| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 530002 | A. BUILDING _____ B. WING _____ | C 03/05/2026 |

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| CAMPBELL COUNTY MEMORIAL HOSPITAL | 501 SOUTH BURMA AVENUE GILLETTE, WY 82716 |

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| A 000 | INITIAL COMMENTS<br><br>A complaint health survey for compliance with Emergency Medical Treatment and Labor Act (EMTALA) 42 CFR Part 489.20 Basic Section Commitments Relevant to Section 1867 Responsibilities and 42 CFR Part 489.24 Special Responsibilities of Medicare Hospitals in Emergency Cases, was conducted from 03/02/2026 through 03/05/2026. The survey was prompted by complaint intake WY00004586. Based on the findings of the survey team, Campbell County Memorial Hospital was found not in compliance with the following requirements: A-2400, A-2406 and A-2409. | A 000 | Campbell County Health (CCH) self-reported complaint intake WY00004586. CCH will ensure compliance with Emergency Medical Treatment and Labor Act (EMTALA) 42 CFR Part 489.20 Basic Section Commitments Relevant to Section 1867 Responsibilities and 42 CFR Part 489.24 Special Responsibilities of Medicare Hospitals in Emergency Cases. This will be accomplished by performing a medical screening exam (MSE) on all patients presenting to the Emergency Department (ED). | |
| A2400 | COMPLIANCE WITH 489.24<br>CFR(s): 489.20(l)<br><br>[The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24.<br>This STANDARD is not met as evidenced by:<br>Based on medical record review, patient interview, staff interviews, and review of facility policies and procedures, and the emergency department (ED) log, the facility failed to ensure an appropriate medical screening examination was completed for 2 of 20 sample patients (#5, #17). In addition, the facility failed to ensure that a patient was not transferred unless the patient requested the transfer in writing or a physician signed a certification that the medical benefits outweighed the risks for 4 of 4 patients (#6, #8, #9, #10) who had an emergency medical condition and were transferred to another facility.<br>The findings were:<br><br>1. Refer to A-2406 for details on the facility's failure to provide an adequate medical screening examination for patients #5 and #17. | A2400 | The Director and Emergency and Surgical Services for CCH and the Managing Partner of Aligned Providers of Wyoming (APW) will be responsible for implementing and continued compliance with the corrective action plan. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Matthew Shahan
Matthew Shahan (Jul 24, 2026 09:01:14 MDT)

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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| A2400 | Continued From page 1<br><br>2. Refer to A-2409 for details on the facility's failure to ensure a physician signed the transfer certifications for patients #6, #8, #9 and #10. | A2400 | | |
| A2406 | MEDICAL SCREENING EXAM<br>CFR(s): 489.24(a) & 489.24(c)<br><br>(a) Applicability of provisions of this section.<br>(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-<br>(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<br>(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.<br><br>(2)(i) When a waiver has been issued in accordance with section 1135 of the Act that | A2406 | A)<br>Patient #5 has been discharged from the ED at CCH therefore we are unable to impact the care. Going forward, CCH will ensure an MSE is performed on each patient on the premises who is requesting emergency care. This will be accomplished by each licensed emergency medicine (EM) provider completing initial EMTALA education by 8/28/2026 and then annually thereafter. Objective evidence of completion will be achieved through class rosters and/or course completion certificates. Starting August 1, 2026 CCH will audit 100% of charts for patients that have a disposition of left without being seen (LWBS) and left before visit complete (LBVC) for a period of no less than three months, depending on audit results.<br><br>B) Patient #17 has been discharged from the ED at CCH therefore we are unable to impact the care. Going forward, CCH will ensure an MSE is performed on each patient on the premises who is requesting emergency care. This will be accomplished by each licensed emergency medicine (EM) provider completing initial EMTALA education by 8/28/2026 and then annually thereafter. Objective evidence of completion will be achieved through class rosters and/or course completion certificates. Starting August 1, 2026 CCH will audit 100% of charts for patients that have a disposition of left without being seen (LWBS) and left before visit complete (LBVC) for a period of no less than three months, depending on audit results. | Education Completion Date: 8/28/2026<br><br>Audit Completion Date: 10/312026<br><br>Education Completion Date: 8/28/2026<br><br>Audit Completion Date: 10/312026 |

