Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 420067	**(X3) Date Survey Completed** 03/26/2025
Name of Provider or Supplier Beaufort County Memorial Hospital	**Street Address, City, State** 955 Ribaut Rd, Beaufort, SC	

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	22198 An onsite Emergency Medical Treatment and Labor Act (EMTALA) Complaint survey was conducted at Beaufort County Memorial Hospital from 03/24 /25 to 03/26/25 for complaint SC00060744. The facility was found to be out of compliance with EMTALA law respective to 42 CFR 489.24 and the related requirements at 42 CFR 489.20. Complaint SC00060744 was substantiated with citations cited at A2400 (compliance with EMTALA law) and A2406 (Medical Screening Exam) related to the complaint. The hospital was certified for 201 in-patient beds. The average daily census 116. The hospital census upon entrance was 125.
A2400	22198 Based on Emergency Department (ED) medical record reviews, interviews, ED staffing, Emergency Medical Treatment and Labor Act (EMTALA) policy review, and staff's EMTALA education and competency, the hospital: 1. Failed to provide an appropriate medical screening examination (MSE) for one (1) of five obstetric (OB) patients (P) seeking emergency medical care and treatment (P1). 2. Failed to ensure that all staff working in the ED and Birthing Center (OB) had the same EMTALA training provided to the ED staff for four of four OB staff (OB Labor and Delivery (L&D) Registered Nurse (RN) 11, OB Nursery RN12, and OB Unit Secretary (US) 13 and one of one ED Security Officer (SO) 14) staff personnel files reviewed in a total sample of seven ED or OB personnel assigned on 03/11/25. 3 Failed to follow hospital ED staffing protocols for ensuring the ED had an ED Triage RN in the lobby on 03/11/25 for anyone presenting to seeking emergency medical care or treatment. Findings include: 1. The hospital failed to provide an appropriate medical screening exam for one (1) of five obstetric patients (P) out of a total sample of 20 patients reviewed (P1). Cross Reference: A2406 Appropriate Medical Screening Examination. 2. Review of the hospital wide annual EMTALA training revealed the four-page training had basic EMTALA information for all hospital staff to understand that no one seeking emergency medical treatment could be turned away from the hospital. Review of the ED additional EMTALA training required annually for ED was a YouTube video located at https://www.youtube.com/watch?v=BR49J7kt4sU, required

annually for ED staff provided education on the money penalties related to EMTALA violations, and how EMTALA was an insurance policy for anyone seeking emergency medical treatment. The training lacked EMTALA definitions, and the EMTALA requirements for policies and procedures, requirements for sign posting, medical record requirements, mandatory reporting requirements for potential EMTALA violations, the physician on-call requirements, the EMTALA MSE (Medical Screening Exam) and stabilizing treatment requirements, the ED responsibility to not delay an examination or treatment to inquire about insurance or payment status, the hospital ED's responsibility for ED transfers and what an appropriate transfer requires. The training failed to address the whistleblower protections of staff reporting EMTALA violations or the recipient hospital's responsibilities. During an interview of 03/25/25 at 11:28 AM, the ED Manager 3 confirmed the hospital wide annual training was for the hospital as a whole, it was for all hospital staff to understand basic EMTALA requirements that no one can be turned away no matter where they present on the hospital property. The ED Manager 3 stated their "Relias" EMTALA training was a YouTube video found at https://www.youtube.com/watch?v=BR49J7kt4sU, provided annually to the ED staff as their additional ED specific EMTALA training. ED Manager 3 confirmed the YouTube video for EMTALA specific training lack EMTALA requirements for a hospital's ED's responsibilities for an MSE to anyone who comes to the emergency department or hospital property seeking emergency medical treatment, prohibiting the hospital's ED from refusing to provide and MSE or treat individuals with an emergency medical condition (EMC). The ED Manager 3 provided one additional EMTALA training that was provided only to the ED staff in June of 2024 by the hospital Quality and Compliance Leadership. Review of the in-person