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

May 2, 2018

Mr. Timothy Ford, CEO
Springfield Hospital
Po Box 2003
Springfield, VT 05156-2003

Dear Mr. Ford:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **March 21, 2018.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Suzanne E. Leavitt RN, MS

Suzanne Leavitt, RN, MS
State Survey Agency Director
Assistant Division Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471306	A. BUILDING _____ B. WING _____	C 03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HOSPITAL	PO BOX 2003 SPRINGFIELD, VT 05156

(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
C 000	INITIAL COMMENTS A unannounced recertification survey was conducted on 3/19/17 through 3/21/18 by the Division of Licensing and Protection to determine compliance with the Conditions of Participation for Critical Access Hospitals (CAH) for 42 CFR Part 485, Subpart F. The following regulatory violations were identified: At the time of the recertification survey complaint #16363 was investigated during the PPS Excluded Distinct Part Psychiatric Unit survey which was completed on 3/20/2018. No regulatory findings were identified related to the complaint.	C 000		
C 226	MAINTENANCE CFR(s): 485.623(b)(5) [The CAH has housekeeping and preventive programs to ensure that- there is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas. This STANDARD is not met as evidenced by: Based on observations, staff interview and record review CAH failed to install and monitor temperature and relative humidity levels in the Central Sterile Processing, Perioperative, and Endoscopy areas. Findings include: During a tour on 3/19/18 at 11:47 AM of the perioperative area, central supply area (including decontamination, preparation and packing and sterile storage), and endoscopy procedure rooms, there were no gauges noted in these areas to monitor the temperature and relative	C 226	Humidity monitors have been ordered and will be installed in the Central Sterile Processing, Perioperative and Endoscopy areas. Humidity levels will be monitored systematically on daily during hours of operation by assigned staff in those areas to assure that humidity levels are within the ranges as indicated by AORN. Variances in humidity levels will be reported to Engineering for adjustment to acceptable range. A log will be maintained for each monitor documenting humidity levels and will include any action made to correct those levels and will include the corrected humidity level(s). The log will be reviewed daily during operations by the area(s) department manager or designee. C226-Acceptable 5.1.18 fm KSP	04 30 18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Robert DeMarco, RN, BSN, MA
Chief of Quality and Chief Information Officer

(X6) DATE
04 20 18

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

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C 226	Continued From page 1 humidity to prevent microbial and bacterial growth. Per interview with the Nurse Manager of Peri-operative services at that time s/he stated that the maintenance department was measuring the temperatures and relative humidity in those areas. Per interview on 3/19/18 at 2:38 PM with the Director of Maintenance, s/he stated that the maintenance department was not monitoring the temperature and humidity in those areas and had not been doing so for years. Per national standards developed by AAMI (Association for the Advancement of Medical Instruments) hospitals are expected to monitor and maintain temperatures and relative humidity within recommended levels in all locations associated with Central Sterile Reprocessing (CSR) to include decontamination, preparation & packing and sterile storage. Monitoring and maintaining temperatures and relative humidity at specific parameters is recommended to prevent microbial and bacterial growth in packaged sterilized material and instruments. Per AORN (Association of periOperative Registered Nurses) -Guidelines for a Safe Environment of Care, Part 2, effective May 15, 2014 pgs. 10-17) "Recommendation IV-The health care organization should create and implement a systemic process for monitoring HVAC (heating, ventilation, air conditioning) performance parameters and a mechanism for resolving variances ..... IVe.1.The relative humidity in a restricted area should be maintained within a range of 20-60%. IVe.2.The humidity in a semi-restricted area: -sterile storage-maximum 60% IVe.3.The relative humidity in an unrestricted	C 226	Acamt 5.1.18 fm	

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C 226	Continued From page 2 area: -PACU (post-operative care unit)-20-60%; -endoscopy procedure room-20-60% -procedure room-20-60% IV.f.1.The temperature range in a restricted area should be 68 degrees F to 75 degrees F (20 to 24 degrees C) IV.f.2.The temperature in a semi-restricted area: -sterile storage-75 degrees F (24 degrees C) -decontamination room-60 degrees F to 73 degrees F (16 degrees C to 23 degrees C) IV.f.3.The temperature of an unrestricted area should be between 70 degrees F and 75 degrees F (21 degrees C and 24 degrees C) IV.f.4.The temperature of an endoscopy procedure room should be between 68 degrees F and 73 degrees F (20 degrees C and 23 degrees C)"	C 226		
C 272	PATIENT CARE POLICIES CFR(s): 485.635(a)(2), (a)(4) §485.635(a)(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1). §485.635(a)(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH. This STANDARD is not met as evidenced by: Based on staff interview and record reviews, the CAH (Critical Access Hospital) failed to assure that all policies were reviewed and/or revised at	C 272	POC amt 5.1.18 SM/SC	

