STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010051	A. BUILDING _____ B. WING _____	C 04/01/2021

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GREENE COUNTY HOSPITAL	509 WILSON AVENUE EUTAW, AL 35462

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A 000	INITIAL COMMENTS An unannounced on-site Emergency Medical Treatment & Labor Act (EMTALA) complaint survey, AL00041314, was conducted at Greene County Hospital of Greene County on 3/30/2021 - 4/1/2021, specifically for the review of EMTALA requirements. The Chief Executive Officer was notified on April 29, 2021, at 9:20 a.m. that Immediate Jeopardy (IJ) existed. Based on review of the facility policies and procedure, Medical Staff Bylaws and Rules and Regulations, facility registration log, Emergency Department (ED) log, Medical Records (MR), Hospital B Medical Records, EMS (Emergency Medical Services) Patient Care Reports (PCR), 911 call log, and staff interviews, it was determined Greene County Hospital (Hospital A) failed to ensure: 1. A MR was initiated and maintained on two patients who presented to the ED requesting treatment. 2. A physician was on duty and available to respond to an emergency. 3. All patients arriving on the hospital property requesting emergency care were entered into the ED log. 4. All patients requesting emergency care had a Medical Screening Examination (MSE) performed. 5. Stabilizing treatment was performed prior to transfer to another hospital.	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jacobus | TITLE: M.D | (X6) DATE: 5/12/2021

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.

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A 000	Continued From page 1 6. Examination and treatment was not delayed. 7. An appropriate transfer of two patients was arranged for two patients who were transferred to Hospital B. This deficient practice did affect Patient Identifier (PI) # 1 and PI # 2 and had the potential to affect all patients presenting to this hospitals Emergency Department (ED). Patient Identifier (PI) # 1 was a 23 year old (35 weeks gestation) patient whose labor started at approximately 5:00 AM on 3/25/2021. PI # 1 called 911 to request an ambulance but none were available at that time. PI # 1's family arrived later and transported her to Hospital A, arriving at approximately 7:00 AM. Upon arriving at Hospital A PI # 1 was reportedly told by hospital staff that Hospital A did not deliver babies. PI # 1 was never brought inside to the ED, no assessment was performed by the hospital nurses or physician and no MSE was performed by the physician. Employee Identifier (EI) # 8, RN, confirmed in an interview he/she went to the car and saw PI # 1 sitting in the car. EI # 8 stated he/she noticed a bulge in PI # 1 pants and thought the baby had already been delivered. EI # 8 stated PI # 1 was not able or willing to help him/her get out of the car so he/she went back inside to call for help. There was no documentation of the patients arrival, treatment, assessment, or transfer of the patient at Hospital A. The hospital staff stated in interviews that EI # 4, physician, was contacted by phone and informed of the patient in labor. EI # 4 stated he/she was unable to come to the ED at that time and called EI # 3, physician, to come to hospital for the patient in labor. PI # 1's family called 911	A 000		

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A 000	Continued From page 2 requesting an ambulance to the hospital parking lot at 7:34 AM. Hospital A also called 911 at 7:35 AM stating they need an ambulance at the front door, they had a lady in labor. EMS arrived to Hospital A parking lot at 7:37 AM to find PI # 1 in her car and two nurses standing some distance away at hospital awning. No apparent care was delivered prior to EMS arrival. PI # 1 stated she started having contractions around 5 AM. PI # 1 pointed to her groin and advised "I already had it". The paramedic documented he/she could visually see a bulge in her groin, patient fully clothed. The clothing was cut from PI # 1 and it was discovered PI # 2 was already delivered from the waist up. Further review of the EMS Event Clinical Presentations dated 3/25/2021 revealed the paramedic documented "2 females in blue scrubs are in the parking lot with us, it appeared there was no evidence of care rendered prior to EMS arrival." EMS delivered the fetus and provided care to PI # 1 and Cardiopulmonary Resuscitation (CPR) to PI # 2. EMS transported both patients to Hospital B at 7:54 AM. EI # 3 arrived at hospital at approximately 7:38 AM and witnessed care being delivered to PI # 1 and PI # 2 by EMS. EI # 3 verified in an interview no assessment or MSE of mother or baby was performed. EI # 3 stated he/she asked EMS if the patients should be brought inside because this might be an EMTALA violation. EI # 3 stated he/she did not arrange for the transfer of PI # 1 or PI # 2 and neither patient was stabilized prior to transfer to Hospital B. PI # 1 and PI # 2 were transported by ambulance from Hospital A enroute to Hospital B at 7:54 AM. PI # 2 was pronounced dead upon arrival at Hospital B at 8:33 AM.	A 000		

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A 000	Continued From page 3 The hospital's failure to provide a medical screening exam, stabilizing treatment and arrange for an appropriate transfer to Hospital B posed an immediate and serious threat to Patient #1 and Patient #2's health and safety and inappropriately delayed treatment for their emergency medical conditions. 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. The following is a description of the non-compliance.	A 000	A 2400- COMPLIANCE WITH 489.24 CFR(s): 489.20(1) This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. **1. A physician was on duty and available to respond to an emergency.** The patient arrived at approximately 7:27 a.m. per Exhibit A statement. The physician was called at 7:35 a.m. per Exhibit B statement. The physician responded at approximately 7:38 a.m. from within 250 yards of the facility per Exhibit C. We will continue to have to a physician call schedule posted which will include a back-up physician.	
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 policies and procedure, Medical Staff Bylaws and Rules and Regulations, facility registration log, Emergency Department (ED) log, Medical Records (MR), Hospital B Medical Records, EMS (Emergency Medical Services) Patient Care Reports (PCR), 911 call log, and staff interviews, it was determined Greene County Hospital (Hospital A) failed to ensure: 1. A physician was on duty and available to respond to an emergency. 2. All patients requesting emergency care had a Medical Screening Examination (MSE)	A2400	a. The Emergency Department Policy is being modified indicating the physician is to respond within 5 minutes of being called. (See Exhibit D). all modifications will be completed and added to the policy by 5/16/21. Staff are currently reviewing this policy and will be formally in-serviced on the updated changes to the policy by CNO. RN's, LPN's, and PCTs will be in-serviced on the changes with a sign-in sheet for verification. Any staff not in-serviced will be required to do so before they resume any shifts after the deadline of 5/16/21. b. 100% of all emergency department charts will be reviewed daily for two weeks or until 90% compliance reached then 50% weekly until 100% compliance reached. (See Exhibit D) All results will be reported through the hospital QAPI Program and up to the governing body. CEO will report to the governing body at their standard monthly meeting. Results will be reported to the governing body weekly for two weeks to determine the hospital is making progress with compliance. With noted compliance, reporting will be done monthly.	5/16/21

