STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	531315	A. BUILDING _____ B. WING _____	C 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN MEDICAL CENTER - CAH	711 ONYX STREET KEMMERER, WY 83101

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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 12/15/25 through 12/17/25. The survey was prompted by complaint intake WY00004571. Based upon the findings of the survey team, South Lincoln Medical Center was found not in compliance with the requirements for C-2400, C-2405, C-2406, and C-2409. On 12/17/25 a finding of immediate jeopardy (IJ) (immediate threat to the health and safety of patients) was identified in the area of 489.24 (a); Appropriate Medical Screening Examination. The facility was notified verbally of the preliminary finding of IJ on 12/17/25 at 2:30 PM and the IJ template was provided on 12/17/25 at 3:09 PM. The facility submitted a plan to remove the IJ on 1/7/26, with a correction date of 1/15/26. An onsite visit was conducted on 1/16/26, and based on the steps the facility had taken, the surveyor determined that the IJ was removed on 1/16/26. The facility was notified on 1/16/26 at 11:17 AM.	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 staff and patient interviews,	C2400		

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

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C2400	Continued From page 1 emergency department (ED) log review, and review of outside records, electronic medical record system, and policies and procedures, the facility failed to ensure an appropriate medical screening examination was provided for 4 of 20 sample patients (#4, #7, #11, #15). In addition, the facility failed to ensure a physician certified that the benefits of a transfer outweighed the risks for 2 of 3 patients (#14, #20) who were transferred. The findings were: 1. Refer to C-2406 for details on the facility's failure to ensure patients #4, #7, #11, and #15 were provided a medical screening examination. On 12/17/25 a finding of immediate jeopardy (IJ) (immediate threat to the health and safety of patients) was identified in the area of 489.24 (a); Appropriate Medical Screening Examination related to patient #7. The facility was notified verbally of the preliminary finding of IJ on 12/17/25 at 2:30 PM and the IJ template was provided on 12/17/25 at 3:09 PM. 2. Refer to C-2409 for details on the facility's failure to ensure a physician certified that the benefits of a transfer outweighed the risks for patients #14 and #20. The facility submitted a plan to remove the IJ on 1/7/26, with a correction date of 1/15/26. An onsite visit was conducted on 1/16/26 and the surveyor determined that based on verification of a new EMTALA policy, staff education for all ED staff, verification of staff knowledge and medical record review, the IJ was removed on 1/16/26.	C2400		

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C2400	Continued From page 2 The facility was notified on 1/16/26 at 11:17 AM.	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 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 staff and patient interviews, emergency department (ED) log review, and review of policies and procedures, the facility failed to ensure all individuals who came to the ED were tracked on the central log for 1 of 20 sample patients (#7). The findings were: 1. The following concerns were identified related to patient #7: a. During interviews on 12/15/25 at 6 PM and on 12/16/25 at 6:52 PM patient #7 stated she went to the ED on 12/2/25 around 6:30 PM or 7 PM because she was having contractions that were 10 to 15 minutes apart. She stated she was about 20 weeks pregnant. She stated a certified nurse aide (CNA) and registered nurse (RN) #1 took her to a bay inside the ED. The CNA took her vital signs and she told RN #1 what was going on. She stated physician #1 came into the	C2405		

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C2405	Continued From page 3	C2405		

room and stated ultrasound was not available and so he couldn't do anything for her. He said it was better if she went somewhere else. The patient stated she and her husband started traveling by private vehicle towards Logan, Utah, where her OB/GYN (obstetrics and gynecology) provider was.

b. On 12/15/25 at 7:10 PM CNA #1 stated she remembered patient #7 from 12/2/25. She stated the patient was complaining of labor pains. She stated ultrasound was not available after 5 PM and the physician had her hold off registering the patient. She stated the physician spoke to the patient and stated he would hate to charge her when he couldn't do anything for her. She stated the patient called a friend and she thinks they were going to go to Rock Springs. She stated she thought the patient's vitals were OK, but could not recall what they were. She stated she "reversed it out in the log" so the patient wouldn't be charged.

c. During an interview on 12/15/25 at 7:27 PM RN #1 stated she recalled patient #7 from 12/2/25. She stated she took her vitals. She stated the patient told her she had contractions all throughout the day and had called her OB/GYN who told her to take a bath and go the ED if the contractions came back. She stated her recollection was the patient said she was having contractions every hour that lasted 20-30 seconds. She stated she could tell the patient was in pain and the patient stated she had issues with previous pregnancies. She stated the facility did not have ultrasound available after hours and the physician told the patient he could work her up and send her by ambulance somewhere else,

