UNITED STATES COMMISSION ON CIVIL RIGHTS
STATUTORY ENFORCEMENT BRIEFING

FEBRUARY 14, 2014

PATIENT DUMPING:
EMTALA ENFORCEMENT AND THE PROTECTION OF CIVIL RIGHTS

COMMENTS BY:
Staci Pratt, Legal Director
American Civil Liberties Union of Nevada

American Civil Liberties Union of Nevada
601 S. Rancho Drive, Ste. B11 – Las Vegas, NV 89102 – 702.366.1536 – 702.366.1331 (fax)
1325 Airmotive Way, Ste. 202 – Reno, NV 89509 – 775.786.1033 – 775.786.0805 (fax)
www.aclunv.org

United States Commission on Civil Rights, February 14, 2014
2014 Statutory Enforcement Briefing
Patient Dumping: EMTALA Enforcement and the Protection of Civil Rights

The purpose of the briefing is to examine the enforcement of the Emergency Medical Treatment and Labor Act (EMTALA)[1] and the polices in place to ensure hospitals, localities, or states are not "dumping" patients disabled by a psychiatric medical condition and in need of emergency care. Violations of EMTALA threaten these patients' civil rights. The Commission is studying how best to protect the rights of these individuals under federal law.

Comments by Staci Pratt, Legal Director, ACLU of Nevada

I. Background:

A. James Flavy Brown

On behalf of James Flavy Coy Brown, the ACLU of Nevada and the law office of Mark E. Merin filed a class action complaint on June 11, 2013, against Rawson-Neal Psychiatric Hospital[2] and the state actors responsible for overseeing discharge planning from its emergency psychiatric observation unit. *Brown v. Rawson-Neal, et al*. Case 2:13-CV-01039 (D. Nev.). The story of James and the chain of events leading to this suit present of powerful indictment of a disintegrating system of emergency mental health care. We are witnessing a failure of individuals, institutions, and enforcement mechanisms aimed at ensuring EMTALA compliance.

Let us begin with his story. James is a 48-year-old, schizophrenic man, who was involuntarily committed to Rawson-Neal Psychiatric Hospital on February 9, 2013. Enduring auditory hallucinations, acute psychosis, and strong suicidal impulses, he needed stabilization and professional care. Instead, he received cursory services and a "Discharge to Greyhound Bus Station by Taxi," on February 11, 2013, two days prior to his scheduled Legal 2000 court hearing set for February 13. The listed address on the discharge form signed by the Rawson-Neal registered nurse identifies the address on discharge as "Greyhound Bus Station to California." For this journey, he received a three-day supply of medication and several bottles of Ensure. He received neither money nor identification. The state agencies and employees responsible for his treatment and care made no arrangements for any follow-up care for his psychiatric and medical needs, and provided no advance notice of James' arrival to any person or agency in Sacramento, California.

[1] 42 U.S.C. § 1395dd.
[2] Note, the formal state designation for Rawson-Neal Psychiatric Hospital is "Southern Nevada Adult Mental Health Services" (SNAMHS). For ease of reference, this document will use the commonly used appellation "Rawson-Neal" to refer to this entity.

James knew no one in Sacramento or California. He was simply instructed to "call 9-1-1" when he arrived. Without a phone, and still delusional and suicidal, he wandered homeless on the streets. Eventually, through the assistance of a homeless shelter and a police officer, he found his way to the UC Davis Emergency center and then Heritage Oaks Hospital, where he was finally treated and stabilized. Admission notes reveal that James stated, "I was looking for a bridge to jump off from and kill myself. I'm tired of trying to survive. I can't make it on the streets no more." His history with Rawson-Neal had only served to exacerbate his suicidal state. According to physician notes:

> The patient reported that he had been anxious and depressed, and has been having suicidal ideations as he believes…that people do not care about him. The patient reported that he has not been sleeping at night, having low energy level, feeling hopeless and helpless. Apparently, the patient had been traveling from back east toward west…Most recently…Nevada apparently put him on a bus to California, telling him that the mental health services are better in California than they were in Nevada. The patient has been feeling very frustrated with this as he feels he cannot get mental health treatment where he is at. As a result, the patient reported feeling suicidal and felt that life was no longer worth living for him.

Notably, no one at the admitting departments had received any communication from Rawson-Neal regarding James' care. The UC Davis Health System had to resort to calling all known Nevada treatment centers to locate any information related to James. They had received no information prior to his arrival.

News reports from the Sacramento Bee, based upon Greyhound bus receipts, demonstrate that more than 1,000 people were bused from Rawson-Neal to cities across the country over the past three years. Rawson-Neal sent at least 325 of them to California.[3] "Patients typically were dispatched by taxi to a Las Vegas Greyhound station and put on buses, alone and sometimes heavily medicated, for journeys that in many cases spanned multiple states and several days," Hubert and Reese reported. Furthermore, former patients and their families have stressed that Rawson-Neal made no arrangements for their treatment or care and "shipped former patients off to cities where they had tenuous ties, or none at all. Many of those interviewed ended up on the streets, at public hospitals or in shelters." Short term warehousing of patients, followed by routine "discharge to greyhound bus" reflected the norms of practice at Rawson-Neal.

[3] Cynthia Hubert & Phillip Reese, *Mental Patients Bused—And Crime Followed*, SACRAMENTO BEE, Dec. 15, 2013, http://www.Sacbee.com/2013/12/15/6045063/crime-followed-as-inmates-were.html. The Sacramento Bee's extensive coverage of Rawson-Neal discharge practices commenced in March of 2013.

B. Abandonment of Individuals with Psychiatric Needs

What is particularly troubling, beyond the horrors visited on the individuals treated by Rawson-Neal, is the reality that this practice was in place for years. Rawson-Neal's transportation policy titled "Client Transportation Back to Home Communities" was developed in 1984. Under the original terms, out-of-state transports required approval by Rawson-Neal's director. In 2009, the policy was revised to eliminate the need for review and approval by the agency head. As articulated by the written policy, one goal was "to remove the burden of treatment from the State of Nevada." The unsupervised discharge of patients to out of state locations continued from 2009 until April 2013, when pressure from the *Brown v. Rawson-Neal* case and news reports forced modification.[4] Notably, a Greyhound bus company spokesperson revealed that Rawson-Neal developed its ongoing contract with the out-of-state transportation provider in the very year the policy removed supervision and approval requirements.[5]

