

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

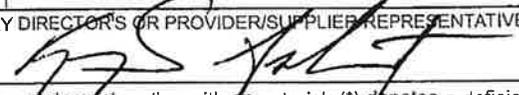
PRINTED: 12/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 531316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/18/2025
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF CARBON COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 2221 WEST ELM STREET RAWLINS, WY 82301
--	--

(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
--------------------	--	---------------	---	----------------------

C 000	INITIAL COMMENTS A complaint health survey for compliance with Emergency Medical Treatment and Labor Act (EMTALA) 42 CFR Part 489.20 Basic Section Commitments Relevant to Section 1867 Responsibilities and 42 CFR Part 489.24 Special Responsibilities of Medicare Hospitals in Emergency Cases, was conducted from 8/11/25 through 8/18/25. The survey was prompted by complaint intake WY0004461. Based upon the findings of the survey team, Memorial Hospital of Carbon County was found not in compliance with the requirements for C-2400, C-2406 and C-2409.	C 000		
C2400	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 medical record review, staff, patient and family interviews, and review of policies and procedures, the facility failed to ensure a transfer was effected through qualified personnel and transportation equipment for 2 of 6 sampled patients (#7, #9) who were transferred. The findings were:	C2400		
C2409	APPROPRIATE TRANSFER CFR(s): 489.24(e)(1-2) (1) General If an individual at a hospital has an emergency medical condition that has not been stabilized (as	C2409		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE CEO (X6) DATE 12/24/2025

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.

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

PRINTED: 12/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 531316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/18/2025
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF CARBON COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 2221 WEST ELM STREET RAWLINS, WY 82301		
(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)	
C2409	<p>Continued From page 2 and benefits upon which it is based.</p> <p>(2) A transfer to another medical facility will be appropriate only in those cases in which -</p> <p>(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;</p> <p>(ii) The receiving facility</p> <p>(A) Has available space and qualified personnel for the treatment of the individual; and</p> <p>(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment.</p> <p>(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and</p> <p>(iv) The transfer is effected through qualified personnel and transportation equipment, as</p>	C2409		

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

PRINTED: 12/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 531316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/18/2025
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF CARBON COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 2221 WEST ELM STREET RAWLINS, WY 82301
--	--

(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
--------------------	--	---------------	---	----------------------

C2409	Continued From page 4 transferred to hospital B. The mode of transport was listed as "private auto." b. Review of the ED disposition documentation dated 6/24/25 at 12:32 AM showed the patient was being transferred due to requiring specialty care. The mode of transfer was listed as "private vehicle." c. Review of a nursing note dated 6/24/25 at 12:28 AM showed the patient stated he didn't think he would be able to go to hospital B that night to see the urologist. He stated he was tired and thought he would fall asleep. The nurse reinforced to the patient the need and importance of being evaluated tonight "due to potential irreversible damage." The patient verbalized understanding and stated he would have his father drive him. d. During an interview on 8/12/25 at 2:24 PM physician #1 stated the patient had scrotal pain, and the scrotum was swollen and ecchymotic (bruised). His concern was for torsion (twisting of the testicle) or penile fracture (rupture of fibrous coverings on the penis; considered a urological emergency). He stated he called urology at hospital B and they said the patient needed to go there emergently. He stated the facility did not have ultrasound after 5 PM, therefore he needed to be transferred. He stated the patient had an emergency medical condition and needed further care. He stated the mode of transport was usually left up to the patient, but if the patient was unstable, they would be sent via ambulance. When asked if this patient was stable, he replied that his recollection was the patient didn't want to go via ambulance and wanted to go in a private vehicle. When asked if patients who wanted to go in a private vehicle and not in an ambulance were asked to sign something to indicate they understood the risks, he stated not in this case.	C2409		
-------	---	-------	--	--

