STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	531317	A. BUILDING ______ B. WING ______	C 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PLATTE VALLEY MEDICAL CENTER	1300 WEST BRIDGE AVE SARATOGA, WY 82331

(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 8/19/25 through 8/21/25. The survey was prompted by complaint intake WY00004498. Based upon the findings of the survey team, North Platte Valley Medical Center 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 emergency department (ED) logs, police reports, ambulance reports and policies and procedures, the facility failed to ensure an appropriate medical screening examination was provided for 1 of 20 sample patients (#16). In addition, the facility failed to ensure a transfer was effected through qualified personnel and transportation equipment for 3 of 8 sampled patients (#8, #10, #12) who were transferred to another healthcare facility. Furthermore, the facility failed to ensure a mid-level practitioner consulted with a physician at the time of transfer who agreed with, and subsequently signed, the certification for 8 of 8 patients who were transferred (#1, #2, #5, #6, #8, #10, #12, #17) The findings were:	C2400	C2400-The facility implemented the process to ensure mid-level Practitioners are notifying the Medical Director via Phone and Email immediately upon an Impatient or Swing Bed Admission. A) The facility implemented tracking Sheet that is checked every morning By the Director of Clinical Education To ensure Medical Director has noted the Patient chart to add the review that was Completed and ensuring documentation is Listed in the patient chart to support the Medical Director's agreement of the mid-level Admission. In addition, the (Referenced Policy ID# 19455494) outlines the requirements implemented for communication on possible transfers to ensure compliance with EMTALA related transfers and documentation supporting communication between Medical Director and ER Provider. B) Medical Director is responsible for Adding a chart note regarding the communications between the mid-level and Medical Director prior to the admit. Medical Director will then add a chart Note in the EMR to ensure supporting documentation is noted for review.	04/01/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Gilleland (signature) TITLE: CEO (X6) DATE: 3/30/26

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

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C2400	Continued From page 1 1. Refer to C-2406 for details on the facility's failure to ensure patient #16 was provided an appropriate medical screening examination. 2. Refer to C-2409 for details on the facility's failure to ensure the transfers for patients #8, #10 and #12 were effected through qualified personnel and transportation equipment. In addition, 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 patients #1, #2, #5, #6, #8, #10, #12, and #17.	C2400		
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)	C2406	C2406- The facility updated (Policy Stat ID #18819376) and provided Additional training to ER Staff to ensure Compliance with all EMTALA Related documentation and support. A) Director of Clinical Education has implemented weekly chart audits to ensure all patients receive the appropriate medical screenings as set forth in the EMTALA guidelines. that ensures All patients receive the appropriate medical screenings in compliance with ETMALA guidelines set forth. B) HR and the Director of Clinical Education have worked to provide the Updated Policy and guidelines to all ER staff and ensure the Acknowledgment is received to ensure compliance with all changes to ensure any deficiencies are eliminated. HR will maintain those acknowledgments on file in their personnel record.	03/28/26

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C2406	Continued From page 2 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 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	C2406	C) In addition, the facility has implemented a Re-Training and Re-Acknowledgement of Policy Stat #18744705 & Policy Stat #18883933. Administration implemented a quarterly process to ensure all providers are following the Mid-Level Admission Process and policy. HR has sent all the acknowledgements to providers to ensure compliance. D) Facility implemented monthly Med-Staff imitative to review all admissions and transfers with Trauma Coordinator/Director of Clinical Education and Medical Director to ensure compliance. Monthly Med Staff meeting minutes will be compiled and cross-compared to tracking initiatives implemented to ensure all patients receive appropriate screening exams and EMTALA guidelines are followed. HR will be required to ensure during quarterly meetings that all providers have documented acknowledgement of updated policies and procedures.	

