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	454108	A. BUILDING _____ B. WING _____	C 05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS CREEK HOSPITAL	17750 CALI DRIVE HOUSTON, TX 77090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS Note: The CMS-2567 is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. If information is inadvertently changed by the provider, you should notify the state Survey Agency. If the SA notices any discrepancy in the information related to scope and severity assigned or the deficiency citation (s), the SA will report this occurrence to the Dallas Regional Office. The Regional Office will make a referral of possible fraud to the Office of the Inspector General (OIG). An unannounced visit was made on the morning of 5/21/2013 to this hospital to conduct an investigation regarding a possible Emergency Medical Treatment And Labor Act (EMTALA) violation. The investigation was conducted per Sections 5300-5370 of the State Operations Manual (SOM). In addition, Appendix V-"Interpretive Guidelines-Responsibilities of Medicare Participating Hospitals in Emergency Cases" was utilized to determine hospital's compliance with 42 CFR 489.24 and the related requirements at 489.20 (l), (m), (q), and (r). An entrance conference was held on the morning of 5/21/2013 with the key administrative personnel to explain the nature of the allegation, the purpose of the investigation, and the requirements against which the complaint would be investigated. The hospital was informed that the Centers for Medicare & Medicaid Services (CMS) would determine whether or not an EMTALA violation occurred.	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	Continued From page 1 An exit conference was held on the afternoon of 5/23/2013 with key administrative and supervisory personnel. The facility was informed of the findings of the investigation and was given an opportunity for discussion and to provide additional information. They were informed CMS would make a determination and inform them in writing.	A 000		
A2405	489.20(r)(3) EMERGENCY ROOM LOG [The provider agrees,] in the case of a hospital as defined in §489.24(b) (including both the transferring and receiving hospitals), to maintain a central log on each individual who comes to the emergency department, as defined in §489.24(b), seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged. §489.24 The provisions of this regulation apply to all hospitals that participate in Medicare and provide emergency services. This STANDARD is not met as evidenced by: Based on record review, and interview, the facility failed to provide documentation on the intake unit's log that four (4) patients came to the facility seeking medical treatment. The facility failed to provide information on the log of the patients' condition on arrival to the hospital and their final disposition. Citing 4 of 4 patients named in a complaint investigation, Patients #1, 2, 3 and 4. Findings: Review of complaint narrative revealed patients	A2405		

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A2405	Continued From page 2 #1, 2, 3 and 4 went to the hospital seeking medical treatment and were sent away because the facility did not have beds. Review of the facility's sign-in logs located in the lobby at the facility revealed Patient #2 signed her name on the log on 5/12/2013 and Patient #4 signed his name on the log dated 3/24/2013. Review of the facility's surveillance tapes dated 5/5/2013 along with interview revealed Patient #1 went to the facility but was not allowed inside. The sign-in sheet and intake log did not have his name. Interview on 5/22/2013 at 10:14 am with the mother of Patient #3 revealed the patient went to the hospital on 3/24/2013 and was not examined. There was no indication on the logs that Patient #3 went to the hospital. Review of the facility's EMTALA Policy provided by the Chief Executive Officer (Staff FA) revealed the following information: The hospital must maintain a central log for each individual who "comes to the emergency department" seeking assistance and list the individual's disposition as: Refused treatment or was refused treatment Was transferred or was stabilized and transferred Was admitted and treated or was discharged During an interview on 5/23/2013 at 8:45 am with Staff FA, he stated all staff were instructed to log each patient on the ER logs.	A2405		
A2406	489.24(r) and 489.24(c) MEDICAL SCREENING EXAM	A2406		

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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

(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.

(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

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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.

(c) Use of Dedicated Emergency Department for Nonemergency Services
If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

This STANDARD is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to assess four (4) patients who came to the hospital for treatment, to determine whether or not the patients had a medical emergency condition. This failed practice had the potential to adversely affect all four patients. Citing 4 of 4 patients named in a complaint, Patients #1, 2, 3 and 4.

Findings:

Patient #1

Review of complaint narrative revealed information that Patient #1 went to Hospital Q on

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5/5/2013 seeking hospital treatment for his suicidal ideations. According to the patient when he arrived at the hospital two males in scrubs came outside and told him there were no beds and he should go to Hospital B for treatment.