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A2400	Continued From page 4 performed. 3. Stabilizing treatment was performed prior to transfer to another hospital. 4. An appropriate transfer of two patients was arranged for two patients who were transferred to another hospital. 5. An EMTALA (Emergency Medical Treatment and Labor Act) policy was adopted and approved. This deficient practice did affect Patient Identifier (PI) # 1 and PI # 2 and had the potential to affect all patients presenting to this hospitals ED. Refer to Tags: A2404, A2406, A2407, and A2409.	A2400	**2. All patients requesting emergency care had a Medical Screening Examination** **3. Stabilizing treatment was performed prior to transfer to another hospital.** **4. An appropriate transfer of two patients was arranged for two patients who were transferred to another facility.** **5. An EMTALA policy was adopted ad approved** a. The organizational By-Laws that are presently being revised will add the approval for Nurse Practitioners to perform medical screenings. (See Exhibit E) All nursing and medical staff will receive EMTALA training. The training videos are in Exhibit F. This video training will be done by all new hires and annually. b. An on-site emergency birthing class will be conducted for all nursing staff and physicians. CNO and Chief of Staff will perform this training. The videos being used can be found at: 5 minute video https://brooksidepress.org/brooksidepress/?page_id=151&cn-reloaded=1 Deliver the placenta https://obgynmorningrounds.com/blog6/skills-lab/obstetrics/delivery/deliver-the-placenta/ Pelvic examination during labor https://brooksidepress.org/brooksidepress/?page_id=285 A copy of the test for this video can be found in Exhibit G. All results will be reported through the hospital QAPI Program and up to the governing body. CEO, will report to the governing body at their standard monthly meeting. Results will be reported to the governing body weekly for two weeks to determine the hospital is making progress with compliance. With noted compliance, reporting will be done monthly.	
A2403	HOSPITAL MUST MAINTAIN RECORDS CFR(s): 489.20(r)(1) [The provider agrees,] in the case of a hospital as defined in §489.24(b), (including both the transferring and receiving hospitals), to maintain medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of the transfer. This STANDARD is not met as evidenced by: Based on review of the facility policies, facility registration log, Hospital A Medical Records (MR), and staff interviews, it was determined Greene County Hospital (Hospital A) failed to ensure a MR was initiated and maintained on a patient presenting to hospital in active labor and on the newborn who was delivered while on hospital premises. This deficient practice affected 2 of 2 patients	A2403		5-18-21

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A2403	Continued From page 5 presenting to the ED with no MR completed including Patient Identifier (PI) # 1 and PI # 2, and had the potential to affect all patients presenting to this hospital. Findings include: General Policy Statement Policy # 100 Date reviewed: 5/15/2018 ... 8. All nursing staff shall record the details and time of all relevant medical information history, observations, patient complaints, vital signs, tests ordered, medical orders, received and care or treatment rendered on the triage form or emergency department record for each patient. ... ER (Emergency Room) Policies and Procedures Recording Policy # 107 Date reviewed: 5/15/2018 1. The ER Record must be completely filled out and signed by the nurse. 2. It should include a brief history of what precipitated the ER visit... 6. Special points to record: 1. Patients time of arrival 2. Physician's time of arrival, and physicians time notified 3. Patient's condition on discharge 4. Time the patient left and disposition... ER Registration Policy and Procedure Policy # 101	A2403	A 2403- HOSPITAL MUST MAINTAIN RECORDS CFR(s): 489.20(r)(1) This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. 1. **The ER Record must be completely filled out and signed by the nurse.** 2. **It should include a brief history of what precipitated the ER visit.** 3. **Special points to record are identified.** a. All Emergency Department staff will be in-serviced on EMTALA guidelines related to patient presenting to the facility as well as the parameters included in the "on campus" range (See Exhibit H). This in-service was initiated the day after the survey. The following staff will be in-services: All RN's, All LPN's, All Patient Care Techs (PCTs), all Registrars and any other staff providing care in the Emergency Department. The in-service will be done by CNO. b. 100% of all emergency department charts will be reviewed daily for two weeks or until 90% compliance reached then 50% weekly until 100% compliance reached. (See pages 1 and 2 of Exhibit D). The audit will be done by CNO. All results will be reported through the hospital QAPI Program and up to the governing body. CEO will report to the governing body at their standard monthly meeting. Results will be reported to the governing body weekly for two weeks to determine the hospital is making progress with compliance. With noted compliance, reporting will be done monthly.	5|16|21

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A2403	Continued From page 6 Date reviewed: 5/15/2018 Registration information may be obtained from a patient or a family member at any time ... 1. Review of Hospital B ED Patient Notes dated 3/25/2021 at 8:33 AM revealed PI # 1 stated she began to have labor pains at home at approximately 5:00 AM on 3/25/2021. After attempts to obtain an ambulance for transport were unsuccessful, PI # 1 was taken by family members to Hospital A by private car and arrived at approximately 7:00 AM. PI # 1 stated she notified the staff at Hospital A she was labor and then had a spontaneous delivery of PI # 2 in the car in the hospital parking lot. Copies of the MR of PI # 1 and PI # 2 were requested on 3/30/2021 at 4:00 PM but no medical record documentation could be provided to the surveyors. An interview was conducted on 3/31/21 at 10:47 AM with Employee Identifier (EI) # 8, Registered Nurse (RN), day shift 7 AM to 7 PM. EI # 8 was asked was a chart completed on PI # 1 and PI # 2? EI # 8 replied by stating "no, we did not know her name. A chart should have been done but it was not." An interview was conducted on 3/31/21 at 2:30 PM with EI # 9, RN, 7 AM to 7 PM shift. EI # 9 was asked did you complete a medical record on (PI # 1 or PI # 2)? EI # 9 responded, "No, I did not." In an interview conducted on 4/1/2021 at 3:30 PM EI # 1, Administrator, and EI # 2, Director of Nurses, confirmed PI # 1 arrived at	A2403	A2403 Continued from page 6 The information on this page has a factual misrepresentation from the surveyor in relation confirmation of the patient's arrival time at the hospital. The interview held on 4/1/2021 at 3:30 p.m. was the actual exit interview held after review of information by the ADPH survey team. During this interview, there was no conversation. The Administrator and Director of Nurses merely sat and listened to the presentation without any confirmation of any information provided by the surveyor. Neither the Administrator nor the Director of Nurses was present during the associated incident.	

