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

September 20, 2019

Mr. Steven Gordon, Administrator
Brattleboro Memorial Hospital
17 Belmont Ave
Brattleboro, VT 05301-3498

Provider ID #: 470011

Dear Mr. Gordon,

The Division of Licensing and Protection completed a survey at your facility on **August 21, 2019**. The purpose of the survey was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **September 20, 2019**.

Sincerely,

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

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470011	A. BUILDING _____ B. WING _____	08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO MEMORIAL HOSPITAL	17 BELMONT AVE BRATTLEBORO, VT 05301

(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
E 000	Initial Comments	E 000		

During an unannounced on-site re-certification survey, 8/19/19 through 8/21/19, the Division of Licensing and Protection conducted a review of the hospital's Emergency Preparedness Program. The hospital was found to be in substantial compliance with Emergency Preparedness planning.

A 000	INITIAL COMMENTS	A 000		

An unannounced on-site re-certification survey was conducted on 8/19/19 through 8/21/19 by the Division of Licensing and Protection to determine compliance with the Conditions of Participation for Acute Care Hospitals. The following regulatory violations were identified:

Based on observations, staff interviews, and record review the Condition of Participation: Surgical Services was not met as evidenced by the hospital's failure to to ensure access to the operative; recovery area; and Central Sterile Processing was limited to authorized individuals.

A 143	PATIENT RIGHTS: PERSONAL PRIVACY CFR(s): 482.13(c)(1)	A 143	**Corrective Action:** Access to the identified areas will be limited through the installation of a keypad entry system which will be installed at the back door of the elevator. **BMH Staff Member Responsible:** Rob Prohaska/Director of Plant Operations Jodi Stack, RN/ Vice President of Patient Care Services	**Date of Completion:** 10/15/2019

The patient has the right to personal privacy.

This STANDARD is not met as evidenced by:
Based on observation and staff interviews, the facility failed to maintain the personal privacy of patients presenting to the Emergency Department (ED). Findings include:

Cameras were observed in the ceilings in hallways of the Emergency Department during an environmental tour with the Director of Emergency Services on 8/19/2019. Per the

Corrective Action:
A. Notification: Signs notifying patients that cameras are present and will be recording for health and safety reasons will be installed at key areas throughout the Emergency Department.

Date of Completion: 10/04/2019

tag A 143/ POC accepted SS/DW 9/20/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Chief Medical Officer	9/17/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 143 Continued From page 1

Director of Emergency Services, the capacity of the ED could reach 18 patients, which would include the utilization of up to 5 stretchers in the hallways where patients could receive medical care and services.

During an interview at 2:15 PM on 8/20/2019, the Network Manager confirmed that five cameras were recording activity in the Emergency Department. The Executive Director for Quality confirmed that patients were not informed of the recording taking place in the Emergency Department and that patient assessments occurred in the hallways on stretchers, "all the time".

A 438 FORM AND RETENTION OF RECORDS
CFR(s): 482.24(b)

The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

This STANDARD is not met as evidenced by:
Based on observation and interview the hospital failed to store medical records in a manner that ensured protection from potential water damage. Findings include:

During a tour of the Medical Records Department on 8/20/19 at 9:42 AM with the Lead Analyst, the "Annex" room, "File Room", and "Volume Land" room areas contained multiple rows of medical records that were stored on open faced shelving

A 143 B. Staff Education: ED Personnel have been educated about the importance of maintaining patient's privacy and to, whenever possible, deliver care in private treatment rooms. Education will occur in mandatory Staff Meetings on 9/17/2019 and 9/19/2019.

Date of Completion: 10/04/2019

C. The BMH *Consent to Treat Form* has been revised to include notification to patients about the presence of recording devices in high risk areas.