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C2405	Continued From page 4 or she could have somebody pick her up. She made the decision to go by personal vehicle because an ambulance would be expensive. She stated the patient was registered in the system, but they ended up reversing out the registration. d. On 12/16/25 at 9:01 AM physician #1 stated he thought he recalled patient #7. He stated he had a conversation with her and told her they did not have OB services or ultrasound. He told her he would feel guilty checking her in when he couldn't do anything and she would get a big bill. He stated he wouldn't feel right billing her when he couldn't provide any services. e. Review of the ED log for December 2025 showed patient #7 was not on the log. f. During an interview on 12/16/25 at 9:22 AM the acute care supervisor stated if staff backed out the registration then it sounded like maybe the patient was concerned about cost. However, she stated charges were put in manually, so there was a way to have a patient be registered and handle the charges separately. g. Review of the policies provided by the facility related to EMTALA showed no policy that addressed the ED log.	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	C2406		

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C2406	Continued From page 5 (b) of this section, the hospital must- (i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section. (2)(i) When a waiver has been issued in 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	C2406		

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C2406	Continued From page 6	C2406		

preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.
(C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.
(D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act.
(E) There has been a determination that a waiver of sanctions is necessary.
(ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under section 1135(e)(1)(B) of the Act.

(c) Use of dedicated emergency department for nonemergency services. If an individual comes to 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 staff and patient interviews, emergency department (ED) log and medical record review, and review of policies and

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C2406	Continued From page 7	C2406		

procedures, the facility failed to ensure an appropriate medical screening examination was provided for 4 of 20 sample patients (#4, #7, #11, #15,). The findings were:

1. The following concerns were identified related to patient #7:

a. During interviews on 12/15/25 at 6 PM and on 12/16/25 at 6:52 PM patient #7 stated she went to the ED on 12/2/25 around 6:30 PM or 7 PM because she was having contractions that were 10 to 15 minutes apart. She stated she was about 20 weeks pregnant. She stated a certified nurse aide (CNA) and registered nurse (RN) #1 took her to a bay inside the ED. The CNA took her vital signs and she told RN #1 what was going on. She stated physician #1 came into the room and stated ultrasound was not available and so he couldn't do anything for her. He said it was better if she went somewhere else. He stated he was not going to check her in so she wouldn't get a bill for the visit. She stated the physician did not do an examination of her. The fetal heart rate (FHR) was not assessed. She stated when she had a contraction, the RN felt the contraction with her hand and told the physician it was really strong. When asked if the physician offered to evaluate her or transfer her to another facility, she stated no. She then added that he told her she needed to go to Rock Springs, Wyoming (about 89 miles away) or Logan, Utah (about 94 miles away). She stated he did say that he could get her an ambulance, "...but you won't like it," but by that time she was already on the phone with a friend to arrange transportation. The patient stated she and her husband started traveling by private vehicle

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C2406	Continued From page 8	C2406		

towards Logan, Utah, where her OB/GYN (obstetrics and gynecology) provider was. She stated she got near Lake Town, Utah (about 45 miles away) when her contractions slowed down. So they turned around and went home. She went to an already scheduled OB/GYN appointment two days later. She stated she has placenta previa (pregnancy complication where the placenta grows low in the uterus, partially or completely covering the cervix) and she was put on restrictions, including no lifting and no standing for long periods.

b. On 12/15/25 at 7:10 PM CNA #1 stated she remembered patient #7 from 12/2/25. She stated the patient was complaining of labor pains. She stated ultrasound was not available after 5 PM and the physician had her hold off registering the patient. She stated the physician spoke to the patient and stated he would hate to charge her when he couldn't do anything for her. She stated the patient called a friend and she thinks they were going to go to Rock Springs. She stated she thought the patient's vitals were OK, but could not recall what they were. She stated she "reversed it out in the log" so the patient wouldn't be charged.

c. During an interview on 12/15/25 at 7:27 PM RN #1 stated she recalled patient #7 from 12/2/25. She stated she took her vitals. She stated the patient told her she had contractions all throughout the day and had called her OB/GYN who told her to take a bath and go the ED if the contractions came back. She stated her recollection was the patient said she was having contractions every hour that lasted 20-30 seconds. She stated she could tell the patient

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C2406	Continued From page 9	C2406		

was in pain and the patient stated she had issues with previous pregnancies. She stated the facility did not have ultrasound available after hours and the physician told the patient he could work her up and send her by ambulance somewhere else, or she could have somebody pick her up. She made the decision to go by personal vehicle because an ambulance would be expensive. She stated the patient was registered in the system, but they ended up reversing out the registration. When asked if they had the patient sign something that showed she understood the risks and was choosing to not be seen by the physician and travel by personal vehicle, she stated no. She stated they didn't have her sign anything because they were not going to charge her.