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| A2406 | Continued From page 2<br>includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an 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:<br>(A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.<br>(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.<br>(C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.<br>(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.<br>(E) There has been a determination that a waiver of sanctions is necessary.<br>(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.<br><br>(c) Use of dedicated emergency department for nonemergency services. If an individual comes to a hospital's dedicated emergency department and | A2406 | | |

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| A2406 | Continued From page 3<br>a request is made on his or her behalf for examination or treatment for a medical condition, 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.<br>This STANDARD is not met as evidenced by:<br>Based on medical record review, patient interview, staff interviews, and review of policies and procedures and the emergency department (ED) log, the facility failed to provide an appropriate medical screening examination to determine whether or not an emergency medical condition existed for 2 of 20 sample patients (#5 and #17). The findings were:<br><br>1. Review of the ED log showed patient #5 presented to the ED on 01/16/26 at 7:16 AM with complaint of bug bite to his/her right forehead that became a spreading rash with a headache and right eye twitching. The following concerns were identified:<br>a. Review of the ED provider note by physician #1 at 8:12 AM read "this patient was not seen by this physician due to infection risk, RN (registered nurse) discussed options with patient regarding sending to optometry clinic vs returning when dual coverage is available."<br>b. During an interview conducted on 3/4/26 at 4:14 PM physician #1 stated that the nurse who had roomed the patient suspected the patient had shingles. She was concerned given that she was pregnant and provided options to the patient to wait 2 hours when there would be another physician in the ED to see him/her, that she could contact an optometry clinic to schedule for | A2406 | | |

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| A2406 | Continued From page 4 | A2406 | | |

him/her to be seen or s/he could leave and return at 10 AM. The physician relayed that she planned to discuss these options with the patient from the doorway, but s/he had already left with a plan to return later per the RN. She shared that she discussed the patient with the oncoming physician, but the patient did not return to the ED.

c. Interview with RN #1 on 3/4/26 at 3:24 PM revealed that she served like a go between with the patient and physician. Based on visualization of the rash she suspected shingles and with permission from the patient she took a photo to show the physician. As she (the physician) was pregnant she was hesitant to directly assess the patient. She offered options to call an ophthalmologist, for the patient to stay until 10 AM for dual coverage, to come back at 10 AM or the physician would gown up and stay at the door to assess him/her. The RN conveyed that the patient offered to come back at 10 AM.

d. Interview with the medical director on 3/4/26 at 3:30 PM revealed he became aware of the encounter after the fact but was aware that options including screening from the door, waiting until 10 AM for the dual coverage physician to arrive, leaving and returning at 10 AM or following up with an optometrist were provided and given the acuity seemed appropriate.

e. Interview with the Executive Director of Urgent & Emergent Services and the Director of Emergency & Surgical Services on 3/4/26 at 4:28 PM revealed that they became aware of the encounter and discussed with the medical director as it was clear that a medical screening had not taken place.

f. Interview with patient #5 on 3/5/26 at 8:15 AM revealed s/he was taken back to a room and due to suspicion of shingles the doctor wouldn't see him/her. "They said I could come back later".

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| A2406 | Continued From page 5<br>S/he reported that they were able to see their primary care physician at [Healthcare Agency Name]. They confirmed that s/he had shingles with eye involvement and was prescribed medication and s/he was continuing care at this time for continued symptoms from eye involvement.<br>g. Review of the medical record from [Healthcare Agency Name] revealed that the patient "originally presented to the emergency department on the morning of 1/16/26 for concerns of a facial rash and headache" and "the provider is pregnant and could not see him/her due to [his/her] symptoms being related to shingles."<br><br>2. Review of the ED log showed patient #17 arrived to the ED on 2/4/26 at 9:36 PM for suicidal ideation and revealed s/he left before the visit was complete. Review of the medical record showed the patient medical history was significant for anxiety, bipolar disorder, chronic cannabis use disorder, alcoholism, and depression. The ED triage note revealed that the patient stated s/he will be suicidal tomorrow because of his/her daughter's birthday. The ED provider note revealed that the patient reported experiencing suicidal thoughts and when physician #2 asked about why s/he was suicidal the patient stated "it has been a long week. You guys are busy, I'm going to leave." The medical record also noted that the patient was intoxicated appearing and had frequent visits to the emergency department for similar complaints. Furthermore, it was documented that "there was no reason to title [place on an involuntary hold] him/her at this time." The following concerns were identified:<br>a. Further review of the medical record showed no medical screening exam (MSE) or | A2406 | | |

