Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 010001	**(X3) Date Survey Completed** 04/03/2020
Name of Provider or Supplier Southeast Health Medical Center	**Street Address, City, State** 1108 Ross Clark Circle, Dothan, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0000	An unannounced federal Emergency Medical Treatment & Labor Act (EMTALA) complaint survey, AL 38747, was conducted at Southeast Alabama Medical Center from March 30, 2020 through April 3, 2020, specifically for the review of EMTALA requirements. The Chief Exeutive Officer, Chief Medical Officer, Director of the Emergency Department, Director of Quality Management, Assistant Chief Nursing Officer, and the Chief Nursing Officer were notified on October 28, 2020 at 12:15 P. M. that Immediate Jeopardy (IJ) existed. Based on review of the facility policy, transferring hospital (Hospital B) medical record (MR), air ambulance run report, facility Physician Transfer Line documentation, Physician Link audio files, facility Critical Care Unit (CCU) bed census, and interviews, it was determined Southeast Alabama Medical Center (SAMC, Hospital A) refused to accept from a transferring hospital an appropriate transfer, Patient Identifier (PI) # 1, who was on a ventilator. When Southeast Alabama Medical Center (SAMC) was contacted by the transferring hospital (Hospital B) which had no available Critical Care beds, and SAMC had the capability and capacity to treat the patient. PI # 1. Patient #1 presented to Hospital B's Emergency Department (ED) on 3/24/2020 via ambulance with a chief complaint of shortness of breath. The ED physician at Hospital B intubated and placed PI # 1 on mechanical ventilation at 4:13 AM. The ED physician at Hospital B requested a transfer to SAMC on 3/24/2020 at 12:51 PM. During the request for transfer call the ED physician told the on-call physician at SAMC the patient had been diagnosed with Pneumonia, had a pending test for coronavirus, was on mechanical ventilation, and required a transfer due to Hospital B critical care diversion for approximately 11 days from high instance of coronavirus in the area and PI # 1 was on the last mechanical ventilator available at the facility. The SAMC on-call physician (Hospitalist) notified hospital B's ED physician that he/she would need to talk with the Medical Director and would return the call to hospital B. At 1:26 PM, SAMC's on-call physician returned call to Hospital B's ED physician and refused to accept the transfer to SAMC. On 3/24/2020 at 6:56 PM, PI # 1 was placed in an air ambulance to be transferred from Hospital B's ED to Hospital C (accepting hospital). At 7:00 PM, PI # 1 went into Cardiac Arrest and was

transferred from air ambulance back to Hospital B at 7:15 PM. PI # 1 expired on 3/24 /2020 at 7:55 PM. The hospital's failure to accept the transfer posed an immediate and serious threat to PI #1's health and safety and inappropriately delayed treatment for his/her emergency medical condition. The hospital was found to be not in compliance with the Federal Regulations at 42 CFR 489.20 and CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Cases.

A2400

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 review of the facility policy, transferring hospital (Hospital B) medical record (MR), air ambulance run report, facility Physician Transfer Line documentation, Physician Link audio files, facility Critical Care Unit (CCU) bed census, and interviews, it was determined Southeast Alabama Medical Center (SAMC, Hospital A) refused to accept from an referring hospital (Hospital B) an appropriate transfer, of Patient Identifier (PI) # 1, who was on a ventilator, and required the SAMC 's specialized capabilities,. SAMC had the capability and capacity to treat patient #1, when contacted by the transferring hospital (Hospital B) which had no available Critical Care beds. Findings include: Refer to Tag- A2411 for findings.