Date of Completion: 10/15/2019

BMH Staff Member Responsible:
Rob Prohaska/Director of Plant Operations
Taylor Wellington, RN/ Director of Emergency Services
Bill Hogue/Network Manager

A 438 **Corrective Action:**
There are concerns from the State Fire Marshall that are in conflict with this interpretation by the surveyors. At this time, all paper medical records will be covered with flame-retardant material. Will also continue efforts to reduce /destroy older paper files to mitigate the potential risk of fires.

Date of Completion: 10/15/2019

It should be noted that the appropriate solution may need to be revisited based on written opinion of the State Fire Marshall that is still pending as of this date.

BMH Staff Member Responsible:
Rob Prohaska/Director of Plant Operations
Charmaine Vinton/ Director of Health Information

tag A 438 (POC accepted ss/bw 9/20/19

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A 438 Continued From page 2

located directly under exposed piping and sprinklers. The way the records were stored created an opportunity for potential water damage. The Lead Analyst confirmed this on 8/20/19 at 9:55 AM, and stated "charts could get wet".

A 502 SECURE STORAGE
CFR(s): 482.25(b)(2)(i)

§482.25(b)(2)(i) - All drugs and biologicals must be kept in a secure area,
and locked when appropriate.
This STANDARD is not met as evidenced by:
Based on observation and staff interview, the facility failed to ensure medication was stored securely in all areas of the hospital. Findings include:

In the presence of the Director of Pharmacy, 2 ampoules of ammonia inhalant (respiratory stimulant used for the prevention/ treatment of fainting) were observed taped to the wall in a plastic bag above the head of the hospital bed in a patient room on the Birthing Center of the hospital on the morning of 8/21/2019. The bag had a piece of tape with the date of 6/22 written on it. The Director of the Birthing Center confirmed that 7 patient rooms and their adjoining bathrooms had ampoules of the ammonia inhalant taped on the wall so the medication would be, "readily available" if needed by a patient. The Director of the Birthing Center stated that staff took the medication from the large box of 10 ampoules in the locked medication room and wrote the expiration date on the bag prior to taping it to the wall in the patient rooms.

Upon observing the presence of the ammonia

A 438

A 502 **Corrective Action:**

A. All ammonia ampules have been removed from unsecured areas in all Outpatient and Hospital-based patient care areas. **Date of Completion:** 9/04/2019

B. Mandatory Staff Education: Staff have received education on the basic principles for safe medication storage and handling. **Date of Completion:** 10/01/2019

C. The *EOC Rounding Form* has been revised to include safe medication storage. This form, completed by Nursing Staff on the Birthing Center and by Medical Assistants in the Outpatient Practices on a daily basis, has been updated to include assessing for the presence of any unsecured medication, including ammonia inhalants. **Date of Completion:** 10/01/2019

BMH Staff Member Responsible:
Erinna Cooper, RN/ Director of Birthing Center
Jessica Bird, RN/ Care Manager: Brattleboro Obstetrics and Gynecology