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A2404	Continued From page 8 call or to permit on-call physicians to have simultaneous on-call duties. This STANDARD is not met as evidenced by: Based on review of the facility policies and procedure, Hospital B Medical Records (MR), and staff interviews, it was determined Greene County Hospital (Hospital A) failed to ensure a physician was on duty and available to respond to an emergency. This deficient practice affected 2 of 2 patients who presented to the ED requesting treatment when no physician was available for treatment including Patient Identifier (PI) # 1 and PI # 2, and had the potential to affect all patients presenting to this hospital. Findings include: Emergency Staffing Patterns Policy # 123 Date reviewed 5/15/2018 A. Emergency staffing for 24 hour period: There is a registered nurse on duty 24 hours per day who is responsible for the immediate assessment and treatment of the ER (Emergency Room) patients until the on-call MD (Medical Doctor) arrives. B. A physician is on-call 24 hours per day to provide immediate medical services to patients presenting to the ER. The physician's call list is posted at the nurses station. Unless otherwise indicated, the physician indicated as "on-call" will be notified. C. Types of Emergencies treated at GCH	A2404	A2404 ON CALL PHYSICIANS CFR(s): 489.20(r)(2) and 489.24 (j)(1-2) The information on this page has a factual misrepresentation from the surveyor in relation to the statement that "Greene County Hospital (Hospital A) failed to ensure a physician was on duty and available to respond to an emergency. 1. **A physician was on duty and available to respond to an emergency.** The patient arrived at approximately 7:27 a.m. per Exhibit A statement. The physician was called at 7:35 a.m. per Exhibit B statement. and arrived at approximately 7:38 a.m. from within 250 yards of the facility per Exhibit C. The surveyor indicated the physician had to be inside of the facility and not within 250 yards as he indicated this was insufficient. We will continue to have a physician call schedule posted which will include a back-up physician.	

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A2403	Continued From page 7 approximately 7:00 AM on 3/25/2021 and the patient was not registered as being seen in the ED there was no medical record documentation of PI # 1 or PI # 2.	A2403	A2404 ON CALL PHYSICIANS CFR(s): 489.20(r)(2) and 489.24 (j)(1-2) The information on this page has a factual misrepresentation from the surveyor in relation to the sequence of events as provided by the staff present and statements provided by those staff members.	
A2404	ON CALL PHYSICIANS CFR(s): 489.20(r)(2) and 489.24(j)(1-2) §489.20(r)(2) [The hospital (including both the transferring and receiving hospitals), must maintain] a list of physicians who are on call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition. §489.24(j)(1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians. §489.24(j)(2)(i) The hospital must have written policies and procedures in place to respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control. §489.24(j)(2)(ii) The hospital must have written policies and procedures in place to provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on	A2404	a. The organizational By-Laws that are presently being revised will add the approval for Nurse Practitioners to perform medical screenings. (See Exhibit E) All nursing and medical staff will receive EMTALA training. The training videos are in Exhibit F. This video training will be done by all new hires and annually. b. Chief of Staff generates the physician on-call schedule. The hospital administrative office works with the Locum Tenens company to get needed coverage as requested by Chief of Staff. The calendar of on-call physicians is kept at the Nurses Station. If there are changes to the calendar, the changes are made on the calendar kept at the Nurses Station and the CNO is made aware. The organization will continue to provide the on-call physician schedule. (See Exhibit I) Back-up call is done between the two staff physicians. If a physician is ill, it is his responsibility to notify the on-call physician presently working within 2 hours of his scheduled shift. The issue of the on-call physician that was ill was that he did not notify anyone regarding his illness. An Audit Tool will be utilized by the Chief of Staff and CNO to assure compliance (See Exhibit M). All results will be reported through the hospital QAPI Program and up to the governing body. CEO will report to the governing body at their standard monthly meeting. Results will be reported to the governing body weekly for two weeks to determine the hospital is making progress with compliance. With noted compliance, reporting will be done monthly.	5-18-21 Board Meeting Date

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A2404	Continued From page 9 (Greene County Hospital):.. 14. Obstetrical patients... 1. Review of Hospital B Emergency Department (ED) Patient Notes dated 3/25/2021 at 8:33 AM revealed PI # 1 stated she began to have labor pains at home at approximately 5:00 AM on 3/25/2021. After attempts to obtain an ambulance for transport were unsuccessful, PI # 1 was taken by family members to Hospital A by private car and arrived at approximately 7:00 AM. PI # 1 stated she notified the staff at Hospital A she was labor and then had a spontaneous delivery of PI # 2 in the car in the hospital parking lot. An interview was conducted on 3/30/21 at 10:20 AM with Employee Identifier (EI) # 5, Marketing Coordinator, who stated "I told them to get the patient out of the car and in a wheelchair and take her to the Emergency Room and call the doctor on call and 911." An interview was conducted on 3/30/21 at 4:56 PM with EI # 4, physician, who stated when asked how are you notified of a patient requiring Emergency Treatment he/she stated "the nurse contacts me by phone and lets me know an ER patient is at the hospital." He/she then stated (EI # 8, RN, Registered Nurse) "called me and I told (him/her) I was sick and I called (EI # 3, physician). He/she came to the hospital in about 1 to 2 minutes. We usually call each other at the end of the shift and (EI # 3) did not call me that morning which was strange. I got dressed and came in." An interview was conducted on 3/31/21 at 9:40 AM with EI # 3, physician, who stated "my shift was over and (EI # 4) called and asked me to see	A2404	A2404 ON CALL PHYSICIANS CFR(s): 489.20(r)(2) and 489.24 (j)(1-2) The information on this page has a factual misrepresentation from the surveyor in relation to the statement made by Employee Identifier (EI) #5, Marketing Coordinator that states, "I told them to get the patient out of the car and in a wheelchair and take her to the Emergency Room and call the doctor on call and 911." The Marketing Coordinator reports in her statement in Attachment A that the patient did not arrive at 7:00 a.m. She further stated during interview with the organization's Administrative staff that upon her entry to the hospital Emergency Department Nurses Station, the nurse had already called the physician and ambulance. Upon arrival of the nurse outside to get the patient out of the car, the ambulance service had already arrived. The patient reported to the nurse that her "water broke around 5". When she called for an ambulance, she was told that both trucks were out. The nurse called to verify the location and let the ambulance service know the patient had arrived. It is not uncommon for a patient to wait hours for ambulance to transport.	

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A2405	Continued From page 11 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 review of the facility policies, facility registration log, Emergency Department (ED) log, Hospital B Medical Records, and staff interviews, it was determined Greene County Hospital (Hospital A) failed to ensure an accurate ED log was kept and all patients presenting to the ED for treatment were entered. This deficient practice affected 2 of 2 patients who presented to the ED for treatment but were not entered into the ED log including Patient Identifier (PI) # 1 and PI # 2, and had the potential to affect all patients presenting to this hospital. Findings include: ER Policies and Procedures Recording Policy # 107 Date reviewed: 5/15/2018 1. The ER Record must be completely filled out and signed by the nurse.	A2405	A2405 EMERGENCY ROOM LOG CFR(s): 489.20(r)(3) a. The electronic central log is available in the present Electronic Health Record at all times. This log is housed inside of the CMR Electronic Health Record. Entering only a name and transfer date generates a patient chart and account. We have never before had a patient that was not seen or medically screened in the Emergency Department. This incident was managed as a Quality investigation issue. A paper log was established for this type of incident and the entries made as a late entry (See Exhibit J). 100% of all emergency department charts will be reviewed daily for two weeks or until 90% compliance reached then 50% weekly until 100% compliance reached. (See pages 1 and 2 of Exhibit D). The audit will be done CNO. All results will be reported through the hospital QAPI Program and up to the governing body. CEO, will report to the governing body at their standard monthly meeting. Results will be reported to the governing body weekly for two weeks to determine the hospital is making progress with compliance. With noted compliance, reporting will be done monthly.	