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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 medical record review, staff interview, and review of policies and procedures and the emergency department (ED) log, the facility failed to ensure an appropriate medical screening examination (MSE) was provided for 1 of 20 sampled patients (#16) who presented to the ED. The findings were:

1. Review of the ED log showed patient #16 arrived to the ED on 8/10/25 at 11:26 PM and was discharged from the ED on 8/11/25 at 1:20 AM. Review of the triage showed the patient was pregnant and complained of abdominal pain and vaginal bleeding for 3 days. The patient was recently treated for a urinary tract infection (UTI) and had a history of ectopic pregnancy (fertilized egg implanted outside of the womb). The provider documentation showed the patient was 7 weeks pregnant and reported severe right lower quadrant (RLQ) pain. She reported pressure as if

C2406

E) The Medical Director and Administrator will review documentation of transfers during monthly med-staff meetings and review all EMTALA and COBRA forms to ensure Compliance in conjunction with the Director of Clinical Education tracking sheet.

F) The facility also implemented a monthly review of all patient admissions and transfers including the COBRA forms into the QAPI meetings. QAPI is held monthly and the Medical Director, Director of Clinical Education and Administrator will review all charts to ensure compliance with updated the submitted plan of correction.

G) Director of Nursing will complete a monthly audit of all patients to ensure COBRA forms are scanned into the EMR to ensure appropriate documentation is thorough and includes tracking mechanism developed by Director of Clinical Education and Medical Director.

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she needed to urinate and a few days of brownish discharge. The provider's examination showed "TTP [tenderness to palpation] in the RLQ, but no rebound tenderness noted, bowel sounds active." The provider documented that acetaminophen given in the ED did not help much with pain. He consulted a physician at the ED in hospital B (located in town B, 99 miles away) who stated they could call in ultrasound. The differential diagnosis was "likely abdominal pain, acute appendicitis and calculus of kidney." He further documented he was concerned with elevated white blood cells (elevated WBCs indicate the immune system is responding to an issue, such as infection, inflammation or injury) and elevated neutrophils (elevated neutrophils usually indicates the body is fighting infection or experiencing inflammation). There was no sign of UTI. The following concerns were identified:

a. Further review of the medical record showed the medical screening examination did not include an ultrasound to rule out potential emergency medical conditions such as ectopic pregnancy. The provider's note showed the patient's disposition was "home, self care" and the clinical impression was abdominal pain, RLQ. He further documented the facility was unable to get an ultrasound that night and the patient was instructed to go to the ED at hospital B.

b. Review of the discharge assessment showed the patient was not transferred to another facility, but was discharged "home." There was a note that the patient was going to town B via a personal vehicle for an ultrasound.

c. Review of the medical record from hospital B showed the patient was admitted to the ED on 8/11/25 at 3:28 AM. The ED note documented the patient presented with a chief complaint of right lower quadrant abdominal pain. The examination

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included a transvaginal ultrasound which showed an ectopic pregnancy. The ED provider documented the ultrasound technician confirmed it was a right sided ectopic pregnancy and the patient was taken to the operating room.

d. Interview with physician assistant (PA) #1 on 8/21/25 at 9:28 AM revealed the facility did not have ultrasound. He stated he was concerned it could be an ectopic pregnancy or appendicitis and the patient needed an ultrasound. He stated he called the ED at hospital B. When asked why the patient was not transferred via an ambulance but was discharged and instructed to go to hospital B in their personal vehicle, he stated the patient seemed stable and after 8 PM it was difficult to get an ambulance for a transfer.

2. Review of the facility's policy "EMTALA," revised 8/2025, showed "...An appropriate medical screening examination should address the presenting symptoms and comply with current policies and procedures for assessment of those presenting symptoms, including but not limited to a history of the presenting problem; a documented physical examination of the involved ware of system; and the use of on-call physicians and ancillary tests or services routinely available to the Hospital if needed to determine whether an emergency medical condition exists. The chart should document continued monitoring until the patient is stabilized or transferred..."