tag A 502/POC accepted
SSlow 9/20/19

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A 502	Continued From page 3 inhalant in the patient room, the Director of Pharmacy stated at 10:10 AM, "it should not be taped to the wall". The presence of the medication in an unsecured room potentially could have been accessed by by unauthorized individuals.	A 502		
A 701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observations and interviews the hospital failed to develop and maintain an environment that assured the safety and well-being of patients. Findings include: 1. During a tour of the Birthing Center on 8/19/19 at 12:30 PM with the Birthing Center Director, the clean utility room door was unlocked and contained 4 bottles of 4 oz of Hydrogen Peroxide, 3 bottles of 4% Chlorohexidine solution (disinfectant and antiseptic that is used for skin disinfection), lubricating jelly, lotions, soaps, and mouthwash. The dirty utility room was also unlocked and contained a container of Oxivir (one-minute disinfectant cleaner that has hydrogen peroxide as its primary active ingredient) wipes, a 946 milliliter (ml) bottle of Oxivir, a 1 gallon container and 2 quart containers of Renuzyme (high performance enzyme detergent), and a container of Clorox bleach wipes. Per interview with the Birthing Center Director at 1:04 PM, s/he stated that the doors to both the clean utility room and dirty utility room "have never been locked" to prevent unauthorized	A 701	**Corrective Action:** Installation of touchless keypad locks on all unsecured dirty and clean utility/storage rooms on MS II, PCU, the ED and the Birthing Center will occur. This work will be added to the ongoing Lock Project in which all secure hospital doors will have keypad locks installed. **BMH Staff Member Responsible:** Rob Prohaska/Director of Plant Operations Bill Hogue/ IS Network Manager **Corrective Action:** A. Removal of all patient care supplies and equipment from dirty utility room on MS II B. Mandatory Staff Education on basic Infection Prevention principles. Education to include importance of clear separation of patient supplies from contaminated/ soiled areas. Compliance will be monitored through assessment at regularly scheduled EOC rounds conducted by the Infection Preventionist, RN. **BMH Staff Member Responsible:** Jackie Amidon, RN/ Director of Inpatient Services Meredith Burt, RN Infection Preventionist tag A 701 POC accepted SS DW 9/25/19	**Date of Completion:** 10/15/2019 **Date of Completion:** 8/21/2019 **Date of Completion:** 10/01/2019

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A 701	Continued From page 4	A 701		

access.

2. The following was observed during a tour of the medical surgical unit on 8/19/19 beginning at 2:35 PM.

a. The "Respiratory Closet" adjacent to second floor nurse's station, which had no lock and was accessible to patients and visitors, had no signage to identify the presence of oxygen cylinders. This was confirmed by the nurse accompanying the surveyors on 8/19/19 at 2:45 PM.
b. The "Dirty Stock Room" adjacent to the second floor nurse's station, which had a Biohazard sign on the door was not secured. The nurse who accompanied surveyors during the tour confirmed on 8/19/19 at 2:45 PM that the room was accessible and has never had a locking mechanism to prevent unauthorized access by patients and visitors.
c. The "Dirty Stock Room" which contained biohazard trash containers, also included patient care equipment on the shelves. This included six "Hemo-Force" machines used for venous compression (to prevent blood clots) which were stored in plastic bags, 2 intravenous pump devices, and an "Air Pal" machine used to inflate mattresses to assist with moving patients. The nurse accompanying the surveyors stated, "I'm not sure why they are here.. they shouldn't be... they've always been here. I would not assume they have been cleaned. They would be wiped down before use."

3. The following was observed during a facility tour accompanied by the Director of Plant Services on 8/20/19 at 8:45 AM:

Corrective Action:
Installation of touchless keypad locks on all unsecured dirty and clean utility/ storage rooms on MS II, PCU, the ED and the Birthing Center will occur. This work will be added to the ongoing Lock Project in which all secure hospital doors will have keypad locks installed.

Date of Completion: 10/15/2019

BMH Staff Member Responsible:
Rob Prohaska/Director of Plant Operations
Bill Hogue/ IS Network Manager

Corrective Action:
A. Removal of all patient care supplies and equipment from dirty utility room on MS II

Date of Completion: 8/21/2019

B. Mandatory Staff Education on basic Infection Prevention principles, will occur on 9/04/2019, 9/24/2019, 10/03/2019 and 10/22/2019. Education to include importance of clear separation