Nevada lawmakers began cutting mental health funding in 2007; the state now spends $80 million less on the mental health care system now, than it did then. Cuts at the state level led to local service gaps. Rawson-Neal is licensed to house 289 patients, but has averaged staffing sufficient for 190, despite the fact that its service area, the Las Vegas metro, includes roughly 1.9 million people.[6] One Rawson-Neal staffer explained that budget cuts "mean Rawson-Neal employees are overworked, that Las Vegas has too few shelters, and that what happened to Brown 'is not isolated.'"[7] Stuart Ghertner resigned in 2012 as Rawson-Neal director, after enduring more than $20 million in budget cuts.[8] "You cannot just give someone who is seriously mentally ill a plane or bus ticket and a little food, and expect them to fend for themselves," Ghertner said.[9] "A lot of people are not doing their jobs over there right now. Social workers, psychologists, the medical staff, the administrators. No one is attending to detail. It's as if no one is managing the cases."[10]

Between 2009 and 2012, Nevada reduced spending on mental health services by 28 percent, according to the National Alliance on Mental Illness. "Even before those cuts, Nevada fell well below the national average in spending on mental health services. In 2009, it spent $64 per capita on such services compared with a national average of about $123."[11] An unabashed focus on cost

[4] The new policy establishes that non-attending medical staff, as well as the hospital administrator, must review out-of-state transportation decisions. It also requires the provision of a chaperone for individuals traveling out of state.
[5] Cynthia Hubert, Phillip Reese & Jim Sanders, *Nevada Buses Hundreds of Mentally Ill Patients to Cities Around Country*, SACRAMENTO BEE, Apr. 14, 2013, http://www.sacbee.com/2013/04/14/5340078/nevada-buses-hundreds-of-mentally.html.
[6] Dan Morain, Op-Ed., Vegas' Dicey Mental Policy, SACRAMENTO BEE, Mar. 10, 2013, http://www.sacbee.com/2013/03/10/5248134/dan-morain-vegas-dicey-mental.html
[7] *Id.*
[8] *Id.*
[9] Cynthia Hubert, More Cases Found of Nevada Busing Mental Patients Out of State, SACRAMENTO BEE, Apr. 2, 2013, http://www.sacbee.com/2013/04/02/5309145/more-cases-found-of-nevada-busing.html.
[10] *Id.*
[11] Hubert, Reese & Sanders, supra note 5.

savings apparently drove the decision to bus patients with unstable psychiatric needs out-of-state. The Sacramento Bee analysis showed that Rawson-Neal spent a total of $205,000 putting patients on buses over the last five years. Inpatient care at the facility runs around $500 per day per client, according to former Rawson-Neal director Ghertner.[12] D.J. Jaffe, Executive Director of the Mental Illness Policy Organization, observed that Rawson-Neal's "patient dumping" practices occur across the country. "It's profitable for hospitals to get rid of homeless patients. These discharges were not mistakes. It's policy."[13]

Dr. Jeffrey Geller, director of public sector psychiatry at the University of Massachusetts Medical School, has observed that profound consequences ensue when psychiatric patients are bused out of town, without proper treatment or arrangements for future care. These include: "New jail and hospital occupants. Burdens to general hospital emergency departments, courts, sanitation departments and mayor's office." For the affected individuals, "there is a further estrangement from any natural supports that might exist, and an increasing sense in the individual with mental illness of being unwanted and unworthy."[14]

II. Cursory Investigations Ignore Problems and Permit their Continuance

At the outset, it is worth noting that the EMTALA enforcement process is currently complaint driven. When a complaint is received by the state survey agency (SA) or the regional office (RO) of the Centers for Medicare and Medicaid Services (CMS)[15], the RO has the power to authorize an investigation. The investigation is typically handled by the state survey agency, in Nevada's case, the Nevada Department of Health and Human Services (NV DHHS), through the Bureau of Health Care Quality and Compliance (BHCQC).[16] This structure is loose, ill-formed, and lacks the type of consistent oversight necessary to make the guarantees of EMTALA meaningful.

In the case of Rawson-Neal, cursory investigations by the BHCQC on behalf of CMS failed to identify transportation policy changes, illegal patient dumping practices and poor case management, even though those practices were complained about and persisted for years. On the one occasion patient discharge problems were substantiated, corrective actions were not enforced in a systematic, proactive or continuous manner. Instead, it was only after news reports highlighted Rawson-Neal's patient dumping practices that probing investigations ensued and structured demands for corrective action plans emerged. For this reason, it is instructive to

[12] *Id.*
[13] Renee Byer, US Probe Turns Up More Homeless Patients Bused from Nevada Mental Hospital, SACRAMENTO BEE, Aug. 27, 2013, http://www.sacbee.com/2013/08/27/5683406/us-probe-turns-up-more-homeless.html.
[14] Hubert & Reese, *supra* note 3.
[15] For ease of reference, this document will use "CMS" to refer to both the Centers for Medicare and Medicaid Services and its predecessor the Health Care Financing Administration (HCFA).
[16] *See* DHHS, OFFICE OF INSPECTOR GENERAL, THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: THE ENFORCEMENT PROCESS, Jan. 2001, OEI-09-98-00221.

compare the BHCQC investigation and reviews prior to March 2013, when the Sacramento Bee stories emerged, and those that followed in their wake.

A. Prior to Sacramento Bee Coverage (March 2013)

BHCQC investigations covering the period between early 2009 and late 2012 reflect a lack of specificity. Those taking place from 2009 through mid-2010 generally cite only the complaint number, without identifying the nature or type of allegation. One is left to wonder what, specifically, was alleged. Certainly, those charged with supervising the process would need access to more detailed information to ensure appropriate and thorough investigations were taking place.

During this same time frame, numerous complaints regarding patient assessment and discharge practices appeared. (NV00025532; NV00026864; NV00027825; NV00027946; NV000294 NV00030105; NV00030108; NV00030392; NV00031042). Other complaints challenged inadequate staffing at the facility. (NV00028675; NV00029544). With one remarkable exception, such complaints were summarily dismissed.

In June of 2010, complaint NV00025532 highlighted very specific failures in discharge planning practices. In response, BHCQC found that the facility "failed to verify appropriate and safe housing was available at time of discharge of Patient #1. There was no documented description of the community based housing arrangements or documentation of communication and exchange of information with the apartment complex owner." The associated Plan of Correction mandated the development of an audit instrument to monitor discharge practices "until 95% or above compliance is maintained for three consecutive months by all Social Services employees."[17] Reinstitution of the audit instrument is nowhere mentioned in subsequent evaluations of patient discharge complaints. (NV00026864; NV00027825; NV00027946; NV000294; NV00030105; NV00030108; NV00030392; NV00031042). The table below provides BHCQC investigation details.

