STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	531309	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH BIG HORN HOSPITAL DISTRICT	1115 LANE 12 LOVELL, WY 82431

(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 4/22/25 through 4/24/25. North Big Horn Hospital was found not in compliance with the following requirements: C2400, C2405 and C2406.	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 observation, medical record review, staff interview, review of the central log, the admission/emergency room video recording, the emergency medical services reports, and policy and procedure review, the facility failed to ensure C-2405 and C-2406 were met. The findings were: 1. Refer to C-2405 for details on the facility's failure to ensure patient #1 was included on the emergency room log. 2. Refer to C-2406 for details on the facility's failure to provide an appropriate medical screening examination to patient #1.	C2400		
C2405	EMERGENCY ROOM LOG CFR(s): 489.20(r)(3) [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	C2405		

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

CEO | 9/10/25

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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C2405	Continued From page 1 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 medical record review, staff interview, review of the admission/emergency room entry lobby video recording, review of the central log, and policy and procedure review, the facility failed to ensure 1 of 20 sample patients (#1) was included on the emergency room log. The findings were: 1. Observation of the admission/emergency room entry lobby video recording showed on 4/16/25 at 11:02:03 AM patient #1 arrived with staff from a long-term care facility via wheelchair. The admission clerk had placed the patients arm band on at 11:04:16 AM. At 11:08:42 AM, the director of nursing talked with person in the lobby and took the patient out of lobby via wheelchair towards the nursing home. 2. Review of the April 2025 Emergency Department log showed the facility failed to include patient #1 when s/he presented to the emergency room on 4/16/25. 3. Review of patient #1's "Encounter Search" showed the 11:03 AM registration on 4/16/25 for "Emergency" was a canceled visit. Further, it showed the discharge date was 4/16/25 at 11:10 AM.	C2405		

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C2405	Continued From page 2 4. Interview with the chief nursing officer on 4/23/25 at 4 PM revealed he had asked admissions to cancel the patient's admission. 5. Review of the policy and procedure "EMTALA Guidelines" reviewed on 2/14/23 showed "...6. This facility will maintain a Central Log for each individual who comes to the emergency department seeking assistance..."	C2405		
C2406	MEDICAL SCREENING EXAM CFR(s): 489.24(a) and 489.24(c) (a) Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must- (i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under	C2406		

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C2406	Continued From page 3 this section ends, as specified in paragraph (d)(2) of this section. (2)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met: (A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period. (B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan. (C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay. (D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act. (E) There has been a determination that a waiver of sanctions is necessary. (ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under	C2406		

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C2406	Continued From page 4 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, medical record review, staff interview, review of the admission/emergency room video recording, and emergency medical services reports, and policy and procedure review, the facility failed to ensure an appropriate medical screening examination was completed for 1 of 20 sample patients (#1) who presented to the emergency department. The findings were: 1. Observation of the admission/emergency room entry lobby video recording showed on 4/16/25 at 11:02:03 AM patient #1 arrived with staff from a long-term care facility via wheelchair. The admission clerk had placed the patients arm band on at 11:04:16 AM. At 11:08:42 AM, the director of nursing talked with person in the lobby and took the patient out of lobby via wheelchair towards the nursing home. 2. Review of the "Encounter Search" for patient #1 showed on 4/16/25 at 11:03 AM the registration dated for "Emergency" was a canceled visit. Further, it showed the discharge	C2406		

