

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  010001	<b>(X3) Date Survey Completed</b>  08/02/2021
<b>Name of Provider or Supplier</b>  Southeast Health Medical Center	<b>Street Address, City, State</b>  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.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>A2411</b>	<p><b>RECIPIENT HOSPITAL RESPONSIBILITIES</b> CFR(s): 489.24(f)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on review of the facility policy and procedure, Southeast Health Medical Center (SH, Hospital A) Medical Record (MR) review, transferring hospital (Hospital C and Hospital D) MR, receiving hospital (Hospital B) MR, ambulance run report(s), facility Physician Link Transfer Line documentation, Physician Link Transfer Line audio files, Southeast Health Diversionary Status Report, SH Unassigned Emergency Room (ER) Call Roster(s), facility Critical Care Unit (CCU), Family Birth Center (FBC) and Neonatal Intensive Care Unit (NICU) bed census documentation, and interviews, it was determined Southeast Health Medical Center (SH, Hospital A) refused to accept from referring hospitals (Hospital C and Hospital D) an appropriate transfer, of: 1. Patient Identifier (PI) # 2, who was experiencing a possible ST-Segment Elevation Myocardial Infarction (STEMI), and required SH's specialized capabilities. SH had the capability and capacity to treat PI # 2, when contacted by the transferring hospital (Hospital C) which did not have the capability of treating PI # 2. 2. PI # 22, who was 35 weeks pregnant and in active labor and</p>

required SH's specialized capabilities. SH had the capability and capacity to treat PI # 22, when contacted by the transferring hospital (Hospital D) which did not have the capability of treating PI #22. This deficient practice affected 2 of 2 emergency transfer requests reviewed, who were appropriate for transfer to the facility and, which SH had the capability and capacity to treat. This did affect PI # 2 and PI # 22, and had the potential to affect all patients with a request for transfer to SH.

Findings include: Facility Policy: Emergency Medical Treatment and Labor Act (EMTALA) Administrative Policy Effective Date: 4/1/19 Purpose: To comply with the EMTALA... Procedure: ...Recipient Hospital Responsibilities ...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.

1. Hospital C (transferring hospital) documentation: PI # 2 presented to Hospital C's emergency department (ED) on 7/14/21 at 7:01 PM with a chief complaint of Chest Pain. Review of the Triage note dated 7/14/21 at 7:01 PM revealed the following documentation: "pt (patient) c/o (complaint of) left sided pressure-like chest pain for 1 day. Pt has history of MI (Myocardial Infarction), CABG (Coronary Artery Bypass Graft), Pacer/Defibrillator, and Cardiac Stents..." with vital signs documented as: Blood pressure 134/69, Pulse 74, Respirations 19, Oxygen Saturation 94 % on room air and pain 10 on a 1-10 scale. Review of the EKG 12 Lead dated 7/14/21 at 7:14 PM revealed impression documentation of "ST Elevation (STEMI) Myocardial Infarction of Unspecified Site..." Review of the ED Physician assessment dated 7/14/21 at 7:29 PM revealed documentation of "...presents with extensive cardiac history presents with sudden onset left-sided chest pain since last night after coughing. Patient reported having intermittent chest pain today. Reported the pain was 10 out of 10 (0-10 scale). Reported having history of CAD (Coronary Artery Disease) with open heart surgery, recent cardiac catheterizations about 6 months ago leading to a 10 stent placement. Patient appeared in no acute distress...EKG (Electrocardiogram) demonstrated marked ST elevations to the anterior leads without reciprocal changes. Patient does have a pacemaker but compared to EKG from January of this year ST changes are now present....Provided with a full dose Aspirin...Call placed to Southeast Medical (SH) but wasn't (was on) critical care admission (diversion). (Hospital B, Receiving Hospital) was then contacted...accepted transfer..." Review of the Nursing Treatment Notes dated 7/14/21 at 7:41 PM revealed documentation of "called SH Transfer line...who states they are on Critical Care diversion..." Review of the Laboratory (lab) test completed on 7/14/21 at 7:59 PM revealed a Troponin level of 7.84 (Normal range from 0.02 to 0.10). Review of the Disposition documentation revealed PI # 2 was transferred to Hospital B on 7/14/21 at 8:12 PM via ambulance.