d. On 12/16/25 at 9:01 AM physician #1 stated the facility did not have OB services available and did not have ultrasound available after 5 PM. He stated if a patient came to the ED after hours who was having contractions, they would need to send her to a hospital who had that resource. He explained he would call a facility who had OB services and ultrasound and would follow the regular EMTALA process including the transfer form. The physician stated he thought he recalled patient #7. He stated he had a conversation with her and told her they did not have OB services or ultrasound. He told her he would feel guilty checking her in when he couldn't do anything and she would get a big bill. He stated he wouldn't feel right billing her when he couldn't provide any services. When asked if vital signs were taken he stated he did not think so. He stated she was about 20 weeks pregnant and stated the fetal heart rate was not assessed. When asked if a

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C2406	Continued From page 10	C2406		

medical screening examination was completed he stated "I visualized her" as he spoke to her face to face. He stated she said the contractions were 15 minutes apart. When asked if she had any contractions in the ED, he replied "she did have a couple while with me." He said the patient refused an ambulance and stated her husband would take her. When asked if there was anything signed by the patient, he stated no, she had agreed to not be checked in.

e. During an interview on 12/16/25 at 9:22 AM the acute care supervisor stated if a patient refused a medical screening exam it should be documented in the medical record. She further stated if a patient wanted to be transferred via private vehicle instead of an ambulance then the transfer form had a place to sign for that. She looked at the electronic medical record system at that time and stated there was no medical record for the ED visit on 12/2/25 for patient #7. She stated if staff backed out the registration then it sounded like maybe the patient was concerned about cost. However, she stated charges were put in manually, so there was a way to have a patient be registered and handle the charges separately.

f. On 12/17/25 at 9:03 AM the medical director stated ultrasound was not available all the time. He stated if a pregnant woman needed ultrasound then they would need to transfer her to another facility. He stated the ED provider would call a facility and find an accepting physician. He stated the mode of transportation would depend on the patient's condition, but an ambulance was always offered. If the patient wanted to go by private vehicle, the transfer form

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C2406	Continued From page 11	C2406		

had a place for the patient to sign after the risks were discussed. He stated he was not familiar with the case of patient #7, but generally a medical screening examination should be done. He stated maybe the provider was trying to be considerate of the cost for the patient. However, he did state it is better to document something. He further confirmed the facility did have a policy for pregnant women in the ED which showed the fetal heart rate should be assessed.

g. Review of the ED log for December 2025 showed patient #7 was not on the log.

h. Review of the electronic medical record system showed no medical record for 12/2/25 for patient #7. However, there was an earlier visit from 9/9/25 which showed the patient presented at about 8.5 weeks pregnant with vaginal bleeding. A transvaginal ultrasound showed a single live intrauterine pregnancy which predicted a gestational age of 8 weeks and 5 days. The fetal heart rate was 158 beats per minute. The discharge diagnosis was threatened miscarriage.

i. Review of the medical record from an OB/GYN office visit dated 12/4/25 showed an ultrasound was completed and showed the gestational age was 20 weeks and 6 days. The interpretation of the ultrasound included " ...Technically a marginal/partial previa. Extensive counseling given."

j. Review of the facility's policy "Pregnant Patients in the Emergency Room," approved 1/30/25, showed "Pregnant Patients < 20 Weeks Gestation 1. Pregnant patients <20 weeks gestation may be treated in the ED 2. Conduct a

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C2406	Continued From page 12 full assessment and obtain patients OB provider information 3. Document presence of FHR [fetal heart rate] by Doppler on admit and prior to discharge 4. If HTN [hypertension; high blood pressure] > 149/90, begin OB consult process for evaluation of preeclampsia 5. If severe HTN; SBP [systolic blood pressure] > 160 or DBP [diastolic blood pressure] > 110, initiate OB Emergency Checklist for Severe Hypertension 6. Consider initiating communication with patient's primary OB/GYN" and "Pregnant Patients > 20 Weeks Gestation 1. Conduct a full assessment and obtain patients OB provider information 2. Document presence of FHR by continuous FHR (NST) monitoring for 20 minutes 3. Evaluate and treat as indicated 4. If severe HTN; SBP > 160 or DBP >110, initiate OB Emergency Checklist for Severe Hypertension 5. Consider initiating communication with patient's primary OB/GYN." In addition, "Pregnant High Risk Care >20 Weeks Gestation 1. Initiate consult with the patient's primary OB/GYN or on-call provider at available transfer center 2. If severe HTN; SBP > 160 or DBP > 110, initiate OB Emergency Checklist for Severe Hypertension." k. An interview on 12/16/25 at 8:20 AM with the supervisor of radiology confirmed ultrasound was generally not available after hours. She stated only two technicians were able to take call for ultrasound and generally ultrasound would only be done for "a real emergency" such as hemorrhaging or testicular torsion. A policy on the availability of ultrasound was requested but not provided. On 12/16/25 at 10:30 AM the acute care supervisor stated the facility did not have a specific policy related to the availability of ultrasound because it was "situation dependent."	C2406		