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C2406	Continued From page 5 date on 4/16/25 at 11:10 AM. There were no other emergency room records for the patient. 3. Review of the "Long Term Care/Swing Bed Documents" for patient #1 showed the following: a. Review of the progress note dated 4/16/25 at 10:40 AM showed "...inability to transfer and walk, ambulated via wheelchair back to room. Right sided weakness, drooling from the right side of mouth, complaint of neck and back to the right side..." b. Review of the "Facility Transfer LTC Form" entered on 4/16/25 at 11:24 AM showed "...Transfer Information. Medical Reason for Transfer LTC: Mental status change, Cardiac, Neurological. Medical Reason Comments LTC: Change of condition, with right sided weakness and increasing pain..." c. Review of the progress noted dated 4/16/25 at 12:54 PM showed "Resident [patient #1] was sent to the [hospital #2] ER via ambulance at noon..." The progress notes failed to show the patient was first sent to the North Big Horn Hospital emergency room. 4. Review of the emergency medical services "Patient Care Report" dated 4/16/25 at 11:14 AM showed "...Narrative: Dispatched to Care Center to take [patient #1] complaining of a headache that started at 1045 to hospital. Patient is a resident at [name of long-term care facility] and started complaining of headache while having a BM (bowel movement). Care Center staff decided patient was not acting right and took patient to NBHH [North Big Horn Hospital] ER [Emergency Room]. Due to NBHH CT scan being down, DON [name] and PA-C [name] told Care Center staff to take patient back to care center instead of checking in to ER and called 911 for transport to	C2406		

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C2406	Continued From page 6 [hospital #2] ER the next closest facility." The activities showed the patient was placed on 2 liters of oxygen, glucose was checked, IV - Saline Lock to left wrist, using a 22-gage catheter. 5. Interview on 3/24/25 at 10:33 AM with patient #1's power of attorney revealed they had assumed they saw the patient in the Lovell hospital, but was not sure. The patient did go to [hospital #2] that day because the Lovell hospital did not have a CT machine. S/he was showing signs of dragging his/her right side. S/he probably had a mini stroke. 6. Interview on 4/23/25 at 4 PM with the chief nursing officer revealed he had found out the facilities CT scanner was already torn apart, and the mobile CT scanner was down. The long-term care facility was sending someone over with right sided weakness. He tried to stop the patient from coming over, so the long-term care facility could just send the patient to hospital #2. The patient was already checked in, so the patient was taken back to the long-term care facility and 911 was called. At that moment we just wanted to get him/her the help that they needed. We did not intentionally try and dump the patient. He further stated he did ask admissions to cancel the patient on the admission log. 7. Interview on 4/23/25 at 4:07 PM with the emergency room provider on duty for 4/16/25 revealed he was familiar with the patient. He had seen him/her before. However, on that date he did not see the patient and was unaware s/he came to the ED. 8. Review of policy and procedure "EMTALA Guidelines" review date of 2/14/23 showed	C2406		

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C2406	Continued From page 7 "Policy: ...Any individual who comes to the hospital seeking or requesting examination or treatment of a medical condition, including women in active labor, will be given an appropriate medical screening exam."	C2406		

Plan of Correction for EMTALA Survey Findings
North Big Horn Hospital
Lovell, Wyoming
Survey Dates: April 22–24, 2025
Submission Date: August 15, 2025

1 Introduction

North Big Horn Hospital (NBHH), a Critical Access Hospital participating in Medicare, is committed to full compliance with the Emergency Medical Treatment and Labor Act (EMTALA) under 42 CFR §§489.20 and 489.24. This Plan of Correction (POC) addresses deficiencies identified during the CMS complaint survey conducted April 22–24, 2025, for tags C2400 (overall EMTALA compliance), C2405 (emergency room log), and C2406 (medical screening examination). The POC details corrective actions for affected individuals, identification of others potentially affected, systemic measures to prevent recurrence, monitoring mechanisms, responsible parties, and completion dates. All actions are integrated into the hospital's Quality Assessment and Performance Improvement (QAPI) program for sustained compliance.

2 C2400: Compliance with §489.24

2.1 Deficiency Summary

The hospital failed to comply with §489.24, as evidenced by non-compliance with C2405 (failure to log Patient #1) and C2406 (failure to provide an appropriate medical screening examination for patient #1) on April 16, 2025.

2.2 Corrective Actions

1. **Systemic Measures to Prevent Recurrence:**
    - Revised the "EMTALA Guidelines" policy (last reviewed March 11, 2025) to mandate logging all ED presentations, prohibit registration cancellations without MSE documentation, and require MSEs regardless of equipment availability (e.g., CT scanner downtime).
    - Implemented mandatory EMTALA training for ED staff, admissions clerks, nursing leadership, and on-call providers, covering log maintenance, MSE requirements, and equipment downtime protocols.

