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A 000	INITIAL COMMENTS	A 000		

On behalf of the Centers for Medicare & Medicaid Services (CMS), an unannounced on-site Emergency Medical Treatment and Labor act (EMTALA) survey (ASPEN # 355W11, KS00176701) conducted at the above-named hospital from 12/13/22 to 02/07/23 resulted in a finding of noncompliance with the Responsibilities of Medicare Participating Hospitals in Emergency Cases 42 CFR §489.24 and noncompliance with other essentials of Provider Agreements at 42 CFR §489.20.

The hospital's emergency department saw an average of 5,691 patients each month from June through November.

On April 10, 2023 at 2:50 PM, the CMS Kansas City location notified the hospital's Risk Manager that Immediate Jeopardy conditions existed, placing the health and safety of all patients at risk. On August 2, 2022, at approximately 11:35 PM, a high-risk pregnant patient (# 17) presented to the hospital's labor and delivery unit seeking care for an emergency medical condition (EMC). The hospital failed to stabilize patient # 17 within its capability and capacity when it determined it would not provide the necessary stabilizing treatment due to its interpretation of Kansas law. The hospital discharged the patient at approximately 1:20 AM on August 3, 2022 with an un-stabilized EMC. On September 12, 2022 at approximately 10:38 PM, a patient (# 15) presented to the emergency department (ED) requesting care. At 10:52 PM, a physician acknowledged the patient had an abnormal EKG and per hospital surveillance video, the patient was taken by wheelchair to an ED waiting room

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

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A 000	Continued From page 1 prior to a medical screening examination (MSE). At approximately 10:56 PM the hospital video footage ended. Approximately 90 minutes later, at 12:34 AM, the video footage resumed, and staff can be seen pushing the patient in a wheelchair from the waiting room with his head slumped forward and appearing unresponsive. The medical record does not contain evidence that the hospital provided an appropriate MSE prior to this time. At 12:52 AM, the patient was declared deceased after unsuccessful attempts at resuscitation. The hospital's noncompliance creates a reasonable expectation that an adverse outcome resulting in serious injury, harm, impairment, or death has occurred and is likely to occur to current or future individuals in similar situations if not immediately corrected. See Tags A2406 and A2407 for details.	A 000		
A2400	COMPLIANCE WITH 489.24 CFR(s): 489.20(l) [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on document review, record review, policy review and interview the Hospital failed to ensure the emergency medical treatment and labor act (EMTALA) requirements were met by failing to provide within its capabilities and capacity, an appropriate medical screening exam (MSE) to patient 15, and failed to provide stabilizing treatment to patient 17 who presented to the emergency department (ED) seeking care for an emergency medical condition (EMC). Failure to provide an appropriate MSE and stabilizing treatment places patients at risk for harm and injury up to and including death.	A2400		

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Findings Include:

During a tour of the OB ED on 12/14/22 at 3:00 PM, the survey team noted EMTALA signage posted, 4 OB triage bays, 11 labor rooms, 3 Post Anesthesia Care rooms, and 2 operating rooms. Staff indicated the L & D unit is staffed with an attending physician and 2 residents (physicians receiving advanced training in obstetrics) who are onsite 24/7. MFM available for consult. Hospital has a level III NICU, it is also a level 1 trauma center with 1,045 licensed beds, and staffs for 985 beds.

Review of a hospital policy titled, "Emergency Medical Treatment and Active Labor Act Compliance (EMTALA)," last revised 10/2015 and approved 11/2022 showed, the "Purpose" of the policy included: "It is the policy of The University of Kansas Hospital to: A. Provide an appropriate medical screening examination to all individuals seeking emergency services to determine the presence or absence of an emergency medical condition. B. Stabilize an emergency medical condition within the Hospital capability and capacity prior to discharge or transfer;
C. Transfer patients in compliance with State and Federal laws and regulations (including 42 USC 1395d and regulations) and Hospital policies and procedures."

... DEFINITIONS: Medical Screening Examination (MSE): "The medical screening examination is the initial and ongoing process reasonably calculated to determine whether an emergency medical condition exists. The medical screening examination includes history, physical examination and appropriate testing within the

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capabilities of the Hospital as well as completion of appropriate documentation The MSE will be the same for any individual coming to the Hospital with the same signs and symptoms, regardless of the individual's ability to pay. Services routinely available to the Hospital including the use of on duty and/or on-call specialists are reasonably available to the Emergency department for MSE and stabilizing treatment of an emergency medical condition."
Qualified Medical Personnel (QMP): "A physician, physician assistant, an Advance Practice Registered Nurse in the Emergency Department or a Certified Nurse Midwife in Obstetric Unit with demonstrated competency acting within the scope of his or her license under a medically approved protocol."
Emergency Medical Condition: "A condition manifesting itself by acute symptoms of sufficient severity that the absence of 'immediate medical attention' could reasonably be expected to result in placing the health of the person in serious jeopardy, or result in serious impairment to bodily functions or serious dysfunction of body organ or part. The scope of this definition is not limited to patients with traditional evaluations of 'emergent' or 'urgent' and may include individuals with traditional evaluations of 'non-urgent' and possibly 'chronic' conditions. The phrase 'immediate medical attention' has been applied to situations in which the need for medical assessment and care was in a time frame of days rather than hours. Special categories of emergency medical conditions under Federal statute include undiagnosed acute pain, pregnancy with contractions present, symptoms of substance abuse (includes alcohol intoxication), and psychiatric disturbances."
Stabilize: "With respect to an emergency medical

