, 7, 8,16, 22 and 28.</p> <p>Findings:</p> <p>1. Patient #2 was a 15-month old child, who was brought by the parents on January 20, 2015, at 23:00, with complaints of "breathing rapidly, uncomfortable, fever, might need breathing treatment." The RN noted that the oxygen saturation level at 00:10 was 95% with coarse breath sounds; nebulizer treatment was given. Temperature was recorded as 101.2F, was given Ibuprofen 100mg suspension</p> <p>Patient #2 was seen by a physician, at 23:25, who noted that Patient #2 had "tachypnea with accessory muscles of respiration in use." No further assessments done and/or treatment provided. Patient #2 was discharged home at 00:45.</p> <p>Patient #2 was brought back to the ED by parents on January 22, 2015, at 09:37. The RN noted that Patient #2 had "grunting and difficulty breathing." The oxygen saturation level was</p>	A2406			



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A2406	<p>Continued From page 48</p> <p>recorded as 95% with a pulse rate of 138 per minute. Patient #2 was examined by a pediatrician who noted that the patient was in "respiratory distress." Diagnostic work-up done at this time. Nebulizer treatments ordered and administered. Pediatrician decided to transfer patient to a hospital in Sioux City, IA for for stabilizing treatment.</p> <p>The failure of the staff to use all available resources in the management of this patient during the first presentation placed the health and welfare of this patient in serious jeopardy.</p> <p>2. Patient #3 was 60-year old, who had multiple presentations to the Emergency Department with the same complaint of acute chest pain but appropriate medical screening examination was not provided.</p> <p>Patient #3 presented to the Emergency Department on June 14, 2014, at 02:04, complaining of chest pain on inspiration and rated it as 6 on a 0 -10 pain scale (10 being the worst pain). He stated that he had a cough for the past 3 days prior to presentation. Patient #3 was seen by a physician at 02:30 AM. The physician noted that Patient #3 has a history of COPD (chronic obstructive pulmonary disease) and was "SOB (short of breath) mostly in recumbent position." The physician further noted that the lung fields of Patient #3 was "clear to auscultation bilaterally." However, Patient #3 was treated with Albuterol nebulizer at 03:08 AM. Patient #3 was discharged home at 04:15 AM.</p> <p>No further examination or diagnostic work-up was done to evaluate the acute chest pain. Acute</p>	A2406			

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A2406	<p>Continued From page 49</p> <p>chest pain is an emergency medical condition that may represent ischemia or infarct.</p> <p>Patient #3 presented to the Emergency Department again on July 3, 2014, at 12:12, with similar complaints. Patient #3 was assessed by a Registered Nurse (RN) but no medical screening examination completed by a Qualified Medical Practitioner. Patient #3 was discharged home. The RN was unavailable for interview.</p> <p>Patient #3 presented to the Emergency Department again on July 3, 2014, at 12:49, with complaints of "chest pains/breathing problems." The RN noted that "Pt (patient) c/o (complaint of) difficulty breathing when he tries to lay down, then experiences a burning pain across his upper chest ... .." A Physician Assistant (PA) examined Patient #3 and noted that Patient #3 had "sinus tach (tachycardia)," lung fields were "clear to auscultation bilaterally, normal respiratory effort" and diagnosed the patient with "COPD exacerbation." No physician examined the patient during this presentation. Patient #3 was discharged home at 02:05 AM. The PA was unavailable for interview.</p> <p>No further examination or diagnostic work-up was done to evaluate the acute chest pain. Acute chest pain is an emergency medical condition that may represent ischemia or infarct.</p> <p>Patient #3 presented to the Emergency Department again on July 3, 2014, at 02:58, with similar complaints. The RN noted that "Pt is in car outside ambulance entrance unable to walk per family members." The RN further noted that Patient #3 was "SOB, tearful and grabbing his chest." Patient #3 was examined by a PA at</p>	A2406			

