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

April 24, 2023

Joseph Woodin, CEO
Copley Hospital
528 Washington Highway
Morrisville, VT 05661

Dear Mr. Woodin:

The Division of Licensing and Protection completed a survey at your facility on **January 6, 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 **April 24, 2023.**

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
	471305	A. BUILDING ______ B. WING ______	C 01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPLEY HOSPITAL	**528 WASHINGTON HIGHWAY MORRISVILLE, VT 05661**

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C 000	INITIAL COMMENTS An unannounced on-site investigation of complaint #21418 was conducted on 1/5/23 through 1/6/23 by the Division of Licensing and Protection as authorized by the Centers for Medicare and Medicaid to determine the Acute Care Hospital's compliance with the EMTALA (Emergency Medical Treatment and Labor Act) regulations. The complaint was authorized by the Centers for Medicare and Medicaid to determine the Acute Care Hospital's compliance with Sections of 1866 and 1867 of the Social Security Act and the related regulations of 42.CFR 489.24, Responsibilities of Medicare Participating Hospitals in Emergency Case (EMTALA requirements) The allegations of non-compliance with the EMTALA requirements were substantiated. The following regulatory violations were identified.	C 000	POC approved. Jane Kendall, RN	
C2406	MEDICAL SCREENING EXAM CFR(s): 489.24(a) and 489.24(c) (a)Applicability of provisions of this section. (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- (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	C2406	Revised current Emergency Medical Condition Screening and Stabilization (EMTALA) policy to clearly state that all patients presenting for assessment and treatment in the ED or within 250 yards of the main building will receive a Medical Screening Exam by a QMP.	Will be presented to Clinical Practice Committee for review and approval by 05/23/2023 Education will be rolled out after CPC meeting and complete by June 15, 2023

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C2406	Continued From page 1 meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (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. (2)(i) When a waiver has been issued in accordance with section 1135 of the Act that 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: (A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period. (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. (C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay. (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.	C2406	EMTALA training continues to be mandatory and annually for staff at Copley Hospital.	Annually by December 2023

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C2406	Continued From page 2 (E) There has been a determination that a waiver of sanctions is necessary. (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. (c) Use of dedicated emergency department for nonemergency services. If an individual comes to a hospital's dedicated emergency department and 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. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to provide an appropriate medical screening examination within the capability of the hospital's emergency department for 1 of 21 patients (patient #1). Findings include: Review on 1/5/23 of an anonymous complaint revealed a concern specific to a potential EMTALA (Emergency Medical Treatment and Labor Act) violation occurring on 12/25/22. The complaint was specific to patient #21 being transported to the hospital via EMS (Emergency	C2406		

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C2406		C2406		

Continued From page 3
Medical Services)/ambulance and being turned away and redirected to another hospital after arriving at the hospital. The Director of Quality, Risk, and Informatics provided the Emergency Department (ED) patient roster logs for the period of 1/5/22 - 1/5/23 as well as the transfer patient roster log for the same periods of time.

Review on 1/5/23 of the hospital Emergency Department's patient roster from 7/5/22 - 1/5/23 revealed a total number of ED visits to be 7,441 with an average monthly visit total of 1,240. Of those 7,441 ED visits there were 179 patient transfers to another medical facility. Patient #21 was not listed on the ED log for the month of 12/2022 and was not listed on the transfer log for the month of 12/2022. A request was made for a list of persons/patients who arrived at the hospital campus ED requesting treatment but were not seen or did not receive care, and a list of "left without being seen" (LWBS) and those who left "against medical advice" (AMA) for the period of 1/5/22 - 1/5/23 was provided by the Director of Quality, Risk, and Informatics. Patient #21 was not on either of these lists.