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condition as defined above, to provide treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration is likely to result from (or occur during) the transfer of the individual. With respect to a pregnant female experiencing contractions stabilize means the QMP, after examining certifies the woman is in false labor or that the baby and placenta have been delivered. This definition is broader in concept than hemodynamic stability and includes inherent risks of deterioration from the condition, the risks of deterioration induced by movement of the patient, and the potential for deterioration that must be presumed in cases of differential diagnoses that have not yet been excluded."
Stable for discharge: "Physician has determined, within reasonable clinical confidence, that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonable performed as an outpatient or later as an inpatient with no material deterioration in condition, provided the patient is given a plan for plan for appropriate follow-up care with the discharge instructions."
Stable for transfer: "Physician has determined, within reasonable clinical confidence that the patient is expected to leave the hospital and be received at the second facility with no material deterioration in his/ her medical condition and the transferring physician reasonably believes the receiving facility has the capability to manage the patient's medical condition and any reasonably foreseeable complication of that condition."

Under the "Policy" section, it specified, ... Medical screening examination: "When an individual comes to the hospital or presents and a request is made on his or her behalf for the primary

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assessment of acute conditions or emergency services on a walk-in or non-scheduled basis, including but not limited to the Emergency Department and Obstetrics Units, an appropriate medical screening examination conducted by QMP will be provided to determine the existence of an emergency medical condition."

Review of a second hospital policy titled, "OB Triage Care" last revised and approved 10/2022, showed, ..."In the care of an OB patient presenting to the hospital to evaluate obstetrical complaint, the RN will: ...3. Initiate and document a targeted complaint specific physical assessment 4. Assess and document routine vital signs which include HR, BP, RR, SpO2, and pain. a. Upon presentation to triage Obtain temperature upon admission and every hour if febrile" ...5. Verify fetal heart rate within 10 minutes of patient's rooming. Follow guidelines for gestational age: a. <22 weeks, auscultate fetal heart rate upon presentation. ... 7. RN or physician should conduct a Vaginal exam, unless the following conditions are present: If any of the listed conditions apply, notify provider a. Is Complaining of vaginal bleeding b. Is Complaining of leaking of fluid ...

On 12/14/22 the hospital was asked to provide a policy and procedure for Preterm Premature Rupture of Membranes (PPROM) and policies related to Preterm Labor and Delivery. On 12/14/22 at 12:48 PM, Staff B, Accreditation & Regulatory Compliance Manager, emailed a document that showed Lippincott Procedures - Prelabor rupture of membranes (PROM) patient care. Staff B noted in the email that the hospital does not have specific preterm Labor and Delivery policies (the OB Triage policy addresses

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A2400	Continued From page 6 their initial plan of care) ... Review of the document "THE UNIVERSITY OF KANSAS HEALTH SYSTEM Prelabor rupture of membranes (PROM) patient care", last revised February 17, 2022 showed the following under the section titled "Critical Notes!" "At TUKH (The University of Kansas Health): Temperature is obtained Q2 (every 2) hours after rupture of membranes is determined. Obtain vital signs per orders." Under the section "Special Considerations", third bullet point, "Care of a patient with PPROM before viability (23 to 24 weeks' gestation) is based on clinical presentation and the patient's wishes. The practitioner should explain the risks and benefits of outpatient expectant management and surveillance and offer immediate delivery. If the patient chooses expectant management, the patient should be admitted to an antenatal unit for monitoring for infection and fetal well-being, antibiotic prophylaxis, and antenatal corticosteriods once the gestation reaches viability." Under the section "Complications" the document noted "The risk of complications generally increases the earlier and longer the membranes are ruptured. PROM places the patient and fetus at risk for infections due to the breach of the natural barrier that the amniotic membrane provides as well as the close proximity of vaginal and fecal bacteria. Placental abruption also complicates PPROM, placing the mother and fetus at risk for hemorrhage, hypoxia, and death. Other potential maternal complications include endometritis and retained placenta." ... Review of a document provided by the hospital titled, "2021 Kansas Statutes" showed, ..."76-3308. Powers and duties of authority;	A2400		

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limitations on performance of abortion in authority facilities. ...(i) Notwithstanding any provision of law to the contrary, no abortion shall be performed, except in the event of a medical emergency, in any medical facility, hospital or clinic owned, leased or operated by the authority. The provisions of this subsection are not applicable to any member of the physician faculty of the University of Kansas school of medicine when such abortion is performed outside the scope of such member's employment on property not owned, leased or operated by the authority. As used in this subsection, "medical emergency" means a condition that, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert the death of the woman or for which a delay necessary to comply with the applicable statutory requirements will create serious risk of substantial and irreversible physical impairment of a major bodily function. No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function."