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

PRINTED: 12/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 531316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/18/2025
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF CARBON COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 2221 WEST ELM STREET RAWLINS, WY 82301		
(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	
C2409	Continued From page 6 physician's exam at 4:15 PM showed the physician received a phone call from another physician stating the patient was coming to the ED. The patient had severe upper abdomen pain and laboratory testing showed elevated AST (aspartate aminotransferase; shows liver health), ALT (alanine aminotransferase; shows liver health) and alk phos (alkaline phosphatase; shows liver health) and a lipase of over 900 (elevated levels shows problems with pancreas). In the ED, a CT (computed tomography) scan was done which showed gallbladder wall thickening with pancreatitis. The physician spoke with a gastroenterologist at hospital C (in a town about 117 miles away) who agreed to see the patient. He consented to the patient traveling by private vehicle. The assessment was documented as common duct stone and pancreatitis. The following concerns were identified: a. Review of the "COBRA Transfer Form" dated 7/9/25 showed the patient was being transferred by private vehicle to hospital C for gastroenterology. b. Review of the ED disposition documentation showed the patient was being transferred to hospital C by private vehicle with family. c. On 8/12/25 at 4:36 PM the patient stated the facility offered an ambulance but s/he wanted to go by private vehicle. The patient stated family was with him/her in the car. When asked if the facility had him/her sign something to show s/he understood the risks of transferring via a personal vehicle, s/he stated they signed "something" but s/he wasn't sure if it was that. d. During an interview on 8/12/25 at 5:06 PM RN #2 stated the physician talked to the receiving physician and he was comfortable with the patient	C2409			

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

PRINTED: 12/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 531316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/18/2025
NAME OF PROVIDER OR SUPPLIER MEMORIAL HOSPITAL OF CARBON COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 2221 WEST ELM STREET RAWLINS, WY 82301		
(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	
C2409	Continued From page 8 patients declined ambulance transport and wanted to go in a private vehicle.	C2409			

NAME OF PROVIDER OR SUPPLIER

MEMORIAL HOSPITAL OF CARBON COUNTY 2221 W.ELM STREET RAWLINS.WY. 82301

PROVIDERS IDENTIFICATION NUMBER (CCN) 531316

DATE SURVEY COMPLETED AUGUST 18, 2025

Complaint Intake: WY0004461

Deficiency Cited

C2400 – Compliance with 489.24 CFR(s): 489.20(l) Hospital failed to ensure transfers were effected through qualified personnel and transportation equipment for 2 of 6 sampled patients (#7, #9).

C2409 – Appropriate Transfer CFR(s): 489.24(e)(1-2) Hospitals must ensure transfers are effected through qualified personnel and transportation equipment, including the use of necessary and medically appropriate life support measures during the transfer.

This STANDARD is not met as evidenced by:

Based on medical record review, patient and staff interview, and review of policies and procedures, the facility failed to ensure the transfer was effected through qualified personnel and transportation equipment for 2 of 6 sampled patients (#7, #9) who were transferred to other health care facilities.

- Facility policy "Transferring of Patients" (print date 11/5/2021) stated: "The transfer is an appropriate transfer in which... the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer."
- Further review showed policy did not address procedures for when patients refuse ambulance transport.

Plan of Correction:

1. Policy Revision/Change (See attached):

- EMTALA Transfer Policy updated to prohibit staff from arranging or endorsing POV transfers for patients with emergency medical conditions.
- Refusal of EMS transport documented as **Against Medical Advice (AMA) and refusal of transfer**. Transfer paperwork (COBRA) is not completed if EMS services are refused.
- Policy now incorporates **489.24(e)(1-2)** requirements:
 - If physician is not physically present, qualified medical person may sign certification after consultation, with physician countersignature. Certification must summarize risks and benefits.
 - Transfers only occur when:
 - Hospital provides stabilizing treatment within capacity.
 - Receiving facility has space, personnel, and agrees to accept patient.
 - All relevant medical records and Transfer forms sent at time of transfer.

- Transfer effected through qualified personnel and transportation equipment, including medically appropriate life support measures.

2. Staff Education

- Mandatory EMTALA training for ED staff, physicians, and nurses within 30 days.
- Training includes appropriate transfer standards, risks of POV transport, documentation requirements.
- Annual refresher training required.

3. Monitoring and Compliance

- ER Nurse Supervisor will audits 100% of transfers for 90 days starting on 1/1/26 and then 10% of transfer monthly for six months through September 2026.
- Any refusal of EMS transport will be reported to the Compliance Officer.
- Compliance Committee reviews transfer refusals quarterly.

4. Responsible Parties

- Director of Nursing Outpatient Services
- Manager of Emergency Room and EMS Services
- Supervisor of EMS Services
- Compliance Officer

5. Completion Date

- Policy revision and staff training completed within **30 days** of submission of the Plan of Correction to both the **Wyoming Department of Health-Healthcare, Licensing and Survey Department** and **The KC & Denver Survey Operations Group Center for Clinical Standards & Quality Centers for Medicare & Medicaid Services**.
- Monitoring and audits will begin January 2026 and will continue for at least **nine months**.
- The Plan of Correction will become a quality measure reported to the Quality Committee.