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A 701	Continued From page 5 a. On the PCU, a dirty Utility Room, containing biohazardous waste, a sharps container, and soiled linen was unlocked and had no locking mechanism on the door. b. The first floor care unit had an unlocked dirty Utility Room which contained soiled linen. These observations were confirmed during the environmental tour with the Director of Plant Services.	A 701	of clean supplies from contaminated/ soiled areas. Compliance will be monitored through assessment at regularly scheduled EOC rounds conducted by the Infection Preventionist. **BMH Staff Member Responsible:** Jackie Amidon, RN/ Director of Inpatient Services Meredith Burt, RN Infection Preventionist	**Date of Completion:** 10/01/2019
A 713	DISPOSAL OF TRASH CFR(s): 482.41(b)(4) (4) The hospital must have procedures for the proper routine storage and prompt disposal of trash. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure there were procedures in place for the appropriate containment of trash in all areas of the hospital. Findings include: During an environmental tour of the kitchen on 8/19/2019 at 10:10 AM, three garbage cans were observed near food preparation areas without covers. Garbage cans at a hand washing station and sink were also observed without covers. A 4:00 PM on 8/20/2019, the Director of Nutrition Services confirmed that there were five garbage cans in the kitchen that were, "sometimes covered, sometimes not" and there was no policy currently in place addressing the storage of trash in the kitchen.	A 713	**Corrective Action:** A. Purchase and installation of covered trash bins in all food preparation areas. Compliance will be monitored during regularly scheduled EOC Rounds.	**Date of Completion:** 10/01/2019
			B. Mandatory Staff Education: Regarding the importance of protecting food preparation areas from open trash bins.	**Date of Completion:** 10/01/2019
			C. Policy: Disposal of Waste Policy will be updated, citing mandate to cover all garbage bins in food service and preparation areas. **BMH Staff Member Responsible:** Jamie Baribeau/ Director Food Services	**Date of Completion:** 10/01/2019
A 724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(d)(2)	A 724	**Corrective Action:** A. All currently opened face masks and O2 tubing have been removed from patient care areas and discarded.	**Date of Completion:** 08/20/2019

tag A713 + A724
POC accepted
SS/DW 9/25/19

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A 724	Continued From page 6 Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation and interview the hospital failed to ensure that patient care supplies and equipment were maintained with acceptable levels of safety and quality. Findings include: 1. During a tour of the Birthing Center on 8/19/19 at 12:30 PM with the Birthing Center Director, rooms 225, 227, and 229 contained neonatal isolates/warmers that had opened packaging with resuscitation masks, opened tubing that was attached to the isolates/warmers, and opened packages of oxygen tubing ready for use. Each of these rooms also had separately opened packages that contained an oxygen mask and tubing that was attached to the wall mount at the head of the bed ready to be used by the expectant mother. There was no indication when the supplies were opened and how long they had been there in the rooms. Per interview at that time with the Birthing Center Director, s/he stated that all of the labor and delivery rooms were set up in the same manner so that the staff would have the equipment and supplies "at the ready". S/he further confirmed that there was no indication when the supplies had been opened and how long they had been in the rooms. Per interview on 8/21/19 at approximately 3:00 PM with the Director of Quality, s/he confirmed that s/he was aware of the above findings and stated, "They should not be opened and ready for use, it is not good practice". 2. During a tour on 8/19/19 at 1:25 PM of the peri-operative service locations accompanied by the nurse manager the following observations	A 724	B. Breathing circuit tubing and face masks will be opened, assembled, checked and then sealed in clear plastic bags with the "Assembled" and "Expiration" dates clearly labeled. All open and/or used equipment will be discarded after each delivery. C. Mandatory Staff Education: All Birthing Center staff will receive education on the basic principles for infection prevention, including strategies to minimize the potential for disease transmission through the adoption of safe handling practices for all respiratory equipment. A practice change memo has been placed in the Birthing Center break room for review by Birthing Center personnel. D. This practice change will also be reviewed at the mandatory Birthing Center Staff Meeting on September 24 and again at the next NRP training on October 9, 2019 E. The *EOC Rounding Form* has been revised to include safe equipment maintenance and storage. Compliance will be insured through the completion of daily rounds by Nursing Staff on the Birthing Center and will also be monitored by the Infection Prevention RN during monthly EOC Rounds. **BMH Staff Member Responsible:** Erinna Cooper, RN/Director Birthing Center Meredith Burt, RN Infection Preventionist **Corrective Action:** A. A survey of all OR equipment currently in use will be conducted by the Infection Prevention Nurse and Nursing Administration. B. All patient care equipment in poor condition will be identified and repaired and/ or replaced.	**Date of Completion:** 10/01/2019 **Date of Completion:** 9/24/2019 & 10/09/2019 **Date of Completion:** 09/04/2019 **Date of Completion:** 10/01/2019 **Date of Completion:** 10/01/2019