C2409 APPROPRIATE TRANSFER C2409
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

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C2409	Continued From page 6 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 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.	C2409	C2409- The facility has ensured that all staff have been educated in depth regarding the EMTALA and transfer policy to ensure compliance and are following the EMTALA policy that has been Updated to ensure compliance at the facility. A) Communication requirements Outlined in EMTALA Policy note communication directly to Medical Director via phone to communicate Regarding possible unsafe transfers. Policy dictates that all providers must consult with Medical Director and document accordingly to ensure compliance with EMTALA. B)Policy Outlines documentation of communication in the patient chart while also requiring the Medical Director to communicate Directly with receiving facility to ensure appropriate level of communication regarding patient's stability.	03/28/26

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(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 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

C) Patient transfers documentation will be presented daily and signed by the Medical Director within 24 hours of initiating the transfer. Facility will also review all transfer Forms during Med-Staff & QAPI Monthly Meetings to ensure accuracy of communication and appropriate follow-up with receiving facility.
D)Facility also implemented a Trauma Review protocol within 24 hours to ensure the Trauma Director and Trauma Coordinator review all transfers regardless of stability to ensure transfer was completed safely and in Compliance with all state and federal regulations.

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medically appropriate life support measures during the transfer.
This STANDARD is not met as evidenced by:
Based on medical record review, staff, patient, family and outside staff interviews, and review of emergency department (ED) logs, police reports, ambulance records and policies and procedures, the facility failed to ensure a transfer was effected through qualified personnel and transportation equipment for 3 of 8 sampled patients (#8. #10, #12) who were transferred to another healthcare facility. Furthermore, the facility failed to ensure a mid-level practitioner consulted with a physician at the time of transfer who agreed with, and subsequently signed, the certification for 8 of 8 patients who were transferred (#1, #2, #5, #6, #8, #10, #12, #17) The findings were:

1. Review of the ED log showed patient #8 arrived to the ED on 7/4/25 at 10:02 PM. Review of the trauma activation documentation showed the patient arrived with family and law enforcement. The patient's chief complaint was "penetrating firework injury/burn/blunt trauma." The trauma documentation showed the patient had third degree burns to 18% of the left arm and there was active uncontrolled bleeding and a partial amputation to the left hand. A tourniquet was placed above the wrist. Review of the provider ED note showed the patient had extensive third degree burns to the left upper extremity with skin avulsions/lacerations with tendon and bone exposure. A transfer to hospital C in a neighboring state was initiated. The provider documented there was a high concern for emergent neurovascular and orthopedic complications due to the mechanism of injury such as compartment syndrome (painful condition caused by pressure buildup from

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internal bleeding or swelling of tissues, decreasing blood flow), large vascular injury, hemorrhagic shock (shock caused by loss of blood), penetrating nerve injury and multiple fractures seen on imaging. The provider received recommendations from the trauma team to irrigate wound and loosely suture with pressure dressings applied after. The patient was then splinted and a sling applied due to multiple hand, wrist, and forearm fractures. Air ambulance services were contacted but declined due to weather. Local ambulance services were contacted and declined due to no crew availability. Multiple other agencies were contacted and declined initially due to weather or no available crews. Further review of the ED record showed the patient was on 4 LPM (liters per minute) of oxygen and was administered a total of 8 milligrams of Dilaudid (opioid pain medication used to treat moderate to severe pain; respiratory depression is a potential adverse reaction) from 10:23 PM to 12:46 AM. The following concerns were identified:

a. Review of the ED provider note showed the patient was transferred to an acute care hospital. Review of the ED discharge assessment showed on 7/5/25 at 1:12 AM the patient was transferred to another facility and the condition was "critical." It documented the patient was discharged with family and "called all ground and air transport, denied due to weather or no staff. Taken by POV [privately owned vehicle] to trauma center." Review of the transfer certification (COBRA Transfer form) showed the patient was being transferred due to needing a higher level of care (orthopedic/trauma). The patient was accepted by a physician at hospital C. The form documented "all services declined to transfer pt [patient]. Pt requested POV." Review of the

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trauma flow sheet showed the family was aware there was no medical transportation via ground or air ambulance and stated their dissatisfaction. The provider discussed family transport via POV. Law enforcement agreed to assist with patient's transfer via POV (truck). The back seat of the patient's POV (truck) was prepared with a mattress and linens and a full portable oxygen tank. The patient was placed in the vehicle, had two PIVs (peripheral intravenous line) saline locked, a Foley catheter in place and 4 LPM of oxygen placed on the patient. At 1:12 AM the private vehicle with the patient left the facility with law enforcement ahead and behind the vehicle. A note at 3 AM showed a person returned to the ED to return the mattress and oxygen tank and reported they met up with an ambulance crew near an exit to the interstate (about 20 miles away).