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A2404	Continued From page 10 the patient. I came back and the ambulance people were here. EI # 3 was asked who treated the patient in the parking lot? EI # 3 responded by stating EMS was doing CPR on the baby and we were all there but we were waiting on a person to come to help with the mother. I told my nurse (EI # 7, RN) we needed to get them inside. There was myself, the EMS people and the nurses from the hospital." EI # 3 was asked did you or the hospital employees provide any treatment to the patient? EI # 3 responded "No, EMS was doing it." EI # 3 was then asked how long does it take you to get to the hospital? EI # 3 responded "It does not take me long." An interview was conducted on 3/31/21 at 10:47 AM with EI # 8, RN, who stated "a man came in and said a lady was having a baby. I called (EI # 4, physician) and I told him." An interview was conducted on 3/31/21 at 3:35 PM with EI # 7, RN who stated "I went and got a wheelchair and the man knocked on the door and I asked him when her water broke. He said 5:00 AM. He said he did not know why 911 did not come. I told him the other nurse is on the phone now with the doctor and we would be to the car in a minute." PI # 1 and PI # 2 were transported by ambulance to Hospital B on 3/25/2021 at 7:54 AM. In an interview conducted on 4/1/2021 at 3:30 PM, EI # 1, Administrator, and EI # 2, Director of Nurses, confirmed a physician was not immediately available when PI # 1 arrived at the hospital.	A2404		
A2405	EMERGENCY ROOM LOG	A2405		

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A2405	Continued From page 12 2. It should include a brief history of what precipitated the ER visit... 6. Special points to record: 1. Patients time of arrival 2. Physician's time of arrival, and physicians time notified 3. Patient's condition on discharge 4. Time the patient left and disposition... ER Registration Policy and Procedure Policy # 101 Date reviewed: 5/15/2018 Registration information may be obtained from a patient or a family member at any time ... 1. Review of Hospital B ED Patient Notes dated 3/25/2021 at 8:33 AM revealed PI # 1 stated she began to have labor pains at home at approximately 5:00 AM on 3/25/2021. After attempts to obtain an ambulance for transport were unsuccessful, PI # 1 was taken by family members to Hospital A by private car and arrived at approximately 7:00 AM. PI # 1 stated she notified the staff at Hospital A she was labor and then had a spontaneous delivery of PI # 2 in the car in the hospital parking lot. Review of the ED Log and Registration Log at Hospital A revealed no documentation of PI # 1 or PI # 2 presented to the ED per hospital policy. In an interview conducted on 4/1/2021 at 3:30 PM EI # 1, Administrator, and EI # 2, Director of Nurses, confirmed that PI # 1 arrived at approximately 7:00 AM on 3/25/2021 and the	A2405	A2405 Continued From Page 12 The information on this page has a factual misrepresentation from the surveyor in relation to the patient's arrival time at the Hospital A. The ED Log and Registration Log at Hospital A revealed no documentation of PI # 1 or PI # 2 presented to the ED per hospital policy as per the surveyor. As per Attachment C, an Emergency Medical Services staff onsite was approached by the physician onsite and informed to bring both patients inside of the hospital Emergency Room as the patients were still outside of the facility. The response received by the physician onsite is in Exhibit C. EMS refused to bring the patient inside to be stabilized. EMS stated they "have control of it now". In the exit interview, the Administrator questioned scene control by the MD versus EMS. The surveyor confirmed that EMS controls the scene upon their arrival and not the MD. A meeting will be scheduled with the EMS Director to discuss scene control and assure that MD control of a scene is maintained in his/her presence and that a medical screening is performed prior to transfer.	

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A2405	Continued From page 13 patient was not registered on the ED log as being seen in the ED.	A2405	A2406 MEDICAL SCREENING EXAM CFR(s): 489.24(a) & 489.24(c)	5-18-21
A2406	MEDICAL SCREENING EXAM CFR(s): 489.24(a) & 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) 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	A2406	a. The organizational By-Laws that are presently being revised will add the approval for Nurse Practitioners to perform medical screenings. (See Exhibit E) All nursing and medical staff will receive EMTALA training. The training videos are in Exhibit F. This video training will be done by all new hires and annually. b. The Emergency Department Policy is being modified indicating the physician is to respond within 5 minutes of being called. (See Exhibit D). all modifications will be completed and added to the policy by 5/16/21. Staff are currently reviewing this policy and will be formally in-serviced on the updated changes to the policy by CNO. RN's, LPN's, and PCTs will be in-serviced on the changes with a sign-in sheet for verification. Any staff not in-serviced will be required to do so before they resume any shifts after the deadline of 5/16/21. c. 100% of all emergency department charts will be reviewed daily for two weeks or until 90% compliance reached then 50% weekly until 100% compliance reached. (See Exhibit D) All results will be reported through the hospital QAPI Program and up to the governing body. CEO will report to the governing body at their standard monthly meeting. Results will be reported to the governing body weekly for two weeks to determine the hospital is making progress with compliance. With noted compliance, reporting will be done monthly.	

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A2406	Continued From page 14 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 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,	A2406		

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A2406	Continued From page 15 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 review of the facility policies and procedure, Hospital B Medical Records, EMS (Emergency Medical Services) Patient Care Reports (PCR), EMS Event Clinical Presentations, 911 call log, and staff interviews, it was determined Greene County Hospital (Hospital A) failed to ensure a Medical Screening Examination (MSE) was conducted on a patient presenting to the hospital in active labor or on the newborn who was delivered while on hospital premises and failed to develop and adopt an EMTALA policy to guide staff of their responsibilities. This deficient practice did affect 2 of 2 patients who presented to the ED requiring emergency treatment and did not have a MSE including Patient Identifier (PI) # 1 and PI # 2 and had the potential to affect all patients presenting to this hospitals Emergency Department (ED). Findings include: Physician Procedures Policy # 105 Date reviewed 5/15/2018 1. The on-duty emergency physician shall provide a medical screening examination to all patients presenting. ...	A2406		

