EXHIBIT 211
(Rev. 148, Issued: 10-09-15, Effective: 10-09-15, Implementation: 10-09-15)

MODEL LETTER FOR A VIOLATION OF 42 CFR 489.24 AND/OR THE RELATED PROVISIONS OF 42 CFR 489.20 NOTICE OF TERMINATION

(**Date**)

Hospital*/Critical Access Hospital (CAH)* Name
Address
City, State, ZIP Code

Re: CMS Certification Number (CCN)

Dear (**Hospital*/CAH CEO*** **Name**):

In order to participate in the Medicare program, a hospital *or CAH* must meet the requirements established under title XVIII of the Social Security Act (the Act) and must also meet the additional requirements established by the Secretary of Health and Human Services under the authority contained in §1861(e) of the Act. Further, §1866(b) authorizes the Secretary to terminate the provider agreement of a hospital *or CAH* that fails to meet these provisions.

After a careful review of the facts, we have determined that (***facility name***) no longer meets the requirements for participation as a provider of services in Medicare. Our review of the (**date**) survey conducted by the (**State Survey Agency**) indicates that your hospital violated:

(**Select as appropriate**)

•The requirements of 42 CFR 489.24, based on: **(*select all that apply:* failure to screen, treat, appropriately transfer, or accept an individual who required the hospital's specialized capabilities; or delay in examination or treatment*; or imposing* a penalty or adverse action against a physician *or* qualified medical person *for refusal to authorize transfer of an unstabilized individual, or against any* hospital employee *for reporting an EMTALA violation*)**.

•The related anti-dumping provisions of 42 CFR 489.20, based on failure to: ***(select all that apply:*** **have and enforce policies to ensure compliance with the requirements of §1867 of the Act, maintain transfer records, maintain an on-call list of physicians, maintain a central emergency services log, report *receipt of an inappropriate transfer,* or meet the *signage* requirements)**.

The deficiencies cited by the (**State Survey Agency**) are listed on the enclosed Form CMS-2567, Statement of Deficiencies and Plan of Correction.

In accordance with 42 CFR 489.53, a hospital *or CAH* that violates the provisions of 42 CFR 489.24 and/or the related provisions of *42 CFR* 489.20 is subject to termination of its provider agreement in accordance with §1866(b) of the Act. Consequently, we are terminating your participation in the Medicare program.

The date on which your agreement terminates is (**date**). The Medicare program will not make payment for hospital services furnished to patients admitted on or after (**termination date**). For patients admitted prior to (**termination date**), payment may continue to be made for up to 30 days for covered inpatient *and, when applicable, skilled nursing facility-level swing bed* services furnished on or after (**termination date**). A list showing the names and health insurance claim numbers of the Medicare patients remaining in your facility on (**day before termination date**) should be forwarded to (**RO contact and address**).

As the requirements for participation in the Medicaid program under 42 CFR 440.10(a)(3)(iii) include meeting Medicare requirements, we *will notify* the appropriate State officials concerning your hospital's violation of 42 CFR 489.20 and/or 42 CFR 489.24.

(**Insert for 42 CFR 489.24 violation:** We are also notifying the Office of Inspector General, which has responsibility for the enforcement of the civil monetary penalties prescribed by §1867 of the Act).

(Insert for referral to OCR: In addition, we are notifying the regional Office of Civil Rights, which may take action under the Hill- Burton Subpart G Community Service regulations at 42 CFR 124.603(b)(1).)

(If this is the first notice after the survey, add the following: *Termination can only be averted by correction of the deficiencies, through submission of an acceptable plan of correction (PoC) and subsequent verification of compliance by (**State Agency)**. The Form CMS 2567 with your POC, dated and signed by your facility's authorized representative must be submitted to **(State Agency)** no later than **(enter date that is 10 calendar days after the date of this notice)**. Please indicate your corrective actions on the right side of the Form CMS-2567 in the column labeled "Provider Plan of Correction", and list the corresponding deficiency number in the column to its left, labeled "ID Prefix Tag". Additionally, indicate your anticipated completion dates in the column labeled "Completion Date".*

An acceptable PoC must contain the following elements:

1. The plan for correcting each specific deficiency cited;

2. The plan for improving the processes that led to the deficiency cited, including how the hospital is addressing improvements in its systems in order to prevent the likelihood of recurrence of the deficient practice;

3. The procedure for implementing the PoC, if found acceptable, for each deficiency cited;

4. A completion date for correction of each deficiency cited;

5. The monitoring and tracking procedures that will be implemented to ensure that the PoC is effective and that the specific deficiency(ies) cited remain corrected and in compliance with the regulatory requirements; and

6. The title of the person(s) responsible for implementing the acceptable PoC.

Copies of the Form CMS-2567, including copies containing the facility's PoC, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 CFR 401.133(a). As such, the PoC should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names. It must, however, be specific as to what corrective action the hospital will take to achieve compliance, as indicated above.

Your facility will be revisited to verify necessary corrections. If CMS determines that the reasons for termination remain, you will be informed in writing, including the effective date of termination. If corrections have been made and your facility is in substantial compliance, the termination procedures will be halted, and you will be notified in writing.)

*If your Medicare agreement is terminated and you wish to be readmitted to the program, you must demonstrate to the (**State agency**) and CMS that you are able to maintain compliance. Readmission to the program will not be approved until CMS is reasonably assured that you are able to sustain compliance.*

If you *disagree with this termination action,* you *or your legal representative* may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 CFR 498.40, et seq. *You must file your hearing request electronically by using the DAB's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov,* no later than sixty (60) days *after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request must also be submitted electronically to:*

INSERT REGIONAL OFFICE CONTACT INFORMATION

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet

service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. *At an appeal hearing,* you may be represented by counsel at your own expense.

If you have any questions *regarding* this *matter,* please contact *the CMS (**insert city**) Regional Office by phone at (**insert phone number**) or by e-mail at (**insert email address**).*

Sincerely,

Associate Regional Administrator/*E*quivalent

Enclosure*s*: Form CMS-2567, Statement of Deficiencies
DAB E-filing Instructions

CC:
State Survey Agency
State Medicaid Agency
OIG (if appropriate)
OCR/FO (if appropriate)
Accredit*ing* Organization