Interview on 1/5/23 at 2 PM with the Director of Quality, Risk, and Informatics, confirmed she/he has been in this role for 5 years. She/he explained that there are times when the hospital needs to divert a patient to another hospital for care/services. There have been times in the recent past when a diversion was necessary due to staffing issues, no power, the CT scanner is down, or when the ED is full of "boarders" (patients awaiting psychiatric placement and cannot be discharged) - "this happened 2 weeks ago when we had 6 boarders who were waiting for inpatient psychiatric, and we have people in

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C2406	Continued From page 4 isolation for the flu." The hospital does not have a log of patients who were diverted since they didn't come to this hospital. When a diversion occurs, a call is made to the states HANS line to notify the state of the issues requiring patient diversion. She/he explained that HANS is part of emergency mobile response in Vermont. Interview on 1/5/23 at approximately 2:20 PM with the prior Director of Acute Care Services and ED who stated to her/his recollection there was only one case where a person presented to the ED for care and was directed after arrival to the ED to go to another hospital and this was on 12/25/22. She/he stated, "It was a patient with an incision and swelling below the site and the EMS provider should have made that determination prior to getting here." The prior Director of Acute Care Services and ED explained that she/he had stepped down from the role of Director of Acute Care Services and ED and started a new role in the IT (Information Technology) department last week. She/he had been in the role of Director of Acute Care Services and ED, as well as the interim manager of the ED for the past 4 years and was also a licensed paramedic in the State of Vermont. She/he explained the process of EMS services and stated that the hospital will receive a patient in transit report via the radio or phone and if the patient is critical, they "may not get a call if the rescue is real close by". She/he stated that the EMS departments that bring patients to the hospital "know that this hospital may not have the resources to provide the needed care for a certain patient and we would divert them elsewhere depending on the medical issue." She/he explained that when EMS calls the ED, they provide a brief patient report and depending on the report the hospital ED provider may	C2406		

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C2406	Continued From page 5 recommend diversion to another hospital that has the resources to manage the patient's medical needs, and this would be the closest hospital that has those resources. She/he explained that if a patient is having abdominal pain and the hospitals CT is down they may have to divert to another hospital as well, if someone needs an ultrasound after hours, they might be diverted because there is no one on call for ultrasound "and since we don't have someone after hours it's best the patient is sent to a different hospital to not delay care", and "as an EMS provider I will ask to talk to the doctor." Tour on 1/6/23 at 9 AM with the prior Director of Acute Care Services and ED, and the Corporate Compliance and Privacy Officer. The survey team was present when a call came in from EMS on the hospital radio and was triaged by the charge nurse for the day. The prior Director of Acute Care Services and ED explained that the charge nurse role is rotated to a new nurse each day. The RN charge nurse answered the radio and received report from the ambulance personnel which included a female patient who had fallen at home and had a laceration to her head that would require either sutures or staples, in addition, the patient did not recall the fall or what happened, indicating a possible loss of consciousness. She/he documented the patient report on a form titled, "PREHOSPITAL COMMUNICATION RECORD". This form contained areas for the patients name, date, time notified by EMS, on scene time, Estimated Time of Arrival (ETA), arrival time, ambulance service name, nature of call and location of call, patients date of birth (DOB), patient info, Chief Complaint/history of present/physical exam/treatment, time and vitals, orders from	C2406	The Copley Hospital Prehospital Communication Report Form was modified. (Modified form is attached) The form will be completed to document all communication between transporting Ambulance Services and Referring Facility for all ED patients. This form will be placed in a binder, audited by ED Nurse Manager, scanned and saved for at least 5 years. Prehospital Communication Modified Form will be sent to all ED staff by email with read receipt confirmation for staff completion tracking. The current binder will be updated with modified forms.	Modifications to form completed 04/17/2023 Audits will be completed by ED Nurse Manger starting June 15-August 15, 2023 to monitor for documentation compliance.

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C2406		C2406		

Continued From page 6
medical control (hospital), the medical control MD, the person taking the report, the room assigned upon arrival and updates after intervention. Both the prior Director of Acute Care Services and ED and the Corporate Compliance Officer confirmed that the completed forms are not saved. It was noted that the RN charge nurse for the day was having difficulty understanding the EMS personnel on the radio and asked them to call back on the ED phone. Additional information was received by the RN charge nurse for the day over the phone. It was observed at this time that the RN charge nurse for the day and another RN collaborated in discussion regarding the call and room placement upon arrival. At no time was the ED MD consulted regarding this call prior to the surveyors leaving the ED.