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A2406	Continued From page 16 ... 3. The physician providing the medical screening examination shall physically examine the patient and, where necessary to rule out any potential emergency medical condition ... The physician's observations, evaluation of differential diagnoses, testing ordered, and results of all testing shall be recorded in the medical record. 4. Necessary definitive care ... to stabilize the patient's condition shall be rendered in the hospital. ... 1. Review of Hospital B ED Patient Notes dated 3/25/2021 at 8:33 AM revealed PI # 1 stated she began to have labor pains at home at approximately 5:00 AM on 3/25/2021. After attempts to obtain an ambulance for transport were unsuccessful, PI # 1 was taken by family members to Hospital A by private car and arrived at approximately 7:00 AM. PI # 1 stated she notified the staff at Hospital A she was labor and then had a spontaneous delivery of PI # 2 in the car in the hospital parking lot. The MR and documentation of a MSE examination on PI # 1 and PI # 2 was requested on 3/30/2021 at 4:00 PM but could not be provided to the surveyors. Review of the 911 call log and phone recordings revealed PI # 1 called 911 on 3/25/2021 at 6:12 AM requesting an ambulance because she thought she was in labor. The 911 dispatcher informed PI # 1 that no ambulance was available at that time. At 6:44 AM PI # 1 called 911 again to advise the dispatcher to cancel the ambulance. At 7:34 AM the parent of PI # 1 called 911 stating "(his/her) daughter is in labor about to have a baby and they telling her they don't deliver babies	A2406		

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A2406	Continued From page 17 out there and she is about to have the baby. Advised, they (are) at the front and a lady came out saying they don't deliver no babies and then went back in, guess she might come back out, not sure what they going to do." At 7:35 AM an ambulance was dispatched to Hospital A. Review of the Greene County EMS PCR dated 3/25/2021 revealed the ambulance arrived at Hospital A at 7:35 AM. Upon arrival they found a 23 year old female in the passenger seat of her car in the hospital parking lot who stated she started having contractions around 5 AM. The patient pointed to her groin and advised "I already had it". The paramedic documented he/she could visually see a bulge in her groin, patient fully clothed. The clothing was cut from PI # 1 and it was discovered PI # 2 was already delivered from the waist up. Further review of the EMS Event Clinical Presentations revealed the paramedic documented "2 (persons) in blue scrubs were in the parking lot with us, it appeared there was no evidence of care rendered prior to EMS arrival." EMS delivered the fetus and provided care to PI # 1 and Cardiopulmonary Resuscitation (CPR) to PI # 2. EMS transported both patients to Hospital B at 7:53 AM. On 3/31/2021 at 8:00 AM a copy of the Internal Investigation Summary, Event Clinical Presentations dated 3/25/2021 conducted by Greene County EMS was provided to surveyors. Review of the Investigation summary interview with Paramedic revealed "Dr. (Employee Identifier (EI) # 3) approached the side ambulance door appearing nervous and asked (the Paramedic) ...	A2406	A2406 Continued From Page 17 The information on this page has a factual misrepresentation from the surveyor in relation to the physician's appearance when approaching "...the side ambulance door..."and the comment reportedly made to the Paramedic. The mention of the possible appearance of the physician "appearing nervous" has no bearing on the investigation in relation to the provision of care of the patients. When questioned regarding these statements in this report, the physician said he did not address the possibility of an EMTALA violation with the EMS staff person. He stated he did talk with the nurse regarding his concern that the EMS staff person would not bring the patients into the facility for medical screening, care and stabilization.	

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A2406	Continued From page 18 if this could be an EMTALA (Emergency Medical Treatment and Labor Act) violation. Per (Paramedic) the Physician (EI # 3) stated 'should we take them inside? I think this may be an EMTALA violation...Yes, I think this is one.' Paramedic...responded, 'too late for that. They are in my care now'." An interview was conducted on 3/31/21 at 9:40 AM with EI # 3, physician, who stated "I came back and the ambulance people were here. They were doing CPR on the baby. (EI # 8, RN), told me they tried to get the mom out of the car and she refused because she said the baby was in her pants. I told the ambulance people we needed to get them in the hospital because this would be an EMTALA. The ambulance people said they already have the mom and the baby loaded in the ambulance and they were just going to take them." EI # 3 was then asked who treated the patient in the parking lot? EI # 3 stated "EMS was doing CPR on the baby and we were all there but we were waiting on a person to come to help with the mother. I told my nurse (EI # 7), we needed to get them inside. There was myself, the EMS people and the nurses from the hospital." EI # 3 was asked did you or the hospital employees provide any treatment to the patient? EI # 3 stated "no EMS was doing it." In an interview conducted on 4/1/2021 at 3:30 PM, EI # 1, Administrator, and EI # 2, Director of Nurses, confirmed there was no MSE performed on PI # 1 or PI # 2.	A2406	A2406 Continued From Page 18 a. An on-site emergency birthing class will be conducted for all nursing staff and physicians. CNO and Chief of Staff will perform this training. The videos being used can be found at: 5 minute video https://brooksidepress.org/brooksidepress/?page_id=151&cn-reloaded=1 Deliver the placenta https://obgynmorningrounds.com/blog6/skills-lab/obstetrics/delivery/deliver-the-placenta/ Pelvic examination during labor https://brooksidepress.org/brooksidepress/?page_id=285 A copy of the test for this video can be found in Exhibit G. b. All nursing and medical staff will receive EMTALA training. The training videos are in Exhibit F. This video training will be done by all new hires and annually. c. The Emergency Department staff will be in-serviced by CNO regarding the transfer policies and procedures (See Exhibit K). The staff initiated this in-service beginning April 1, 2021. This will be continuous until May 16, 2021.	
A2407	STABILIZING TREATMENT CFR(s): 489.24(d)(1-3) (1) General. Subject to the provisions of	A2407	All results will be reported through the hospital QAPI Program and up to the governing body. CEO will report to the governing body at their standard monthly meeting. Results will be reported to the governing body weekly for two weeks to determine the hospital is making progress with compliance. With noted compliance, reporting will be done monthly.	