b. Review of a police report for 7/4/25-7/5/25 showed air ambulance was unable to fly due to weather and two ground ambulances were not available. The family was informed that the only option was they would have to transport. After the family left the ED with the patient, 911 was called and a ground ambulance crew stationed in another town met the family near an exit by the interstate. The ground ambulance crew also contacted an air ambulance which was able to launch and meet them at that location.

c. Review of the 7/5/25 report from ground ambulance A showed they received a call from dispatch to intercept a vehicle with a patient who had been injured in a firework accident. The ambulance arrived at the intercept location at 1:21 AM. The air ambulance made contact with them who stated they were launching and would have an ETA of 12 minutes after getting blood at the hospital. The patient arrived at 1:28 AM and

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s/he was on a mattress in the back of private vehicle. The patient's left hand looked severely burned. They noted singing and small burn mark to the patient's left cheek. They also noted fluid and blood was visible on the sheets and bandaging near the left arm and elbow. They advised all on scene that the helicopter was en-route but it was unknown where they would transport the patient. The patient was on 3 LPM of oxygen via a bottle and regulator that had been sent with the patient. The family advised them that the patient had been administered multiple doses of Dilaudid before they left the ED. The patient was monitored by the ground crew until the helicopter arrived.

d. Review of the air ambulance report from air ambulance A dated 7/5/25 showed the unit was dispatched at 1:18 PM and was at the patient at 1:48 AM. The narrative showed they were dispatched to a rendezvous with a ground ambulance off the interstate for a patient with burns and fractures. The decision was to transport the patient to hospital D due to weather, condition and fuel. The patient's condition required a trauma center and preferably a burn center. The narrative showed that the patient was continued on 4 LPM of oxygen from the ambulance. The patient quickly had difficulty staying awake and when asleep his/her respiratory rate would drop below 10 with drops in oxygen saturation. Not long before reaching the destination they also noted two episodes of heart rate drops from the high 90's to the 60's. The decision was to RSI [rapid sequence intubation; emergency airway management] for patient safety due to compromised respiratory effort causing bradycardia. The patient arrived at hospital D at 3:30 AM.

e. Review of an ED triage note from hospital

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D dated 7/5/25 at 3:51 AM showed the patient arrived by air ambulance and was already intubated. The flight team reported the patient had estimated 8% burns to the face and left arm and had received 8 mg of Dilaudid in a very short time before leaving the sending hospital. The patient had a low respiratory rate and so the flight crew intubated the patient enroute for airway safety. Review of the trauma history and physical dated 7/5/25 showed the patient had fractures to the left arm and fingers, an open fracture to the left wrist with exposed tendon, estimated 6% burn to total body surface area, acute respiratory failure related to opioid administration, lactic acidosis (buildup of lactic acid in bloodstream), and alcohol intoxication. Further review showed the patient was transferred to hospital E, which had a burn center, at 5:30 AM.

f. Review of the medical record from hospital E showed the patient arrived on 7/5/25 at 6:16 AM. Review of a plastic surgery consult showed the patient had a dysvascular thumb (compromised blood flow), in addition to the fractures to the hand and arm. Due the severity of the injury and the dysvascular thumb, the patient was transferred to hospital I for revascularization of the left thumb.

g. Review of the medical record from hospital I showed the patient was admitted on 7/5/25 and was discharged on 7/18/25. The diagnoses included complex elbow fracture dislocation, radial and ulnar (bones in lower arm) fractures, multiple wrist fracture dislocations, multiple finger fractures and burns to the forearm and elbow.

h. During on interview on 8/20/25 at 10:31 AM a family member stated they were with the patient that night. She stated the ED staff stated there was no air or ground ambulance transportation available to transfer the patient so the patient was