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A 724	Continued From page 7 were made: a. In the Sterile Supply Room a head extension positioning board used during surgical eye procedures was noted to have cracked vinyl in multiple areas. b. In operating room #1 a slide board used to transfer patients on and off operating room table was observed to have cracked and ripped edges. A foot board, used in the operating room for surgical procedures was also noted to be in disrepair with cracks in vinyl. c. In operating room # 2 a roller/slide board was also identified to have worn and torn edges. d. In operating room #3 a door which exits to a corridor within the peri-operative location did not close tightly after staff entered or exited resulting in potentially canceling out the safety effects of the positive pressure system designed to keep regular germ-filled air out of the OR. 3. During a tour of the medical surgical unit on 8/19/19 at 2:25 PM, the "Dirty Stock Room" which also had a Biohazard sign present, contained patient care equipment that was outdated. Findings include: a. A disposable forced air warming blanket had expired in October 2016. b. An "Argyle Salem Sump" tubing had an expiration date of January 2017. The nurse accompanying the surveyors on tour stated " I would not normally come in to pull clean supplies from this room."	A 724	C. Mandatory Staff Education: All OR staff will receive education on the basic principles for infection prevention, including strategies to minimize the potential for disease transmission through the maintenance of intact barriers on all patient handling equipment. D. Compliance will be insured through the completion of daily rounds by Nursing Staff in the Peri-Op Department and will also be monitored by the Infection Prevention RN during monthly EOC Rounds. **BMH Staff Member Responsible:** Jodi Stack, RN/ Vice President of Patient Care Services Meredith Burt, RN Infection Preventions **Corrective Action:** OR #3 Door has been ordered, purchased and will be installed upon receipt. **BMH Staff Member Responsible:** Rob Prohaska/Director of Plant Operations **Corrective Action:** A. All outdated patient care supplies and equipment have been removed from the dirty utility room on MS II B. Mandatory Staff Education: Staff education on basic Infection Prevention principles will occur on 9/04/2019, 9/24/2019, 10/03/2019 and 10/22/2019. Education to include importance of the storage of clean supplies away from contaminated/ soiled areas. Staff will also be educated on the importance of maintaining equipment for patient care that are within safe established usage dates. C. Compliance will be insured through the completion of daily rounds by Nursing Staff in the Peri-Op Department and will also be monitored by the Infection Prevention RN during monthly EOC Rounds. **BMH Staff Member Responsible:** Jackie Amidon, RN/ Director of Inpatient Services Meredith Burt, RN Infection Preventions	**Date of Completion:** 10/01/2019 **Date of Completion:** 10/01/2019 **Date of Completion:** 10/01/2019 **Date of Completion:** 8/21/2019 **Date of Completion:** 10/01/2019
A 940	SURGICAL SERVICES CFR(s): 482.51	A 940		

tag A 940 POC accepted
SS/DW 9/25/19

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A 940	Continued From page 8 If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered. This CONDITION is not met as evidenced by: Based on observations, staff interview and record review the Condition of Participation: Surgical Services was not met as evidenced by the hospital's failure to to ensure access to the operative; recovery area; and Central Sterile Processing was limited to authorized individuals. During a tour on 8/19/19 at 12 noon accompanied by the manager of peri-operative services an elevator was observed to be unsecured creating potential access to the operative suites; endoscopy room; recovery areas and Central Sterile Processing by unauthorized individuals. Although all other entrances to the peri-operative area are secured requiring employee ID badge authorization to access the area, this specific elevator is unsecured and does not require ID badge authorization. The elevator opens onto 2 main hospital corridors utilized by the public but also opens directly into a corridor located within the peri-operative service location, creating easy access to this restricted location by anyone using the elevator. There is a small worn floor decal which states "Restricted do not enter area" located on the floor in front of the elevator with the intention of alerting unauthorized individuals not to enter the peri-operative services various locations. However, the failure to fully prevent unauthorized individuals from exiting from the	A 940	**Corrective Action:** Through the installation of a "lockout entry system" the elevator in the perioperative suites will be secured, limiting access to the Department to only authorized personnel. **BMH Staff Member Responsible:** Rob Prohaska/Director of Plant Operations Jodi Stack, RN/ Vice President of Patient Care Services	**Date of Completion:** 10/15/2019