[17]This complaint involved discharge practices for inpatients, and Nevada Administrative Code discharge mandates. NAC § 449.332, "Discharge Planning" states "A hospital shall: (a) Have a process for discharge planning that applies to all inpatients; and (b) Develop and carry out policies and procedures regarding the process for discharge planning."

BHCQC Investigations and Reviews: Statements of Deficiencies

DATE	COMPLAINT (#)	RESOLUTION	ANALYSIS
02/06/09	20402	"Not substantiated"	
	19047	"Not substantiated"	
	19055	"Not substantiated"	
	20919	Substantiated w/o deficiencies	
03/03/09	21079	"Not substantiated"	
04/08/09	NV00021482	"Not substantiated"	
	NV00021526	"Not substantiated"	
	NV00016810	"Not substantiated"	
	NV00021061	"Not substantiated"	
10/20/09	NV00022294: Quality of care	"Not substantiated" w/an unrelated deficiency cited	Facility failed to ensure accurate documentation of allergies, based on record review and interviews
	NV00022669	"Not substantiated"	
	NV00022494: Quality of care	"Not substantiated" w/an unrelated deficiency cited	
	NV00023291	"Not substantiated"	
12/02/09	NV00023721	"Not substantiated"	
12/21/09 (letter re: 12/11 investigation)	NV00022928	"Not substantiated"	
01/26/10	NV00024091	"Not substantiated"	
04/09/10 (letter re: 04/08 investigation)	24868	"Not substantiated"	
04/14/10	NV00025039	"Not substantiated"	
05/04/10	NV00025196: Psychiatric Services	Substantiated with deficiencies cited	Facility failed to follow NRS 449.767; 449.780; 449.786 for 10/10 patients reviewed – failed to follow Seclusion or Restraint of Patients policy, based on observation, interview, record and document review

DATE	COMPLAINT (#)	RESOLUTION	ANALYSIS
06/08/10	NV00025532: **Discharge Planning;** Assessment of Patient	Substantiated with deficiencies cited	**Facility failed to verify appropriate and safe housing was available at time of discharge of Patient #1; no documented description of community based housing arrangements or documentation of communication and exchange of information with the apartment complex owner; based on interview, record and document review Facility failed to provide a safe environment for Patients #1 and #3. They verbalized concerns regarding Patient #2's sexual behavior, staff did not assess impact of the behavior on #1 and #3); based on interview and record review**
10/21/10	NV00026671	"Not substantiated"	
11/22/10	NV00026864: **Patient Discharge**	"Not substantiated" no regulatory deficiencies identified	**Allegation regarding patient discharge was not substantiated through document review, clinical record review and interviews with facility staff**
04/20/11	NV00027825: Patient Assessment	"Not substantiated"	Allegation regarding patient assessment was not substantiated through document and record review; record revealed patient provided written consent for meds received
	NV00027946: Patient Assessment	"Not substantiated"	Allegation regarding patient assessment was not substantiated through staff interview, document and record review
07/29/11	NV00028598	"Not substantiated"	No regulatory deficiencies were identified
09/21/11	NV00028675: Inadequate Staffing	"Not substantiated"	Complaint of inadequate staffing not substantiated through staff interviews and record review; no regulatory deficiencies identified
11/03/11	NV00029697: Nursing Services; Improper administration of meds	Substantiated	Interview, record and document review: Dir. of Nursing failed to ensure facility staff followed patient grievance and patient abuse reporting policies/procedures to ensure prompt investigation & resolution; nursing staff failed to provide proper care to ensure patient did not receive meds the patient had a document allergy to; facility failed to follow state mandated abuse reporting laws and facility patient abuse policy by failing to conduct investigation into patient allegations

DATE	COMPLAINT (#)	RESOLUTION	ANALYSIS
	NV00029471: Lack of protective supervision in psych outpatient services	"Not substantiated"	Observation, clinical record review, document review and interviews with facility staff
	NV00029409: Quality of care, visitation rights and inspection/copying of records	"Not substantiated"	Clinical record review, document review and interviews with facility staff
	NV00029729: Patient rights	"Not substantiated"	Clinical record review, document review and interviews with facility staff
	NV00029544: Inadequate staffing/safety	"Not substantiated"	Observation, staffing policy and procedure review and interviews with facility staff
02/09/12	**NV00030105: Admission discharge problems**	"Not substantiated"	Record and document review
	NV00030436: Poor quality of care and treatment	"Not substantiated"	Observation and interview with facility staff
	NV00030108: Unsafe discharge to unlicensed facility	"Not substantiated"	Record and document review
	NV00029893: Falsification of medical records	"Not substantiated"	Record and document review
	NV00030373: Physician & responsible party not notified of patient change in condition	"Not substantiated"	Record and document review
	NV00030392: Admission & discharge rights; inadequate patient assessment and discharge issues	"Not substantiated"	Record review and document review
	NV00029762: Denial of patient rights	"Not substantiated"	Record and document review
	NV00030105: Legal 2000 patients, concerns about "stability" and discharge practices	"Not substantiated"	Record and document review, and interview with facility staff
	NV00031042: patients not treated with dignity; not appropriately discharged or treated;	"Not substantiated"	Staff to patient observation, clinical record review and interview
	NV00030941: Improper medication dispensing	"Not substantiated"	Clinical record review and interview
03/21/12	NV00030611: Inadequate staffing at facility	"Not substantiated"	Staff interview, record review of facility staffing documentation, and policy review
09/26/12	NV00033028: Admission rights and proper diagnoses	"Not substantiated"	Interview, record review and document review

B. Post Sacramento Bee Investigations by BHCQC

Following the publication of the Sacramento Bee articles, and public uproar, investigations undertaken by BHCQC took on a more rigorous flavor. BHCQC consistently substantiated the problems associated with Rawson-Neal's discharge practices.