Interview on 1/6/22 at approximately 9:45 AM with the Director of Quality, Risk, and Informatics regarding the "PREHOSPITAL COMMUNICATION RECORD" form that was being used in the ED for EMS calls and the disposition of the completed forms. She/he stated that these forms are just used for the purpose of collecting the patient report from EMS calls and are discarded when the case is complete. She/he confirmed that there is no tracking method for people/patients who present to the ED and are not seen, specifically in the case of person/patient #21. She/he was not able to provide any documentation that this person/patient #21 had presented to the ED on 12/25/22.

On 1/6/23 at approximately 10 AM a recording of two calls that were received in the ED on 12/25/22 regarding the person/patient #21 listed

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in the complaint revealed the following dialogue:

1.) 12/25/22 at 0841 a radio transmission revealed: "Copley ER", there was no further dialogue. The voice answering this radio call was confirmed on 1/6/23 at 10:02 AM to be that of the prior Director of Acute Care Services and ED.

2.) 12/25/22 at 0845 a phone call recording revealed:

ED/Nurse: "Copley ED this is [proper name omitted] you're on a recorded line."
EMS: "Hey [proper name omitted] this is [inaudible dialogue] with [proper name of rescue] we have a [inaudible dialogue] 1/5/55, he's a 55-year-old male. He's having some, uh, pain, in what he reports as swelling after a valve replacement surgery at [hospital name omitted]. Pulse is 71 BP is 211 on 70 sat 99 on room air.
We're on Park St. right now so I imagine we're 2-3 minutes out. Do you require anything further?"
ED/Nurse: "Um, can you repeat the name?"
EMS: "[proper name omitted] and last name was spelled out.
ED/Nurse: "[repeated last name spelled out], ok and what was the BP?"
EMS: Uh, 211 on 70."
ED/Nurse: "Ok, alright, we'll see you in a couple of minutes, thank you."
EMS: "Awesome, see you then." Call ended

Review on 1/6/23 of the ED staffing schedule for 12/25/22, confirmed that the above noted nurse (RN) was working at the time of these incoming calls.

Interview on 1/6/23 at approximately 10:15 AM

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C2406	Continued From page 8 with the above noted RN, she/he confirmed that she/he did work the day shift on 12/25/22. The 12/25/22 at 0845 phone call recording was played back for this nurse who confirmed she/he had taken this call, and that the voice from ED heard on this recording was her/him. She/he stated that she/he has been a traveler here at this hospital since August of this past year and that she/he recently renewed her/his contract for an additional 13-week assignment at this hospital. She/he is "used to working at a level 3 trauma center." She/he does recall the above documented conversation with the EMS caller for a "patient with a valve replacement that was done at [hospital name omitted]". She/he confirmed that a conversation with the ED doctor did not occur while EMS was still on the phone. She/he stated that, "I always tell a provider and the team what's coming in. This is what might have spurred the conversation as to send him to [hospital name omitted]." She/he stated that sometimes EMS asks to speak with a provider but that was not the case with this call. When asked if she/he had received training on EMTALA, she/he stated she/he had and that she/he understands some of what EMTALA means - "that we don't turn away anyone at the door." When asked what types of scenarios does, she/he know would be directed to go to the next closest hospital, she/he stated, "medical issues that can't be managed here." When asked if she/he had any concerns about whether this was a situation that should have been diverted to another hospital, she/he stated she didn't think so but was not sure of the hospital policy." Interview on 1/6/23 at approximately 10:35 AM with the prior Director of Acute Care Services and ED regarding the above calls, she/he stated that	C2406		