Hospital A, Southeast Health (SH) Medical Center: Review of the facility Physician Link Transfer Line Log documentation on 7/28/21 revealed no documentation of a transfer request from Hospital C on 7/14/21 at 7:41 PM. An interview was conducted on 7/28/21 at 3:19 PM with Employee Identifier (EI) # 3, Director of Patient Placement, who verbalized the facility Physician Link Transfer Line does not fill out the a Physician Line Transfer Line Form on patient's when the facility does not have beds and so the transfer request would not be on the facility log. EI # 3 verbalized the call on 7/14/21 at 7:41 PM from Hospital C did offer the diagnosis of the patient but no other information. Review of the Physician Link Transfer Line audio file and transcript dated 7/14/21 at 7:41 PM revealed the facility received a call from Hospital C requesting a transfer for a "...patient here in the ER (Emergency Room) that...may be having a STEMI and...wanting to talk with someone about (him/her) please." Hospital C was then told by SH Physician Link Transfer Line staff, "we are on Critical Care diversion..." There was no documentation an on-call physician and/or ED Physician was notified of the transfer request and provided clinical information

on the patient to determine where the patient would need to be evaluated and treated. Review of the SH Diversionary Status Report revealed no documentation the facility was on Critical Care (CCU) diversion on 7/14/21 at 7:41 PM. Review of the CCU bed census for 7/14/21 at 7:41 PM revealed documentation the CCU had 1 bed available. Review of the SH Unassigned ER Call Roster for 7/14/21 revealed documentation the facility had an on-call Cardiologist and Cardiothoracic Surgeon. An interview was conducted on 7/29/21 at 9:44 AM with EI # 3, who verbalized PI # 2 would have been transferred to CCU if the transfer request would have been accepted. An interview was conducted on 8/2/21 at 4:16 PM with EI # 7, Director of Critical Care, who confirmed the facility CCU did have 1 available bed and adequate staffing on 7/14/21 at 7:41 PM. The facility failed to ensure that their policy and procedure was followed as evidenced by refusing to accept an appropriate transfer of PI #2 on 7/14/21, who had an identified emergency medical condition, as SH had the capability and capacity to treat PI # 2.

2. Hospital A, Southeast Health (SH) documentation: Review of the facility Physician Link Transfer Line Log documentation dated 4/4/21 revealed documentation of a transfer request from Hospital C, Transferring Hospital, at 11:44 PM for a patient who was "...35 weeks active labor..." with a "Non-Admit Reason... Other - See Comments...(EI # 8, SH on-call Obstetrics and Gynecology (OB/GYN) physician identified) suggested pt (patient) go to closer facility for evaluation d/t (due to) high risk pregnancy..." Review of the Physician Link Transfer Line audio file and transcript dated 7/14/21 at 7:41 PM revealed the following information: Hospital D, ED called the Physician Link Transfer Line and stated, "...I have a...35 weeks pregnant...in active labor, 5 minutes apart... and we don't want to deliver a baby, especially not a preterm, so I needed to speak to somebody either to do an ER to ER transfer or something." SH obtained the patient information and then connected the call to EI # 8. EI # 8 was provided the following information on PI # 22 by Hospital D's, ED Provider, "...patient that came in, just came in through the ER door that was um, she is traveling through....She is 35 weeks, high risk, both her other children, this is her third child, both of her other ones were delivered between 35 and 36 weeks and she is having contractions 5 minutes apart that last about a minute and I needed to see if I could transfer her ER to ER or something cause I certainly don't need to have her in my ER." EI # 8 then asked if the ED provider was able to check PI # 22's cervix. The ED Provider stated, "...I was afraid to. her water hasn't broken. She is having difficulty even laying back on the stretcher and so it is just kind of like, I am 45 minutes away from any place that I send her...but I don't mind checking it." EI # 8 then verbalized "it would just be helpful...I don't know how far your town is from where we are, but she is certainly better off delivering there than she would be in the ambulance on the way here...if that is not something in your wheelhouse, no worries, I just didn't know if it was a possibility...where is (Hospital D's City identified)." The ED Provider then tried to describe the location of where they were located. EI # 8 then asked, "Are there not any town with obstetrical units between here and there?" The ED Provider stated, "There is one but because she is 35 weeks, they would defer. That would be (city of other hospital identified) and it's about 13 miles, but they deferred because she is 35 weeks. She knows she has high risks and so they just deferred and said I need to go to a different facility." EI # 8 then asked how far away the other hospital was from Hospital D and was told by the ED Provider the other hospital was "...about 13 miles." EI # 8 then asked how far away SH was from the facility and was told by the ED Provider about 45 minute drive by car. EI # 8 then verbalized, "...So I mean I am happy to help you of course...I guess it would stand to reason for her to go to a place with an obstetrical unit...for someone to check her cervix and all that kind of stuff if they are 10 minutes away, get stable...and make sure she is able for the drive if she is indeed in labor and needs a place with a NICU (Neonatal Intensive Care Unit) and