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A2406	<p>Continued From page 50</p> <p>03:00. No physician examined the patient. PA unavailable for interview.</p> <p>Diagnostic laboratory tests for cardiac enzymes done at this visit showed elevated levels: CKMB - 5.6 (normal 0 - 3), Troponin I - 0.500 (normal &lt;0.35), Myoglobin - 151.0 (normal 30 - 90), B-Type Natriuretic Peptide - 193.0 (100 - 300 suggest heart failure is present). Patient #3 was seen by a PA and no physician examined the patient.</p> <p>Patient #3 was eventually transferred to a hospital in Sioux City, IA for the required stabilizing treatment of the cardiac emergency medical condition. Patient left the hospital at 13:00 by ambulance.</p> <p>The failure of the hospital staff to conduct an appropriate examination and conduct diagnostic tests to evaluate a likely cardiac emergency condition during the previous presentations placed the patient in an Immediate Jeopardy situation with the likelihood of serious harm, injury and death.</p> <p>3. Patient #6 was a 6-month old child, who was brought to the Emergency Department on February 13, 2015, at 10:00, by the mother. The mother informed the RN that the child had "bad congestion, phlemy (sic) nose, shallow breathing." Patient #6 was seen by a PA who noted that there was "no wheezing appreciated throughout lung fields, no retractions, no additional work of breathing, no see-saw breathing." No further examination was done and/or any diagnostic work-up. PA unavailable for interview.</p>	A2406			

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A2406	<p>Continued From page 51</p> <p>Patient #6 and mother were escorted to the Outpatient Department of the hospital at 10:30. A pediatrician examined Patient #6 who noted that there was "wheezing HEARD WITHOUT STETHOSCOPE." The pediatrician further noted that there were "wheezes all over lung fields, SUBCOSTAL retractions present." Diagnostic work-up were done at the Outpatient Department and treatment provided to Patient #6.</p> <p>ED physician on record interviewed on May 12, 2015, at approximately 13:00. The ED physician was asked if he examined Patient #6 and/or conducted diagnostic work-up to determine whether an emergency medical condition existed. The ED physician stated that the PA examined the patient and there was no indication that he should have to see the patient himself. The ED physician was asked to explain the discrepancy between the PA's finding regarding the patient's respiratory status and the pediatrician's finding of respiratory distress upon arrival at the Outpatient Department. The ED physician stated that he "did what was required of me by law. I didn't have to do anything else. I understand EMTALA well, and let me tell you about the law ..... "</p> <p>The ED hospital staff failed to utilize all available resources in the hospital to address the medical condition of the patient. The failure of the ED staff to provide appropriate medical examination including diagnostic work-up, and necessary stabilizing treatment within the capability of the hospital placed this patient with the likelihood of serious injury, harm or death.</p> <p>4. Patient #7 was 30-year old, who presented to</p>	A2406			

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A2406	<p>Continued From page 52</p> <p>the Emergency Department on May 4, 2015, at 12:29, after reportedly drinking for 3 weeks. Patient #7 stated that "his last drink was around 9am." Further, Patient #7 informed the RN that he was "having frequent episodes of emesis whic (sic) is clear phlegm." Blood pressure reading was recorded as 144/91 with a pulse rate of 124 beats per minute.</p> <p>Patient #7 was seen by the ED physician and noted the blood pressure reading as 179/100 with a pulse rate of 144 beats per minute. The blood pressure was rechecked (time not indicated) and the reading was 185/104 with a pulse rate of 131 beats per minute.</p> <p>Intravenous (IV) fluid of Sodium Chloride with 20 mEq of potassium at 250 ml/hour was started at 14:30. The IV was discontinued at 19:25, and Patient #7 was discharged home at 19:30. No further assessment was done and/or treatment provided prior to discharge to ensure that the patient alcohol withdrawal status was resolved.</p> <p>Patient #7 was brought back to the Emergency Room by the family on May 5, 2015, at 15:21, after at least 2 seizure activities at home. The RN noted that the family members stated that Patient #7 was "just shaky." The RN noted that Patient #7 has fever (101.2F), irregular heart rate (144 beats per minute), and high blood pressure (179/100).</p> <p>The ED physician examined Patient #7. Electrocardiogram was done and showed "atrial fibrillation with RVR (Rapid Ventricular Rate)." Laboratory tests were done and showed that Patient #7 was in "high anion-gap metabolic acidosis, hyponatric/hypochloremic dehydration,</p>	A2406			