1. The Hospital failed to follow its policy to provide an appropriate medical screening exam (MSE) to determine if an emergency medical condition (EMC) existed for 1 of 20 (Patient 15) patients reviewed. Patient 15 presented to the ED on 09/12/22 at 10:38 PM with complaint of cough and was found unresponsive on 09/13/22 at 12:34 AM in the ED waiting area. The medical record showed his time of death was 12:52 AM on 09/13/22. (Refer to Tag A-2406)

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A2400	Continued From page 8 2. The Hospital failed to follow its policy and provide stabilizing treatment for 1 of 20 patients (Patient 17) reviewed. Patient 17 presented to the Labor & Delivery triage department seeking medical care for an EMC. (Refer to Tag A-2407)	A2400		
A2406	MEDICAL SCREENING EXAM CFR(s): 489.24(a) & 489.24(c) (a) Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must- (i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section. (2)(i) When a waiver has been issued in	A2406		

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accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met:
(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.
(B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.
(C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.
(D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act.
(E) There has been a determination that a waiver of sanctions is necessary.
(ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under section 1135(e)(1)(B) of the Act.

(c) Use of dedicated emergency department for nonemergency services. If an individual comes to

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a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.
This STANDARD is not met as evidenced by:
Based on document review, policy review, video review, record review and interview, the Hospital failed to provide an appropriate medical screening exam (MSE) to determine if an emergency medical condition (EMC) existed for 1 of 20 (Patient 15) patients reviewed. Failure to provide an appropriate MSE has the potential to place patients at risk for adverse outcomes including death.

Findings Include:

Review of a hospital policy titled, "Triage, emergency department" last revised August 18, 2022, showed, "Because a patient's condition can decline while waiting in the ED, continue to monitor triaged patients who remain in the ED waiting area. Multiple factors may limit the opportunity to have the patient seen in the ED immediately."

Review of a hospital document with a title, "ESI Triage ED Nurse" showed, ...In order to assign a patient ESI level 2, the patient must meet one of the following three criteria: high-risk situation, new onset confusion/lethargy/disorientation, or

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severe pain or distress. Further review of the document showed, ...Assessment, 2-hour Vitals/more if pt is unstable or critical.

Review of Patient 15's Emergency Medical Service's Patient Care Report dated 09/12/22 showed the ambulance was dispatched at 9:22 PM, to Patient 15's home, for coughing and vomiting. The report narrative showed, upon arrival at 9:31 PM, Patient 15 was found sitting on the side of his bed coughing into a trash can. Patient 15 reported that about 2 hours prior to calling the ambulance he began coughing and had been coughing up a lot of mucus. During the ambulance transport, Patient 15 had rested and did not experience any coughing. Vital signs at 10:30 PM showed Blood Pressure BP 141/61, Pulse (P) 90, Respirations (R) 18 and SPO2 (oxygen level) 94%. Patient 15 was assisted from the ambulance cot to a wheelchair where Patient 15 began coughing again and Patient 15's care was turned over to ED staff.

Review of Patient 15's Emergency Department (ED) medical record showed he presented to the ED via ambulance on 09/12/22 at 10:38 PM with a chief complaint of dry cough. The record showed the triage assessment started on 09/12/22 at 10:41 PM by Staff V, Registered Nurse (RN). The sepsis screening tool showed Respiratory signs & symptoms: cough, shortness of breath. Patient 15 denied pain. Vital signs on 09/12/23 at 10:44 showed: Temperature 98.6, P 106, R 20, SPO2 98%, and BP at 10:46 PM was 174/52. Patient 15's acuity showed a 2, ED destination Critical Care. At 10:51 PM an ECG (electrocardiogram, measures electrical activity of the heart to detect cardiac problems) was completed and read by Staff BB, MD, Attending

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Physician at 10:52 PM.

Review of the ECG dated 09/12/22 at 10:51 PM, showed, Vent. Rate (ventricular rate is the number of times the main pumping portion of the heart beats in a minute) 126 BPM (beats per minute) (normal vent. Rate 60-100 BPM), Poor data quality, interpretation may be adversely affected Undetermined rhythm, Nonspecific ST abnormality, Abnormal ECG. Handwritten on the ECG was frequent PVC's (Premature ventricular contractions, extra heartbeats that begin in one of the heart's two lower pumping chambers), zero STEMI, initialed by Staff BB, with a time 10:52 PM.

Review of video footage from video camera (HC - ED Triage Desk #2), showed the double doors opened and Patient 15 arrived in the ED triage area at 10:37:11 PM in a wheelchair, he was holding what appeared to be a white container with a bag attached up to his face and he was coughing into it. He had what appeared to be a mask across his forehead. He continued to sit in the wheelchair by the triage desk with the container held up near his face. At 10:40:22 PM an unidentified staff walked by Patient 15, who raised his head and nodded. At 10:40:51 PM, Staff V, RN, pushes Patient 15 to the doorway of a small room in the triage area. Staff V, RN remained with Patient 15. At 10:45:20 PM an unidentified staff in black scrubs came through the double doors and approached Patient 15, it appeared the staff was talking to Patient 15, then is no longer seen in the video. At 10:48:00 Staff V stepped in front of Patient 15 and at 10:48:32 began placing patches on Patient 15's chest. At 10:49:48 PM Staff V could be seen attaching wires to Patient 15. At 10:53:00 PM, Staff V RN

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turns Patient 15 around in the wheelchair and takes him through the double doors and turns right. At 10:55:06 PM, Patient 15 is brought back through the double doors by Staff V. He is taken to the right towards the camera. Patient 15 is holding his head up looking forward and is no longer holding the container to his face and does not appear to be coughing. At 10:55:11 Patient 15 is no longer in view of the triage area camera.