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C2406	Continued From page 13 2. Review of the medical record showed patient #4 presented to the ED on 10/5/25 with a chief complaint of vaginal bleeding. The nursing assessment showed the patient had right lower quadrant and left lower quadrant tenderness. In addition, the nurse documented the patient stated she started bleeding a week ago, and had passed golf ball sized clots since 9:30 PM on 10/4/25, "passing 7 in total since this time." The nurse also documented the patient complained of pain at a "6" on a scale of 0 to 10 in the lower back and lower abdomen described as "cramping." Review of the physician's note showed he performed a physical exam, but did not perform a pelvic exam. Laboratory results showed the hemoglobin (iron-containing protein in red blood cells) was 14.7 g/dL (within the reference range), the hematocrit (percentage of red blood cells in the total blood volume) was 38.1 % (within the reference range), and the pregnancy test was negative. The physician documented the patient was given normal saline and Toradol (pain medication) in the ED. He stated the patient had an improvement in her discomfort and was instructed to follow-up with her OB/GYN physician. She was also instructed to return to the ED if she bled through a pad in an hour more than 4 hours in a row. The patient was discharged home. The following concerns were identified: a. Review of the physician's documentation showed vital signs were not recorded to determine if the patient had a fever, tachycardia (increased heart rate), tachypnea (rapid, shallow breathing), or hypotension (low blood pressure), which could be indicative of a hemorrhagic or infectious process.	C2406		

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C2406	Continued From page 14 b. During an interview on 12/16/25 at 6:16 PM the patient stated she had been passing golf ball sized clots. She also stated she bled through an adult diaper. She stated when she went to the ED all they did was put in an IV and give her pain medication. She stated the physician told her they didn't have imaging available so he couldn't do anything. She stated she followed up with her OB/GYN and had surgery that Friday. c. On 12/17/25 at 11:45 AM physician #1 stated he would have done an ultrasound if the H/H (hematocrit/hemoglobin) or vital signs were concerning. He stated a pelvic exam was not indicated. He stated the patient was to follow-up with OB/GYN in the next couple of days. 3. Review of the medical record showed patient #11 presented to the ED on 7/9/25 with a chief complaint of "kidney infection." Review of the nursing assessment showed left lower quadrant tenderness, suprapubic tenderness, and urinary urgency. In addition, the nurse documented the patient rated the pain as "8" on a scale of 0 to 10 and described it as "cramping." The patient reported difficulty with urinating and urgency. The following concerns were identified: a. The medical record lacked evidence the patient was provided a medical screening examination to determine whether or not the patient had an emergency medical condition, and there was no documented informed refusal of examination or treatment. b. During an interview on 12/17/25 at 9:03 AM physician #2 stated he did not have patient #11 sign an AMA (against medical advice) form because if a patient signed it, then insurance won't pay. He stated the patient's symptoms	C2406		

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C2406	Continued From page 15	C2406		

were minimal and if somebody can't urinate, then he lets them come back later.

c. Review of the facility's policies related to EMTALA showed they did not address patients who left without being seen (LWBS) or patients who refused examination or treatment against medical advice (AMA).

4. Review of the medical record showed patient #15 arrived to the ED on 11/23/25 for a chief complaint of drug overdose. Review of the nursing documentation showed the patient arrived with family. The patient wouldn't talk to the nurse. The family member told the nurse they found the patient in his car in the back seat. The patient stated he overdosed and took "30 pills of hydrocodone [opioid medication used to treat pain]." Under affect, the nurse documented "depressed," "sad," and "upset." Review of the physician's note showed the patient was brought in by family after found on the other side of the river in a parked car. The patient was removed from the home the previous night by police after a domestic dispute. Approximately 12 to 14 hours before arrival to the ED the patient drank 6 cans of beer and took 30 tablets of 10 milligrams (mg) strength Lortab. This was prescribed a couple of weeks ago; the patient stated s/he has had chronic sciatica secondary to a fractured back. It was reported when s/he was found, the patient was very drowsy but has become progressively more awake and alert. The patient stated they vomited multiple times through the night and early morning. The patient stated that s/he was not trying to end their life, but "was trying to stop the pain." The patient did write DNR (do not resuscitate) on his/her pants. Laboratory results showed a positive result for opiates. The