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A2406	<p>Continued From page 53 and alcoholic hepatitis."</p> <p>Based on the diagnostic work-up on this second presentation, a day after Patient #7 presented with symptomatology of alcohol withdrawal, Patient #7 was in a state of delirium tremens and autonomic instability that required critical care services. This could have been avoided if appropriate examination was done during the initial presentation and treatment was provided within the capability of this hospital rather than discharging the patient home when he was in an alcohol withdrawal state.</p> <p>Patient #7 was transferred to a hospital in Sioux City, IA via ambulance to obtain the critical care services required.</p> <p>5. Patient #8 was a 28-year old pregnant woman, who was a Gravida 4 and para 3 (Pregnancy 4, delivered 3) with gestational age of 36 weeks.</p> <p>Patient #8 presented to the Emergency Department on May 5, 2015, at 03:38, complaining of contractions since 23:00. The patient indicated that the contractions are about 4 to 5 minutes apart. She described the pain as 8 on a 0 - 10 pain scale (10 being the worst pain). Also, stated that the contraction lasted about 2 minutes each.</p> <p>Medical record indicated that at 03:45, Patient #8 was placed on the uterine fetal monitor and according to the ED staff documentation, the fetal heart rate were at 140's to 150's with "Good variability with no decelerations noted." At 03:55, Patient #8 was assessed by the provider and determined she was 2 centimeter dilated with</p>	A2406			

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A2406	<p>Continued From page 54</p> <p>50% effacement.</p> <p>Review of the patient fetal monitor strip (monitor fetal heart rate and uterine activity for contraction) revealed:</p> <ol style="list-style-type: none"> <li>1. The date printed in the monitor strip was 05/12/44. The patient was monitored on 05/05/15.</li> <li>2. The nursing staff documented the fetal heart rate had "good variability" but there was no variability present in the monitor strip.</li> <li>3. The nursing staff documented, "no contractions." However, the external tocometer revealed several waves with no reassurance of the location. External uterine contraction monitor can be affected by patient movements, patient size and location of the monitor. The staff monitoring the patient needs to be present during a contraction and mark the monitor strip to indicate that a contraction started and ended. The staff should always document the frequency of the contraction.</li> <li>4. The external uterine contraction monitor read on the 70's that can be interpreted as an indication of abruptio placenta. No further assessment done. Abruptio placenta occurs when the placenta separates from the wall of the uterus before the birth of a baby which can result in severe, uncontrollable bleeding. These external monitor readings can often be affected by positioning of the patient, patient size, placement of the tocometer in the uterus. The staff monitoring the patient should manually palpate the abdomen to ensure uterine relaxation. The staff should document intensity of the contraction with palpation of the abdomen.</li> </ol>	A2406			

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A2406	<p>Continued From page 55</p> <p>Results of the review of the patient fetal monitor strip above showed that the staff were unable to adequately assess the condition of Patient #8 either due to inadequate training or no training at all. Lack of competency in the care of obstetric patient places the health and welfare of all obstetric patients that come to this hospital in immediate jeopardy.</p> <p>The medical record indicated that Patient #8 was a high risk obstetric patient with possible pre-term rupture of membranes and possible pre-eclampsia.</p> <p>Record review of the patient fetal monitor strip showed that on May 5, 2015, at 04:45, the patient was removed from the external fetal monitor. The entry in the monitor strip by the provider read "Good variability-no decelerations, no contractions."</p> <p>On May 13, 2015, at 14:20, the hospital DON was interviewed concerning the care for obstetric patients. During the course of the interview, the fetal monitor strip for this patient was presented. The DON stated there was no fetal heart accelerations recorded on the monitor strip. The DON also verified that the uterine tocometer needed to be repositioned or the nurse needed to palpate the uterus to verify contractions. When asked, when was the last time the ED nursing staff and providers got training on fetal heart monitor reading, the DON stated, "in 2011".</p> <p>6. Patient #16 was 74-year old, who presented to the Emergency Department on April 25, 2015, at 08:58, with complaints of "unable to urinate</p>	A2406			