BHCQC Investigations and Reviews: Statements of Deficiencies

DATE	COMPLAINT (#)	RESOLUTION	ANALYSIS
03/20/13	**NV00034829: Unsafe discharge of patients**	**Substantiated**	Document review, clinical record review and interviews with facility staff: extensive interviews showing lack of documentation in patient records, lack of discharge planning
	NV:00034829: Nursing Services	Substantiated	Record review, interview and document review: nurses failed to ensure physicians' orders were followed for patient monitoring
05/09/13	**NV00035394: Inappropriate medical screening exams, patient transfers, and discharges**	**Substantiated**	Document review and interview; regulatory deficiencies identified: Emergency room log; medical screening exam; stabilizing treatment

C. Investigations and Reviews by CMS

For the most part, CMS relies upon investigations undertaken by the state survey agency in evaluating regulatory and statutory compliance. On occasion, however, CMS conducts facility surveys employing independent federal contractors. This took place for the survey completed on 7/26/2013. (Attached as Appendix A). The 7/26/2013 survey reflects rigorous analysis, detailed observations and specific recommendations for the alteration of Rawson-Neal practices. It represents a model for effective oversight of medical screening, record keeping and discharge planning. The summary statement of deficiencies included:

> B134: 482.61(e): Discharge Planning. The record of each patient who has been discharged must have recommendations from appropriate services concerning follow-up or after care…
>
> The facility failed to ensure that follow-up appointments were included in discharge summaries for 4 of 5 patients…whose discharge records were reviewed. The lack of a definite follow-up appointment forces patients who may still be compromised in their ability to act for themselves to negotiate with agencies or offices which they find difficult to do, and therefore may fail to do.
>
> B135: 482.61(e): Discharge Planning. The record of each patient who has been discharged must have a brief summary of the patient's condition on discharge.

> The facility failed to ensure that the discharge summaries for 5 of 5 sampled discharged patients…contained a summary of the patient's condition on discharge. Therefore, critical information indicating the patient's level of psychiatric symptomatology and risk were not available to the aftercare providers…[For all 5 patients], condition on discharge was documented only as "stable."

Arguably, this form of rigorous review and probing inquiry, if engaged in when patient discharge complaints first emerged, could have prevented the injury faced by James Brown.

CMS Oversight of Investigations

DATE	COMPLAINT (#)	RESOLUTION	ANALYSIS
3/20/2013	**#NV00034829 Allegation regarding unsafe discharge of patients; Governing Body; Discharge Planning; Medical Staff Accountability; RN Supervision of Nursing Care**	**Substantiated**	Evidence in observation, document review, clinical record review, and investigation
5/9/2013	**#NV00035394 Inappropriate medical screening exams, patient transfers and discharges**	**Substantiated**	Evidence in document review, investigations
6/20/2013	Patient rights-Informed Consent; Governing Body; Medical Staff; Nursing Services	Substantiated	Evidence in clinical record review, document review, interviews,
7/26/2013	**Special medical record requirements for psychiatric hospitals (Discharge planning, Treatment planning)**	**Substantiated**	Evidence in observation, record reviews, and interviews. **Study performed by independent federal contractor.**

III. Patient Civil Rights

Psychiatric Patients Possess a Right to Stabilizing Treatments in Emergency Settings

EMTALA arose out of concerns over the denial of emergency medical care to indigent and uninsured patients, as well as hospital transfer practices that discharged patients to public or charity hospitals without the receipt of stabilizing emergency medical treatment. Enacted in 1986, as part of COBRA, it requires that hospitals receiving Medicare funds conduct a "medical screening examination" and provide "necessary stabilizing treatment" to any patient requesting emergency medical care in an emergency setting. More specifically, § 1395dd(a) states:

> In the case of a hospital that has a hospital emergency department, if any individual...comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for 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.

Pursuant to § 1395dd(b)(1),

> If any individual…comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—
>
> (A) …for such further medical examination and such treatment as may be required to stabilize the medical condition, or
> (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section [restricting transfers until individual stabilized].

The statute includes a broad understanding of circumstances amounting to an "emergency medical condition." § 1395dd(e)(1)(A) covers:

> a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
>
> (i) placing the health of the individual...in serious jeopardy;
> (ii) serious impairment to bodily functions; or
> (iii) serious dysfunction of any bodily organ or part.

Where an "emergency medical condition" arises, EMTALA imposes a duty of stabilization upon the hospital. 42 C.F.R. § 489.24(b) specifically clarifies that a "medical condition" includes "severe pain, psychiatric disturbances and/or symptoms of substance abuse."

> *Legitimate Transfers, Including Discharges, Can Only Occur Where a Psychiatric Patient is Stabilized or Capable of Knowingly Providing Informed Consent*

Under EMTALA, "to stabilize" means "to provide such medical treatment of the emergency medical condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the facility." § 1395dd(e)(3)(A).

A "transfer" occurs when a hospital employee directs the movement, including discharge, of a patient outside a hospital's facilities. EMTALA prohibits the transfer of "unstable" patients,

unless very specific statutory constraints are met.[18] For example, the hospital may not transfer the individual unless a physician has signed a legal certification indicating that the transferring physician believes that the receiving facility has the necessary resources, capabilities, and expertise to stabilize the patient's emergency medical condition. The legal certification must weigh the medical risks and benefits associated with the transfer of the unstable patient. Several further conditions precedent apply to the "appropriate" transfer of an unstable patient. 42 U.S.C. § 1395dd(c).[19]

In a similar case, issues related to the stabilization of a psychiatric patient who suffered from psychosis, based on the hospital's treatment of simply directing the patient to immediately cease taking a triggering steroid, precluded summary judgment on an EMTALA claim. *Thomas v. Christ Hosp. and Med. Ctr.*, 328 F.3d 890 (7th Cir. 2003).

IV. The Failures of the EMTALA Enforcement Paradigm

"Patient dumping represents a cold, unconscionable disregard for human life," researchers from Harvard Medical School have observed.[20] It occurs when hospitals refuse to provide emergency medical treatment to indigent, uninsured patients or when they transfer those patients before their emergency conditions are stabilized. *Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856 (4th Cir. 1994). While EMTALA prohibits "patient dumping" and grants every person a federal right to emergency medical care, government enforcement has tragically failed to control this deplorable practice.[21]

According to the CMS State Operations Manual,

> Medicare participating hospitals must meet the Emergency Medical Treatment and Labor Act (EMTALA) statute codified at § 1867 of the Social Security Act, the accompanying regulations in 42 CFR § 489.24 and the related requirements at 42 CFR § 489.20(l)(m)(q) and (r). EMTALA requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition (EMC).

[18] If a hospital can demonstrate that the emergency medical condition has been stabilized, EMTALA does not govern a transfer.
[19] A transfer to a medical facility is "appropriate" where (1) the transferring hospital provides the patient medical treatment within its capabilities which minimizes the risks to the individual's health; (2) the receiving facility has space and qualified personnel to treat the individual, and agrees to accept and treat the individual; (3) the transferring hospital sends the receiving facility all relevant, available medical records; (4) the individual is transferred by qualified personnel and transportation equipment. 42 U.S.C. § 1395dd(c)
[20] Thomas A. Gionas et al., *The Intentional Tort of Patient Dumping: A New State Cause of Action to Address the Shortcomings of the Federal Emergency Medical Treatment and Active Labor Act (EMTALA)*, 52 AM. U. L. REV. 173, 175 (2002).
[21] *Id.* at 179.