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C2406	Continued From page 16	C2406		

following concerns were identified:

a. Review of the physical exam documented by the physician showed "Psychiatric: Tearful, Judgement and insight appear normal." There lacked evidence of a more thorough psychiatric history and physical completed by the ED physician or a psychiatric/behavioral health consult.

b. Review of the physician's note showed "As [s/he] has a warrant out for [his/her] arrest [s/he] was taken to jail where [s/he] will be evaluated by [name of company] behavioral health." The discharge diagnoses were listed as possible drug overdose and suicidal ideation.

c. During an interview on 12/17/25 at 11:45 AM physician #1 stated there was a behavioral health consult that could be done via telemedicine. He stated he did not think the patient was actively suicidal in the ED so the behavioral health evaluation could wait until s/he was in jail.

d. Review of the facility's policies related to EMTALA showed no policy related to psychiatric/behavioral health. The facility did have a "Behavioral Health Crisis Response Protocol" (diagram) which showed the responsibilities of the provider, the nurse, and the behavioral health agency. Under provider, it showed "Behavioral Health Screening is Needed?" If yes, then the nurse would call the behavioral health agency.

5. Review of the policies provided by the facility during the survey showed no policy to address the medical screening examination for all patients who presented to the ED. The facility did have a policy titled "EMTALA During a Disaster," dated 6/14/24, which stated the medical screening

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C2406	Continued From page 17 examination was a requirement of EMTALA.	C2406		
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 defined in paragraph (b) of this section), the hospital may not transfer the individual unless - (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer. (B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or (C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules	C2409		

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C2409	Continued From page 18	C2409		

and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

(2) A transfer to another medical facility will be appropriate only in those cases in which -
(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;
(ii) The receiving facility
(A) Has available space and qualified personnel for the treatment of the individual; and
(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment.

(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

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C2409	Continued From page 19 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 (iv) 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. This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to ensure a mid-level practitioner consulted with a physician at the time of transfer who agreed with, and subsequently countersigned, the certification for 2 of 3 sample patients who were transferred (#14, #20). The findings were: 1. Review of the provider ED (emergency department) note by physician assistant (PA) #1 showed patient #14 presented to the ED on 12/9/25 by ambulance for a possible stroke. Family did inform the provider that the patient had a ground-level fall that day. The head CT (computed tomography) scan showed a subarachnoid hemorrhage (bleeding into the pace between the brain and its covering membranes) in the right hemisphere. The provider spoke to a physician at another hospital who accepted the patient as a transfer. The following concerns were identified: a. Review of the transfer form showed the provider (PA #1) signed the certification for transfer. However, there lacked evidence the provider consulted with a physician at the time of transfer; the transfer certification was not	C2409		

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C2409	Continued From page 20 countersigned by a physician. b. During an interview on 12/17/25 at 9:56 AM PA #1 stated he was not aware of the requirement for a physician to be consulted and the certification countersigned by a physician. 2. Review of the ED note by PA #1 showed patient #20 presented to the ED on 11/28/25 by ambulance for a possible stroke. A CTA (computed tomography angiography) showed no evidence of acute large vessel occlusion. The provider spoke to a physician at another hospital who accepted the patient as a transfer. The diagnosis was acute ischemic stroke versus transient ischemic attack. The following concerns were identified: a. Review of the Transfer Form showed the provider did not sign for the certification of the transfer; that signature line was blank. In addition, there lacked evidence the provider consulted with a physician at the time of transfer; the transfer certification was not countersigned by a physician. b. During an interview on 12/17/25 at 9:56 AM PA #1 stated he was not aware of the requirement for a physician to be consulted and the certification countersigned by a physician. In addition, he stated he must have overlooked his signature on the transfer form for patient #20. He stated he usually signs the form in front of the patient. 3. Review of the facility's policies related to EMTALA showed no policy regarding mid-level practitioners consulting with a physician at the time of a transfer or having the physician countersign the certification of transfer.	C2409		

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C2409	Continued From page 21 4. During an interview on 12/17/25 at 9:03 AM the medical director stated he was not aware of the requirement for physician assistants to consult with a physician at the time of transfer and to have the physician countersign the transfer form.	C2409		