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| A2406 | Continued From page 6 | A2406 | | |

behavior health assessment was completed after the patient verbalized suicidal ideation. In addition, it was documented that the patient appeared intoxicated, but a MSE including labs was not completed.

b. During an interview with physician #2 on 3/5/26 at 8:30 AM the physician explained that for patients presenting to the ED for suicidal ideation (SI) that routine care included talking with the patient to determine what they were thinking, if they had a plan in place, obtaining a medical history, and labs would be ordered including a urinalysis for possible substance abuse. The provider could involve a crisis counselor or the psychiatric team. If in addition to SI the patient appeared intoxicated, that care would include having to wait until the patient was no longer intoxicated, in order to be evaluated by the mental health consultant. Regarding patient #17 physician #2 remembered he saw the patient in the chairs by triage and that in less than 5 seconds the patient had started to exit. The patient indicated thinking suicidal things and was moderately intoxicated. The physician described moderately intoxicated as s/he was slurring words, but gait was stable and s/he seemed frustrated. The physician indicated that the patient had been in the ED multiple times in the past and in previous stays would verbalize SI but as s/he sobered they would then deny SI and choose to leave (discharge). The physician stated this patient had a history of sobering and improving, he didn't have reason to stop the patient from leaving and verbally provided return precautions.

c. Review of the medical record showed patient #17 returned to the ED on 2/5/26 at 8:43 AM intoxicated and expressing SI. Labs were drawn and the ethanol blood test was 132 mg/dl

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| A2406 | Continued From page 7<br>[legal limit for intoxication 80mg/dl]. The patient was evaluated by psychiatry for crisis encounter of suicidal thoughts with preparation behaviors. During the initial evaluation the patient was intoxicated, so s/he was re-evaluated again when clinically sober. When sober the patient was no longer suicidal, but reported that if s/he left s/he would not be able to stop from drinking and the suicidal thoughts would likely return. Voluntary admission to inpatient psych was initiated as the patient was medically cleared.<br>d. Review of the policy "Suicidal Patients" last revised 12/2025 stated "Individuals experiencing suicidal ideation who do not receive proper care can escalate from suicidal ideation to suicidal acts and even death." It further reads "All patients arriving at the ECD [Emergency Care Department] are triaged, those expressing suicidal ideation or actions necessitate interventions and care to reduce risk of suicide completion...ED physician will evaluate and request consultation, evaluation, admission or refer appropriately to the physician or psychiatrist based on clinical judgement and degree of risk."<br><br>3. Review of the policy "Triage and Medical Screening Exams" last revised 10/2024 revealed "2. All patients presenting to the ECD [Emergency Care Department] must have a Medical Screening Exam (MSE). A medical screening is an examination by a licensed physician or qualified medical professional to determine with reasonable clinical confidence whether an emergency medical condition exists." | A2406 | All EM providers will be assigned to review and acknowledge the Suicidal Patients policy and the Triage and Medical Screening Exam policy in UKG Prolearning by 8/28/2026. Verification of completion will be performed on 9/1/2026. | Policy Review Completion Date: 8/28/2026 |
| A2409 | APPROPRIATE TRANSFER<br>CFR(s): 489.24(e)(1)-(2)<br><br>(1) General | A2409 | | |

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| A2409 | Continued From page 8<br>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 -<br>(i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and<br>(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.<br>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.<br><br>(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, 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<br><br>(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 | A2409 | | |