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A2407	Continued From page 19 paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either- (i) within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition. (ii) For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section. (2) Exception: Application to inpatients. (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual (ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment. (iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation. (3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual	A2407	A2407 STABILIZING TREATMENT CFR(s): 489.24(d)(1-3) The information on this page has a factual misrepresentation from the surveyor in relation to the physician's appearance when approaching "...the side ambulance door..."and the comment reportedly made to the Paramedic. The mention of the possible appearance of the physician "appearing nervous" has no bearing on the investigation in relation to the provision of care of the patients. When questioned regarding these statements in this report, the physician said he did not address the possibility of an EMTALA violation with the EMS staff person. He stated he did talk with the nurse regarding his concern that the EMS staff person would not bring the patients into the facility for medical screening, care and stabilization. a. All nursing and medical staff will receive EMTALA training. The training videos are in Exhibit F. This video training will be done by all new hires and annually. b. 100% of all emergency department charts will be reviewed daily for two weeks or until 90% compliance reached then 50% weekly until 100% compliance reached. (See Exhibit D) All results will be reported through the hospital QAPI Program and up to the governing body. CEO will report to the governing body at their standard monthly meeting. Results will be reported to the governing body weekly for two weeks to determine the hospital is making progress with compliance. With noted compliance, reporting will be done monthly.	5-16-21

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A2407	Continued From page 20 of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both. This STANDARD is not met as evidenced by: Based on review of the facility policies and procedure, Hospital B Medical Records, EMS (Emergency Medical Services) Patient Care Reports (PCR), EMS Event Clinic Presentations, and staff interviews, it was determined Greene County Hospital (Hospital A) failed to ensure Stabilizing treatment was performed on a patient presenting to the hospital in active labor or on the newborn who was delivered while on hospital premises. This deficient practice affected 2 of 2 patients who did not received stabilizing treatment prior to transfer to another facility including Patient Identifier (PI) # 1 and PI # 2 and had the potential to affect all patients presenting to this hospitals Emergency Department (ED). Findings include: Physician Procedures Policy # 105 Date reviewed 5/15/2018	A2407		

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A2407	Continued From page 21 1. The on-duty emergency physician shall provide a medical screening examination to all patients presenting. ... ... 3. The physician providing the medical screening examination shall physically examine the patient and, where necessary to rule out any potential emergency medical condition ... The physician's observations, evaluation of differential diagnoses, testing ordered, and results of all testing shall be recorded in the medical record. 4. Necessary definitive care ... to stabilize the patient's condition shall be rendered in the hospital. ... Nursing ER Responsibility Policy # 125 Reviewed 5/15/2018 The nurse is responsible for the following actions for each patient who presents to the ER. 1. For the patient requiring assistance with airway, the nurse will establish and maintain an airway. 2. For those in need the nurse will attempt to establish and support respiratory efforts... 3. For patients requiring a venous access, the nurse will establish and maintain this access... 4. The nurse will remove all clothing and visually examine each patient. Clothing may be cut away if necessary to allow visualization... 5. Measure vital signs and repeat as necessary...	A2407		

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A2407	Continued From page 22 6. Obtain adequate history from patient, family, ambulance attendants, friends... 7. Provide emotional support to patient and family or friends. Protocol: Obstetrical Conditions Policy # 131 Reviewed 5/15/2018 Patients admitted to the Emergency Room will have a complete set of Vital Signs taken by a member of the nursing staff. The nurse will make an assessment of the patient and will inform the physician of the patient's condition. Someone will remain with the patient at all time. ... 1. Obtain OB (Obstetrical) history and report to the Physician 2. Patient's chief complaint. 3. Estimated date of delivery. 4. Vital signs and Fetal Heart Rate. 5. Fundal Height and date of delivery according to pregnancy calculator wheel. 6. Onset, duration, frequency, and location of pain. 7. Symptoms associated with pain. 8. Status of membranes, intact, ruptured, or leaking. 9. Presence or absence of vaginal discharge.	A2407		

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A2407	Continued From page 23 10. Judgement regarding presence of or progress of active labor. Note: the patient may be placed on the fetal monitor to determine the presence or absence of uterine contractions. 1. Review of Hospital B ED Patient Notes dated 3/25/2021 at 8:33 AM revealed PI # 1 stated she began to have labor pains at home at approximately 5:00 AM on 3/25/2021. After attempts to obtain an ambulance for transport were unsuccessful, PI # 1 was taken by family members to Hospital A by private car and arrived at approximately 7:00 AM. PI # 1 stated she notified the staff at Hospital A she was labor and then had a spontaneous delivery of PI # 2 in the car in the hospital parking lot. The MR of PI # 1 and PI # 2 including documentation of stabilizing treatment was requested on 3/30/2021 at 4:00 PM from Employee Identifier (EI) # 2 Director of Nurses, but could not be provided to surveyors. Review of the Greene County EMS PCR dated 3/25/2021 revealed the ambulance arrived at Hospital A at 7:35 AM. Upon arrival they found a 23 year old female who stated she started having contractions around 5 AM. The patient was in the passenger seat of a car in the hospital parking lot. The patient pointed to her groin and advised "I already had it". The paramedic documented he/she could visually see a bulge in her groin, patient fully clothed. The clothing was cut from PI # 1 and it was discovered PI # 2 was already delivered from the waist up. Further review of the EMS Event Clinical	A2407		

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A2407	Continued From page 24 Presentations dated 3/25/2021 revealed the paramedic documented "2 (persons) in blue scrubs are in the parking lot with us, it appeared there was no evidence of care rendered prior to EMS arrival." EMS delivered the fetus and provided care to PI # 1 and Cardiopulmonary Resuscitation (CPR) to PI # 2. EMS transported both patients to Hospital B at 7:54 AM. An interview was conducted on 3/30/21 at 4:56 PM with EI # 4, physician, who stated during the interview if a "patient is on campus we are responsible for them." EI # 4 stated, "We are supposed to do a medical screening. (EI # 3, physician) said he told them to bring the mom and baby into the hospital but I guess they didn't." An interview was conducted on 3/31/21 at 9:40 AM with EI # 3, physician, was asked the question who treated the patient in the parking lot? EI # 3 responded stating "EMS was doing CPR on the baby and we were all there but we were waiting on a person to come to help with the mother." EI # 3 was then asked did you or the hospital employees provide any treatment to the patient? EI # 3 responded by stating "no EMS was doing it." An interview was conducted on 3/31/21 at 10:47 AM with EI # 8, Registered Nurse, (RN) was asked what do you do if a pregnant patient comes in requesting treatment? EI # 8 responded by stating "I have not had that happen until last week. A (person) came in and said a lady was having a baby. I called (EI # 4) and I told him and called 911. There were only 2 nurses here myself and EI # 7. I called 911 for assistance to help get	A2407		

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A2407	Continued From page 25 the patient out of the car. This happened between 7:25 AM and 7:35 AM. I went out to the car and the lady said she could not get up because she had the baby and it was in her pants." EI # 8 then stated "I went outside and asked the patient her name and age and if this was her first baby and she said no it was her second one. I told her to get into the wheelchair and she said she could not that the baby was in her pants already. I only touched the patients skin I did not do vital signs. I did feel the area and the baby was in her pants. I did not assess the baby because the baby was in her pants." EI # 8 further stated "the ambulance arrived and they opened the car door and cut the pants off the patient. I saw the baby was blue. The other ambulance person was in the back of the ambulance getting the supplies that were needed. They suctioned the baby and started CPR on the baby. EI # 7 came around with a blanket and the ambulance person put the baby in the blanket. The other ambulance person was with the mother. He cut and clamped the umbilical cord." EI # 8 was asked was the mother and baby brought into the hospital? EI # 8 responded stating "no. I was told EMS would not bring them in. The other EMS person and myself got the mom on the stretcher." EI # 8 was asked how would you assist to get a patent out of a vehicle? EI # 8 stated "I would use a stretcher or a wheelchair and use who ever is available to help get the person out. We took a wheelchair out there but the patient refused to get up because the baby was in her pants. I called 911 to get some help to get her out of the car that's it I did not call them to take her anywhere. Also, the (parent) of the patient was there and the	A2407		

