VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 9, 2023

Shawn Tester, Administrator
Northeastern Vermont Regional Hospital
1315 Hospital Drive
Saint Johnsbury, VT 05819-9758

Dear Mr. Tester:

The Division of Licensing and Protection completed a re-certification survey at your facility on **May 17, 2023**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC), which was found to be acceptable on **June 9, 2023.**

Sincerely,

Suzanne Leavitt, RN, MS
State Survey Agency Director
Assistant Director, Division of Licensing & Protection

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471303	A. BUILDING _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHEASTERN VERMONT REGIONAL HOSPITAL	1315 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

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C 000	INITIAL COMMENTS An unannounced on-site re-certification survey and staff vaccination requirement review were conducted on 5/15/23 through 5/17/23 by the Division of Licensing and Protection to determine compliance with the Conditions of Participation for Critical Access Hospitals (CAHs) at 42 CFR. Part 485, Subpart F. The following regulatory violations were identified:	C 000	Patricia A. Lamek 6.8.2023	
C 912	CONSTRUCTION CFR(s): 485.623(a) The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of services. This STANDARD is not met as evidenced by: Based on observation and interview the CAH (Critical Access Hospital) failed to ensure the Emergency Department's environment maintained patient safety as evidenced by failing to secure a soiled utility room that contained housekeeping chemicals. Findings include: During a tour of the Emergency Department (ED) on 5/15/23 at approximately 3:00 PM with the Director of Quality and Director of the Emergency Department, a soiled utility room located near Exam Room #1 was noted to be unsecured and easily accessible to unauthorized individuals. The room contained a hopper ("Flushing-rim clinical service sink with a bedpan-rinsing device used for disposal of liquid clinical waste.") where two, one-quart bottles of Clorox bleach were located. Per interview on 5/15/23 at 3:11 PM, the Director of the Emergency Department confirmed that the	C 912	CONSTRUCTION: On the tour of the ED, the Director of Quality/Infection Prevention, and the Director of the Emergency Department, acknowledged that the dirty utility room located near Exam Room #1 was not locked. It was noted that patients and visitors would need to pass within view of the nurse's station, but could access both the dirty utility room and contents. Of concern were the housekeeping chemicals. **Corrective Action:** ✓ Plant management was notified and the chemicals were immediately moved to the ED housekeeping closet which is locked and therefore not accessible to unauthorized personnel ✓ Educational update sent to all ED and EVS staff reminding them that any housekeeping chemicals should be kept in the closet designated for housekeeping (sent 6/8/2023) ✓ Plant management will install a lock on the dirty utility room by 6/30/2023	

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

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C 912	Continued From page 1 soiled utility room door should be locked and that "anyone" could access the contents of the room.	C 912	**Tag C 912 POC accepted on 6/9/23 by T. Dougherty/S. Leavitt**	
C1006	PATIENT CARE POLICIES CFR(s): 485.635(a)(1) (1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on interview and medical record review the CAH failed to ensure care was provided in accordance with written policies and procedures regarding the use of restraints for 1 applicable patient (Patient #2). Findings include: Per review of an ED physician's note from 4/24/23 at 13:26, Patient #2 was brought into the ED by paramedics for alcohol intoxication. S/He was discharged from the ED earlier in the day into the care of his/her family member who took Patient #2 back to his/her apartment. While at his/her apartment, Patient #2 drank hand sanitizer and came back to the ED inebriated and violent. Upon physical exam, Patient #2 had a "disheveled" appearance; speech and movement were "agitated"; mood was "irritable"; and his/her attitude was "belligerent" which required chemical and physical restraints. Per review of a nursing triage note from 4/24/23 at 13:42, it states, "Pt very combative, swearing at and threating to punch security in the face, spitting at "VSP" (State Police), very uncooperative and unable to reason with". Per review of a restraint/seclusion assessment from 4/24/23 at 13:30 it states, "Behavior requiring Restraints/Seclusion ...Harm	C1006	PATIENT CARE POLICIES: Surveyor found no evidence in the record that a licensed independent practitioner evaluated Patient #2 face-to-face after the initiation of restraints, and based on the information reviewed, the restraints for Patient #2 were not terminated at the earliest possible time. **Corrective Action:** ✓ Restraint audits are conducted monthly by the Quality Improvement staff with results reported to department directors. Moving forward the results of the restraint audits will be incorporated into the work of the Safety Management Team, allowing for discussion and identification of improvement opportunities. (to begin with committee meeting 6/22/2023) ✓ Educational review of the Restraint Policy will be an annual requirement for all clinical staff, including providers. ✓ Educational reminder presented as part of ED Committee meeting (6/14/2023) **Tag C1006 POC accepted on 6/9/23 by T. Dougherty/S. Leavitt**	