A2411

RECIPIENT HOSPITAL RESPONSIBILITIES
CFR(s): 489.24(f)

A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers, which, for purposes of this subpart, means hospitals meeting the requirements of referral centers found at 412.96 of this chapter) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. This requirement applies to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

This STANDARD is not met as evidenced by:
Based on review of the facility policy, transferring hospital (Hospital B) medical record (MR), air ambulance run report, facility Physician Transfer Line documentation, Physician Link audio files, facility Critical Care Unit (CCU) bed census, and interviews, it was determined Southeast Alabama Medical Center (SAMC, Hospital A) refused to accept from an referring hospital (Hospital B) an appropriate transfer, of Patient Identifier (PI) # 1, who was on a ventilator, and required the SAMC 's specialized capabilities,. SAMC had the capability and capacity to treat patient #1, when contacted by the transferring hospital (Hospital B) which had no available Critical Care beds. This deficient practice affected 1 of 1 emergency transfer requests reviewed, who were appropriate for transfer to the facility and, which SAMC had the capability and capacity to treat. This did affect PI # 1, and

had the potential to affect all patients with a request for transfer to SAMC. Findings include: Southeast Alabama Medical Center Patient Care Policy and Procedure Title: Emergency Medical Treatment and Active Labor Act (EMTALA) Administrative Policy Effective Date: 4/1/19 Purpose: To comply with the EMTALA... EMTALA Requirements: ...Further, any participating Medicare hospital is required to accept appropriate transfers of individuals with emergency medical conditions if the hospital has the specialized capabilities not available at the transferring hospital and has the capacity to treat those individuals. Hospital B (transferring hospital) documentation: PI # 1 presented to Hospital B's emergency department (ED) via ambulance on 3/24/2020 at 2:09 AM with a chief complaint of shortness of breath. Review of the Triage note dated 3/24/2020 at 2:20 AM revealed the following documentation: "pt (patient) in severe resp (respiratory) distress; coughing up frank red blood, tachypneic (breathing fast), sats (saturation) in low-mid 80s on 100 % NRB (non-rebreather mask). EMS (Emergency Medical Services) states pt was in 60-70 % on room air upon arriving on scene to collect pt for transport to facility...expresses onset of symptoms approx (approximately) 2 hours prior to calling EMS; states he/she skipped HD (hemodialysis) on 3/21/2020 due to weakness and chronic diarrhea...audible expiratory wheezing and crackles/rhonchi bilat (bilateral) lungs; actively coughing up bright red blood." Further review of the Triage note dated 3/24/2020 at 2:20 AM revealed assessment findings of: Airway: "Copious Secretions, Audible Wheezing, Hemoptysis" Respiratory Distress: "Severe Distress" Respiratory Effort: ' Labored, short of breath, tripoding, grunting" Respiratory Pattern: "Tachypnea" Temperature: 99 F (Fahrenheit) Heart rate: 103 Respirations: 28 O2 (Oxygen) Sat (Saturation): 84 on a NRB. Review of the ED note dated 3/24/2020 at 2:22 AM revealed documentation of PI # 1 had a 2 hours history of dypnea (shortness of breath), associated chest pain which had resolved, and hemoptysis by the ED physician. The ED physician further documented physical exam findings of "General appearance: Present: alert, in distress...Respiratory exam: Present: respiratory distress..." Review of the chest X ray report dated 3/24/2020 at 3:59 AM revealed documentation of "Multifocal parenchymal opacities suggesting multifocal pneumonia" and "dense opacity in the suprahilar region on the right and mass cannot be excluded." Review of the ED assessments/treatments note revealed, PI # 1 was intubated and placed on mechanical ventilation at 4:13 AM. Review of the chest computerized tomography (CT) scan report dated 3/24/2020 at 8:39 AM revealed documentation of "...Extensive airspace disease involving the inferior aspect of both upper lobes, right middle lobe and posterior aspect of both lower lobes. A portion of this infiltrate in the inferomedial right lower lobe has air bronchograms coursing though it..." Review of the second chest X ray report dated 3/24/2020 at 9:14 AM revealed documentation of "...persistent and worsening bilateral perihilar and bibasilar opacities which may represent pneumonia..." Review of the ED note dated 3/24/2020 at 2:32 PM revealed documentation by the ED physician of "case d/w (discussed with), Employee Identifier (EI) # 2, On-Call physician at SAMC,...who refused the pt in transfer." Review of the ED note dated 3/24/2020 revealed the following vital signs prior to the ED physician's request for transfer to SAMC: At 12:37 PM, PI # 1 temperature was documented as 102.7 F At 2:30 PM, PI # 1 pulse was 87, respirations 20, and blood pressure 151/73. Review of the ED Assessment/Treatment note dated 3 /24/2020 at 6:10 PM revealed PI # 1 was placed in an air ambulance for transfer to hospital C with the following assessment: No acute respiratory distress, respiratory effort was mechanically ventilated, level of consciousness was sedated, blood pressure was 138/64, pulse was 83, respirations were 18, temperature was 102.8 F, and oxygen saturation was 100 % on the vent. Review of the air ambulance run report dated 3/24 /2020 revealed PI # 1 was placed in the air ambulance at 6:56 PM. Further review of the air ambulance run report dated 3/24/2020 revealed at 7:00 PM "cardiac arrest was