Review of video footage from video camera (HC - ED Waiting Room Center Looking North), showed at 10:55:41 PM, Staff V RN pushing Patient 15 in a wheelchair to the north end of the waiting area, along the west side, near a man in a ball cap. There were 11 other people in this area of the waiting room. At 10:56:03 Staff V could be seen stepping to the left of Patient 15's wheelchair, and at 10:56:04 the video footage ended.

The video footage from video camera (HC - ED Waiting Room Center Looking North) resumed on 09/13/22 at 12:34:15 AM, 7 people in the waiting area are seen on the video. Patient 15 remained in the wheelchair, backed up to the west wall on the north end of the waiting area, next to the man in the ball cap. The man in the ball cap is looking at Patient 15, whose head is slumped forward. At 12:34:27 AM the man in the ball cap stands up and turns looking towards the south end of the waiting area. At 12:34:28 AM, Staff W, RN could be seen entering the waiting area with papers in her hand and walking towards the man in the ball cap. At 12:34:35 AM Staff W reached the man in the ball cap who appeared to gesture with his left arm towards Patient 15. At 12:34:39 AM Staff W can be seen stepping toward Patient 15. The man in the ball cap continues to stand and

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visualization of Patient 15 and Staff W was obscured. At 12:35:06 AM, the video showed Staff W begin to push Patient 15 in the wheelchair towards the south end of the waiting area. Patient 15's head is slumped down, and he is leaning slightly to the right, the skin of his right leg is visible and appears very dark in color. The video ended at 12:35:18 AM after Patient 15 was taken through the doors into the triage area.

The video camera (HC - ED Waiting Room Center Looking North) failed to showed footage of events, staff or other people in the waiting area between 10:56:04 PM on 09/12/22 and 12:34:56 AM on 09/13/22, hindering the ability to determine if assigned staff were in the waiting area during that time and when the event may have occurred.

During an interview on 02/07/23 at 12:50 PM, Staff A, Senior Director, Regulatory and Risk Management, when asked why the video between 10:56:04 on 09/12/22 and 12:34:15 on 09/13/22 was not saved, stated that the person who saved the video "just didn't save in between." She stated that he only saved the part of the video of when Patient 15 was taken into the waiting area and when he was taken out.

Review of Patient 15's "ED Provider Notes" dated 09/13/22 at 12:52 AM, by Staff Y, MD showed "History of Present Illness: Patient is a 73-year-old male with a past medical history of CAD (coronary artery disease), CHF (congestive heart failure), DM (diabetes), hypertension, hyperlipidemia (high level of fats in the blood), who presents to the emergency department the chief complaint of cough. Patient presented to triage with a chief complaint of dry cough. While patient was in the waiting room, RN rechecked

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vitals and at this time patient was unresponsive and did not have a pulse. Patient was taken back to the trauma bay at this time."

Further review of the "ED Provider Notes" by Staff Y, MD showed, "ED Course: Patient is a 73 y.o. male who presented to the ED for cough. Patient was found unresponsive in the waiting room and was immediately roomed. At this time CPR (cardiopulmonary resuscitation) was started and patient was ventilated with a BVM (Bag Valve Mask). Following the ACLS (Advanced Cardiac Life Support) algorithm patient was given a total of 4 rounds of epinephrine (primary drug administered during cardiopulmonary resuscitation (CPR) to reverse cardiac arrest), 2 bicarb (Sodium bicarbonate frequently used for patients unresponsive to cardiopulmonary resuscitation (CPR), 1 calcium. Patient was asystole (no heart rhythm) on multiple pulse checks. Patient was intubated. No cardiac activity appreciated with POCUS (Point of Care Ultrasound). Time of Death 0052 (12:52 AM)."

During an interview on 02/06/23 at 2:50 PM, Staff D, RN ED Manager, when asked what acuity system they have adopted for triaging patients, she stated that they use ESI (Emergency Severity Index is a five-level emergency department (ED) triage algorithm (a process to be followed) that provides clinically relevant stratification (arrangement) of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs).

During an interview on 02/06/23 at 2:53 PM, Staff V, RN stated that Patient 15 arrived by ambulance and complained of a "nagging" cough.

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He stated that Patient 15 denied chest pain and shortness of breath. He stated that Patient 15 had an irregular heart rate that was in the 120's and it was decided to do an EKG. He stated that Patient 15 was triaged at an acuity of 2 because the irregular heart rate was new to Patient 15 and he felt something else was going on with him besides the cough. Staff V stated that acuity is based on the patient's present symptoms, if they had chest pain it would be more urgent. He stated that the patients go back to a room based on acuity, and within the assigned acuity, who is the sickest. Staff V stated that the ED beds were full at the time Patient 15 was there and they had 35-40 people in the waiting room. Staff V stated that if Patient 15 would have complained of chest pain, he may have been bedded sooner. Staff V stated that after patient's are triaged and go to the waiting room, staff are required to do vital signs every 2 hours.

During an interview on 02/06/23 at 3:33 PM, Staff X, ED Tech, Emergency Medical Technician (EMT) stated that she took Patient 15's EKG to the attending physician to read. She stated that if the physician sees anything abnormal then they would tell them to room the patient immediately, otherwise the attending usually doesn't say anything.