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put in their private vehicle with oxygen and no way to monitor his/her vital signs. She further stated his/her wrist was hanging off by the tendons. She stated the patient had received a lot of Dilaudid in the ED and she was worried about their airway. She stated they drove to a location down the highway where they were met by an ambulance. She stated about 10 minutes later a helicopter arrived and the patient was taken to a facility in a neighboring state.

i. On 8/20/25 at 10:58 AM the patient stated their arm was injured by a firework. The patient stated s/he had a lot of pain and received a lot of Dilaudid. They were told no ambulances would pick him/her up so they went in a vehicle. They met up with an ambulance and a helicopter down the highway. S/he stated while in the helicopter his/her respiratory system shut down and they had to intubate him/her in the helicopter. S/he was flown to one hospital and then transferred to another. The patient stated s/he was still healing and had about 30% function of their arm.

j. During an interview on 8/20/25 at 2:58 PM the director for ground ambulance service A stated the initial call was for a BLS (basic life support; non-emergency) transfer to a facility in a neighboring state. The ambulance service is primarily volunteer and a message was sent out to volunteers for a BLS transfer but nobody accepted it. He spoke with highway patrol and explained that one crew (ambulance) needed to be available for 911 calls and since this patient was in a safe place in a hospital they couldn't tie up the crew with a transfer to another facility. He stated once the patient was in the private vehicle 911 was called and so the crew was dispatched to meet up with them in the private vehicle. He stated they called the air ambulance and they were able to launch and meet them. He stated

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the patient needed IV fluids, pain medications, airway monitoring, oxygen, had numerous fractures and was not appropriate to be in a private vehicle for transport.

k. On 8/21/25 at 10:01 AM nurse practitioner (NP) #1 stated the patient had extensive burns due to a fireworks incident and she was concerned with vascular injury. The patient also had several fractures in the arm. She stated the patient was accepted to hospital C as a transfer quickly but the hard part was transportation. She stated air ambulances declined due to weather and ground declined due to no crew; difficulty getting volunteers. She stated this was a "life or limb situation." The family was real concerned and agreed to take the patient themselves because of the need to save him/her and to save the limb. When asked if there was a form the patient or family signed to indicate they knew the risks of going in a POV and were declining ambulance transport, she stated there was no form. She stated she talked to the family and made sure she filled out the risks on the transfer certification. When asked why the patient was on oxygen in the ED she stated the patient was given pain medications and it was to protect airway function. When asked to describe the patient's condition at the time of transfer/discharge she stated the patient may be at risk for deterioration during transfer. She stated they couldn't keep the patient there or s/he might lose the arm. She further stated she heard later that 911 was called and a flight crew met them and he was transported to a hospital, but not to hospital C.

l. During an interview on 8/21/25 at 12:57 PM registered nurse (RN) #1 stated she was in the ED when the patient arrived. She stated s/he had an extensive injury to the hand from fireworks and

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a tourniquet was applied above the injury. She stated the patient had burns all the way up the arm. She stated the patient was administered pain medications and oxygen was put on him/her so s/he didn't decompensate. She explained that pain medications can cause sedation and she watched his/her respirations because at any minute the drive to breathe could have stopped. She stated she helped the patient into a truck and s/he went with a full oxygen tank and oxygen on.

m. On 8/21/25 at 1:09 PM ED technician (tech) #1 stated she called around for transport that night. She stated air ambulances declined due to weather and the ground ambulances declined due to having no crew.

n. Further review of the medical record and transfer certification showed no evidence NP #1 consulted a physician at the time of transfer. The transfer certification was not countersigned by a physician. On 8/21/25 at 10:01 AM NP #1 stated physicians were not consulted on the certifications for transfers and did not countersign the certifications. She stated having one provider sign off was OK.