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C 272	Continued From page 3 least annually by members of the group of professional personnel as required, and reviewed by the CAH as necessary. Findings include: At the time of the recertification survey, department policies were reviewed to confirm CAH staff had conducted a annual review and/or revision of policies. The following departments failed to demonstrate compliance with the regulation to include: 1. Per record review and staff interview, the Laboratory (Lab) Supervisor confirmed on 3/20/18 at 9:41 AM that Lab policies are not consistently reviewed or revised annually. The following Lab policies were last reviewed in 2016: "SYSMEX XN-200 Automated hematology analyzer" - approved 2/23/16; "Sure-VUE Mono" - approved 10/31/16; "QA04 Guidelines for Record and specimen retention" - approved 12/14/16"; and "QA03 - CAP terms of accreditation" - approved 12/18/16 and reviewed 12/9/16. 2. Per record review and staff interview, the Health Information Management Director confirmed on 3/20/18 at 2:40 PM that Health Information policies are not consistently reviewed or revised annually. The following Health Information polices were last reviewed on the following dates: "Medical Completion" - approved 4/21/09 and reviewed 4/25/14; "Chart Analysis" - approved 4/24/14; and "De-identification of Protected Health Information" - reviewed 4/24/14. 3. Per record review Emergency Department policies were not consistently reviewed or	C 272	Springfield Hospital's "Patient Care Policy and Procedure Development" states that each policy and procedure will be reviewed at a minimum of once each year. Review and revision may be done more frequently when deemed necessary. 1. Each Lab policy indicated has been reviewed and is now current. The Laboratory is CAP accredited. CAP standards and policy require policy review every two years. Upon the advisory of a CMS surveyor a statement has been added to this policy to indicate that all laboratory policies will be reviewed on an annual basis. Managers will be reeducated to policy requirement. Oversight and monitoring to assure compliance for annual policy review will be provided by the Department Manager and Division Head. 2. Each Health Information policy indicated has been reviewed and is now current. Monitoring for completion as stated in section #1. POC compl 5.1.18 fm/sl	04 17 18 04 17 18

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C 272	Continued From page 4 revised annually. The following Emergency Department policies were last reviewed on the following dates: "Admission of Patients to the Emergency Department", last reviewed 8/25/2016, Discharge Criteria, Summary, and Instructions for the Emergency Department", last reviewed 8/18/2016 and "Clinical Conflict Resolution in the Emergency Department" last reviewed 5/19/2014.	C 272	3. Each Policy as indicated has now been reviewed and is current. Monitoring for completion as stated in section #1.	04 17 18
	4. Per review of the policy "Malignant Hyperthermia in the OR", start date of 2/13/14, there was no evidence that the policy was reviewed or revised annually. Per interview on 3/20/18 at 3:00 PM with the Nurse Manager of Peri-operative services s/he confirmed that the policy was not updated.		4. The "Malignant Hyperthermia" policy as indicated has now been reviewed and is current. Monitoring for completion as stated in section #1.	04 17 18
	5. Per record review the following Anesthesia Department policies were not revised or reviewed annually: "Anesthesia Provider Duties and Responsibilities" reviewed 7/12/13, "Guidelines for the Ethical Practice of Anesthesiology" reviewed 7/12/13, "Standards for Patient Care" prepared 7/17/13, "Malignant Hyperthermia" no revised or reviewed date, "Safety Guidelines for Anesthesia" reviewed 7/17/13, and Documentation of Anesthesia Care Guidelines" reviewed 7/17/13. Per interview on 3/21/18 at 8:30 AM with the Nurse Manager of the Operating room, s/he confirmed that the anesthesia policies had not been updated.		5. Each Anesthesia Policy as indicated has now been reviewed and is current. Monitoring for completion as stated in section #1.	04 17 18
	6. Per record review and staff interview, the Infection Control RN confirmed employee health policies were in need of updating, to include: "Employee Influenza Immunization", last reviewed 2/8/2016.		6. The "Employee Influenza Immunization" policy as indicated has now been reviewed and is current. Monitoring for completion as stated in section #1. Reviewed 5.1.18 FM/SI	04 17 18