During an interview on 02/07/23 at 7:30 AM, Staff Y, ED, MD, Attending, stated that an attending is to review and sign an EKG within 10 minutes. She stated that if there was anything concerning on an EKG, staff would be asked to room the patient right away. Staff Y stated that a patient with an Acuity of 2 would be seen as soon as they can find a room. She stated that the night Patient 15 came in there were about 40 patients in the

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ED, more than average. She stated that Patient 15's vital signs looked good, his O2 (oxygen) was good and his heart rate was elevated. When asked about wait time, Staff Y stated that 2 hours isn't a long time to wait and sometimes the wait can be a lot longer. She stated that an overhead page went out and Patient 15 was taken to the Trauma bay, he had no pulse and was intubated. Staff Y stated that she couldn't answer how long Patient 15 was down. She stated that the ECG was initially reviewed and signed by an attending physician prior to her shift. Staff Y stated that she confirmed the ECG after the code.

During an interview on 02/07/23 at 8:46 AM, Staff AA, RN, Night Shift Supervisor, stated that while patients are in the waiting room, vital signs are to be done every 2 hours. She stated that the EMT/Techs go out and take the vital signs and that they are assigned for that purpose. She stated that there is a track board tab in the electronic medical record, for patients in the waiting room, that turns red when the 2 hours comes up. She stated that this flags them to go do vital signs. Staff AA stated that Patient 15 was in the waiting room for 1 hour and 38 minutes, when another visitor asked the nurse to come check on him. She stated that the nurse assessed him, he was unresponsive, then took him to the trauma bay. She stated that there were no rooms available.

During an interview on 02/07/23 at 9:30 AM, Staff BB, Attending Physician, stated that he did not specifically remember Patient 15. He stated that Patient 15's heart rate was not ideal and that the cough would not raise a red flag. Staff BB stated the primary purpose of having an ECG within 10 minutes was to determine whether there is a

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A2407	STABILIZING TREATMENT CFR(s): 489.24(d)(1-3) (1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either- (i) within the capabilities of the staff and facilities available at the hospital, for further medical	A2407		

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examination and treatment as required to stabilize the medical condition.
(ii) For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

(2) Exception: Application to inpatients.
(i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual
(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.
(iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

(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

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reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

This STANDARD is not met as evidenced by:
Based on record review, document review and interview the Hospital failed to provide stabilizing treatment for 1 of 20 patients (Patient 17) who presented to the emergency department seeking emergency medical care. Failure to provide stabilizing treatment has the potential to place patients at risk for deterioration of the emergency medical condition (EMC) causing harm or injury up to and including death.

Findings Include:

Review of Patient 17's medical record showed she had advanced maternal age (> 35 years of age) and presented to the ED on 08/02/22 at 11:27 PM with chief complaint of PPROM (Preterm Premature Rupture of Membranes). Patient 17's documented past medical history included deep vein thrombosis (blood clots), arrhythmia (irregular heartbeat), asthma (a lung disorder characterized by narrowing of the airways), polycystic ovarian disease (common health problem caused by an imbalance of reproductive hormones), and multiple complex abdominal surgeries. Her OB (Obstetrical) history showed Gravida (G) 2 Para (P) 0. Gravida and Para are the number of times a woman is or has been pregnant (Gravida) and carried the pregnancies to a viable gestational age (Para).

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Review of the "History of Present Illness" showed Patient 17 was 17 weeks and 6 days pregnant and "notes she had two large gushes of fluid earlier that morning around 5:00 AM." Patient 17 reported "some vaginal bleeding throughout the day, but no heavy vaginal bleeding." The record showed Patient 17 had "reported to [Hospital 2] and was told they could not do anything for her since her fetus had a heartbeat. She traveled to KU to see if she could be offered delivery or a D&E" (Dilatation and evacuation). Patient 17 denied "fever, chills, nausea, vomiting. She feels well. She denies contractions."

The physical exam showed, ..."SSE (sterile speculum exam) + (positive) pooling (fluid in the vaginal area), + nitrazine (test performed during pregnancy that measures the pH of vaginal fluid to determine whether the membranes have ruptured), + ferning (commonly used as a test for rupture of the amniotic sac during pregnancy). Visually 1 cm (centimeter), small clot at the cervical (lower part of the uterus) os (opening), no active bleeding from the cervix." The bedside ultrasound showed the fetus was breech, anhydramnios (a condition, occurring in pregnancy, in which there is no amniotic fluid around the fetus) with fetal heart tone in the 160's (normal 110-160 beats per minute).

Review of the "Plan" showed Patient 17 and her partner were counseled on outcomes in cases with PPROM at 17 weeks gestational age, they do not desire to continue this pregnancy in light of those outcomes. "Due to + FHT (fetal heart tones), cannot offer IOL (induction of labor) or D&E, will refer to local abortion clinics. Patient and partner state D&E at abortion clinic is cost

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prohibitive for them and will likely need to 'wait it out.' Patient counseled on chorioamnionitis (a bacterial infection of the fetal membranes that is usually considered a medical emergency that can lead to infection in the blood stream and lining of the uterus) signs/symptoms and how quickly she could become ill from chorioamnionitis. Counseled that if she experienced symptoms she should report to her local hospital and if they needed to transfer her to another facility, they would. Counseled that if at any point there is no FHT and they desire IOL or D&E, we could perform at KU."