2. Review of the ED log showed minor patient #12 arrived at the ED on 7/19/25 at 1:59 AM with a chief complaint of abdominal pain. Review of the ED provider note showed the patient complained of upper and lower abdominal pain and nausea. The provider noted the patient had a white blood count (WBC) of 12.9 (normal is 4.3 to 11.3) and diffuse abdominal TTP (tenderness to percussion) worse in the right lower quadrant. The computerized tomography (CT) scan showed mild/early retrocecal (condition where the appendix is located behind the cecum, which is the first part of the large intestine) appendicitis (inflammation of the appendix). The provider

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consulted a surgeon at hospital B who agreed to see the patient. The provider documented the assessment was acute appendicitis and plan of treatment was IV antibiotics given in the ED and the patient was being transferred by POV to hospital B (located about 80 miles away). The following concerns were identified:

a. Review of the discharge assessment and the transfer certification showed the patient was being transferred via POV. Further review of the medical record showed no evidence the patient was offered an ambulance for transport or that the patient/family was educated on the risks of transferring via POV.

b. Review of the history and physical (H&P) from hospital B dated 7/19/25 showed the patient had acute appendicitis and the plan was for a laporascopic appendectomy (surgical removal of the appendix). Further review of the medical record showed the patient had an appendectomy on 7/19/25.

c. During an interview on 8/21/25 at 8:31 AM physician assistant (PA) #2 stated he spoke to the provider at hospital B and they accepted the patient and it was fine to send him/her by POV. He stated sending a patient by POV was usually rare, but was done for more "mild" things when there was time for them to get to the other facility. He stated the was no specific form that patients signed when they were transferred via POV instead of ambulance; the transfer certification form was the only form they signed.

d. On 8/21/25 at 10:37 AM the parent of patient #12 stated the patient was found to have an enlarged appendix. She stated the patient needed to go to hospital B. She further stated an ambulance was not offered. When asked about the condition of the patient during the transport (in the POV) she stated the patient's pain was worse

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as they approached the town where hospital B was.

e. Review of the certification for transfer showed it was signed by PA #2. Further review of the medical record showed no evidence the PA consulted with a physician at the time of transfer who agreed with the certification. The certification was not countersigned by a physician.

f. During an interview on 8/21/25 at 8:31 AM PA #2 stated the accepting provider at other hospitals was a physician, but stated they didn't consult a physician "here" at the time of transfer. He further stated the certifications were not countersigned by a physician.

3. Review of the ED log showed patient #10 arrived to the ED on 7/10/25 at 2:07 PM. Review of the ED provider note showed the chief complaint was abdominal pain. The physical exam "without peritoneal signs. No evidence of acute abdomen at this time." The CT (computed tomography) scan showed "mild intrahepatic and extra hepatic biliary dilation with suggested filling defect in the mid common bile duct. Correlation with LFTs [liver function tests] recommended. MRCP [magnetic resonance cholangiopancreatography; technique that shows images of the bile ducts, gallbladder and pancreatic duct] or ERCP [endoscopic retrograde cholangiopacreatography; procedure that combines endoscopy and x-rays to examine and treat problems in the bile ducts and pancreatic ducts] recommended for further evaluation." The provider wrote the patient likely had cholelithiasis [gallstones]. A transfer was initiated to hospital E. The following concerns were identified:

a. The provider documented that the patient declined transport and requested POV. The provider documented she thought that was an

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acceptable request as the patient was hemodynamically stable. However, there lacked evidence the patient was educated on the risks of transferring via POV.

b. Review of the discharge assessment dated 7/10/25 at 7:51 PM showed the condition at discharge was "fair" and the disposition was "AMA [against medical advice]." However, further review of the medical record showed no evidence the patient signed an AMA form.

c. Review of the transfer certification showed the patient's condition (risk of deterioration during transfer) was left blank. The reason for the transfer was "surgeon" and the destination hospital was listed as hospital E. The mode of transport was listed as POV.

d. During an interview on 8/21/25 at 10:01 AM NP #1 stated the patient's condition at discharge would have been stable; the patient might have surgery and s/he might not.

e. Review of the certification for transfer showed it was signed by NP #1. Further review of the medical record showed no evidence the NP consulted with a physician who agreed with the certification. The certification was not countersigned by a physician.

f. On 8/21/25 at 10:01 AM NP #1 stated physicians were not consulted on the certifications for transfers and did not countersign the certifications. She stated having one provider sign off was OK.