noted" and the air ambulance diverted back to Hospital B with the arrival time of 7:05 PM at hospital B. The air ambulance transfer the care of PI # 1 back to hospital B at 7: 15 PM. Review of the Code Blue Flow Sheet dated 3/24/2020 revealed PI # 1 experienced a cardiac arrest and was resuscitated at 7:20 PM. Review of the Code Blue Flow Sheet dated 3/24/2020 at 7:48 revealed PI # 1 experienced a second cardiac arrest in the resus room of the ED and expired at 7:55 PM. Review of the ED note dated 3/24/2020 at 7:58 PM revealed documentation by the ED physician of "Pt was in the helicopter - just lifted off when he/she arrested and the chopper turned to come back - on return, CPR in progress....pt - presented as COVID 19... Hospital A, SAMC, documentation : Review of the SAMC Physician Transfer Line documentation dated 3 /24/2020 at 12:51 PM revealed a call was received from Hospital B (transferring hospital) ED physician with a request for the On-Call physician. EI # 2, On-Call physician for SAMC, responded to the call from hospital B at 12:53 PM. Further review of the SAMC Physician Transfer Line documentation dated 3/24/2020 at 12:51 PM revealed PI # 1 was COVID-19 pending, negative for influenza, and positive for pneumonia. At 1:24 PM, EI # 2 was advised by Medical Director to decline the patient." Review of the SAMC Physician Transfer Line audio recording on 3/24/2020 revealed the following voice recordings: At 12:51 PM: Hospital B: "I have a patient here that is an ICU (Intensive Care Unit) patient. We are on ICU divert. My question is, do you have an ICU bed available?" SAMC (Physician Transfer Line staff member): "We are not on critical care diversion right now..." Hospital B then shared the patient information with SAMC including "they did swab him for Covid -19, but we are still waiting on results. It may take a couple of days, and we are on ICU divert...shortness of breath, he/she is on dialysis, he/she missed dialysis....we did confirm pneumonia and he/she is intubated." At 12:53 PM: SAMC notified EI # 2 of the following information reported by hospital B: PI # 1's name, date of birth, was positive pneumonia, had shortness of breath, a dialysis patient that missed dialysis, was on Levophed, and had a Covid-19 test that was pending. EI # 2 responded by stating, "From what I heard, if there is someone pending for a Covid-19, we try to keep them at their facility until they have the test ruled out." At 12:57 PM: (transfering physician call to on-call physician) Hospital B's ED physician notified EI # 2 of the following: PI # 1 was an intubated dialysis patient with a history coronary artery disease and diabetes who came in about 2:30 a.m. with 2 hours history of shortness of breath and hemoptysis and ended up intubated. PI # 1 had a CAT scan that showed extensive airspace disease and "...some air bronchograms, which looked more like pneumonia...", troponin was a "little bumped at 1.48, but he/she had missed dialysis..." PI # 1 had a fever up to 103.1 in the ED. PI # 1 had a normal white count, "lactate was okay" at "1.5", was "a little bit acidotic, 7.25, that was after intubation." PI # 1 had received "a couple of amps of bicarb (bicarbonate)," Vancomycin, Zosyn, and Doxycycline. PI # 1 was on Fentanyl and Versed for sedation PI # 1 was "... screened him/her for Covid but obviously that is not going to be back..." PI # 1 "... appears to be more infectious then anything else. Unfortunately, we have a high density of the Coronavirus in the community right now." PI # 1's "...had a little bit of hypertension and was on a whiff of levo (Levophed)" but had been titrated off Levophed. The most "recent blood pressure in the computer is 146/68" EI # 2 then asked if Hospital B had an ICU bed and Hospital B's ED physician responded with "We are on diversion. We have actually been on diversion for ... like 11 days now." EI # 2 then asked about lab values for PI # 1 and the ED physician responded with "...sodium 139...potassium 3.7...bicarb was 17 with a chloride of 97, and his/her BUN was 65, Creatinine was 10.24, glucose was 122, lactate was 1.5, alk phose was trivially elevated at 105. The rest of his/her LFT's (liver function test) were okay...trop was, like I said, 1.48 a little elevated. Flu was negative." EI # 2 then told the ED physician "I have some instruction that, try to keep patients at their facility if