Review of a note created on 08/03/22 at 12:04 AM by Staff G, MD, Maternal Fetal Medicine (MFM) showed, "I discussed [Patient 17's] care with [Staff F] and agree with the assessment and plan. [Patient is] P0 with previable PPROM. No signs of infection No active heavy bleeding Patient was counseled on options Reviewed return precautions Provided appropriate resources May f/u (follow up) with primary OB if continues pregnancy."

The medical record failed to show that staff checked Patient 17's temperature to determine if she had a fever, or completed a pain assessment to determine her level of pain. There was no evidence in the medical record that stabilizing treatment was provided for Patient 17's previable PPROM.

The medical record showed Patient 17 discharged on 08/03/22 at 1:29 AM with a disposition of home or self-care.

Patient 17's PPROM at 17 weeks and 6 days gestation, advanced maternal age, and

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anhydramnios, was indicative of an emergency medical condition consistent with an emergency medical condition as defined in the hospital's policy 850040 "Emergency Medical Treatment and Active Labor Act Compliance (EMTALA)." "A condition manifesting itself by acute symptoms of sufficient severity that the absence of 'immediate medical attention' could reasonably be expected to result in placing the health of the person in serious jeopardy, or result in serious impairment to bodily functions, or serious dysfunction of body organ or part." Further, as defined in the hospital's policy "The scope of this definition [an emergency medical condition] is not limited to patients with traditional evaluations of 'emergent' or 'urgent' and may include individuals with traditional evaluations of 'non-urgent' and possibly 'chronic' conditions. The phrase 'immediate medical attention' has been applied to situations in which the need for medical assessment and care was in a time frame of days rather than hours. Special categories of emergency medical conditions under Federal statute include undiagnosed acute pain, pregnancy with contractions present, symptoms of substance abuse (includes alcohol intoxication), and psychiatric disturbances."

Additionally, as noted in the hospital's "Prelabor rupture of membranes (PROM) patient care" document, "Care of a patient with PPROM before viability (23 to 24 weeks gestation) is based on clinical presentation and the patient's wishes. The practitioner should explain the risks and benefits of outpatient expectant management and surveillance and offer immediate delivery" (treatment to stabilize patient 17's EMC).

Review of a document provided by the hospital

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titled, "2021 Statutes" showed, ..."76-3308. Powers and duties of authority; limitations on performance of abortion in authority facilities. ... (i) Notwithstanding any provision of law to the contrary, no abortion shall be performed, except in the event of a medical emergency, in any medical facility, hospital or clinic owned, leased or operated by the authority. The provisions of this subsection are not applicable to any member of the physician faculty of the University of Kansas school of medicine when such abortion is performed outside the scope of such member's employment on property not owned, leased or operated by the authority. As used in this subsection, "medical emergency" means a condition that, in reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert the death of the woman or for which a delay necessary to comply with the applicable statutory requirements will create serious risk of substantial and irreversible physical impairment of a major bodily function. No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function."

During an interview on 12/16/22 at 12:30 PM, Staff O, MD, Chair of the Department of OB/GYN stated that the hospital is under the authority act "which is a state governing piece of documentation" that specifically states we are under the authority act and we cannot perform an abortion here unless the mother's life is in danger or any delay would have any threat of bodily harm or loss of organ.

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During an interview on 12/14/22 at 4:35 PM, Staff A, Senior Director, Regulatory and Risk Management, confirmed the hospital does not have a policy for pregnancy termination of a nonviable fetus separate from the University of Kansas Hospital Authority Statute.

During an interview on 12/5/22 at 7:03 AM, Staff H, Registered Nurse (RN) Labor and Delivery (L&D), Night shift coordinator, stated that when pregnant patients present to the ED, if they are 16 weeks or further along, they come to L&D. Under 16 weeks they are seen in the ED. Staff H stated that when Patient 17 arrived she was scared and upset about her situation and that she had found out at previous hospital that her water broke. Staff H stated that Patient 17 was just hoping to get the care she wanted because of the laws in different states. She stated that Patient 17's assessment was normal, vitals were fine, no fever, and no infection. When asked about obtaining Patient 17's temperature, Staff H stated that it would be documented on the flow sheets. However, there was no documented temperature in the record to determine fever. Staff H stated that she remembered Patient 17 was cramping but did not remember Patient 17 rating her pain or the intensity. She stated that due to having fetal heart tones they were not able to offer induction of labor.