During a telephone interview on 5/21/2013 at 10:30 am with Patient #1, he stated on 5/5/2013 he went to Hospital Q seeking treatment. He stated he arrived shortly after 7:30 am and the front door was closed and would not be opened until 8:00 am. Patient #1 stated he went to the side door and rang the bell and a "white man in scrubs" came to the door. He explained that he was in a bad situation and needed treatment, that he felt suicidal. The male told him there was no beds. Patient #1 stated a "black dude" also came to the door and both men stepped outside closing the door behind them. He was instructed to go to Hospital B and was given directions to get there. Patient #1 stated he told the staff he did not think he could make it but they never allowed him to go into the hospital. He left and went to Hospital B where he received care.

Review of the facility's sign-in sheets and intake logs dated 5/5/2013 revealed no documentation that Patient #1 was at the facility.

During observation on 5/23/2013 it was revealed that the facility had surveillance cameras on the compound. Review of the facility's surveillance tapes dated 5/5/2013 at approximately 7:49 am revealed the following information:

A male was seen approaching a closed door, a female staff went to the door, had a brief discussion with the individual at the door then went back inside closed the door.

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A2406	Continued From page 6 At 7:54 am two male staff in scrubs came to the door. Both males stepped outside the door, had a discussion with the individual, then went back in the facility closing the door behind them. The individual at the door walked away shortly after one of the male staff returned to the door carrying a sheet of paper in his hands. He went through the door. (visual ended). During a telephone interview on 5/21/2013 at 3:15 pm with Staff #GS (one of the male staff seen on the surveillance tapes of 5/5/2013) he stated a male did come to the facility to inquire if there were any beds and asking for food. According to Staff #GS he told Patient #1 there were no beds and food was for patients. The Surveyor asked Staff #GS did he send Patient #1 to another hospital. He replied he more than likely did, why wouldn't he since they had no beds and there were other hospitals in the area. Review of medical records for Patient #1 from Hospital B revealed the patient came to the hospital on 5/5/2013 at 9:30 am with complaints of suicidal ideation with plan to use a gun. He stated he went to a hotel room and tried to shoot himself. There was documentation that initial Blood Pressure was 104/71, Pulse 80, Respiration 18 and Temperature 97.3. The patient was alert with clear speech. During the assessment the patient stated "something is wrong with me, I don't feel right". Patient #1 complained of chest pain, started sweating profousely and complained of dizziness. He told staff he had taken crack and beer. The patient appear to have a seizure, went in and out of consciousness. 911 was called and the patient	A2406		

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was sent to an Acute Care Hospital for assessment. He spent twenty four (24) hours at the Acute Care facility and returned to Hospital B on 5/6/2013. He was discharged on 5/8/2013.

Patient #2

Review of complaint narrative revealed information that Patient #2 went to Hospital Q on 5/12/2013 seeking hospital treatment for her drug abuse problems. The narrative documented the patient was told there were no available beds and was told to go to Hospital B.

Review of the facility's sign-in sheets and intake logs dated 5/12/2013 revealed documentation on the sign-in sheets that Patient #2 presented at the facility. She did not appear on the intake logs.

Based on the the time frame the patient was logged in, the surveillance tapes were reviewed starting at 7:30 pm thru 10:00 pm when the front lobby doors are closed. At 8:39 pm, an African American female was seen entering the facility and went to the staff at the desk. There was a discussion, then the female went across the room and picked up a telephone from a small table. She used the telephone for a few minutes, then went back to the desk. She signed the log and was handed a sheet of paper by the staff at the desk. The lady then walked out the front doors and left.

During a telephone interview on 5/22/2013 at 11:20 am with the mother of Patient #2, she stated her daughter called Hospital Q to inform them she was coming in for treatment. Her daughter was told there were no beds at the moment but someone would call back. There

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was no call back so she took her daughter to the hospital. According to the mother, her daughter went into the hospital and staff did not assess her, only told her there were no beds and gave her directions to Hospital B, stating they would inform Hospital B they were on their way. Patient #2's mother stated at Hospital B the staff denied Hospital Q called with information.

When asked, the patient's mother stated her daughter went into the Hospital Q sometime after 8:00 pm and that she was wearing a black outfit. The mother further stated she was very upset because her daughter was crying out for help and the staff turned her away.

During an interview on 5/21/2013 at 2:55 pm with the facility's staff #DC, seen at the desk on the surveillance tapes, she stated she could not remember the incident. She stated she would not tell patients about bed availability because she was never privy to that information. She stated when patients have questions she would allow them to use the phone in the lobby and she would put the call through to the Nurse in the admission intake unit.