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| A2409 | Continued From page 9<br>subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.<br><br>(2) A transfer to another medical facility will be appropriate only in those cases in which -<br>(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;<br>(ii) The receiving facility<br>(A) Has available space and qualified personnel for the treatment of the individual; and<br>(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment.<br><br>(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 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 | A2409 | | |

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| A2409 | Continued From page 10<br>(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.<br><br>This STANDARD is not met as evidenced by:<br>Based on medical record review, staff interviews and review of policies and procedures, the facility failed to ensure that a patient was not transferred unless the patient requested the transfer in writing or a physician signed a certification that the medical benefits outweighed the risks for 4 of 4 patients (#6, #8, #9, #10) who had an emergency medical condition and were transferred to another facility. The findings were:<br><br>1. Review of the medical record for patient #6 showed that on 2/8/26 at 6:22 PM the patient was evaluated in the ED for a headache. The medical examination revealed that the patient presented with abnormal mentation (overall mental activity, encompassing thinking, mood, perception, and cognitive function) s/he was sleepy and inattentive and became easily confused. Computed tomography (CT) scan was concerning for subtle area of low attenuation within anterior limb of left internal capsule which may represent ischemia (a critical reduction of blood flow to tissues, causing oxygen starvation and potential tissue death). Transfer was deemed necessary for higher level of care, including consult with neurological services. The following concerns were identified:<br>a. Further review of the medical record showed that the EMTALA transfer certification indicated the document was electronically signed but only indicated a date not identification of the name or role of the person who had signed. | A2409 | A) Patient #6 has been discharged and care cannot be impacted. Since 3/5/2026 CCH has been printing the EMTALA form from Epic and obtaining wet signatures from the patient/ representative and the attending physician. The form with signatures is scanned and uploaded to the patient's medical record. As of 7/22/2026, CCH will utilize its own EMTLA form (not from Epic) with wet signatures of the patient/representative and attending physician. The form will be scanned and uploaded into the patient's medical record once the house supervisor has validated completion and signed the form. CCH will audit 100% of these forms for all patients with a transfer disposition from 8/1/2026 through 10/31/2026. | Audit Completion Date: 10/31/2026 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 530002 | A. BUILDING _____ B. WING _____ | C 03/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CAMPBELL COUNTY MEMORIAL HOSPITAL | 501 SOUTH BURMA AVENUE GILLETTE, WY 82716 |

| (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 |
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| A2409 | Continued From page 11<br>b. During an interview on 3/4/26 at 3:55 PM physician #3 stated that during a transfer the physician was responsible for initiating the EMTALA form in the electronic health record, but was unaware if a physical signature was included.<br><br>2. Review of the medical record showed that on 12/6/25 at 2:32 PM patient #8 arrived for attempted suicide and drug overdose. Medical screening revealed a history of depression and that the patient took around 50 tabs of migraine medication. The patient was nauseated and fidgety with tinnitus (ringing in the ears without an external source). Necessity of transfer was identified for services not offered at the current facility. The following concerns were identified:<br>a. Further review of the medical record showed that the EMTALA transfer certification indicated the document was electronically signed but only indicated a date not identification of the name or role of the person who had signed.<br>b. During an interview on 3/5/26 at 8:57 AM physician #4 stated that on the EMTALA form in the electronic record the physician was responsible for filling out their part and that they accept and submit the entry and it was signed with an electronic signature. However, she had never followed up to verify that a signature was seen on the form.<br><br>3. Review of the medical record showed that on 1/17/26 at 6:42 PM patient #9 arrived to the ED for evaluation of right arm tingling, severe headache and spatial disorientation. CT revealed ischemic (a critical reduction of blood flow to tissues, causing oxygen starvation and potential tissue death) changes. It was determined that the patient needed to be transferred for a magnetic resonance imaging (MRI) (non-invasive | A2409 | B) Patient #8 has been discharged and care cannot be impacted. Since 3/5/2026 CCH has been printing the EMTALA form from Epic and obtaining wet signatures from the patient/ representative and the attending physician. The form with signatures is scanned and uploaded to the patient's medical record. As of 7/22/2026, CCH will utilize its own EMTLA form (not from Epic) with wet signatures of the patient/representative and attending physician. The form will be scanned and uploaded into the patient's medical record once the house supervisor has validated completion and signed the form. CCH will audit 100% of these forms for all patients with a transfer disposition from 8/1/2026 through 10/31/2026.<br><br>C) Patient #9 has been discharged and care cannot be impacted. Since 3/5/2026 CCH has been printing the EMTALA form from Epic and obtaining wet signatures from the patient/ representative and the attending physician. The form with signatures is scanned and uploaded to the patient's medical record. | |