During an interview on 12/15/22 at 8:00 AM Staff F MD, 3rd year of residency, stated that she remembered Patient 17. Staff F stated that Patient 17 had previously been to a hospital in another state and had a full work up and they could not perform an abortion, but Kansas could. Staff F stated that Patient 17 repeated the

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presenting history, water gushes in the morning and fluid leaking throughout the day. She stated that she performed a sterile speculum exam that showed pooling of clear fluid, a small clot and no active bleeding. She stated that Patient 1 was dilated to 1 cm but did not do a cervical exam due ruptured membrane as this could introduce infection. Staff F stated that she repeated a sonogram that showed FHT in the 160's. She stated that she could not offer IOL (induction of labor) or D&E (dilation and evacuation) because of positive fetal heart tones and Patient 17's life "was not in danger at this point." She stated that Patient 17 was adamant that she wanted to end the pregnancy and she gave Patient 17 information about abortion clinics. Staff F stated that she counseled Patient 17 on potential complications, fever, chills and diarrhea and if she had any concerns she would need to go to the hospital. Staff F stated that Staff I, MD, Maternal Fetal Medicine (MFM) Attending Physician reviewed Patient 17's case and agreed with the plan for Patient 17. When asked about reaching out to Risk Management or ethics committee related to Patient 17's desire to end the pregnancy and her condition, Staff F stated that it would go through her attending and she didn't remember if the attending said anything about reaching out to risk management or ethics.

During an interview on 12/15/22 at 10:34 AM, Staff L, RN, Risk Management Coordinator 2, stated that because of her legal background she does get consulted regarding abortion issues and had been called three times in 2022. She stated that when she is called, she reviews the documentation in the medical record, will call the providers, asks a lot of questions, looks at the statutes, analyzes, makes sure everyone agrees

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on the medical opinion, then figures out what the patient needs. She stated that further information is provided to the pregnant patient who ultimately makes the decision. When asked about Patient 17, Staff L stated that she reviewed Patient 17's record after the fact and stated there was not much in the chart and that documentation could have been better. She stated that she would not have recommended an abortion and would have suggested a watch and wait approach. Staff L stated that Patient 17 did not meet "legal criteria which would be medically emergent," and Kansas statute requires that the fetus be nonviable (fetus or baby has no chance of being born alive). When told that it was said that they weren't able to initiate treatment, IOL or D&E, because there were fetal heart tones, and asked if it was a law, she stated, "No it's not, I don't know where that comes from honestly."

During an interview on 12/15/22 at 2:00 PM, Staff G, MD, Maternal Fetal Medicine (MFM) stated that Patient 17 came into the OB (obstetrics) ED complaining of leakage of fluids at 17 weeks and 6 days. She stated that Patient 17's story was consistent with rupture of membranes and her exam was also consistent with ruptured membranes. Staff G stated that Patient 17 was counseled on outcomes in previable (before a fetus can survive on the outside) PPROM. Staff G stated that when they see Anhydramnios (lack of fluid around the fetus) we counsel the pregnant patient, informing them that there is definitely an increased risk for worse outcomes. She stated that common things that can happen when someone's water has broken is an increased risk for heavy vaginal bleeding or infection in the membranes of the pregnancy that has potential to spread to the uterus and cause an infection in the

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mom or fetus. Staff G stated that when someone has previable rupture of membranes there is not, in the absence of infection or heavy bleeding, a lot that can be done that's evidence based to improve outcomes.

Staff G stated that if the baby did not have a heart rate, they would have offered her induction of labor (IOL) at that time. If the patient felt like a D&E or D&C procedure in the operating room was more appropriate for her than she would have been offered to go home and schedule for the following day, but because she lived far away, she would have been offer to stay until the procedure could be arranged for her.

Staff G stated that they have at least a couple patients a month who present with previable premature rupture of membranes who get counseled on their options and in the absences of bleeding or infection are managed as an outpatient until they either go elsewhere to pursue termination or have a fetal demise (death), then they can come in and have the D&E or IOL termination. She stated that if they have a complication, such as an infection or bleeding and delivery is indicated at that time, it doesn't matter if there are fetal heart tones or not, if the life of the mom is at risk then they could have a D&E or IOL.

During an interview on 01/10/23 at 2:30 PM, Patient 17 stated that she went to the University of Kansas hospital to seek care after she tried many hospitals closer to her, but the final recommendation was through another hospital she had contacted, and they said the University of Kansas (KU) had the largest emergency room and they would be able to help her. Patient 17

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stated that she went to the ED and they immediately got a wheelchair and took her to Labor and Delivery (L&D). She stated that she was experiencing a lot of pain and pressure in her lower abdomen, uterus area, a lot of fatigue and mental fog. She stated that the physical symptoms plus the emotional side were pretty taxing as well. Patient stated that an ultrasound was done to determine if there was any fluid left or if there was a complete loss. She stated that they were hesitant to do any kind of physical exam because they said that would increase the risk of an infection. When asked what she was told about her condition, she stated that the pregnancy was not viable (able to live after birth), that to assist the process she had the option of a D&C or D&E, a surgical option or a delivery option, and that the delivery option would have been the ideal choice. She stated that she and her boyfriend were under the impression that the hospital would be willing to provided that option. Patient 17 stated that the doctor said that inducing labor would have been the option and that a D&E or surgical option would be a little harder to get approved by the legal team because it resembled an abortion. She stated that she told them, "whatever option to save my life." But, ultimately, we wanted to deliver and to hold our daughter. Patient 17 confirmed her wishes to end the pregnancy and was asked if she was provided a reason as to why the hospital could not provide that service. Patient 17 stated that when the doctor came back, the doctor said that unfortunately, due to the political climate, it was too hot and heated right now, that they could not do either of those treatments; because of the legal team, it resembled an abortion and it was too risky. She stated that she was not offered any other options for care after they told her they

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could not perform IOL or D&E. She stated that her general feeling was that they were pretty much abandoned at that point, that there was nothing they could do, and that they were on their own. Patient 17 stated that the hospital did not offer to admit her for observation or to transfer her. She stated that they were very clear about making sure that she knew she had a very serious situation and that she needed care. Patient 17 stated that they wanted her to watch for symptoms that could become emergent at any time, symptoms that included bleeding, sepsis, increase in temperature, fatigue, and nausea. Patient 17 stated that she was already experiencing these symptoms. Patient 17 stated that discharge instructions included going back to the hospital in the state she lived if she had other concerns. She stated that when she was discharged, she was experiencing fatigue, headache, pain in her abdomen that was increasing and that her bleeding was pretty significant.