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A2406	<p>Continued From page 56</p> <p>since yesterday, bleeding." The RN noted on arrival that Patient #16 had a blood pressure reading of 190/95. ED physician examined Patient #16 and noted "hypertensive disorder." Urine specimen was collected via catheterization which showed a "trace" blood in urine. Blood glucose showed an elevated level, 210.2 (65 - 100). Patient #16 was discharged home at 11:27. The ED physician was no longer available for interview.</p> <p>There was no further assessment done on the elevated high blood pressure nor was the elevated blood glucose addressed prior to discharge. No further assessment done and/or treatment given to address the urine retention. There are emergent causes of urinary retention including infections, neurological spinal cord compression, and renal failure.</p> <p>7. Patient #22 was a 30-year old pregnant woman, who was at 25 weeks gestational age. She was a G (gravida) 7, P (para) 6, A (abortions) 0, with a history of premature delivery at 25-weeks.</p> <p>Patient #22 presented to the hospital on May 10, 2015, at 14:20. The RN noted that Patient #22 complained of cramping and vaginal discharge. Patient due date is 08/20/2015. According to medical record the patient had a history of premature labor with other pregnancies. This pregnancy was number 7.</p> <p>At 14:55, the patient was placed on external monitor (Toco) to monitor uterine contractions and fetal heart rate. Medical record indicated that the doctor conducted a vaginal examination at 15:10.</p>	A2406			

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A2406	<p>Continued From page 57</p> <p>The medical record failed to show fetal heart rate with variability, or the uterine contraction patterns.</p> <p>The Emergency Department sent the patient home at 15:30.</p> <p>The patient fetal monitor strip done in the Emergency Department showed the fetal heart tone, not reassuring because the heart rate was recording between 60's to 120's. For over one minute, the fetal heart tones recorded on the external toco was not reassuring. No further assessment or evaluation done. A heart rate of 60 is considered alarming in most cases of an obstetric emergency and requires further evaluation. Fetal heart tone should be between 120 -160's. The uterine contraction toco was not recording any contractions even when the patient said she was cramping. The Emergency Department nurse or doctor did not document anything related to the fetus activity or uterine contractions. The fetal monitor strip completed on the Emergency Department was dated 04/04/44.</p> <p>On May 13, 2015, at 14:00, an interview was conducted with the Emergency Department nurse. During the interview, the nurse stated that he did not realize that the monitor strip dates were wrong. He also stated that it has been years since the hospital provided a fetal monitor training to staff.</p> <p>On May 13, 2015, at 14:00, an interview with the Out Patient Nurse manager was conducted concerning the nurses fetal monitor training. The manager stated that, "nobody here knows how to read a fetal monitor strip. The Director of Nurses may know but she don't come and assess the</p>	A2406			

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A2406	<p>Continued From page 58</p> <p>monitor strips here or the ED. One or two providers may know. When those providers are not here then nobody read the monitor strips, we sent the patient home without an accurate assessment." The manager also stated that she has been requesting the DON for a fetal monitor training for her staff and the ED staff, but the DON has not provided the training.</p> <p>On May 13, 2015, at 14:20, an interview with the hospital DON was conducted concerning the fetal monitor training for the nurses in the ED and Outpatient Department. The DON stated that a contract family practice group comes to the clinic once a week and they see all obstetric patient including reading the monitor strips for that day. The DON stated that if a patient needs to be monitored, the nurses or doctors should know how to read a monitor strip. When asked if any staff had request training on fetal monitor strip the DON stated, "no". During the same interview, the monitor strip of the patient in question was presented. The DON stated that the patient should have been monitored closely to verify the fetal heart tones and ensure there were no contractions. The DON also stated that the doctor should have written the cervical examination. The DON verified that the monitor had the wrong date. She said, she didn ' t know how to change the monitor to the correct date but she will call biomed.</p> <p>On May 13, 2015, at 16:00, the DON stated that the two batteries in the fetal monitor located in the ED were dead and that biomed will change the batteries.</p> <p>On May 14, 2015, at 9:00, the surveyor visited the ED to ensure that the Fetal Monitor machine</p>	A2406			