> …The regulations define "hospital with an emergency department" to mean a hospital with a dedicated emergency department (ED). Furthermore, a "dedicated emergency department" is any department or facility of the hospital that either (1) is licensed by the state as an emergency department; (2) held out to the public as providing treatment for emergency medical conditions; or (3) on one-third of the visits to the department in the preceding calendar year actually provided treatment for emergency medication conditions on an urgent basis…
>
> The enforcement of EMTALA is a complaint driven process. The investigation of a hospital's policies, procedures and processes and any subsequent sanctions are initiated by a complaint. If the results of a complaint investigation indicate that a hospital violated one or more of the anti-dumping provisions of section § 1866 or 1867 (EMTALA), a hospital may be subject to termination of its provider agreement and/or the imposition of civil penalties (CMPs). CMPs may be imposed against hospitals or individual physicians for EMTALA violations.[22]

CMS has correctly identified Rawson-Neal as a facility subject to EMTALA obligations.

> The Rawson-Neal POU (Psychiatric Observation Unit) meets the EMTALA definition of a dedicated emergency department (DED). The facility has published, on the Internet, that services are available for treatment of emergency psychiatric conditions in the outpatient psychiatric observation unit (POU). The Nevada Department of Health and Human Services, Division of Mental Health and Developmental Services website (mhds.nv.gov) revealed "Psychiatric Crisis Services…if the consumer is acutely and severely ill enough, they may be referred to the second unit, or POU…The POU offers rapid screening and stabilization for consumers in an acute psychiatric crisis…" CMS, Statement of Deficiencies, 5/09/2013.

The administrator of Rawson-Neal has resisted its characterization as an emergency care provider, in an effort to avoid EMTALA mandates. Even given EMTALA's application, however, the abandonment of psychiatric patients took place over a series of years at Rawson-Neal, unchecked. For this reason, we must emphasize that the current organizational structure around EMTALA has fallen far short of achieving the stated goals of enforcement, protective oversight and prevention.[23] Furthermore, studies conducted by the Department of Health and

[22] *See* CENTER FOR MEDICARE & MEDICAID SERVICES (CMS) STATE OPERATIONS MANUAL, APPENDIX V – INTERPRETIVE GUIDELINES – RESPONSIBILITIES OF MEDICARE PARTICIPATING HOSPITALS IN EMERGENCY CASES, Part I, Sec. 1 (Rev. 60, 07-16-10).

[23] According to CMS' State Operations Manual, Chapter 5-Complaint Procedures, (Rev. 18, Issued: 03-17-06; Effective/Implementation Dates: 03-17-06) § 5000.1, Purpose of the Complaint/Incident Process.
"The goal of the Federal complaint/incident process is to establish a system that will assist in promoting and protecting the health, safety, and welfare of residents, patients, and clients receiving health care services... The first objective and priority for the complaint/incident management system is protective oversight. This is accomplished

Human Services, Office of Inspector General (OIG), and analyses by the Public Citizen Health Research Group (PCHRG) confirm our experience: enforcement efforts have been anemic throughout time.

The next section will review the enforcement mechanisms provided by the existing statutory scheme, 42 U.S.C.A. § 1395dd(d), and the inadequacies associated with each.

1. **Complaint-driven investigations**: Within DHHS, EMTALA is enforced by CMS and the OIG. CMS typically authorizes state survey agencies to investigate complaints of patient dumping in order to determine if a violation exists.[24] The Regional Office (RO) evaluates and authorizes all complaints and refers cases to the SA that warrant investigation. The first step in determining if a hospital has an EMTALA obligation is for the surveyor to whether the hospital meets the criteria for having a dedicated emergency department.

A study authored by DHHS Office of Inspector General in January 2001 evaluated EMTALA investigations and CMS oversight activities between 1994 and 1998.[25] It noted, "the number of EMTALA investigations, averaging 400 a year between Fiscal Years 1994 and 1998, is very small compared to the number of emergency department visits in the United States, which totaled approximately 97 million in 1999."[26] Confirmed dumping violations emerged at the following levels, as compared to the number of investigations conducted: for, 1994, 28%; for 1995, 40%; for 1996, 58%; for 1997, 39%; for 1998, 40%. Thus, when investigations took place, a high level of noncompliance was substantiated. This suggests the existence of pervasive dumping practices, which will remain unchecked in non-investigated facilities.

A similar examination by PCHRG found that while patient dumping complaints continued to increase, federal attention to associated investigations was "meager," "poor" and "lax."[27] The investigative history of Rawson-Neal, as discussed previously, further demonstrates a

---

by analyzing the complaint allegations and reported incidents received to identify and respond to those that appear to pose the greatest potential for harming beneficiaries (has caused or is likely to cause, serious injury, harm, impairment or death). Complaints/incidents of this type that allege an immediate threat to the health, safety or welfare of individuals are investigated immediately…The second objective is prevention. Complaints/incidents that do not allege a threat of serious harm are investigated to determine if a problem exists that could have a negative impact on the healthcare services provided. The investigation of these complaints/incidents is designed to identify and correct less serious complaints/incident to prevent the escalation of these problems into more serious situations that would threaten the health, safety and welfare of the individuals receiving the service."

[24] CMS' State Operations Manual, Chapter 5-Complaint Procedures, (Rev. 18, Issued: 03-17-06; Effective/Implementation Dates: 03-17-06) § 5000.1, Purpose of the Complaint/Incident Process.

[25] *See* DEP'T. OF HEALTH AND HUMAN SVCS., OFFICE OF THE INSPECTOR GENERAL, OEI-09-98-00221, THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: THE ENFORCEMENT PROCESS (2001).

[26] *Id.* at 8.

[27] Gionas et al., *supra* note 20, at 200.

fundamental failure to dig deeply into patient dumping practices, until public scrutiny forces substantive attention on a crisis situation.

2. **Removal from Medicare program participation:** The Act provides for a bar or a suspension from Medicare participation for hospitals that knowingly and willfully, or negligently, violate the statute. 42 U.S.C.A. § 1395dd(d).