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C1006	Continued From page 2 to self & others ... Alternatives Attempted ...De-escalation ... Date of initiation: 4/24/23 Time of initiation: 13:30 Actions Taken Related to Restraints/Seclusion ...restraints initiated, MD notified, order obtained, evaluated by MD, medication administered ... Restraint Type ...Neoprene Restraint Placement ...all extremities ... Medication Administered ...Ativan (antianxiety) 2 mg (milligrams) Haldol (antipsychotic) 5 mg ... Time of Administration ...13:30 ... Effect of Medication ...patient resting quietly on stretcher". Per review of a Patient Observation Record from 4/24/23, it states, "13:30 Patient State ...Appears to be Sleeping ...pt is laying in bed". "14:15 Patient State ...Appears to be Sleeping ...pt is laying down". "14:30 Patient State ...Appears to be Sleeping, Cooperative ...pt is laying down sleeping". "14:45 Patient State ...Appears to be Sleeping ...pt laying in bed". "15:00 Patient State ...Appears to be Sleeping ...pt is laying in bed". Per review of a restraint/seclusion assessment from 4/24/23 at 15:12, it states, "pt resting quietly on stretcher with eyes closed ... Criteria for Restraint Removal ...No longer immediate threat to self, No longer immediate threat to staff & others ... Date Restraints Removed ...4/24/23 ... Time Restraints Removed ...15:08". Per review of the "Restraint and Seclusion Policy"-approved 2/26/20, it states, "1) When an	C1006		

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C1006	Continued From page 3 order for restraint or seclusion has been obtained, the patient must be seen face-to-face within 1 hour after the initiation of the intervention by a licensed independent practitioner ...2) The one (1) hour face-to-face patient evaluation must be conducted in person ...Termination of Restraint or Seclusion 1) Restraint or seclusion will be terminated at the earliest possible time regardless of the length of time identified in the order. Restraint or seclusion may only be employed while the unsafe situation continues. Once the unsafe situation ends, the use of restraint or seclusion must be discontinued." There is no evidence in the record that a licensed independent practitioner evaluated Patient #2 face-to-face after the initiation of restraints. Per interview on 5/17/23 at 9:15 AM, with an Informatics Nurse, S/He confirmed that a face-to-face was not performed by a licensed independent practitioner after the initiation of restraints for Patient #2. Based on the information above, the restraints for Patient #2 were not terminated at the earliest possible time. Per interview on 5/17/23 at 9:29 AM, with the ED Director, S/He confirmed that the restraints were not removed from Patient #2 at the earliest possible time.	C1006		
C1104	RECORDS SYSTEM CFR(s): 485.638(a)(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	C1104	RECORDS SYSTEM: Record review of patient #5's medical record, revealed that on 5/15/23 patient #5 had a gastroscopy. There was no evidence in the Electronic Medical Record (EMR) or the paper medical record of an operative report for this procedure. There is a completed anesthesia consent	

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C1104	Continued From page 4 failed to maintain medical records that are legible, complete, accurately documented, readily accessible, and systematically organized for 1 patient in a standard survey sample of 27. (Patient identifier #5). Findings include: Record review of patient #5's medical record, it was revealed that on 5/15/23 patient #5 had a gastroscopy. There was no evidence in the Electronic Medical Record (EMR) or the paper medical record of an operative report for this procedure. There is a completed anesthesia consent with pre, and post anesthesia evaluations conducted. Interview on 5/17/23 at approximately 1:30 PM with an Informatics Nurse, s/he confirmed that the operative report was not located in the EMR or the paper medical record. S/he stated that she/he would check with medical records to see if the operative report was in the medical records department waiting to be scanned into the EMR. At approximately 1:45 PM, s/he returned and stated that medical records did not have this document and it "appeared the op [operative] note had not been done by the surgeon". S/he stated that the policy, according to medical records, was that operative notes be completed and in the patient's chart within 4 hours post (after) the surgical intervention. A review of the facility's policy titled "Medical Staff Medical RecordsPolicy [sic]". This policy was approved on "01/16/23" and expires on "12/01/2023". This policy is a 5 page document and on page 2 read the following: "Reports of Operation Documentation requirements for	C1104	with pre, and post anesthesia evaluations conducted. **Corrective Action:** ✓ Current procedure is for HIM to notify both the provider and the Surgical Medical Director when a record is noted to be out of compliance. ✓ Concerns will be reported out to the Surgical committee for further review, identification of improvement issues, and additional education (starting with 7/13/2023 meeting). ✓ Delinquent Records Policy has been developed and is moving thru the approval and activation process (by 7/15/202) **Tag C1104 POC accepted on 6/9/23 by T. Dougherty/S. Leavitt**	