- Established protocols for equipment downtime, immediate communication with leadership, nearby facilities with pre-arranged transfer agreements (e.g., Hospital #2), and all departments within the organization.

2. **Monitoring and Evaluation:**
    - Monthly audits of 20% of ED logs and records (minimum 20 cases) by the Quality Director to verify compliance. Results reported to the QAPI committee quarterly, with corrective actions (e.g., retraining) for noncompliance.
    - Annual EMTALA education, with 100% compliance by staff.

3. **Responsible Parties and Completion Dates:**
    - Responsible: CNO, Quality Director, Compliance Officer.
    - Policy revisions and training: Completed by September 18, 2025.
    - Retrospective audit: Completed by September 15, 2025.
    - Monitoring: Initiated September 18, 2025.

3 C2405: Emergency Room Log (§489.20(r)(3))

3.1 Deficiency Summary

The hospital failed to maintain a central log for patient #1, who presented to the ED on April 16, 2025, at 11:02 AM via wheelchair from an LTC facility. The registration was canceled at the CNO's request, and the patient was not logged despite armband placement and lobby presence.

3.2 Corrective Actions

1. **Systemic Measures to Prevent Recurrence:**
    - Updated the "EMTALA Guidelines" policy to require logging all ED presentations with details (arrival time, mode, chief complaint, disposition, MSE status). Implemented an electronic logging system with automatic timestamps and alerts for incomplete entries. Admissions staff trained to log patients immediately upon presentation.

2. **Monitoring and Evaluation:**

- Monthly audits of 100% of daily logs for the first 3 months, then monthly audits of 20% thereafter, targeting completeness. Results tracked in QAPI, with a compliance threshold of 95% (below triggers retraining).
- Log compliance incorporated into annual staff performance evaluations.

3. **Responsible Parties and Completion Dates:**
    - Responsible: Admissions Director, CNO.
    - Policy updates and training: Completed by September 30, 2025
    - Monitoring: Initiated October 1, 2025.

4 C2406: Medical Screening Examination (§489.24(a) and (c))

4.1 Deficiency Summary

The hospital failed to provide an appropriate medical screening examination (MSE) for Patient #1, who presented on April 16, 2025, with possible stroke symptoms 3 (right-sided weakness, drooling, pain). The patient was registered but redirected to the LTC facility without an MSE due to CT scanner downtime, followed by EMS transfer to Hospital #2.

4.2 Corrective Actions

1. **Systemic Measures to Prevent Recurrence:**
    - Revised the "EMTALA Guidelines" policy to mandate MSEs for all ED presentations, conducted by qualified personnel (physician, PA, NP per bylaws), including triage, history, physical exam, and available ancillary services. MSEs required before redirection or transfer, regardless of equipment downtime.
    - Developed a downtime protocol: Immediate MSE to assess emergency medical condition (EMC), stabilization if EMC exists, and physician-certified transfer if needed.
    - Provided mandatory training for ED providers, nurses, and leadership on MSE processes, non-discrimination, and documentation.
    - Implemented a standardized MSE form in the electronic health record (EHR) with required fields to prevent incomplete records.

2. **Monitoring and Evaluation:**
    - Monthly audits of 20% of ED records (minimum 20 cases) to verify MSE completion and documentation. Results reported to QAPI quarterly, with corrective actions (e.g., provider counseling) for non-compliance.

3. **Responsible Parties and Completion Dates:**
    - Responsible: Medical Director, CNO, Compliance Officer.
    - Policy revisions and training: Completed by September 30, 2025.
    - Protocol implementation: Completed by September 30, 2025~~October 15, 2025.~~
    - Monitoring: Initiated October 1, 2025.

5 Conclusion

North Big Horn Hospital is committed to ensuring sustained EMTALA compliance through policy revisions, staff education, system enhancements, and robust monitoring. Documentation of all corrective actions will be maintained and available for CMS revisit surveys. The hospital respectfully requests CMS approval of this POC and confirmation that the measures address the cited deficiencies. For inquiries, contact the Quality Director at NBHH.