EMTALA education provided to the ED staff only in June 2024 revealed the training was 8 pages that included 11 slides related to EMTALA law, that included, a definition, application of EMTALA law, and an explanation of each element of EMTALA law including (but not all inclusive) the definition of an emergency medical condition (EMC), stabilizing treatment within the capability and capacity of the hospital, transfers and that the hospital must provide an appropriate medical screening exam to rule in or rule out an EMC. During an interview on 03/25/25 at 8:25 AM, the ED Security Officer (SO) 14 was asked about the incident that occurred on 03/11/25. ED SO14, when asked about EMTALA training he/she received stated the ED SO's do not receive EMTALA training that he/she knew about. When asked what he/she knew about EMTALA training, ED SO14 stated, "I don't know." During an interview on 03/25/25 at 11:28 AM, ED Manager 3 confirmed that the in-person training provided by the Quality Risk and Compliance Department was good, but it was a one time in-person training provided in 2024 to the ED staff only. None of the Birthing Center staff and none of the ED security staff received the in-person EMTALA training. Review of the EMTALA training logs in the employee personnel files revealed the following: SO14 had the annual basic hospital EMTALA training documented as completed 09/20/24. OB L&D RN11 had the annual basic hospital EMTALA training documented as completed 09/03/24. OB Nursery RN12 had the annual basic hospital EMTALA training documented as completed 09/03/24. OB US13 had the annual basic hospital EMTALA training documented as completed 10 /01/24. During an interview on 03/25/25 at 3:30 PM after the review of personnel files Human Resource (HR) Manager, Education Director, HR Vice President, ED Manager and Birthing Center Manager, confirmed the OB L&D RN11, the OB Nursery RN12, the OB US13 and ED SO14 did not have the EMTALA training received by the ED staff in June of 2024, related to their roles in for providing care and services in the ED and OB for anyone seeking emergency medical care or treatment. 3. Review of the "ER Daily Staffing Assignments" protocol (not dated) revealed there should be one Triage RN [identified as "Point"] initial point of contact

	in the ED on duty 24 hours a day, seven days a week. Review of the staffing schedule for 03/11/25 revealed there was no "Point" (Triage RN) assigned for 03/11/25, the day P1 presented to the ED after his/her water broke and was sent by an unlicensed staff to the OB department without calling the Charge RN to ensure it was safe for P1 to travel by car to the OB unit, without any time of visual examination as to P1's condition. During an interview on 03/24/25 at 11:28 AM the ED Manager 3 confirmed they do not have an ED staffing policy, but the procedure was built into the staffing assignment sheet (a blank copy provided). The assignment sheet was approved by the hospital based on the ED census and number of bays and beds. The ED Managers confirmed that there was no Triage RN on the assignment sheet on 03 /11/25 stating they had a lot of patients in the ED waiting on inpatient bed assignments. ED Manager 3 confirmed that Patient Care Technician (PCT) 9 should have at minimum called back to the Charge RN to ask for assistance. ED Manager 3 stated the PCT 9 should never have been put in that situation [being left in the registration triage lobby area alone without licensed nursing staff]. Review of the hospital's policy for Triage titled "Triage Procedure for the Emergency Department" last revised 07/2018 revealed, the triage policy did not include a defined obstetric triage process based on a nationally accepted standard of practice for triaging OB patients seeking emergency care and treatment, that would include a systematic approach and scoring tool to improve the process of emergency triage and outcomes factoring in social determinants of health, health equity, and implicit bias. Review of the hospital's policy titled "OB Emergencies" last revised 03/2022 revealed the OB Emergency policy did not include a defined obstetric triage process based on a nationally accepted standard for triaging OB patients seeking emergency care and treatment, that would include a systematic approach and scoring tool to improve the process of emergency triage and outcomes factoring in social determinants of health, health equity, and implicit bias.