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A2406	<p>Continued From page 59</p> <p>batteries were changed as the DON stated the day before. The visit revealed that the batteries were still not change and the date in the monitor strip paper was 04/04/44.</p> <p>On May 15, 2015, at 10:00, an interview with the DON was conducted. The DON stated the batteries will be changed today (05/14/2015).</p> <p>Review of the Fetal Monitor Training record provided by the DON on May 14, 2015, revealed that the last training was completed on October 2011.</p> <p>Patient #22 was discharged home after an inadequate medical screening examination in that the staff were unable to recognize the alarming fetal heart rate recorded on the toco because of either inadequate or no training in that aspect of obstetric care. The monitoring machines used were likely not functioning well due to dead batteries and poor biomedical maintenance as suggested by the wrong date recorded.</p> <p>8. Patient #28 was 38-year old, who presented to the Emergency Department on May 4, 2015, at 01:01, with swollen right ankle. Patient was examined by an ED physician who noted that Patient #28 had "right ankle swelling, painful weight bearing." The ED physician ordered x-ray of the right ankle which showed "a long oblique fracture of the right distal fibula. There is approximately 2 - 3 mm posterior and lateral displacement of the distal fracture fragment with little distraction. In addition, the ankle mortise seems widened especially medially, suspect underlying instability." Patient was discharged home at 02:14.</p>	A2406			

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A2406	Continued From page 60	A2406			
A2407	<p>No further assessment done and/or treatment provided. The diagnostic examination was not adequate because the initial x-ray findings did not include stress views. The x-ray result showed a widened mortise which represents a potentially unstable fracture that may require surgical repair. Emergency providers typically can reduce and splint such fractures but these were not attempted or done prior to discharge.</p> <p>489.24(d)(1-3) STABILIZING TREATMENT</p> <p>(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-</p> <p>(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.</p> <p>(ii) For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section.</p> <p>(2) Exception: Application to inpatients.</p> <p>(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</p> <p>(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.</p>	A2407			

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NAME OF PROVIDER OR SUPPLIER  <b>WINNEBAGO IHS HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>HWY 77-75 WINNEBAGO, NE 68071</b>		
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A2407	<p>Continued From page 61</p> <p>(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.</p> <p>(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.</p> <p>This STANDARD is not met as evidenced by: Based on medical records review, and interview of available and willing staff, the hospital staff failed to provide stabilizing treatment within the hospital's capability to 3 out of 30 randomly selected patients with emergency medical condition. Citing Patient # 2, 14 and 28.</p> <p>Findings:</p>	A2407			

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A2407	<p>Continued From page 62</p> <p>1. Patient #2 was a 15-month old child, who was brought by the parents on January 20, 2015, at 23:00, with complaints of "breathing rapidly, uncomfortable, fever, might need breathing treatment." The RN noted that the oxygen saturation level at 00:10 was 95% with coarse breath sounds; nebulizer treatment was given. Temperature was recorded as 101.2F, was given Ibuprofen 100mg suspension.</p> <p>Patient #2 was seen by a physician, at 23:25, who noted that Patient #2 had "tachypnea with accessory muscles of respiration in use." No further assessments done and/or treatment provided. No diagnostic work-up was done. Patient #2 was discharged home at 00:45.</p> <p>Patient #2 was brought back to the ED by parents on January 22, 2015, at 09:37. The RN noted that Patient #2 had "grunting and difficulty breathing." The oxygen saturation level was recorded as 95% with a pulse rate of 138 per minute. Patient #2 was examined by a pediatrician who noted that the patient was in "respiratory distress." Diagnostic work-up done at this time. Nebulizer treatments ordered and administered. Pediatrician decided to transfer patient to a hospital in Sioux City, IA for further stabilizing treatment.</p> <p>The failure of the staff to use all available resources in the management of this patient during the first presentation placed the health and welfare of this patient in immediate jeopardy.</p> <p>2. Patient #14 was 32-years old, who presented to the Emergency Department on March 16, 2015, at 13:44, with complaints of laceration of</p>	A2407			