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C1104	Continued From page 5 operative and other high-risk procedures, as well as those procedures involving the use of moderate to deep sedation, or anesthesia Must Include: Name and hospital identification number of the patient; Date of procedure Pre-operative and post-operative diagnosis Procedure performed Type of anesthesia administered; Estimated blood loss, Complications, if any; A description of techniques, findings, and tissues removed or altered; Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a progress note shall be entered in the medical record before the patient is transferred to the next level of care. This progress not shall include: The name(s) of the primary physician and his or her assistant(s), Procedure performed and a description of each procedure finding Estimated blood loss Specimens removed, and Post-procedure diagnosis	C1104		

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C1104	Continued From page 6 If there was no blood loss or specimens removed, it is not necessary to include this documentation in the progress note." Review of a 2 page document titled "CHART ANALYSIS HIM [health information management]" provided by the Director of the Medical Records Department (HIM) on 5/17/23. Under "Op (operative) Notes", on page 2 revealed the following: All operations require a report of operation documented in the record immediately after surgery If an Op Note is missing Call provider/put in a deficiency Email [proper name omitted] patient information for an incident report	C1104		
C1206	INFECTION PREVENT & CONTROL POLICIES CFR(s): 485.640(a)(2) The infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the CAH and between the CAH and other healthcare settings; This STANDARD is not met as evidenced by: Based on observation, interview, and record review the CAH failed to ensure the methods for preventing and controlling the transmission of infections were followed related to surgical attire, hand hygiene, and patient care supplies for 3 applicable staff members and 2 patient care areas (Surgical Suite and ED). Findings include: 1. During a tour of the Surgical Suite on 5/15/23 at 12:40 PM, during a patient's cataract surgery in OR#1, Staff #1 and Staff #2 did not have the hair	C1206	INFECTION PREVENT & CONTROL POLICIES: During a tour of the Surgical Suite it was noted that two staff members did not have the hair at the nape of their necks fully covered with appropriate surgical attire. **Corrective Action:** ✓ Educational update outlining appropriate hair coverage in OR sent to all Perioperative Staff (sent 6/6/2023) ✓ Auditing of hair coverage will be part of routine Environmental Rounding in OR (by 6/30/2023). ✓ Reminder to be discussed during Surgical Committee meeting (on 6/8/2023)	