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C2406	Continued From page 9 she/he took the radio transmission call, but the caller was inaudible. She/he stated that everyone at the nurse's station that day were nurses and when the call came in the nurse did tell the team the report, she/he received from EMS. The prior Director of Acute Care Services and ED stated that she/he could not remember if it was doctor [proper name omitted] or doctor [proper name omitted] who gave the direction because we did not have ultrasound, or a vascular surgeon and we don't have interventional radiology or do open heart surgery. The direction came from one of the MD's, mid shift around the 10 AM timeframe. We don't take anyone who is having an MI (heart attack) or stroke EMS will go to another hospital." The prior Director of Acute Care Services and ED was asked if the EMS team should have known to bypass this hospital and go to the next closest hospital based on this person/patient #21's presentation and she/he said, "yeah, they should know this unless they are a new EMT or Paramedic." When asked if she/he knew the person/patient #21 was stable, she/he said, "based on the vital signs, yes. You know, you can tell a lot by the tone of voice of the EMS person if a patient is not good. This patient seemed ok, and it was about getting the patient the appropriate care. Currently 50% of our nurses are travelers." When asked if she/he had received EMTALA training, she/he stated that she/he had received EMTALA training and understood the reasoning behind the regulations. She/he explained that she/he did go out into the ambulance bay to greet the EMS personnel and she/he did direct them to go to [hospital name omitted] (the hospital where the valve replacement was performed). Review of the 250-yard rule was discussed and she/he stated she/he "understood the reasoning behind the	C2406	RN is not a QMP and therefore is not qualified to complete a Medical Screening Exam or divert an ambulance. Internal investigation of events led to referral to VT Board of Nursing. RN Staff no longer employed at Copley Hospital.	

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C2406	Continued From page 10 250-yard rule which was to prevent dumping but this is not a case of dumping" but she/he didn't feel that it was applicable in this case since the ambulance was right down the road and there was not enough time to re-direct the ambulance before it arrived on hospital property. When asked what the process is when a call comes in from EMS regarding when and how the nurses know when to divert to the next closest hospital, she/he stated the nurse that took the call was a travel nurse and she probably didn't know the policy. It was asked when a nurse takes a call from EMS, is there guidance or a policy as to when the nurse should be discussing the case with the doctor to ensure it is appropriate for EMS to bring a patient to this hospital, she/he stated it is nursing judgement based on the hospitals resources and ability to provide the needed care. Review of the physician schedule for 12/25/22, revealed the doctor that was working in the ED at the time of this EMS transport. An attempt was made to interview this physician; however, she/he would not be available until Monday, 1/9/23. Review of the ED physician's credentialing file was reviewed and found to be in compliance with the hospital CoP's. Review of the prior Director of Acute Care Services and ED's employment file was noted that she/he had received EMTALA training on 12/31/2021. Review of the travel RN's employment file, it was noted she/he had received EMTALA training on 12/9/2022. Interview on 1/6/23 at approximately with the	C2406		

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C2406	Continued From page 11 Corporate Compliance and Privacy Officer confirmed a list of 53 training's that are provided to travel staff prior to working on the floor and with patients. Some of the listed training's are: 2022 Acute Care Accreditation/Occupational Safety and Health: EMTALA; 2022 Acute Care Accreditation/Occupational Safety and Health: Patient Rights; 2022 Corporate Compliance; Emergency Nursing Triage 1.1: Chief Complaint: Traumatic Injuries; Emergency Nursing Triage 1.1: Chief Complaint: Wound and Extremity; Emergency Nursing Triage 1.1: Introduction to Triage; Emergency Nursing Triage 1.1: Legal Issues in Triage; Emergency Nursing 1.1: Red Flags in Triage; Emergency Nursing 1.1: The Triage Process: Part I; Emergency Nursing 1.1: The Triage Process: Part II; Emergency Nursing Triage 1.1: Triage and Challenging Situations; etc. Phone Interview on 1/9/23 at approximately 12:30 PM with the doctor who was working in the ED on 12/25/22 day shift, confirmed she/he had reviewed the concerns that brought the survey team to the hospital. She/he does recall working 12/25/22, day shift and that the EMS patient report was brought to her/his attention, and she/he stated recalled "saying something like, hmmmmmmm, I wonder why they would be coming here since he (the person/patient #21) had his procedure at [hospital name omitted]. I would have suggested the patient go to [hospital name omitted] (the hospital where valve replacement was performed)." When asked if she/he had given direction for the ambulance to go to the hospital where the valve replacement had been done, she/he stated, "No, I did not give that direction, although I did wonder what made the EMS staff decide to bring him here." When	C2406	Internal Copley Hospital investigation resulted in practitioner case being reviewed by Peer Review. The Doctor in question clearly understands what process should have been followed, and will alter his practice to have a greater awareness of ensuring the ED functions to follow appropriate practice.	