they have pending Covid test, but I heard you are on diversion" The ED physician respond with "...we are literally out of ventilators, I mean he/she has our last ventilator." EI # 2 said "let me discuss the case with my Medical Director. I just want to make sure that he's/she's (Medical Director) okay so that I can take this patient." The ED physician then asked "what would be the limiting factor?..." and asked if SAMC had beds and vents EI # 2 replied there were beds and vents available at SAMC and "we are trying to decrease exposure, but you have been 11 days on diversion, so I doubt, unless you have anything that might come available soon..." The ED physician responded with how many COVID-19 or presumed COVID-19 patient hospital B had, how many patients were currently on the ventilator, and how many had been extubated over the last two week then stated "I don't think there is anybody reasonably gonna (going to) be coming off anytime in the near future." EI # 2 then asked if SAMC was the first hospital that hospital B requested a transfer from on the patient. The ED physician stated, "No, we have tried to get a transfer, so unfortunately, we have tried to get a transfer to Augusta and we could not get transferred up there because we could not get...ground EMS with a vent, all of the vents that we have for our ground EMS that we have to transport are either not working or all being taken up, so we don't have any accessible vents for ground and air cannot fly to Augusta so the only way that we can get anybody that is vented, transported is by helicopter... (The) helicopter is...not able to go north and they were full in Valdosta." EI # 2 then verbalized he/she would need to contact the Medical Director and the call was ended with the ED physician. At 1:26 PM: EI # 2 returned call to Hospital B's ED physician and told the ED physician, "...I am sorry I cannot take this patient. I just spoke to my Medical Director...they just finished their meeting and we have a lot of patients under investigation and they are not doing too well" Review of the Critical Care Unit bed census for SAMC revealed on 3/24 /2020 at 12:51 PM the 32 bed critical care unit had 1 available bed and 1 bed becoming available and at 1:26 PM had 1 available bed. Interviews: An interview was conducted via phone on 4/1/2020 at 11:45 AM with EI # 3, Registered Nurse, Physician Link Line, who verbalized the EI # 2, SAMC On-call physician, was made aware that the facility was not on diversionary status and there were beds in the Critical Care Unit available prior to talking with Hospital B's ED physician. EI # 3 also verbalized "one bed was available in critical care and one patient was moving out at the time of the call. I remember looking at the board." An interview was conducted via email on 4/2/2020 at 1:44 PM with EI # 1, Director Regulatory Compliance, who stated SAMC had 15 vents in use out of 42 on 3/24/2020. An interview was conducted via phone on 4/2/2020 at 1:45 PM with EI # 1, who confirmed SAMC did have 1 bed in the Critical Care Unit that would have been coming available when the transfer request was initiated at 12:51 PM and 1 bed that was available. The facility failed to ensure that their policy and procedure was followed as evidenced by refusing to accept an appropriate transfer of PI #1 on 3/24 /2020, who had an identified emergency medical condition, as SAMC had the capability and capacity to treat PI # 1.