4. Review of the ED log showed patient #1 arrived at the ED on 5/12/25 at 7:40 PM complaining of abdominal pain and was transferred on 5/13/25 at 2:15 AM. Review of the provider ED note showed a CT scan showed a large right sided 11 millimeter (mm) kidney stone. The provider discussed the case with a physician

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at hospital F who agreed to accept the patient. Review of the transfer certification showed the patient was transferred to hospital F by ambulance. Review of the medical record dated 5/13/25 from hospital F showed the patient was admitted to the hospital and underwent cystoscopy with right ureteral stent placement. The patient was discharged home with a course of antibiotics. The following concerns were identified:

a. Further review of the transfer certification showed it was not completely filled out. The sections for patient condition, reason for transfer and risks and benefits of the transfer were blank. The certification was signed by PA #3.

b. Review of the medical record showed no evidence the PA consulted with a physician at the time of transfer. The certification was not countersigned by a physician.

c. During an interview on 8/21/25 at 10:30 AM PA #3 stated they consult with a physician at another hospital and if they accept the patient they are sent there for higher level of care. He stated the mid-level practitioners sign the certification and a physician does not countersign.

5. Review of the ED log showed patient #2 arrived at the ED on 5/24/25 at 6:15 PM after a fall and was transferred on 5/24/25 at 11:40 PM. Review of the provider ED note showed the patient had a fall. The note showed the patient had elevated WBC with left shift (elevated WBC with increase in number of neutrophils; usually a sign of infection or inflammatory process) and the INR was in excess of 8.0 (international normalized ratio is measurement of how long it takes blood to clot). The patient had findings consistent with age-indeterminate compression

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fractures of the thoracic and lumbar spine. The provider spoke to a physician at hospital G who accepted the transfer of the patient. The clinical impression was metabolic acidosis, elevated INR due to prior anticoagulant medication ingestion and weakness. Review of the transfer certification showed the patient was transferred to hospital G by ambulance. Review of the medical record from hospital G showed the patient was admitted on 5/24/25. A MRI (magnetic resonance imaging) of the thoracic area showed a spinal epidural hematoma (bleeding into the epidural space of the spine). The patient was transferred to another hospital on 5/26/25 for emergency surgery. The following concerns were identified:

a. Review of the certification for transfer showed it was signed by PA #4. Further review of the medical record showed no evidence the PA consulted with a physician at the time of transfer who agreed with the certification. The certification was not countersigned by a physician.

b. During an interview on 8/21/25 at 11:01 AM PA #4 stated he contacted hospital G and a physician accepted the transfer of the patient. He stated he would consult a physician if he needed additional guidance, but if the patient was stable he didn't consult a physician. He stated he did not think the certifications were countersigned by a physician.

6. Review of the ED log showed patient #5 arrived at the ED on 6/8/25 at 8:35 AM after an ATV accident and was transferred on 6/8/25 at 11:53 AM. Review of the ED provider note showed the patient was a minor who was in a ATV roll-over accident. The provider documented the head CT showed intracranial hemorrhage (bleeding within the skull) and skull fractures. The patient also had intrathoracic trauma, pulmonary

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contusion (bruise of the lung), blunt cardiac and facial trauma, trace left pneumothorax (collapsed lung), and intra-abdominal trauma with liver lacerations with concerns for blood products in the abdomen and pelvis. A children's hospital, hospital H, was contacted and a physician accepted the patient as a transfer. Review of the transfer certification showed the patient was transferred to hospital H by air ambulance. Review of documentation from air ambulance A showed the crew was at the patient in the ED at 11:18 AM and arrived at hospital H at 1:25 PM. The following concerns were identified:

a. Review of the certification for transfer showed it was signed by NP #1. Further review of the medical record showed no evidence the NP consulted with a physician at the time of transfer who agreed with the certification. The certification was not countersigned by a physician.

b. On 8/21/25 at 10:01 AM NP #1 stated physicians were not consulted on the certifications for transfers and did not countersign the certifications. She stated having one provider sign off was OK.