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A2407	Continued From page 26 patient was alert and oriented and her skin was warm and dry." An interview was conducted on 3/31/21 at 2:30 PM with EI # 9, RN. During the interview EI # 9 was asked are you familiar with the incident on 3/25/21? EI # 9 stated yes. EI # 9 was then asked how were you involved? EI # 9 replied "I was one of the day shift nurses. I got here about 7:49 AM that day. I had trouble getting here. Two nurses (EI # 7) and (EI # 8) and (EI # 3, physician) were here. (EI # 3) and (EI # 7) were at the ambulance. (EI # 8) was with the mother. I went out and the EMT had the baby and was using an ambu bag. (EI # 8) was assessing for bleeding. I did not do anything. They were trying to load the mom in the ambulance. Then (another) EMT arrived and then they got the mom in the ambulance." An interview was conducted on 3/31/21 at 3:35 PM with EI # 7, RN, and was asked what do you do if a pregnant patient comes in requested treatment? EI # 7 replied by stating "we bring them in and stabilize them." EI # 7 was then asked are you familiar with the incident on 3/25/21? EI # 7 stated "yes, that was a few days ago. My shift was over and me and EI # 8 were giving report. I noticed there was a lot going on so I kind of tuned in to that. An employee was leaning on the counter and I asked her what was going on. She said a (person) said a woman was out in the car having a baby." EI # 7 also stated "I went and got a wheelchair and the man knocked on the door and I asked him when her water broke. He said 5:00 AM. He said he did not know why 911 did not come. I told him the other nurse is on the phone now with the doctor and we would be to the car in a minute."	A2407		

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A2407	Continued From page 27 Did you have any patient contact? "When I returned with the wheelchair one of the 911 people was inside the car with the baby. The mother was in the passenger side and the baby was on her lap. The first 911 person was suctioning the baby's nose and mouth. The second 911 person was ready to assist. I looked over and the back of the stretcher had sheets and a blanket. I folded the blanket to catch the baby. I then saw (EI # 3, physician), walk up to the ambulance. I saw the 911 person had put the 2 clamps on the cord and cut the cord. I handed him the blanket and he placed the baby in the blanket and placed the baby on the stretcher. I was rubbing the baby's leg trying to stimulate the baby." EI # 7 was asked did you assess any part of the baby? "The baby was not breathing and was cold. I asked (EI # 8) if we had a baby ambu bag and the second 911 person went and got one out of the ambulance. The first 911 person started bagging the baby. I told (him/her) I could do the bagging so (he/she) let me. The second 911 person added oxygen on the ambu bag. It was obvious the baby was not breathing and had no heartbeat. I would say by the time EMS finished suctioning it had been 2-3 minutes. I said the baby was cold so one of the 911 people said we needed to take the baby to the ambulance. I offered to take the baby into the hospital but one of the 911 people said they have the baby in the ambulance already. When they were trying to get the mom on the stretcher she wouldn't move and I realized she had nothing on from the waist down so I shielded her with a sheet." EI # 7 was asked if CPR (Cardiopulmonary Resuscitation) started on the baby? EI # 7 stated	A2407		

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A2407	Continued From page 28 "CPR was started on the baby after we got mom on the stretcher. The second 911 person started compressions as he was walking toward the ambulance. I went to the ambulance and asked if I could help and he said no I got this." In an interview conducted on 4/1/2021 at 3:30 PM, EI # 1, Administrator, and EI # 2 confirmed no stabilizing treatment was performed by hospital staff for PI # 1 or PI # 2.	A2407	A2409 APPROPRIATE TRANSFER CFR(s): 489.24(e)(1)-(2) a. All nursing and medical staff will receive EMTALA training. The training videos are in Exhibit F. This video training will be done by all new hires and annually. b. An on-site emergency birthing class will be conducted for all nursing staff and physicians. CNO and Chief of Staff will perform this training. The videos being used can be found at:	5/16/21
A2409	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,	A2409	5 minute video https://brooksidepress.org/brooksidepress/?page_id=151&cn-reloaded=1 Deliver the placenta https://obgynmorningrounds.com/blog6/skills-lab/obstetrics/delivery/deliver-the-placenta/ Pelvic examination during labor https://brooksidepress.org/brooksidepress/?page_id=285 A copy of the test for this video can be found in Exhibit G. c. Staff to be in-serviced on proper transfer and stabilization of patient prior to transfer. CNO will perform this training. The staff to receive the training are RN's, LPN's, PCT's and Medical Staff. d. 100% of all emergency department charts will be reviewed daily for two weeks or until 90% compliance reached then 50% weekly until 100% compliance reached. (See Exhibit D) All results will be reported through the hospital QAPI Program and up to the governing body. CEO will report to the governing body at their standard monthly meeting. Results will be reported to the governing body weekly for two weeks to determine the hospital is making progress with compliance. With noted compliance, reporting will be done monthly.	5/18/21

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A2409	Continued From page 29 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. (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	A2409		

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A2409	Continued From page 30 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 medically appropriate life support measures during the transfer. This STANDARD is not met as evidenced by: Based on review of the facility policies and procedure, Hospital B Medical Records, EMS (Emergency Medical Services) Patient Care Reports (PCR), 911 call log, and staff interviews, it was determined Greene County Hospital (Hospital A) failed to ensure an appropriate transfer was arranged for a transfer to Hospital B of a patient presenting to the hospital in active labor or on the newborn who was delivered while on hospital premises including: 1. No order for the transfer from the physician 2. No transfer form completed 3. No agreement from the patient authorizing the transfer	A2409		

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A2409	Continued From page 33	A2409		

already had it". The paramedic documented he/she could visually see a bulge in her groin, patient fully clothed. The clothing was cut from PI # 1 and it was discovered PI # 2 was already delivered from the waist up.

Further review of the EMS Event Clinical Presentations dated 3/25/2021 revealed the paramedic documented "2 females in blue scrubs are in the parking lot with us, it appeared there was no evidence of care rendered prior to EMS arrival."

EMS delivered the fetus and provided care to PI # 1 and Cardiopulmonary Resuscitation (CPR) to PI # 2. EMS transported both patients to Hospital B at 7:54 AM.