The OIG study showed that "hospitals cited for dumping violations rarely lose their provider agreements. Since 1986, [CMS] has terminated 13 hospitals from Medicare due to EMTALA violations. Only one of those terminations occurred after 1993, and it was voluntary. In practice, [CMS] does not terminate a hospital's provider agreement if the hospital takes corrective action to prevent future violations."[28]

With respect to Rawson-Neal, CMS has threatened termination of their provider agreement. This has yet to take place, however. In August of 2013, CMS sent a letter to Rawson-Neal highlighting their failure to comply with the mandates of 42 CFR § 489 and more specifically, 42 CFR § 489.24(a): Failure to provide appropriate medical screening exam and 42 CFR § 489.24(d) Failure to provide stabilizing treatment. This letter followed the Joint Commission's July 2013 preliminary decision to deny accreditation to the hospital based on lack of compliance with standards such as:

> Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment and services.
>
> The governing body is ultimately accountable for the safety and quality of care, treatment and services.
>
> The hospital has a process that addresses the patient's need for continuing care, treatment and services after discharge or transfer.
>
> When a patient is discharged or transferred, the hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.[29]

The actions of the Joint Commission explained the vote as necessary "due to the hospital placing patients at risk for a serious adverse outcome due to significant and pervasive patterns, trends, and/or repeat findings."[30] In January of 2014, CMS sent another letter to Rawson-Neal regarding

[28] DHHS, *supra* note 24, at 8.
[29] THE JOINT COMMISSION, FINAL STATEMENT 07 24 13 SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES (Jul. 24, 2013) (on file with author).
[30] *Id.*

violations related to 42 CFR § 489.24(r) and § 489.24(c) involving obligations regarding medical screening exams and violations of §489.24(e)(1) on appropriate transfers. This flurry of activity reflects serious, ongoing problems with Rawson-Neal practices, and yet their Medicare status remains intact.

3. **Civil monetary penalties:** DHHS, upon authorization by the Attorney General of the United States, possesses the authority to seek civil penalties against hospitals and physicians that violate EMTALA. "A participating hospital that negligently violates a requirement of [EMTALA] is subject to a civil money penalty of not more than $50,000 for each such violation." Associated penalties can be appealed to the U.S. Court of Appeals. A physician who misrepresents a patient's condition can face similar fines. The OIG Office of Counsel to the Inspector General levies monetary fines against violating hospitals and physicians and removes physicians from the Medicare program.

The OIG study similarly found that "civil monetary penalties are relatively uncommon. The OIG closes more than half of the cases it reviews. To date, OIG has processed 677 dumping cases; it has declined authority to require health plans to pay for the screening and stabilizing treatment that hospitals are obligated to provide under EMTALA."[31] Peer review organizations (PROs) are often involved in blocking the imposition of civil monetary penalties. OIG has observed, "in many instances the PRO's assessment leads OIG to drop a case…In 1997, the OIG noted that in some regions the PROs disputed [CMS]'s decision about a case as much as 33 percent of the time."[32]

42 U.S.C.A. § 1320a-7a(d) identifies additional factors for the imposition of civil monetary penalties. This law requires OIG to consider the nature of the claims and the circumstances under which they are presented, the degree of culpability, the history of prior offenses, the financial condition of the "person" presenting the claim, and "such other matters as justice may require." EMTALA specifies two additional factors: 1) the seriousness of the condition of the individual seeking emergency medical treatment; and 2) the prior history of [EMTALA] offenses of the facility. 42 C.F.R. §1003.106(a)(4)(2000). PCHRG found that between EMTALA's enactment through March 31, 2001, CMS referred 975 cases, including violations both by hospitals and physicians, to the OIG.[33] During that time frame, 261 cases resulted in the imposition of civil monetary penalties, or roughly 26.7% of referred cases.[34]

---

[31] DHHS, *supra* note 24, at 8-9

[32] *Id.* at 16. The OIG can impose civil monetary penalties without PRO review "[i]f a delay would jeopardize the health or safety of individuals or when there was no screening examination…" 42 C.F.R. § 489.24(g)(3).

[33] KAIJA BLALOCK & SIDNEY M. WOLFE, PUBLIC CITIZEN HEALTH RESEARCH GROUP, QUESTIONABLE HOSPITALS: 527 HOSPITALS THAT VIOLATED THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT: A DETAILED LOOK AT "PATIENT DUMPING" 61 (2001).

[34] *Id.*

In 2001, GAO reports also confirmed the dearth of enforcement activity. "The numbers of EMTALA violations have been relatively small, and the hospitals' Medicare provider agreements have rarely been terminated."[35] "From 1995 through 2000, the OIG imposed fines totaling over $5.6 million on 194 hospitals and 19 physicians. The majority of hospital fines were $25,000 or less. The total number of physicians ever fined by OIG for EMTALA violations is 28."[36] Further, OIG declined about 61% of the violation cases forwarded by CMS during this time period.[37]

To date, OIG has not publically disclosed any desire to issue monetary penalties as against Rawson-Neal.

4. **Civil enforcement:** If a patient suffers harm because a hospital violated EMTALA requirements, that patient can sue the hospital for damages under the personal injury law of that state or seek equitable relief. The civil enforcement provision establishes that any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of the statute may obtain damages in a civil action against the participating hospital. 42 U.S.C.A. § 1395dd(d)(2)(A). A plaintiff can bring a cause of action under either the screening or stabilization provisions of EMTALA or both. *See, e.g., Vazquez-Rivera v. Hosp. Episcopal San Lucas, Inc., 620 F. Supp. 2d 264 (D.P.R. 2009).*

Numerous courts have narrowed the reach of EMTALA as a means for obtaining civil enforcement of statutory guarantees. *Ramos-Cruz v. Centro Medico Tel Turabo*, 642 F.3d 17 (1st Cir. 2011) (holding that EMTALA does not require that a hospital deliver the feasible specific treatment that is best, but instead, whatever may be in a given circumstances); *Cruz-Queipo v. Hosp. Espanol Auxilio Mutuo de Puerto Rico*, 417 F.3d 67 (1st Cir. 2005) (holding that faulty screening, as opposed to disparate screening or refusing to screen at all, does not contravene the statute); *Guzman v. Memorial Hermann Hosp. Sys.*, 637 F.Supp.2d 464 (S.D. Tex. 2009) (holding that EMTALA does not require hospitals to impose detailed or symptom-specific screening-exam protocols or procedures; a general screening policy is sufficient); *Marshall on Behalf of Marshall v. East Carroll Parish Hosp. Serv. Dist.*, 134 F.3d 319, (5th Cir. 1998) (holding that a hospital is not required to show that it had uniform screening procedures; to succeed on a claim that she was denied "appropriate medical screening," a patient must show that the hospital treated her differently from other patients); *Vickers v. Nash General Hosp., Inc.*, 78 F.3d 139 (4th Cir. 1996) (holding that a stabilization claim exists only when the patient had an emergency condition and the hospital actually knew of that condition. A hospital is not held

[35] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-01-747, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES 3 (2001).
[36] *Id.* at 4.
[37] *Id.* at 24.

accountable for failing to stabilize conditions of which they are not aware, or even conditions of which they should have been aware).

