

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010005	(X3) Date Survey Completed 09/29/2022
Name of Provider or Supplier Marshall Medical Centers South Campus	Street Address, City, State 2505 U S Highway 431 North, Boaz, 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	<p>An abbreviated unannounced federal Emergency Medical Treatment & Labor Act (EMTALA) complaint survey, AL00042070, was conducted at Marshall Medical Centers, North Campus, part of the Huntsville Hospital Health System, on September 29, 2022 specifically for review of EMTALA requirements. The hospital was found to be not in compliance with the Federal Regulations at 42 CFR 489.24 (a), Responsibilities of Medicare Participating Hospitals in Emergency Cases, and and CFR 489.24(d), Necessary Stabilizing Treatment for Emergency Medical Conditions. Please refer to findings at A 2400 and A 2406. The following is a description of the non-compliance: Patient Identifier (PI) # 1 presented to the Emergency Department (ED) at Marshall Medical Centers North (Hospital A) on 8/5/22 at 12:31 AM, via private vehicle, accompanied by family, with a chief complaint of a broken and leaking central venous line. Review of the Huntsville Hospital (Hospital B) History and Physical Report, dated 8/5/22, revealed Employee Identifier (EI) # 6 (Hospital B physician) documented PI # 1 had/has an underlying mitochondrial genetic disorder that required continuous infusion of TPN (total parenteral nutrition) via a central venous line. Per interview of the complainant (a family member of PI # 1) conducted 9/28/22 at 8:30 AM, the complainant made Hospital A EI # 2, ED Registered Nurse (RN) aware PI # 1 required TPN twenty four hours a day. Review of the Hospital A ED Medical Record (MR) for PI # 1 revealed PI # 1 received a Triage assessment at 12:53 AM by Employee Identifier (EI) # 3, RN, and a nursing assessment at 1:00 AM by EI # 2. There was no documentation a medical screening examination (MSE) was conducted. Further review of the ED MR revealed EI # 2 informed PI # 1's family that he/she had consulted with EI # 4 (Hospital A ED physician), that the services required for repair/replacement of the central venous line were not available at the facility at that time, and EI # 4 recommended following up with the surgeon who had placed the central venous line immediately in the morning. PI # 1 then left the ED at Hospital A via private car, and went to the ED at Hospital B. Review of the Hospital B MR revealed PI # 1 received a MSE by the ED physician, and stabilizing treatment with peripheral intravenous (IV) fluids, until a surgeon removed the broken/leaking central venous line and placed a new central venous line to continue TPN. An</p>

interview with the complainant on 9/28/22 at 8:30 AM confirmed PI #1's family was told services needed were not available at Hospital A, and was advised to return that morning to the surgeon's office that had initially placed the central venous line. The complainant also confirmed PI # 1 received no treatment at Hospital A other than vital signs. Review of the on-call surgery schedule for Hospital A revealed a surgeon was on-call from 5 PM on 8/4/22 to 7 AM on 8/5/22 when PI # 1 presented to Hospital A's ED, that could have provided the stabilizing treatment needed. In an interview conducted 9/29/22 at 11:00 AM with EI # 5 (on-call surgeon) for 8/4/22, EI # 5 stated he/she did not remember being contacted for a case like PI # 1. In an interview with EI # 1, Chief Nursing Officer, on 9/29/22 at 3:23 PM, EI # 1 confirmed that Hospital A did not provide a MSE for PI # 1.