An interview was conducted on 3/31/21 at 9:40 AM with EI # 3, physician, who was asked the following questions. Can you tell me what you understand about the EMTALA (Emergency Medical Treatment and Labor Act) laws? EI # 3 responded by stating "its about medical transfer and Labor Act. We have to treat anyone who comes to the hospital with no questions asked. We show no discrimination at all." Can you tell me what kind of EMTALA training you have had here? EI # 3 replied "I have not had any training here at this hospital."

EI # 3 was then was asked how are you notified of a patient requiring Emergency Treatment? EI # 3 stated "they call me after the nurse triages the patient. If the patient is severe they call me right away." How long does it take you to get to the hospital? "It does not take me long." For after hours do you stay in the house across the street from the hospital? EI # 3 stated "yes". EI # 3 was

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A2409	Continued From page 32 medical record. C. There should be an agreement from the patient or significant other authorizing the physician to seek and carry out the transfer... D. Copies of all treatments, procedures, medications, and other pertinent information should accompany the patient to the accepting facility. E. Services performed in the department...should also accompany the patient. 1. Review of Hospital B Emergency Department (ED) Patient Notes dated 3/25/2021 at 8:33 AM revealed PI # 1 stated she began to have labor pains at home at approximately 5:00 AM on 3/25/2021. After attempts to obtain an ambulance for transport were unsuccessful, PI # 1 was taken by family members to Hospital A by private car and arrived at approximately 7:00 AM. PI # 1 stated she notified the staff at Hospital A she was labor and then had a spontaneous delivery of PI # 2 in the car in the hospital parking lot. A copy of the Medical Record of PI # 1 and PI # 2 was requested from Employee Identifier (EI) # 2, Director of Nurses, on 3/30/2021 at 4:00 PM but no MR or documentation the transfer was arranged by Hospital A could be provided. Review of the Greene County EMS PCR dated 3/25/2021 revealed the ambulance arrived at Hospital A at 7:35 AM. Upon arrival they found a 23 year old female who stated she started having contractions around 5 AM. The patient was in the passenger seat of a car in the hospital parking lot. The patient pointed to her groin and advised "I	A2409		

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A2409	Continued From page 34 asked does the hospital own the property? He/she responded by stating "yes". When asked what do you do if a pregnant patient comes in requested treatment? EI # 3 stated "depending on how far along she is. We do not deliver the baby. I see what is going on by assessing the situation, I do a medical screening first. I then contact an OB (Obstetrical) physician and usually transfer the patient." EI # 3 was then asked have you ever had any pregnant patients present for emergency care? EI # 3 stated "yes, and the last time was last week." EI # 3 continued by stating"my shift was over and (EI # 4. physician) called and asked me to see the patient. I came back and the ambulance people were here. They were doing CPR on the baby. (EI # 8. Registered Nurse (RN) told me they tried to get the mom out of the car and she refused because she said the baby was in her pants. I told the ambulance people we needed to get them in the hospital because this would be an EMTALA. The ambulance people said they already have the mom and the baby loaded in the ambulance and they were just going to take them." The following question was asked of EI # 3, who treated the patient in the parking lot? EI # 3 replied "EMS was doing CPR on the baby and we were all there, but we were waiting on a person to come to help with the mother. I told my nurse (EI # 7, RN), we needed to get them inside. There was myself, the EMS people and the nurses from the hospital." The surveyor then asked did you or the hospital employees provide any treatment to the patient? EI # 3 stated "no EMS was doing it. Ambulance people said they were transferring to	A2409		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HOSPITAL	509 WILSON AVENUE EUTAW, AL 35462

(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
A2409	Continued From page 31 4. No agreement from the accepting Hospital B 5. No medical records of the patients sent with transfer This deficient practice affected 2 of 8 records reviewed of patients transferred to another facility including Patient Identifier (PI) # 1, PI # 2, and had the potential to affect all patients presenting to this hospital. Findings include: Transferring a Patient Policy # 103 Date reviewed: 5/15/2018 A patient can be transferred only by order from the physician and only after that patient has been properly evaluated and has been deemed stable for transfer, or when following the proper evaluation, the physician feels that the risk of transferring the patient outweigh the risk of keeping the patient in the facility. Arrangements for transfer must be made between the transferring physician and the accepting physician. Also there must be an agreement from the facility to which the patient is transferring to accept the patient. The appropriate department must be notified and given pertinent information such as vital signs, patient condition, medication or treatments that the patient has received, mode of transport and time of departure. A. An order for transfer must be documented in the medical record. B. A complete transfer form must accompany the patient and a copy must remain with the patient's	A2409		

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A2409	Continued From page 35 Tuscaloosa.) EI # 3 was asked so, was the transfer arranged by you/hospital? His/her response was (no). The surveyor then asked was a report called to Tuscaloosa? EI # 3 responded by stating "yes, the nurse called to tell them what happened at 7:37 AM and she made the call at 7:50 AM. (EI # 8) called Tuscaloosa to inform what had happened." EI # 3 was asked if this was documented somewhere and EI # 3 stated "I told her to make a note and I think she did I am not sure." The surveyor then asked EI # 3 if any other patients deliver here and he/she responded by stating "about a month to a month and a half ago EMS brought a patient here. The baby was cyanotic. We stabilized both the mother and the baby and then we transferred both of them." During the interview EI # 3 was asked the question were you on diversion during these incidents. EI # 3 replied by stating "we usually only have one nurse and we try not to divert. If we do it's usually only a few hours during the night time. Day time we are ok its night time that we divert. I think last week there was only one nurse on days and I think we were on diversion." EI # 3 was asked when you go on diversion its is due to staffing or bed availability. EI # 3 stated "its always because of staffing." The surveyor then asked do you have a record of when you were on diversion and EI # 3 stated "not to my knowledge but I will check." EI # 3 was then asked by the surveyor do you have a policy to follow for diversion? EI # 3 stated "no, we do not." The surveyor asked EI # 3 for clarification and asked so, if you only have one nurse you go on	A2409		

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A2409	Continued From page 36 diversion and EI # 3 replied "yes". The surveyor asked where is it documented? EI # 3 stated "I am not sure I will check." Who do you notify you are on diversion? EI # 3 stated "we call 911". A copy of the Diversion Policy was requested from EI # 2, Director of Nurses on 4/1/2021 at 2:00 PM. EI # 2 stated the hospital did not have a policy for diversion. EI # 2 stated if they only have one nurse on duty they will notify 911 they are on diversion. In an interview conducted on 4/1/2021 at 3:30 PM, EI # 1, Administrator, and EI # 2, Director of Nurses, confirmed the transfer of PI # 1 and PI # 2 was not arranged by hospital staff.	A2409		