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C 278	PATIENT CARE POLICIES CFR(s): 485.635(a)(3)(vi) [The policies include the following:] A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation and staff interview, the CAH failed to ensure that patient care devices were stored in a manner that reduced the possibility of cross-contamination. Findings include: During a tour on 3/20/18 at 10:30 AM of the stress test lab, radiology exam room 2, and the magnetic resonance imaging (MRI) suite, each of these areas had a wall connector that was used for oxygen with extension tubing coiled around it; and a wall connector used for suction with tubing that was uncovered and coiled around it. This observation was confirmed at the time of the tour by the Director of Radiology. Per interview on 3/20/18 at 4:23 PM with the Nurse Manager of the Medical/Surgical Unit, s/he stated that the facility practice was to leave the oxygen tubing and/or extensions unopened and unattached to the wall connection until the patient arrived to a procedure room and/or hospital room. When the patient was discharged and/or left the procedure area, the oxygen and/or extension tubing would be thrown away. S/he stated that the practice for suction set-up was to cover the suction container and tubing with a plastic bag. S/he stated that if the suction container was used, the system was thrown away and a new system with a bag covering the tubing and suction container was set up.	C 278	In Radiology Department in the areas of the stress test lab, radiology exam room #2, MRI suite and all areas within the department all suction canisters, tubing and suction tubing is to be covered with a thin, clear plastic bag for cleanliness. Equipment will be exchanged after each individual patient use. All suction and oxygen tubing will be monitored and inspected daily for proper function by the Director or designee. ax acupt 5.1.18 FM/DI	03 26 18

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C 302	RECORDS SYSTEMS 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 staff interview and record review the CAH failed to assure patient care records are legible,complete and accurate and the provision of care conducted by providers was consistently documented and completed within the required time frame to facilitate continuity of patient care. Findings include: 1) Per record review of the Health Information Management (HIM) "Chart Deficiency Report" and staff interview, the HIM Director confirmed on 3/20/18 at 2:40 PM that one provider has an outstanding pattern of clinical record deficiencies which is known to the Medical Staff, Administration, Physician Leadership, and Chief of Physician Practices. Per record review of the "Medical Records Completion Policy" dated 4/14/16 and confirmed with the HIM Director on 3/20/18 at 2:40 PM, "The record must be completed promptly after discharge in accordance with State Law and Hospital policy but no later than 30 days after discharge and discharge summaries will be dictated within 7 days of discharge". 2. Per review of the medical records for 2 patients who had surgery at the CAH (Patients # 10 and #19), neither medical record had evidence of Post Anesthesia Evaluations conducted within 48 hours post anesthesia administration. During interview on 3/21/18 at	C 302	1 To assure compliance with chart completion as indicated per requirements of State law, Hospital policy and Medical Staff Bylaws follow up monitoring for completion of charts will occur of outstanding charts will occur at the end of each Hospitalist shift by the Chief of Practice Operations or designee. The provider indicated with outstanding deficiencies has completed these records and has been reeducated to the requirements of chart completion. 2. Educational follow up has occurred with the Anesthesia providers. Anesthesia providers will document post anesthesia evaluations prior to discharge of an outpatient and and a separate 48 hour post anesthesia evaluation for admitted patients.	04 18 18 04 18 18

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

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C 302	Continued From page 7 11:25 AM, the IT (Information Technology) staff person assisting the surveyor with locating the documentation confirmed that the anesthesiologist for these patients confirmed that s/he does hand written evaluations in the medical record progress notes. The notes should have been scanned into the record by HIM staff post patient discharge from the hospital however, they could not be located and were missing from the records. 3. Per record review a patient (Patient #17) had a foreign body removed from his/her left forearm using local anesthetic, the Consent for Operation or Invasive Procedure was not signed and dated by the provider. Per interview on 3/21/18 at 11:43 AM with a Clinical Applications Specialist, s/he confirmed that the consent was not signed or dated by the provider.	C 302	The anesthesia tech will compile a list of patients that were admitted and requiring post anesthesia evaluations. This list will be posted in a secure location in the anesthesia office. The float anesthesiologist will be responsible to assure completion of post anesthesia evaluations. Health Information Management will monitor and assess forms for completion, scan forms into the electronic medical record and report findings to the Director of Anesthesia. All invasive procedures receive informed consent prior to procedure. Consents are monitored and checked by Nursing staff prior to transport to the operating room and again at the "time out" prior to an OR procedure. Providers will be provided education and reminders to assure completion of signed consent.	04 18 18 04 18 18
C 308	PROTECTION OF RECORD INFORMATION CFR(s): 485.638(b)(1) The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use. This STANDARD is not met as evidenced by: Based on observation and staff interview the CAH failed to store medical records in a manner to ensure that they are safeguarded against loss and destruction and failed to ensure confidentiality of all medical records was maintained. Findings include: 1) Per observation of the "Multi Disciplinary Room" on 3/19/18 at 12:12 PM, clinical records with deficiencies waiting for provider review are	C 308		