A2406	22198 Based on interviews, medical record review, and policy review, the hospital's emergency department (ED) failed to provide an appropriate medical screening examination (MSE) when it failed to follow their ED policies for triage and assessment for any individual seeking emergency medical care for one of five ED obstetric (OB) patients (P) seeking emergency medical treatment (P1), The failure to triage and assess P1 seeking emergency medical care delayed the emergency care and treatment that P1 should have had and because P1 was not assessed prior to being sent to the OB unit resulted in P1 delivering a baby in the parking lot between the Surgery Center and the Birthing Center. The failure for the OB to have a SOP for assessment and triage of emergency care for the OB patients seeking emergency medical treatment places all patients that either go directly to the OB or are sent to OB through the ED being pregnant 20 weeks or greater. Findings include: 1. During a telephone interview on 03/25/25 at 8:05 AM, P1 confirmed that on 03/11/25 P1 and his/her significant other came to the hospital's ED seeking emergency services, stating his/her water broke turning into the hospital drive and P1 felt pressure and felt the baby's head coming out. P1 stated his/her significant other went into the ED while P1 waited in the vehicle. The significant other returned to the vehicle stating the ED staff told P1's significant other to go to the Birthing Center and pointed out the direction they should go. P1 confirmed no one from the ED came to talk to him/her or evaluate the situation to determine it was safe for P1 to leave the ED and travel to the Birthing Center. P1 stated when they got to the circle drive, P1's significant other did not where to go because the signage was for both the Birthing Center and the Surgical Center and there was a lot of construction going on, so sections of roads were closed. P1 stated his/her significant other went into the Surgical Center, whose staff assisted P1's significant other to the Birthing Center to get help for P1. P1 confirmed that he/she

delivered a baby boy in the car alone and without the assistants of staff. P1 stated that he/she placed the baby on his/her chest before staff arrived to assist. Review of the video footage from 03/11/25 between 7:40 AM and 7:43 AM revealed the following: First view was an outside view of the ED entrance where a red jeep type vehicle pulls up and a man rushed into the ED. A view of the vehicle's passenger side at 7:42 AM a person can be seen reclined in the front passenger seat bare legs are on the vehicle dashboard with legs separated (knees out). At 7:42 AM the male returns to the vehicle and speeds off. During an interview on 03/24/25 at 12:00 PM the ED Manager (3) confirmed P1 was visible on the cameras with P1's feet on the dash in birthing position. During an interview on 03/24/25 at 12:04 PM, the ED Patient Care Technician (PCT) 9 confirmed he/she was on duty Tuesday 03/11/25 when this incident occurred. PCT 9 stated "I was the only tech in the [ED] lobby" the ED registration area. PCT 9 stated there is/was a lot of construction going on the ED staff direct route to the ED is now walled off and I thought it would be faster to the male who brought P1 to just drive him/her over to the Birthing Center. PCT 9 stated a male entered the ED with a red vehicle and stated, "can I get a wheelchair my wife's [P1] water broke." I thought the best way to send them directly to L&D [labor and delivery]. PCT 9 confirmed there was no Triage Registered Nurse (RN) assigned to the ED lobby [identified as the Point Desk] registration. PCT 9 stated in hindsight, "I should never have done that" referring to sending P1 by car to the birthing center without assessing the safety of the situation. PCT 9 stated when we do not have a Triage RN at the desk, we are supposed to call back to the ED Charge RN, when emergencies come into the ED. When asked if PCT 9 called the Charge RN on 03/11 /25 when P1 was in the vehicle in labor, confirmed "I did not." PCT 9 stated when he /she recognizes an emergency I would "take them immediately back to the ED." ED PCT 9 confirmed "Yes, I should have gone out to assess the situation." The "Point" desk where patients are registered has a direct view through the entrance glass doors. PCT 9 denied seeing P1 in the vehicle in a birthing position. During an interview on 03 /25/25 at 8:25 AM, the ED Security Officer (SO) 14 was asked about the incident that occurred on 03/11/25. ED SO14 confirmed he/she was the SO on duty 03/11/25 in the ED "my wife's [P1] water just broke" then [name] (PCT9) told the male go to the OB unit and pointed in the direction that the male should drive. ED SO14 confirmed there was no Triage RN in the ED Point Desk or Triage room that day. ED SO14 