higher level of obstetrical care than I'm happy to help you...It just seems unwise...in the setting of, I mean...she's in labor, she's had two kids vaginally before and you are walking distance from an obstetrical unit. It would stand to reason for her to go there to get stable and see if our services are required rather than being at a point of being 45 minutes away from anything with a 35 weeker..." The ED Provider verbalized he/she would call them to which EI # 8 responded, "I would, I would, so please know I am happy to help it just seems unwise to drive 45 minutes passed a labor and delivery..." The ED Provider then verbalized he/she would call the other facility and see what they had to say to which EI # 8 responded, "Well I don't think they have a choice you know...I think it is an EMTALA issue...just let me, know we're here...if there is any way we can help..." The call was then ended. Review of the Family Birth Center (FBC, SH Labor and Delivery Unit) bed census for 4/4/21 at 11:44 PM revealed documentation the FBC had 25 beds available. Review of the NICU bed census for 4/4/21 at 11:44 PM revealed documentation the NICU had 6 beds available. Hospital D (transferring hospital) documentation: Review of the triage assessment dated 4/5/21 at 12:38 AM revealed PI # 22 presented to the ED with a chief complaint of "pt (patient) reports being 35 wks (weeks) pregnant and having labor pains every 5 min (minutes)." Review of the ED Provider assessment dated 4/5/21 at 12:54 AM revealed documentation of "The patient presents with abdominal pain during pregnancy...intermittent contractions, 5 minutes apart, lasting 1 minute...Risks factors consist of...high risk pregnancy, traveling. Prior episodes: both children born at 36 weeks...General: alert, appears uncomfortable...Gastrointestinal: pregnant (pregnant) appearing, tense contractions, 2 minutes apart, last 1.5 minutes... The patient is on vacation...She has had contractions late in the day and early evening. They became harder, more regular and lasting longer so she presented to the ER for care. I called SAMC (SH) and spoke with (EI # 8, SH on-call Obstetrics and Gynecology (OB/GYN) physician identified) who is on call for OB. (He/She) stated (he/she) would be glad to accept the mother and child for admission/transfer but wanted her checked by someone who could deliver and manage a preterm baby and handle maternal complications. (He/She) suggested the OB unit at (Receiving Hospital identified) as they are between our facility and (his/her) facility...The visual exam revealed no blood, no fluid, no crowing..." Review of the Disposition documentation revealed the patient was transferred to another facility on 4/5/21 at 1:30 AM. Interviews: An interview was conducted on 7/29/21 at 9:44 AM with EI # 3, who verbalized PI # 22 would have been transferred to Labor and Delivery if the transfer request would have been accepted. An interview was conducted on 7/30/21 at 12:16 PM with EI # 8, SH on-call OB/GYN, who verbalized PI # 22 was a "35 weeker within 13 miles of care, they can't refuse them. They needed to evaluate and stabilize them. We can take after that." EI # 8 was asked can you tell me about the EMTALA laws and when a transfer can be refused? EI # 8 state, "if unable to provide said service." An interview was conducted on 7/30/21 at 4:32 PM with EI # 6, Director of FBC, NICU and Pediatrics, who confirmed FBC had adequate staffing on 4/4/21 at 11:44 PM. An interview was conducted on 8/2/21 at 10:09 AM with EI # 6, who confirmed NICU had 6 available beds and adequate staffing on 4/4/21 at 11:44 PM. An interview was conducted on 8/2/21 at 2:54 PM with EI # 6, who confirmed FBC had 25 available beds on 4/4/21 at 11:44 PM. The facility failed to ensure that their policy and procedure was followed as evidenced by refusing to accept an appropriate transfer of PI #22 on 4/4/21, who had an identified emergency medical condition, as SH had the capability and capacity to treat PI # 22.