tag A 940 | PoC accepted
SS | DO 1/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO MEMORIAL HOSPITAL	17 BELMONT AVE BRATTLEBORO, VT 05301

(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
A 940	Continued From page 9 elevator and accessing any of the locations within the peri-operative services creates a potential safety concern for both staff and patients. These observations were confirmed by the Director of Peri-Operative services at the time of the tour.	A 940		
A1081	STANDARD TAG FOR OUTPATIENT SERVICES CFR(s): 482.54 Standard-level Tag for §482.54 Condition of Participation: Outpatient Services If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that outpatient services were maintained according to acceptable standards of practice. Findings include: During an environmental tour with the RN Care Coordinator on the afternoon of 8/20/2019, an ampoule of ammonia inhalant (respiratory stimulant to prevent or treat fainting) was observed in an unlocked cabinet of exam room #7 of the obstetrics and gynecology outpatient clinic of the hospital. The exam room door was open without staff present, creating the potential for unmonitored access to the room by anyone present in the clinic. At 1:30 PM The RN Care Coordinator confirmed the presence of the ammonia inhalant and the Executive Director for Quality stated that the necessity for securing medication, "makes perfect sense".	A1081	**Corrective Action:** A. All ammonia ampules have been removed from unsecured areas in all Outpatient and Hospital -based patient care areas. B. Mandatory Staff Education: Staff have received education on the basic principles for safe medication storage and handling. C. The *EOC Rounding Form* has been revised to include safe medication storage. This form, completed by Nursing Staff on the Birthing Center and by Medical Assistants in the Outpatient Practices on a daily basis, has been updated to include assessing for the presence of any unsecured medication including ammonia inhalants in patient care areas. **BMH Staff Member Responsible:** Erinna Cooper, RN/ Director of Birthing Center Jessica Bird, RN/ Care Manager: Brattleboro Obstetrics and Gynecology tag A 1081 POC accepted SS/DW 9/25/19	**Date of Completion:** 9/04/2019 **Date of Completion:** 9/04/2019 **Date of Completion:** 9/04/2019

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A1153	DIRECTOR OF RESPIRATORY SERVICES CFR(s): 482.57(a)(1) There must be a director of respiratory care services who is a doctor of medicine or osteopathy with the knowledge, experience and capabilities to supervise and administer the service properly. The director may serve on either a full-time or part-time basis. This STANDARD is not met as evidenced by: Based on staff interviews the hospital failed to assure that a physician was designated as the Director of Respiratory Care Services. Findings include: Based on interview with the Manager of Respiratory Services on 8/20/19 at 8:40 AM and 8/21/19 at 9:15 AM, no physician had been appointed as the Director of Respiratory Services following the departure of the previous Director. The Manager of Respiratory Services stated a that a hospitalist was designated by the previous Chief Nursing Officer but added "I don't know if it's even written anywhere." The Manager of Respiratory Services confirmed that the physician who oversees the blood gas lab does not function as the Director of Respiratory Services. During interview on 8/20/19 at 11:20 AM, the Chief Medical Officer reported that the hospital has not had Director of Respiratory Care Services for the last four and five years.	A1153	**Corrective Action:** Christopher Meyer, MD has been appointed the Medical Director of Respiratory Services **BMH Staff Member Responsible:** Kathleen McGraw, MD/Chief Medical Officer tag A1153 PoC accepted SS/DW 9/20/19	**Date of Completion:** 09/04/2019