Acceptable 5.1.18 FM SL

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C 308	Continued From page 8 stacked on shelves in this area and are unsecured from unauthorized access. Per staff interview, the Health Information Management (HIM) Director confirmed the "Multi Disciplinary Room" where clinical records with deficiencies are located is unsecured from unauthorized access twenty four hours a day seven days a week (24/7) and there are times when no providers or staff are present in this room and the door is left unlocked. 2) Per observation of the Child Birth Center on 3/19/18 at 12:20 PM, clinical records with deficiencies waiting for provider review are located at the nurses station and are visible to staff, patients, and visitors. Per staff interview, the Health Information Management (HIM) Director confirmed on 3/19/18 at 12:20 PM that clinical records with chart deficiencies waiting for provider review are located in an area that is unsecured from unauthorized access 24/7 and there are times when no providers or staff are present at the nurses station. 3) Per observation of the clinical record storage room called "The Cage", there is no barrier present to protect clinical records from water damage if the the sprinkler system is activated or from ceiling water leaks. In case of fire, this room has sprinklers which are located above the clinical records. In addition, brown staining was noted on the ceiling above the storage stacks. Per staff interview and confirmed with the Plant Manager on 3/19/18 at 2:00 PM, the clinical records stored in this area do not have a barrier in place to protect them from water damage if the sprinkler system is activated and that a ceiling water leak occurred in the past causing	C 308	1. A lock will be added to the Multi Disciplinary Room to secure the room from unauthorized entrance twenty four hours a day seven days a week 24/7. The room will be kept secure at all times. Staff will be educated to the need to keep clinical records secure at all times. Monitoring of the room will occur by staff designee. 2. All clinical records that were stored at the nurses station have been removed and relocated to the health Information Management Department. Providers will complete clinical records in the Health Information Department. The Child Birth Center Manager will monitor the unit for continued compliance. 3. A barrier will be added above the records to protect the records from sprinkler water or ceiling leakage. Also a 4" extension to the solid top of the record cabinets will be added to divert any water away from the vertical dimension of the recored cabinet. Ceiling tiles stained will be changed out. This record storage room will monitored daily by Health Information Management Staff.	06 01 18 03 13 18 06 01 18

Rec amt 5.1.18
tm/81

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C 308	Continued From page 9 the brown staining on the ceiling.	C 308		
E 000	Initial Comments At the time of the CAH recertification survey conducted on 3/19/18- 3/21/18 by the Division of Licensing and Protection, the Emergency Preparedness survey was also conducted. The CAH was found to be in Substantial Compliance with the required regulations related to Emergency Preparedness.	E 000		

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	47M306	A. BUILDING _____ B. WING _____	03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HOSPITAL PSYCH UNIT	PO BOX 2003 SPRINGFIELD, VT 05156

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A 000	INITIAL COMMENTS During the unannounced recertification survey of the Critical Access Hospital by the Division of Licensing and Protection, a PPS Excluded Distinct Part Psychiatric Unit survey was completed on 3/20/2018. The unit was determined to be in substantial compliance with regulations 42 CFR 412.25 and 42 CFR 412.27.	A 000		

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

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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	47Z306	A. BUILDING _____ B. WING _____	03/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HOSPITAL SWING BED UNIT	PO BOX 2003 SPRINGFIELD, VT 05156

(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 000	INITIAL COMMENTS An unannounced on-site survey was conducted on 3/19/18 through 3/21/18 by the Division of Licensing and Protection of the Springfield Critical Access Hospital (CAH). The CAH was determined to be in substantial compliance with the Special Requirements for Providers for Long Term Care Services ("Swing Bed") 42 CFR Part 485.645.	A 000		

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