In sum, the dilution, inconsistent application, and reactive nature of these tools has prevented effective enforcement of EMTALA mandates. Furthermore, the process suffers from a devolved system of oversight. DHHS needs to take a stronger lead in ensuring that CMS, and associated regional offices, take a proactive approach to investigation and oversight of patient dumping issues.

Recommendations from the OIG enforcement study early on confirmed that DHHS should increase its oversight of regional offices, as well as improve centralized collection and access to EMTALA data. As for findings, significant federal inadequacies regarding EMTALA enforcement involved: 1) long delays and inadequate feedback from federal overseers; 2) the fact that the number and scope of EMTALA investigations and findings vary widely by CMS region and year; and 3) poor centralized tracking of EMTALA, with incomplete and inconsistent data collection. Investigation logs were found to contain numerous errors and to have omitted key information about patient dumping complaints.[38]

V. Larger Context: Deinstitutionalization and the "Back Alley"

These challenges demonstrate an increasing gap in services for individuals struggling with psychiatric issues and poverty. They also emphasize the consistent absence of adequate financial investment in addressing mental health needs.

Commencing in the 1800s and proceeding until the 1960s, institutionalization of individuals with mental health needs generally led to abysmal conditions, overcrowding and the failure to provide meaningful therapeutic treatments. Sadly, "as welfare institutions such as almshouses and workhouses transferred their residents to mental hospitals, such institutions became virtually indistinguishable from the asylums, almshouses and poorhouses of the 19th century."[39]

President Kennedy pushed for deinstitutionalization as a "bold new approach" for the treatment of mental illness, and supported the Community Mental Health Centers Act of 1963. "The primary purpose of the policy was to reduce the inpatient population of public mental hospitals, reserving hospitalization as an option for the most severely impaired patients who were mentally ill and dangerous."[40] The goal was to shift treatment to community-based mental health centers and to create opportunities for individuals with mental health needs to live in integrated settings;

[38] DHHS, *supra* note 24, at 12-16.
[39] Mary Durham, *The Impact of Deinstitutionalization on the Current Treatment of the Mentally Ill*, 12 INT'L J.L. & PSYCHIATRY 117, 119 (1989).
[40] *Id. at 119.*

unfortunately, the resources necessary to maintain consistent support for associated services never materialized.

> Many of the failures of deinstitutionalization came from the lack of funding for community-based treatment programs which were to take the place of outdated, overcrowded hospitals. Many patients who were discharged from mental hospitals did not return to a supportive home environment linked to treatment, economic and social support; people who otherwise might have been hospitalized in the past never made contact with treatment facilities and were left to make their way in hostile communities.[41]

Furthermore, the broader needs of impoverished individuals with persistent mental illness were ignored. "Many severely disabled people who needed housing, and legal and social services, were poorly matched to community mental health centers because they could not obtain services there."[42] A 2012 study indicates that 636,017 adults are homeless on any given night in the United States, with as many as 2.15 million experiencing homelessness on an annual basis.[43] Of these, 25 to 33 % have a serious mental illness (SMI). "Research suggests that 28% of the sheltered homeless have an SMI, however, this estimate does not include people with SMI who may be among the 42% of unsheltered homeless.[44] "One study found that 36% of those with mental illness discharged from a state hospital became homeless within 6 months."[45] As one researcher observed:

> The process of deinstitutionalization removed the mentally ill from situations in which they could be treated. Although there were undeniable instances of abuse and mistreatment, the abuse mandated reform and better treatment, not necessarily the cessation of all care. Society has not supported adequately the hoped-for alternative of community-based treatment, breaking the implied promise of better care. Instead of a bed—be it in a hospital or community center—many of the mentally ill will sleep on a sidewalk grate tonight.[46]

[41] *Id.* at 122.
[42] *Id.*
[43] Lisa Davis et al., *Deinstitutionalization? Where Have All the People Gone?*, 14 CURRENT PSYCHIATRY REPORTS 259, 262 (2012).
[44] *Id.*
[45] *Id.*
[46] Wayne Edward Ramage, *The Pariah Patient: The Lack of Funding for Mental Health Care*, 45 VAND. L. REV. 951, 975-76 (1992).

VI. Specific Recommendations for Action & Change

Ultimately, individuals struggling with mental illness should receive not only fair treatment, but also recognition of their basic human right to dignity. From a medical perspective,[47] this includes the right:

To be treated with respect and dignity

To have their privacy protected

To receive age and culturally appropriate services

To understand available treatment options and alternatives

To receive care that does not discriminate on the basis of age, race, or type of illness.

These comments are meant to suggest that a better approach is possible. We must do the following to revamp the current paradigm.

A. Proactive Federal Investigation Process. CMS should conduct independent, proactive federal investigations of psychiatric emergency providers, through federal contractors, rather that state survey agencies, on a randomized basis**.** The complaint driven process has failed to yield compliance with EMTALA mandates. The federal review would provide an independent check on conditions, and supplement the complaint driven investigatory process.

B. Establish an Independent Monitor. Where CMS' independent investigation, or the complaint process, highlights the existence of discharge planning violations, DHHS should establish an independent monitor to oversee compliance with corrective action plans and EMTALA mandates. The independent monitor would possess audit authority and focus on the institution in question.

C. Escalate the Imposition of Fines and Place Revenues in "Anti-Dumping Fund." This effort would permit the establishment of a fund to cover the costs of independent, proactive investigations and oversight. Effective federal monitoring and control over patient dumping is a critical step in ensuring the alteration of behaviors that have gone unchecked under the current enforcement paradigm. Institutions may avoid the complete loss of their Medicare status, by negotiating to fund remedial and oversight efforts on a significant monetary scale. These could be structured with distinct, closed timeframes for compliance. This process would require that OIG commit to meaningful imposition of large fines in the substantial majority of cases.

[47] *See Rights for People with Mental Illness*, WEBMD, http://www.webmd.com/schizophrenia/guide/rights-mental-illness (last visited Jan. 30, 2013).

D. Reopen the viability of civil enforcement. Through statutory modification, the government could remove the narrow restrictions on EMTALA litigation imposed by some courts. Some have suggested the development of an intentional tort of patient dumping, for situations where a physician, or entity, causes a patient with an emergency medical condition to be transferred to another healthcare facility or discharged without first having stabilized the patient's emergency medical condition.