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A2407	<p>Continued From page 63</p> <p>left pointer finger and hypertension. The RN noted that the blood pressure (BP) reading was 216/120.</p> <p>Labetalol (anti-hypertensive drug) 20 mg was given intravenously at 14:22. BP was rechecked at 14:30 and recorded as 194/118; at 15:00, BP was 210/105. Labetalol 40 mg was given intravenously at 15:11.</p> <p>Furosemide (diuretic) 40 mg given intravenously (IV) at 16:02, BP was rechecked at 16:15 which was recorded as 180/102.</p> <p>"Nitroglycerin IV 25 mg in 250 mls (milliliter) D5W solution to infuse at 6 mls/hour = 10 mcg/min" was started at 17:14. According to <a href="http://www.dailymed.nlm.nih.gov">www.dailymed.nlm.nih.gov</a>, &lt;<a href="http://www.dailymed.nlm.nih.gov">http://www.dailymed.nlm.nih.gov</a>&gt;,"Nitroglycerin in 5% Dextrose is indicated for treatment of peri-operative hypertension; for control of congestive heart failure in the setting of acute myocardial infarction; for treatment of angina pectoris in patients who have not responded to sublingual nitroglycerin and <math>\beta</math>-blockers; and for induction of intraoperative hypotension." Further, it stated that "severe hypotension and shock may occur with even small doses of nitroglycerin."</p> <p>Blood pressure readings after the initiation of the Nitroglycerine IV were recorded as: 17:45 - 155/99 18:00 - 152/87 18:11 - 191/108 19:00 - 155/90 19:10 - 167/99</p> <p>Medical record showed that the IV was</p>	A2407			



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A2407	<p>Continued From page 64</p> <p>discontinued at 19:31 and patient was discharged home.</p> <p>There was no further observation and/or assessment done to ensure that the hypertensive emergency was resolved. Failure to observe and assess the patient for a reasonable period of time to ensure that the patient did not have severe hypotension from the drugs administered placed the health and welfare of the patient in immediate jeopardy.</p> <p>3. Patient #28 was 38-years old, who presented to the Emergency Department on May 4, 2015, at 01:01, with swollen right ankle. Patient was examined by an ED physician who noted that Patient #28 had "right ankle swelling, painful weight bearing." The ED physician ordered x-ray of the right ankle which showed "a long oblique fracture of the right distal fibula. There is approximately 2 - 3 mm posterior and lateral displacement of the distal fracture fragment with little distraction. In addition, the ankle mortise seems widened especially medially, suspect underlying instability." Patient was discharged home at 02:14.</p> <p>No further assessment done and/or treatment provided. The diagnostic examination was not adequate because the initial x-ray findings did not include stress views. The x-ray result showed a widened mortise which represents a potentially unstable fracture that may require surgical repair. Emergency providers typically can reduce and splint such fractures but these were not attempted or done prior to discharge.</p>	A2407			

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A2409	<p>489.24(e)(1)-(2) APPROPRIATE TRANSFER</p> <p>(1) General If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless - (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer.</p> <p>(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or</p> <p>(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified</p>	A2409			

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A2409	<p>Continued From page 66</p> <p>medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.</p> <p>(2) A transfer to another medical facility will be appropriate only in those cases in which -</p> <p>(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;</p> <p>(ii) The receiving facility</p> <p>(A) Has available space and qualified personnel for the treatment of the individual; and</p> <p>(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment.</p> <p>(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1) (ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and</p>	A2409			

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A2409	<p>Continued From page 67</p> <p>(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.</p> <p>This STANDARD is not met as evidenced by: Based on medical records review, and interview of available and willing staff, the hospital staff failed to effect an appropriate transfer of 3 out of 30 randomly selected patients with emergency medical condition. Citing Patient # 7, 14 and 18.</p> <p>Findings:</p> <p>1. Patient #7 was 30-years old, who presented to the Emergency Department on May 4, 2015, at 12:29, after reportedly drinking for 3 weeks. Patient #7 stated that "his last drink was around 9am." Further, Patient #7 informed the RN that he was "having frequent episodes of emesis whic (sic) is clear phlegm." Blood pressure reading was recorded as 144/91 with a pulse rate of 124 beats per minute.</p> <p>Patient #7 was seen by the ED physician and noted the blood pressure reading as 179/100 with a pulse rate of 144 beats per minute. The blood pressure was rechecked (time not indicated) and the reading was 185/104 with a pulse rate of 131 beats per minute.</p> <p>Intravenous (IV) fluid of Sodium Chloride with 20 mEq of potassium at 250 ml/hour was started at 14:30. The IV was discontinued at 19:25, and Patient #7 was discharged home at 19:30. No further assessment was done and/or treatment</p>	A2409		