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	471305	A. BUILDING ______ B. WING ______	C 01/06/2023

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C2406	Continued From page 12 asked if she/he was aware that the prior Director of Acute Care Services and ED had met the ambulance at the ambulance bay of the hospital and told them the doctor wanted them to go to [hospital name omitted] (the hospital where valve replacement was performed), she/he said, "No, I was not aware that that is what [proper name omitted] (prior Director of Acute Care Services and ED) directed the EMS service to do - [proper name omitted] (prior Director of Acute Care Services and ED) told me [she/he] would go out and speak with the EMS personnel. I did not know [she/he/proper name] had told them to go to [hospital name omitted] (the hospital where valve replacement was performed)." When asked is the prior Director of Acute Care Services and ED was considered a Qualified Medical Person and could perform the required Medical Screening Exam, she/he replied, "No, [she/he/proper name omitted] would not be." She/he wondered if she/he had gone out to the ambulance and assessed the patient and then directed them to go to (the hospital where valve replacement was performed) if that would have met the EMTALA regulations. Per review of the hospital policy, "Medical Screening and Stabilization (EMTALA)", effective 05/31/2017, with a last review or revision on 6/28/2022, it states, "Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected in (a) placing the health of the individual (.......) in serious jeopardy; (b) serious impairment or loss of bodily functions; or (C) serious dysfunction of any bodily organ or part.......Medical Screening Exam (MSE): The process required to reasonably	C2406		

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C2406	Continued From page 13 reveal that an emergency medical condition does or does not exist. The MSE can range from a simple process involving only a brief history and physical examination to a complex process that includes collaboration with multiple disciplines and ancillary studies. It is individualized based on the patient's chief complaint, and the individual's presenting clinical symptoms. A triage screening is not an acceptable substitute for an MSE, which can only be performed by a physician or other qualified medical professional. Qualified Medical Person (QMP): ......Hospital defines QMP as a Doctor of Medicine or Osteopathy, Nurse Practitioner or Physician's Assistant with Emergency Department privileges......Policy Provisions: Provides an appropriate medical screening examination (MSE) by the QMP to determine if an emergency medical condition does or does not exist for every individual who presents at the hospital's Emergency Department (ED) and requests an examination or treatment for a medical condition. Provides an appropriate MSE by a QMP to determine if an emergency medical condition does or does not exist for an individual at the request of a representative acting on behalf of the individual for a medical condition or for a condition that a prudent layperson observer believes, based on the individual's appearance and/or behavior, needs examination or treatment for a medical condition. Provides necessary stabilization treatment for Emergency Medical Conditions and Labor within the capabilities of the staff and facilities at the Hospital. Provides an appropriate transfer of the patient if the Hospital does not have the capability or capacity to provide the treatment necessary to stabilize the Emergency Medical Condition........Maintain medical and other records related to individuals transferred to and from the	C2406		