confirmed no one went out to assess P1 to ensure it was safe for the male to drive P1 out of the ED entrance to the Birthing Center. When asked about EMTALA training he/she received the ED SO14 stated the ED SO's do not receive EMTALA training that he /she knew about. When ED SO14 was asked what he/she knew about EMTALA training, it was stated, I don't know. The ED SO14 denied seeing P1 on camera in the ED entrance reclined in the front passenger seat with his/her legs on the dash. ED SO14 stated he/she did see the "red Jeep" on camera. Review of the hospital's policy titled "Triage Procedure for the Emergency Department" last revised 07/2018 revealed, "To facilitate patient flow by moving patients into a treatment area ASAP [as soon as possible] so that assessment and treatment can begin ... Triage Assessment: Complete triage assessment within the medical record ...Comprehensive assessment: Should be done in a treatment area if at all possible. Should (sic) be chief complaint(s) specific. Should (sic) include more in-depth interview if applicable and full assessment/examination of the patient. Should always include assessment of ALL complaints (for example, here with knee pain after a fall, needs head to toe exam for abrasions ...found some on the elbows). Roles and Process: Point Nurse: Primarily stationed at the reception desk, Point Nurse's role is to "sort" (sick/not sick) and quickly determine [triage] acuity and bed assignment." During an interview at 11:28 AM, ED Manager (3) stated there was no excuse, P1 should have been assisted back to the ED for the triage and MSE. ED Manager (3) confirmed there was no Triage RN

	assigned to the "Point" desk that day and their staffing protocol requires a Triage RN on duty 24/7 for the safety of all patients seeking emergency medical care and treatment. ED Manager (3) confirmed their policy requires all OB patients coming to the ED seeking emergency medical care and treatment were to be transported by hospital staff to the OB unit and confirmed this did not happen for P1. Review of the Hospital policy titled "Admission Assessment of Labor Patient, OB 01.01" last reviewed 10/2024, revealed "Admission to Labor and Delivery: Laboring patients of 20 weeks gestation or greater presenting to any area of the hospital should be transported to Labor and Delivery, where they are to be assessed." Review of the hospital's policy titled " EMTALA Medical Screening Examination (MSE), MS.55" last reviewed and revised 07/2021 revealed "Any person who comes to a hospital facility, requesting assistance for a potential emergency medical condition/emergency services (sic) will receive a medical screening performed by a qualified provider to determine whether an emergency medical condition exists. ... Departments/Locations that conduct medical screening: Emergency Department-triages patient to the most appropriate area within the department based on hospital triage criteria and the patient is seen by the Quality Medical Provider (QMP). Labor and Delivery performs an evaluation and screening for determination of active labor. Comes to the Hospital-all individuals presented on hospital property will be referred to the emergency department for a medical screening examination. ... When is a medical screening examination required? A medical screening examination is required when an individual: Seeks care at the hospital ED. Arrives anywhere on the hospital premises and states that he or she has an emergency. ... Where can the Medical Screening Examination Occur? Medical Screening Examinations may be performed in location other than the Emergency Department. For example, a pregnant woman be moved to the Labor and Delivery Triage for the medical screening. ..." Review of the hospital's policy titled "OB Emergencies" last revised 03/2022 revealed the OB Emergency policy did not include a defined obstetric triage process based on a nationally accepted standard for triaging OB patients seeking emergency care and treatment, that would include a systematic approach and scoring tool to improve the process of emergency triage and outcomes factoring in social determinants of health, health equity, and implicit bias, to ensure that each patient seeking emergency medical care and treatment would be seen in a timely manner to rule in or rule out an EMC. Review of the hospital's policy for Triage titled "Triage Procedure for the Emergency Department" last revised 07/2018 revealed, the triage policy did not include a defined obstetric triage process based on a nationally accepted standard of practice for triaging OB patients seeking emergency care and treatment, that would include a systematic approach and scoring tool to improve the process of emergency triage and outcomes factoring in social determinants of health, health equity, and implicit bias.