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A2409	<p>Continued From page 68</p> <p>provided to ensure that the patient alcohol withdrawal status was resolved.</p> <p>A transfer is defined under 42 CFR 489 as the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital.</p> <p>Patient #7 was brought back to the Emergency Room by the family on May 5, 2015, at 15:21, after at least 2 seizure activities at home. The RN noted that the family members stated that Patient #7 was "just shaky." The RN noted that Patient #7 has a fever (101.2F), irregular heart rate (144 beats per minute), and high blood pressure (179/100).</p> <p>The ED physician examined Patient #7. Electrocardiogram was done and showed "atrial fibrillation with RVR (Rapid Ventricular Rate)." Laboratory tests were done and showed that Patient #7 was in "high anion-gap metabolic acidosis, hyponatric/hypochloremic dehydration, and alcoholic hepatitis."</p> <p>Based on the diagnostic work-up on this second presentation, a day after Patient #7 presented with symptomatology of alcohol withdrawal, Patient #7 was in a state of delirium tremens and autonomic instability that required critical care services. This could have been avoided if appropriate examination was done and treatment was provided rather than discharging the patient home when he was in an alcohol withdrawal state.</p> <p>Patient #7 was transferred to a hospital in Sioux</p>	A2409			

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A2409	<p>Continued From page 69</p> <p>City, IA via ambulance at this time to obtain the critical care services required to stabilize the condition of Patient #7.</p> <p>2. Patient #14 was 32-year old, who presented to the Emergency Department on March 16, 2015, at 13:44, with complaints of laceration of left pointer finger and hypertension. The RN noted that the blood pressure (BP) reading was 216/120.</p> <p>Labetalol (anti-hypertensive drug) 20 mg was given intravenously at 14:22. BP was rechecked at 14:30 and recorded as 194/118; at 15:00, BP was 210/105. Labetalol 40 mg was given intravenously at 15:11.</p> <p>Furosemide (diuretic) 40 mg given intravenously (IV) at 16:02, BP was rechecked at 16:15 which was recorded as 180/102.</p> <p>"Nitroglycerin IV 25 mg in 250 mls (milliliter) D5W solution to infuse at 6 mls/hour = 10 mcg/min" was started at 17:14. According to <a href="http://www.dailymed.nlm.nih.gov">www.dailymed.nlm.nih.gov</a>, <a href="http://www.dailymed.nlm.nih.gov">http://www.dailymed.nlm.nih.gov</a>, "Nitroglycerin in 5% Dextrose is indicated for treatment of peri-operative hypertension; for control of congestive heart failure in the setting of acute myocardial infarction; for treatment of angina pectoris in patients who have not responded to sublingual nitroglycerin and β-blockers; and for induction of intraoperative hypotension." Further, it stated that "severe hypotension and shock may occur with even small doses of nitroglycerin."</p> <p>Blood pressure readings after the initiation of the</p>	A2409		

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A2409	<p>Continued From page 70</p> <p>Nitroglycerine IV were recorded as: 17:45 - 155/99 18:00 - 152/87 18:11 - 191/108 19:00 - 155/90 19:10 - 167/99</p> <p>Medical record showed that the IV was discontinued at 19:31 and patient was discharged home.</p> <p>A transfer is defined under 42 CFR 489 as the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital.</p> <p>There was no further observation and/or assessment done to ensure that the hypertensive emergency was resolved. Failure to observe and assess the patient for a reasonable period of time to ensure that the patient did not have severe hypotension from the drugs administered placed the health and welfare of the patient in serious jeopardy.</p> <p>3. Patient #18 was a 28-year old, pregnant woman, who presented to the Emergency Department on April 12, 2015 at 00:18, complaining of "bleeding." The RN noted that Patient 18 was "14 weeks gestation" and "several attempts were made to find fetal heart tones, but were unsuccessful. No further assessments were done to determine the health</p>	A2409			

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A2409	<p>Continued From page 71</p> <p>status of the fetus. Blood pressure reading on presentation was 129/91. The RN further noted that patient's urine was "turbid, light blood tinged appearance."</p> <p>The RN noted, at 00:45, that Patient #18 went to "bathroom and voids 100ml light blood tinged." At 02:10, "Patient voids 200 ml bright red bloody urine with no clots at this time." Physician unavailable for interview.</p> <p>No further examination and/or diagnostic work-up done. Patient #18 was discharged in care of the mother with an instruction to drive Patient #18 to a hospital in Sioux City, IA via the mother's private vehicle.</p>	A2409			