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C1206	Continued From page 7 at the nape of their necks fully covered with appropriate surgical attire. Per interview at that time with the Director of the OR S/He confirmed that all hair should be fully covered with appropriate attire. Per review of the policy, "Surgical Attire"-approved 10/24/22, it states, "Purpose: Surgical Attire and appropriate personal protective equipment are worn to promote worker safety and a high level of cleanliness and hygiene in the perioperative environment. The expected outcome is that the patient will be free from signs and symptoms of infection ..... Procedure Interventions....All perioperative personnel will cover head and facial hair, including sideburns and the nape of the neck." 2. During a tour of the ED on 5/15/23 at approximately 3:00 PM, Exam Room #3 had an opened package containing a "Yankauer" (type) suction tip (removes secretions from one's mouth) on top of a suction canister. There was no indication when this package was opened and/or how long it had been in the room. Per interview on 3/15/23 at approximately 3:15 PM with the ED Director, S/He stated, "I wouldn't do this" and confirmed that it was not best practice to open patient care supplies without patients present. 3. Per observation of cleaning OR #1 after a surgical case on 5/16/23 at 11:57 AM, Staff #3 cleaned the OR table, removed gloves and without sanitizing his/her hands donned new gloves and proceeded to finish cleaning the OR table. Per interview on 5/16/23 with Staff #3 at that time S/He stated that whenever you remove gloves you need to "sanitize hands" prior to	C1206	INFECTION PREVENT & CONTROL POLICIES: During a tour of the ED on it was identified that a "Yankauer" suction tip was attached to suction tubing. The package had been opened enough to allow for this connection to occur, with entirety of the tip still contained within the packaging. The ED Director noted that she believed that the room had been set up for an imminent patient arrival. **Corrective Action:** ✓ Educational reminder about the need to keep suction tips and tubing in their packaging until patient is in the room, sent to all clinical staff in the ED ✓ Reminder to be discussed during ED Committee meeting (on 6/14/2023). ✓ Auditing will be part of routine Environmental Rounding in ED (by 6/30/2023). INFECTION PREVENT & CONTROL POLICIES: Per observation of cleaning in OR a staff member was observed doffing and donning gloves, without sanitizing their hands in-between. Per interviewer, the staff member identified that they had missed this step. Interviewer shared with Director of Quality/ Infection Prevention that staff member had told the interviewer that she was feeling nervous. The staff member immediately self-reported the lack of hand sanitization to their supervisor.	

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C1206	Continued From page 8 donning clean gloves. Per review of the policy "Hand Hygiene"-approved 12/6/22, it states, "Hands Hygiene must take place: 6. After removing gloves." 4. During a tour on 5/16/23 at 1:46 PM of the Post Anesthesia Care Unit (PACU), the unit had three beds that were equipped with oxygen, suction, and cardiac monitors. In two of the three bed areas oxygen tubing was unwrapped, hanging over suction canisters and attached to the wall mounted oxygen supply. There was no indication how long the tubing had been open and/or how long it had been in the room. Per interview with a staff member at that time, S/He stated that was what they had "always done", the oxygen tubing was opened to be ready for the "next patient". Per interview on 5/17/23 at 11:51 AM with the Infection Preventionist, S/He confirmed that this was not a recommended practice.	C1206	**Corrective Action:** ✓ Educational update sent to all NVRH staff outlining opportunities for hand hygiene (sent 6/8/2023). ✓ Discussion of hand hygiene opportunities to be presented at leadership meeting (6/20/2023). ✓ Monthly hand hygiene audits continue ongoing, and reviewed by the Safety Management Team. INFECTION PREVENT & CONTROL POLICIES: During a tour of the PACU In two of the three bed areas oxygen tubing was unwrapped, hanging over suction canisters and attached to the wall mounted oxygen supply. There was no indication how long the tubing had been open and/or how long it had been in the room.	
C1608	SNF SERVICES CFR(s): 485.645(d)(1) The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: §485.645(d)(1) Resident Rights (§483.10(b)(7), (c)(1), (c)(2)(iii), (c)(6), (d), (e)(2) and (4), (f)(4)(ii) and (iii), (g)(8) and (17), (g)(18) introductory text, (h) of this chapter). " §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law	C1608	**Corrective Action:** ✓ Educational update notifying all Perioperative Staff that effective May 16, 2023, the nasal cannula used in PACU will remain in unopened packages until the patient arrives into the bay (sent 5/23/2023). ✓ Auditing will be part of routine Environmental Rounding in OR (by 6/30/2023). **Tag C1206 POC accepted on 6/9/23 by T. Dougherty/S. Leavitt**	

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C1608	Continued From page 9 to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. " §483.10(c) Planning and implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including: (1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. " §483.10(c)(2)(iii) The right to be informed, in advance, of changes to the plan of care. " §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. " §483.10(d) Choice of attending physician. The resident has the right to choose his or her attending physician. (1) The physician must be licensed to practice, and (2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment. (3) The facility must ensure that each resident	C1608	SNF SERVICES: Review of the CAH's "Swing Bed Patient Bill of Rights", showed no evidence that the CAH afforded swing bed patients the option to choose his/her own attending physician. **Corrective Action:** ✓ The Swing Bed Patient Bill of Rights will be pulled from current use, and updated to include wording offering the patient the option to choose their own attending physician(by 7/15/2023). **Tag C1608 POC accepted on 6/9/23 by T. Dougherty/S. Leavitt**	

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C1608	Continued From page 10	C1608		

remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.