When asked if she sought care elsewhere and what the outcome was, Patient 17 stated that after she was discharged from the University of Kansas, she went back home and then after about 2 hours, went to Hospital 2 at the advice of her OB doctor.

Review of Patient 17's medical record from Hospital 2, showed Patient 17 arrived on 08/03/22 at 9:35 PM with a stated complaint of possible miscarriage and chief complaint of GYN (gynecological) pain/bleeding.

Review of a second OB patient's medical record, showed Patient 4 presented to the ED on 07/13/22 at 7:22 PM with a chief complaint of

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"large gush of fluid." The record showed, "History of Present Illness Patient is a 40 y.o. (year old) G3P2002 (pregnant with her third child and has two living full-term children) at 15w3d (15 weeks and 3 days)." Patient 4 denied vaginal bleeding and contractions. She endorsed lower back pain that has been present for weeks and may be related to increased activity.

The record showed a verbal order for an OB (obstetrical) ultrasound dated 07/14/22 at 2:01 AM, showed: 1. Single living intrauterine pregnancy in breech presentation. The estimated gestational age is 17 weeks and 5 days... 2. Minimal amniotic fluid consistent with oligohydramnios (decreased amniotic fluid volume). Fetal heart rate 154 beats/minute.

Further review of the ED provider note showed ED Course: ... "OB notified, sent to L&D triage for concerns of rupture of membranes."

Review of Patient 4's H&P dated 07/14/22 at 6:37 AM showed Patient 4 was counseled on poor outcomes and likely either chorio (chorioamnionitis) or PTL (preterm labor) with demise due to young gestational age. The H&P showed, "The H&P showed, "Consent: Admit and consented for induction of labor, spontaneous vaginal delivery, possible e-suction (surgical procedure to use suction to remove the contents of uterus) and dilation & curettage. This procedure has been fully reviewed with the patient and written informed consent has been obtained. Risks reviewed including bleeding, infection, allergic reaction, adverse reaction/effects, injury to mom and baby, injury to surrounding organs, nerves, blood vessel, need for blood transfusion, risk of hysterectomy, need

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for further indicated procedures."

Review of an attestation signed by Staff J, MD MFM dated 07/14/22 at 10:15 AM showed, "I personally performed the key portions of the E/M visit, discussed case with resident and concur with resident documentation of history, physical exam, assessment, and treatment plan unless otherwise noted ...
-Patient having back pain that is uncomfortable, consistent with labor
-Patient aware that at this gestation in the setting of previable PPROM, baby will not survive.
-Patient is aware of the risks of expectant management in this clinical scenario which include maternal sepsis, chorioamnionitis and in some rare cases maternal death
-Patient has MO Medicaid however is not clinically stable for transport given current pain and labor
-Discussed case with [Staff O MD, Chair of the Department of OB/GYN], legal [Staff L, RM Coordinator] and augmentation is recommended at this time given clinical scenario."

In review of Patient 4 and Patient 17's medical records, both patients presented with PPROM, in the 17th week of pregnancy. Both patients had experienced large gushes of fluid and both denied contractions. Patient 4 reported lower back pain that had been present for weeks and may have been related to increased activity. There was no pain assessment documented in Patient 17's medical record, however, during an interview on 12/05/22 at 7:03 AM, with Staff H, RN, she stated that she remembered Patient 17 "cramping" but did not remember the intensity. During an interview on 01/10/23 at 2:30 PM, with Patient 17, she stated that she was experiencing

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a lot of pain and pressure in her lower abdomen, "uterus area." Patient 17 reported vaginal bleeding, Patient 4 denied vaginal bleeding. On ultrasound both Patient 4's and Patient 17's fetus had fetal heart rates. Patient 4 had a decrease in amniotic fluid and Patient 17 had no amniotic fluid present on ultrasound. Both patients received similar counseling on the serious risks of PPROM. Patient 17 was counseled on outcomes in cases with PPROM at 17 weeks gestational age, "chorioamnionitis signs/symptoms and how quickly she could become ill from chorioamnionitis." Patient 4 was "counseled on poor outcomes and likely either chorio (chorioamnionitis) or PTL (preterm labor) with demise due to young gestational age."

Unlike Patient 4, who was admitted to the hospital and augmentation of labor was started, Patient 17 was not offered to be admitted. The medical record showed that she was told that because there were fetal heart tones, IOL or D&E could not be offered. Patient 17 was referred to local abortion clinics. Patient 17 was counseled that if at any point there was no FHT and they desired IOL or D&E, it could be performed at KU. There was no documentation in Patient 17's record to show Patient 17's case was discussed with "OB/GYN Chair" or "legal."