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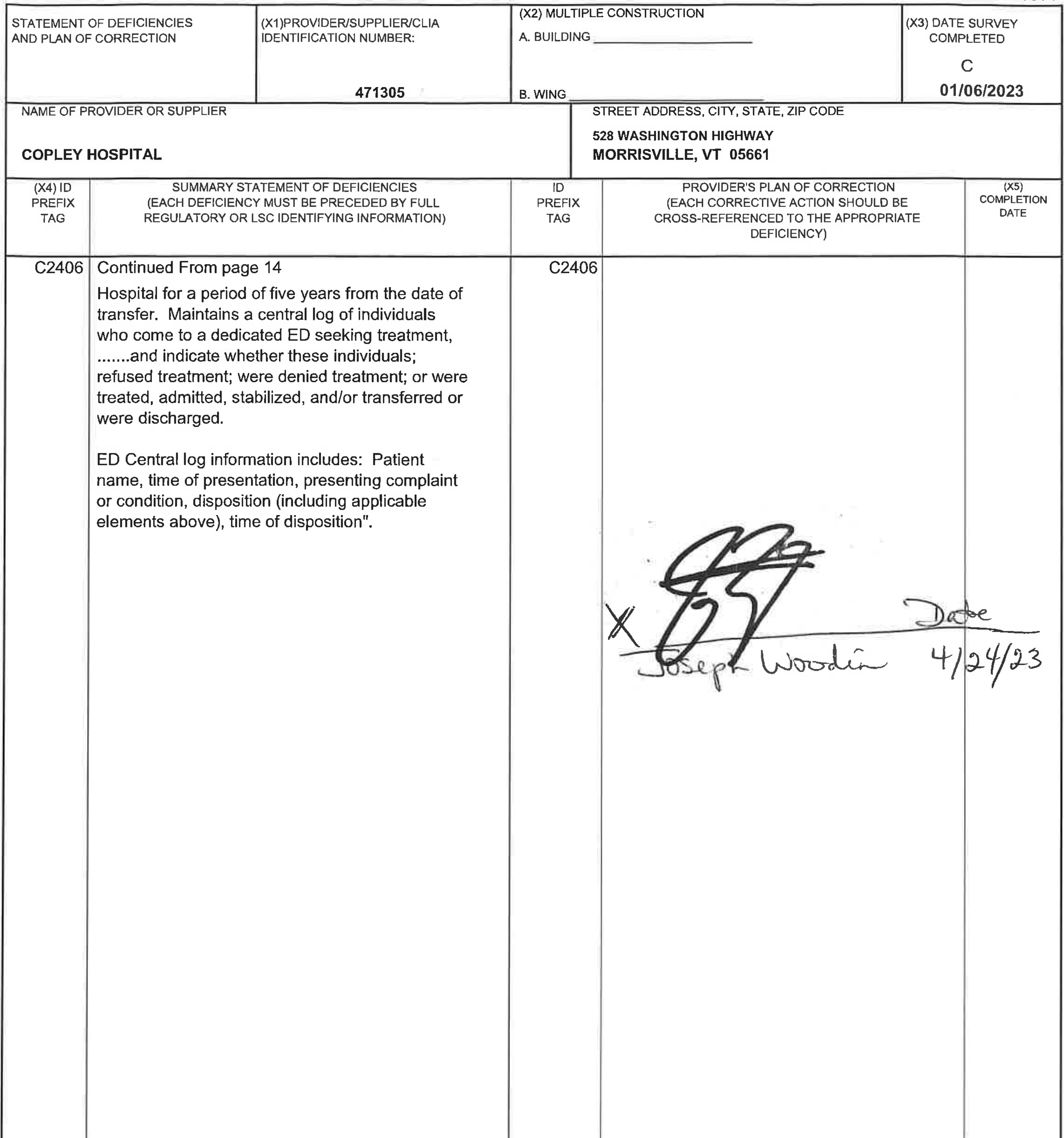
FORM APPROVED
OMB NO. 0938-0391

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



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C2406	Continued From page 14 Hospital for a period of five years from the date of transfer. Maintains a central log of individuals who come to a dedicated ED seeking treatment, ...and indicate whether these individuals; refused treatment; were denied treatment; or were treated, admitted, stabilized, and/or transferred or were discharged. ED Central log information includes: Patient name, time of presentation, presenting complaint or condition, disposition (including applicable elements above), time of disposition".	C2406	X Date Joseph Woodin 4/24/23	