(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

" §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

" §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

" §483.10(f)(4)(ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;

" §483.10(f)(4)(iii) The facility must provide

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C1608	Continued From page 11 immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; " §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. " §483.10(g)(17) The facility must- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	C1608		

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C1608	Continued From page 12 section. " §483.10(g)(18)[introductory text only] The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate. " §483.10(h) Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. (3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as	C1608		

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C1608	Continued From page 13 provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This STANDARD is not met as evidenced by: Based on interview and record review the CAH failed to promote swing bed patients' rights related to choosing an attending physician. Findings include: Per review of the CAH's "Swing Bed Patient Bill of Rights", there was no evidence that the CAH afforded swing bed patients the option to choose his/her own attending physician. Per interview on 5/17/23 at approximately 1:00 PM, with the Care Manager, S/He confirmed that the CAH's "Swing Bed Patient Bill of Rights" did not contain all the required regulatory elements.	C1608		
C1612	FREEDOM FROM ABUSE, NEGLECT & EXPLOITATION CFR(s): 485.645(d)(3) Freedom from abuse, neglect and exploitation (§483.12(a)(1), (a)(2), (a)(3)(i), (a)(3)(ii), (a)(4), (b)(1), (b)(2), (c)(1), (c)(2), (c)(3), and (c)(4) of this chapter). " §483.12(a)(1) Freedom from abuse, neglect, and exploitation. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary	C1612	FREEDOM FROM ABUSE, NEGLECT, & EXPLOITATION: Per review of the policy, "Suspected Abuse/Neglect of Vulnerable Adults"-active as of 5/15/23. There was no evidence that the policy and/or procedure contained the time frame in which allegations involving abuse, neglect, exploitation, or mistreatment, to include injuries of an unknown origin and misappropriation of residents' property were reported, and to the required officials. There was also no indication of the process in which these allegations were to be fully investigated and if substantiated the	

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C1612	Continued From page 14 seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.(a) The facility must-(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; " §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. " §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. " §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. " §483.12(b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	C1612	appropriate corrective actions that would be taken. **Corrective Action:** ✓ "Suspected Abuse/Neglect of Vulnerable Adults" policy will be updated to include missing elements (by 6/30/2023). ✓ The Risk and Compliance Officer will present policy updates to targeted staff including care management, and nursing (by 7/15/2023). **Tag C1612 POC accepted on 6/9/23 by T. Dougherty/S. Leavitt**	

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C1612	Continued From page 15 (2) Establish policies and procedures to investigate any such allegations, " §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate	C1612		

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C1612	Continued From page 16 corrective action must be taken. This STANDARD is not met as evidenced by: Based on interview and record review the CAH failed to develop comprehensive policies and procedures for Swing Bed patients that prohibit and prevent, abuse, neglect, exploitation, and misappropriation of property. Findings include: Per review of the policy, "Suspected Abuse/Neglect of Vulnerable Adults"-active as of 5/15/23. There was no evidence that the policy and/or procedure contained the time frame in which allegations involving abuse, neglect, exploitation, or mistreatment, to include injuries of an unknown origin and misappropriation of residents' property were reported, and to the required officials. There was also no indication of the process in which these allegations were to be fully investigated and if substantiated the appropriate corrective actions that would be taken. Per interview on 5/16/23 at approximately 10:30 AM with the Care Manager, S/He confirmed that the policy did not contain the above information and stated that S/He was not aware of these requirements.	C1612		
C2521	PRIVACY AND SAFETY CFR(s): 485.614(c)(1) The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure patient's personal privacy on the Medical Surgical - locked/secure Psychiatric unit/hall in a standard survey for 1 of 3 units.	C2521	PRIVACY AND SAFETY: Observation of each of the 3 rooms revealed a camera afixed to the ceiling of each room. Upon returning to the hall of this unit, observation of the computer monitor revealed each of these rooms were completely visible on this monitor to anyone in the hall of this unit. **Corrective Action:** ✓ Monitor in transition bed area removed on 6/7/2023 ✓ Policy addressing use of cameras in	