> The patient transfer must be on the basis of neither economic status (e.g. the patient's financial status), non-economic status (e.g. race, ethnicity, sexual orientation…), nor any other reason not based on professional medical standards related to the medical care of the patient.[48]

Another fruitful avenue consists of amending EMTALA to permit a private right of action against physicians, social workers, and other care providers, who fail to provide appropriate medical screening exams, and/or stabilize patients prior to discharge or transfer.

E. Increase Federal and State Investment. The provision of services for individuals with psychiatric needs demands full and fair funding for those efforts. Without federal intervention, as well as state financial commitments, individuals such as James Brown will endure neglect, injury and dislocation.[49]

F. Provide Information on How to Appeal a Discharge Order. Currently, patients using Medicare are provided documentation upon hospital discharge that informs them of their right to appeal if they believe they are being discharge prematurely. 42 C.F.R. § 405.1205(b),(c) (2006). This information should be made available to all patients being discharged or transferred, accompanied by an explanation of the patient's rights, and facilitated by an ombudsman or similar disinterested party to ensure patients are giving informed consent.

G. Report in Sufficient Detail Admittance and Discharge Practices. Institutions should be required to maintain and provide regular, detailed reports indicating the number of patients admitted, the reasons for admission (including the conditions of the patients), the average length of stay, and the places to which they were transferred or discharged. The institution should provide sufficient identifying information so that patients can be contacted in an effort to verify the accuracy of the information.

---

[48] Gionas et al., *supra* note 20, at 300-01.

[49] As an initial step, all psychiatric hospitals should commit to establishing two FTE to assist individuals with Medicare/Medicaid applications, and access to resources under the Affordable Care Act. This could help alleviate the financial burden associated with emergency care.

H. Add an Additional Administrative Check to Discharges. All prospective discharge and transfer orders should be subject to a second layer of approval. A high-ranking administrator, sufficiently removed from the managerial structure of an institution, should be required to countersign all discharge and transfer orders, thus discouraging the practice.

I. Give CSM More Effective Enforcement Power by Maintaining Multiple Institutional Options. Currently, CMS rarely decertifies institutions and rarely withholds funding. Therefore, citations and investigations had little impact on ensuring compliance. CMS should develop a strategy of supporting multiple institutions within any given geographic area, so noncompliant institutions are no longer "too big to fail," and funds can be more easily and quickly shifted to compliant institutions. This practice would make the threat of decertification and funding loss more realistic and influential.

J. Issue More Detailed Regulations Related to Discharge and Transfer. Regulations could require more detailed information about where patients are discharged or transferred, why they have been discharged or transferred, who will specifically be in charge of the patient's care, and any other information needed to ensure that discharges and transfers are in the best interest of patients.

APPENDIX A- Summary of Investigations by Independent Contractor (CMS Report from July 26, 2013)

Tag #	Definition	# of Instances
B103	The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.	-facility failed to perform and document examination for orientation and an estimate of memory functioning with supportive information in the psychiatric evaluation for 3/12 active sample patients -facility failed to perform and document an examination of orientation with supportive information in the psychiatric evaluation for 5/12 active samples -facility failed to provide and document individualized and measurable short and long term goals on the Master Treatment Plans for 12 of 12 active sample patients -facility failed to provide and document individualized interventions on the Master Treatment Plans for 12/12 active sample patients' to address patient's identified treatment needs -facility failed to provide individualized active treatment measures for 12/12 active sample patients
B108	The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.	-facility failed to ensure that the social service assessments included individualized recommendations for social work services from the data gathered from 8/12 active sample patients
B109	When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.	-for 1/12 active sample patients, facility failed to perform and document a screening neurological examination
B116	Each patient must receive a psychiatric evaluation that must estimate intellectual functioning, memory functioning and orientation.	-facility failed to perform and document examination for orientation and an estimate of memory functioning with supportive information in the psychiatric evaluation for 3/12 active sample patients -failed to perform and document an examination of orientation with supportive information in the psychiatric evaluation for 5/12 active sample patients
B117	Each patient must receive a psychiatric evaluation that must include an inventory of the patient's assets in descriptive, not interpretive fashion.	-facility failed to document an inventory of assets in the psychiatric evaluation of 2/12 active sample patients
B119	Treatment Plan- The plan must be based on an inventory of the patient's strengths and disabilities.	-facility failed to list patient strengths in the MTP's in descriptive fashion 12/12 active sample patients
B121	Treatment- The written plan must include short-term and long range goals.	-facility failed to provide MTP's that identified patient-related short-term and long-term goals stated in observable, measurable, behavioral terms for 12/12 active sampled patients
B122	Treatment- The written plan must include the	-facility failed to develop MTPs that identified nursing,

	specific treatment modalities used.	allied therapy and social work interventions that were individualized and specific to patients and treatment needs for 12/12 sampled patients -no physician interventions listed for 11/12 active sample patients -no Social work interventions listed for 4/12 active sample patients
B125	Treatment- The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included.	-facility failed to provide individualized active treatment measures to 12/12 active sample patients -2/12 patients did not attend groups and the facility failed to provide purposeful alternative interventions
B133	Discharge Planning- The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization.	-facility failed to ensure that the discharge summary was dictated, transcribed, and filed within 30 days of discharge in 2/5 discharge records reviewed
B134	Discharge Planning- The record of each patient who has been discharged must have recommendations from appropriate services concerning follow-up or after care.	-facility failed to ensure that follow-up appointments were included in discharge summaries for 4 of 5 patients whose discharge records were reviewed
B135	Discharge Planning- The record of each patient who has been discharged must have a brief summary of the patient's condition on discharge.	-facility failed to ensure that the discharge summaries for 5/5 sampled discharged patients contained a summary of the patient's condition on discharge.
B144	Medical Staff- The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.	-Medical director failed to adequately monitor and evaluate the care provided to patients at the facility
B148	Nursing Services- The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.	-DON (Director of Nursing) failed to ensure that nursing staff developed Master Treatment Plans (MTP) that identified nursing interventions that were individualized and specific to the patients treatment needs for 12/12 sampled patients
B152	Social Services- There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished.	-The Director of Social Services failed to monitor and evaluate the quality and appropriateness of social services provided to patients at the facility -failed to assure that social service assessments included individualized recommendations for social work services for 8/12 sample patients -failed to assu4re that the facility developed MTP's that identified social work interventions that were individualized and specific to the patients treatment needs for 12/12 sampled patients