Review of medical records for Patient #2 from Hospital B revealed the patient and her mother came to the hospital on 5/12/2013 at 20:05 needing to detoxify from Soma and Hydrocodone which she has been abusing for more than a year after surgery. She had been taking 10-15 Soma and 20-30 hydrocodone a day. She was assessed with poor concentration, impaired memory, poor sleep. She was tearful and had not taken her psych medication for the past three years.

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There was documentation on the intake notes that Patient #2 complained she went to Hospital Q prior to her arrival at Hospital B and was turned away.

Patient #3

Review of complaint narrative revealed information that Patient #3 went to Hospital Q on 3/24/2013 seeking hospital treatment for his suicidal and homicidal ideations and was told there were no beds and he should go to Hospital B. It was alleged the staff at Hospital B did not assess the patient.

During a telephone interview on 5/22/2013 at 10:50 am with the mother of Patient #3, she stated she and her husband took their son to Hospital Q sometime in March 2013. According to the patient's mother when they arrived at the hospital a lady came through the door and told her there were no beds, that she had to go to Hospital B. Patient #3's mother stated the staff did not allow them through the door but insisted Hospital B would be expecting them. However, when they got to Hospital B the staff said Hospital Q did not call to say they were coming which resulted in a long wait for admission.

Review of the facility's sign-in sheets and intake logs dated 3/24/2013 revealed no documentation on the sign-in sheets that Patient #3 presented at the facility. The patient did not appear on the intake logs. Surveillance tapes were not available after 30 days.

Review of admission intake assessment notes dated 3/25/2013 from Hospital B for Patient #3 revealed the following information:

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A2406	Continued From page 10 Patient #3 arrived at Hospital B at 07:00 am. His speech was rambling, he was lethargic, said he felt like hurting himself, that he tried to OD on meth four days ago. He stated he had tumors in his knee since he was four years old and had a leg amputation two (2) years. The patient stated he stopped taking his psych medication for a month to see how it feels not to be on any medication. Blood Pressure 141/94, Pulse 102, Respiration 22 and Temperature 97.0 Review of Patient #3's Psychiatric evaluation notes dated 3/25/2013 at 8:00 am documented that the patient stated he went to Hospital Q but was turned away, said they told him they had no open beds. Patient #3 was admitted to the facility for treatment and was discharged on 3/29/2013. Patient #4 Review of complaint narrative revealed information that Patient #4 went to Hospital Q on 3/25/2013 seeking hospital treatment for his suicidal and homicidal ideations and was told there were no beds and he should go to Hospital B. It was alleged the staff at Hospital Q did not assess the patient. Review of the facility's sign-in sheets and intake logs dated 3/24/2013 revealed documentation on the sign-in sheets that Patient #4 presented at the facility; however, the patient's name was not on the intake admission logs. Surveillance tapes were not available after 30 days. Patient #4 was not available for an interview.	A2406		

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A2406	Continued From page 11 Review of Patient #4's medical record at Hospital B revealed the following information: Patient #4 presented at the hospital at 23:31 with complaints of a feeling to hurt himself and others. He had not taken any medications for a month and had been using illegal drugs. He gave history that he tried to OD on meth four (4) days ago and was out for an hour. The patient said he was having bad pain. He is having visual and auditory hallucinations. He is lethargic and had been sleeping for eighteen (18) hours at a time. Patient #4 had a history of multiple medical conditions including Lupus, Diabetes and Hypertension. He is schizophrenic and Bipolar. His assessment: Blood Pressure 144/94, Pulse 97, Respiration 20, Temperature 97.1. Patient #4 was admitted for treatment on 3/25/2013 and was discharged on 4/1/2013. Review of the EMTALA Policy presented by the CEO at Hospital Q titled Do the R.I.G.H.T. Thing included the following information: "The intake/assessment and referral center of a behavioral hospital is a Dedicated Emergency Department (DED) under EMTALA. According to EMTALA when an individual comes to a hospital DED and asks to be assessed for psychiatric or medical condition, the hospital must provide: An appropriate medical screening examination (MSE) to determine whether the individual has an emergency condition; What constitutes "coming to the ED"? The individual -Presents on Hospital property. -Is in an ambulance, but is on Hospital property.	A2406		

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A2406	Continued From page 12 EMTALA applies when a person or someone representing them request examination for an emergency condition."	A2406		