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| A2409 | Continued From page 12<br>diagnostic test creating detailed 3D images of soft tissues, organs and bones) and neurology consult. The following concerns were identified:<br>a. Further review of the medical record showed that the EMTALA transfer certification indicated the document was electronically signed but only indicated a date not identification of the name and role of the individual who had signed.<br>b. During an interview with physician #5 on 3/5/26 at 9:59 AM he reported that an electronic signature was applied to the EMTALA form when he clicked accept on his documentation of the form.<br><br>4. Review of the medical record for patient #10 showed that on 2/26/26 at 5:19 PM the patient had arrived for right sided headache without preceding trauma or fall. Head CT revealed a frontal temporal subdural hematoma (a localized collection of clotted or pooled blood outside blood vessels). It was determined that the patient needed to be transferred for a higher level of care. The following concerns were identified:<br>a. Further review of the medical record showed that the EMTALA transfer certification indicated the document was electronically signed but only indicated a date not identification of the name and role of the individual who had signed.<br>b. Interview with physician #6 on 3/5/26 at 9 AM revealed he documented in the EMTALA transfer form by checking boxes regarding the necessity of the transfer and capabilities of the receiving facility and then it was signed on his end electronically when accepted and saved.<br><br>5. During an interview on 3/4/26 at 4:15 PM RN #2 revealed that for a name to populate on the electronic signature line with the date, a nurse would select the name of the physician from a | A2409 | Continued from page 12<br><br>As of 7/22/2026, CCH will utilize its own EMTLA form (not from Epic) with wet signatures of the patient/representative and attending physician. The form will be scanned and uploaded into the patient's medical record once the house supervisor has validated completion and signed the form.<br>CCH will audit 100% of these forms for all patients with a transfer disposition from 8/1/2026 through 10/31/2026.<br><br>D) Patient #10 has been discharged and care cannot be impacted. Since 3/5/2026 CCH has been printing the EMTALA form from Epic and obtaining wet signatures from the patient/ representative and the attending physician. The form with signatures is scanned and uploaded to the patient's medical record. As of 7/22/2026, CCH will utilize its own EMTLA form (not from Epic) with wet signatures of the patient/representative and attending physician. The form will be scanned and uploaded into the patient's medical record once the house supervisor has validated completion and signed the form.<br>CCH will audit 100% of these forms for all patients with a transfer disposition from 8/1/2026 through 10/31/2026. | |

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| A2409 | Continued From page 13<br>drop-down box. She further clarified that this could be done by either a physician or nurse, but that a nurse was typically the person to "activate" the form for patient signature.<br><br>6. Interview with the medical director on 3/4/26 at 3:30 PM confirmed he was unaware that the physician's name was not appearing where it indicated on the EMTALA transfer certification form. He stated it was electronically signed, but that a "watermark" should be applied under the user login and that he suspected they were "missing a button to click" and that they would be investigating and correcting this issue.<br><br>7. Review of the policy "Transfer of Patients to other facilities/Medical Screening Exam/ EMTALA" last revised 12/25 indicated that "Original COBRA [EMTALA] form signed by the physician and patient...must go with the patient." Additionally, the transfer algorithm included in the policy indicated that the "Nurse ensures that electronic EMTALA form in EPIC [electronic health record] is complete." | A2409 | 7/22/2026 - Director of Emergency and Surgical Services will update the Transfer of Patients to Other Facilities/Medical Screening Exam/EMTALA policy, upload it to Policy Stat, and review with ED staff on 7/22/2026. All EM providers will review and acknowledge the updated policy by 8/28/2026. | Policy Update: 7/22/2026<br><br>Provider Review Date: 8/28/2026 |