7. Review of the ED log showed patient #6 arrived to the ED on 6/15/25 at 1:45 PM and was transferred at 5 PM. Review of the ED provider note showed the patient was riding a horse in a rodeo and s/he was thrown forward and landed on the upper back. A CT scan showed "C7-T1 (7th cervical vertebrae and first thoracic vertebrae) widened anterior disc space and interspinous space with unstable ligament flavum and longitudinal ligament. Also T5 compression fracture." The provider's assessment was an unstable C7-T1 fracture and fracture at T5. The provider spoke to a physician at hospital D who accepted the patient as a transfer. Review of the

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transfer certification showed the patient was transferred to hospital D by air ambulance. Review of documentation from air ambulance A showed the crew arrived at the patient at 4:41 PM and arrived at hospital D at 5:51 PM. The following concerns were identified:

a. Review of the certification for transfer showed it was signed by PA #1. Further review of the medical record showed no evidence the PA consulted with a physician at the time of transfer who agreed with the certification. The certification was not countersigned by a physician.

b. During an interview on 8/21/25 at 9:28 AM PA #1 stated providers would consult with an accepting physician at another hospital but stated they didn't consult a physician at the time of transfer and did not have a physician countersign the certification.

8. Review of the ED log showed patient #17 arrived to the ED on 8/17/25 at 4:25 AM with complaints of abdominal pain and was transferred on 8/17/25 at 10:10 AM. Review of the provider ED note showed the patient had elevated lipase (enzyme produced by the pancreas), AST/ALT (aspartate aminotransferase/alanine aminotransferase; enzymes in the liver), bilirubin (yellow pigment formed in liver and excreted in bile) and WBC with left shift. The CT scan of the abdomen showed acute pancreatitis (inflammation of pancreas). Review of the transfer certification showed the patient was transferred to hospital G by ambulance. Review of the medical record from hospital G showed the patient was admitted on 8/17/25 for treatment of acute pancreatitis and was discharged on 8/19/25. The following concerns were identified:

a. Review of the certification for transfer

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showed it was signed by PA #1. Further review of the medical record showed no evidence the PA consulted with a physician at the time of transfer who agreed with the certification. The certification was not countersigned by a physician.

b. During an interview on 8/21/25 at 9:28 AM PA #1 stated providers would consult with an accepting physician at another hospital but stated they didn't consult a physician at the time of transfer and did not have a physician countersign the certification.

9. Review of the facility's policy "EMTALA," revised 8/2025, showed "...The Hospital may transfer or discharge a non-stabilized patient if:... (2) a provider certifies in writing that the benefits of discharge or transfer outweigh the risks (see Patient Transfer or Discharge Form); or (3) if a provider is not physically present, a qualified medical person consults with a provider and certifies in writing that the benefits of discharge or transfer outweigh the risks. The provider must subsequently countersign the certification...Appropriate transfer. If an individual is to be transferred to another medical facility, the Hospital will: (1) provide medical treatment within its capacity that minimizes the risk to the individual's health or the health of the unborn child during transfer; ...and (4) arrange for transfer by qualified personnel and appropriate equipment...Patient's Refusal to Consent. The person has the right to refuse examination, treatment or an appropriate transfer. In such cases, the Hospital will: (1) offer the individual the examination, treatment, or transferred (sic) required by EMTALA and document in the medical records the examination, treatment or transfer that was refused; (2) explain to the individual the risks and benefits of the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH PLATTE VALLEY MEDICAL CENTER	**1300 WEST BRIDGE AVE SARATOGA, WY 82331**

(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 24 examination, treatment, or transfer and document that such risks and benefits were explained; (3) take reasonable steps to obtain the individual's written informed refusal (see Patient Treatment Consent/Request/Refusal Form); and (4) if the individual refuses to sign a written informed refusal, the Hospital will document the foregoing, including the steps it took to obtain the individuals written informed refusal." 10. On 8/21/25 at 2:30 PM the chief executive officer (CEO) stated there was a medical director for the hospital. She stated he would be available for calls from providers. When asked if the medical director was consulted at the time of a transfer from the ED, she stated she would need to check with him. The surveyor requested that any evidence of consultation be provided, but none was provided.	C2409		