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C2521	Continued From page 17 Findings include: Tour of the Medical Surgical unit with the Director of Medical Surgical/Pediatrics/Infusion units, revealed a locked/badge entry only hall/unit that contained 3 patient rooms. The Director of Medical Surgical/Pediatric/Infusion accessed this locked unit with her/his badge. Observation of each of the 3 rooms revealed a camera afixed to the ceiling of each room. Upon returning to the hall of this unit, observation of the computer monitor revealed each of these rooms were completely visible on this monitor to anyone in the hall of this unit. Interview on 5/15/23 at approximately 1:35 PM with the Director of Medical Surgical/Pediatrics/Infusion units, s/he stated that at this time there were no patients being housed on this secure unit, however this is an open unit and does provide care to psychiatric patients and has done so in the recent past. S/he is fairly new to her/his role as the Director, s/he took this role on 1/1/23. S/he explained the office the computer monitor is in is used by the infusion team/staff and they are not privy to patient information on the psychiatric unit. The computer monitor is turned facing the hall of the psychiatric unit for the benefit of staff working on the psychiatric unit. S/he was asked if patients are required to stay in their rooms or if they are allowed access to the hallway, s/he stated that patients are not required to stay in their rooms and they do have access to the hallways if they choose to come out of their room(s). S/he was asked if patients coming in to the hallway can see the computer screen that is turned facing the hallway of the psychiatric unit, s/he stated, "yes, they are able to see the computer screen". S/he was asked if that is a	C2521	patient areas is currently being modified to reflect best practice, and regulatory guidance (by 6/30/2023) ✓ Education regarding policy updates will be presented to employees thru email, and departmental newsletters (by 7/31/2023) **Tag C2521 POC accepted on 6/9/23 by T. Dougherty/S. Leavitt**	

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C2521	Continued From page 18 breach of patient privacy rights - s/he confirmed that other patient should not have access to other patients rooms without proper consent. Tour on 5/16/23 at approximately 10:35 AM, of the locked/secure psychiatric unit/hall with the Quality Improvement Specialist, it was noted that the computer monitor was still present in the infusion nurses station/office and the monitor was still facing the unit/hall of the psychiatric unit. S/he confirmed that the computer monitor on this unit was visible to anyone who had access to the psychiatric unit/hall, including patients being housed on this unit. S/he confirmed that this would be a violation of the hospital policy and patient rights but s/he would ask the Director of Medical Surgical/Pediatric/Infusion unit to come to the psychiatric unit to discuss further. The Director of Medical Surgical/Pediatric/Infusion unit arrived on the psychiatric unit on 5/16/23 at approximately 10:40 AM. S/he confirmed that the monitor placement had not changed since the surveyors original tour on 5/15/23 and that anyone on the secure psychiatric unit had access to each room, including patients who may be in the hallway. S/he explained that this computer monitor has been on this unit since she took the role as the Director of Medical Surgical/Pediatric/Infusion unit on January 1, 2023. The Director of Medical Surgical/Pediatric/Infusion unit was asked about the computer monitor, s/he stated s/he could not really speak to why it was there. S/he stated that when there are patients on this unit, each patient is assigned a "sitter" who sits outside each room and has a constant visual of their patient to	C2521		

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C2521	Continued From page 19 ensure safety. S/he confirmed that patients are free to stay in their room or come out into the hallway. S/he was asked about the use of the computer monitor and why it was facing the hallway of this unit. S/he explained that the office the monitor is in (nurses station) is for the infusion team/staff to do their documentation and discuss cases/patients. They are not part of the psychiatric unit/hall and would not be privy to what is happening on that unit, therefore, the monitor is turned so staff/sitters have a visual of each room on the computer monitor. This contradicts the original statement that each "sitter" sits outside the patient room and has a constant visual on the patient. The Director of Medical Surgical/Pediatric/Infusion was asked why a computer monitor is needed for the unit if each psychiatric patient has their own assigned "sitter". S/he stated she did not know. Review of the hospital policy titled, "Patient Rights & Responsibilities" on page 2, number 12 states, "To expect privacy, to the extent feasible, during provision of care. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Those not directly involved in the patients care must have the permission of the patient to be present. ..... ".	C2521		
E 000	Initial Comments During an unannounced on-site re-certification survey, on 5/15/23 through 5/17/23, the Division of Licensing and Protection conducted a review of the Critical Access Hospital's (CAH's) Emergency Preparedness Program. The facility was found to be in substantial compliance with the Condition of Participation for CAH's at 485.625, Emergency Preparedness.	E 000		