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

May 20, 2019

Michael Halstead, Administrator
Springfield Hospital
Po Box 2003
Springfield, VT 05156-2003

Dear Mr. Halstead:

The Division of Licensing and Protection completed a survey at your facility on **April 24, 2019**. 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 **May 16, 2019.**

Sincerely,

Suzanne E. Leavitt RN, MS

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
	471306	A. BUILDING _____ B. WING _____	R-C 04/24/2019

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 An unannounced, onsite Critical Access Hospital follow-up visit to the survey of 1/23/19, was completed on 4/24/19 by the Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The following regulatory violations were determined to remain uncorrected.	{C 000}		
{C 253}	STAFFING CFR(s): 485.631(a)(3) The staff is sufficient to provide the services essential to the operation of the CAH. This STANDARD is not met as evidenced by: Based on interview and record review, the Critical Access Hospital (CAH) failed to ensure that there was sufficient staff available at all times to respond to and address behavioral precautionary safety measures in the Emergency Department (ED) by requesting presence from a local police department to assist in the provision of patient care for 1 of 5 patients in the total sample. (Patient #3) Findings include: Patient #3 arrived to the ED on 3/9/19 at 19:31 accompanied by police under warrant after it was determined Patient #3 required mental health evaluation and hospitalization. Patient #3 presented as delusional and paranoid and had been refusing medications for schizophrenia since January 2019. Patient #3 denied suicidal or homicidal ideations; at times refused meals due to fear of being poisoned; often mumbled but would respond to staff questions. At 20:00 Patient #3 was informed by staff s/he would have to remove all clothing and change into a hospital gown and pants. Per nursing progress note	{C 253}	**C 253** A draft policy addressing alternative contraband processes i.e. metal detector wand was developed to eliminate the need for law enforcement involvement in this process. The draft policy will be presented to the appropriate Springfield Hospital committees for approval. Once the policy is approved, ED staff will be required to review, sign and date. 100% of behavior health patient charts are being reviewed by a designated charge nurse. Data is compiled from these records. The data is presented to the Medical and Nursing Directors of the Emergency Department. The data review will include law enforcement presence and utilization in the Emergency Department and documentation of contraband safety assessment. The use of law enforcement in regards to behavioral health patients in the ED will result in a debriefing and review of patient care events. The nursing director then reviews the data with staff at monthly staff meetings, nursing counsel, and safety committee. Reeducation and documented counseling between the employee and the Nursing and/or Medical Directors will be utilized when improper use of law enforcement is noted upon review. Failure to comply with organizational policy and practice could result in disciplinary action and/or termination.	Completion Date: 5/24/2019 Responsible Party: Nursing Dir. of ED

tag C-253 POC accepted 5/16/19 SD/MB

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael Hallisey

TITLE: Interim Chief Executive Officer

(X6) DATE: 5/10/2019

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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{C 253}	Continued From page 1 Patient #3 refused to change and informed staff " ...its my right to keep my clothes on, I'm not in jail". Although hospital security was assigned to observe Patient #3 and sufficient staff was present in the ED to assist in a clothing search, per telephone interview on 4/24/19 at 11:15 AM, the nurse assigned to Patient #3 on 3/9/19 confirmed s/he was directed by the PA-C (physician assistant) and ED charge nurse to call police to come to the ED for the purpose of searching Patient #3. At 20:30 Patient #3 consented to have his/her clothing searched. While hospital staff performed the search, 2 police officers arrived to the ED and remained stationed outside the patient's room in full view of the patient, creating a police presence and potential availability for intervention during the search of the patient's clothing.	{C 253}		
{C 271}	PATIENT CARE POLICIES CFR(s): 485.635(a)(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 staff interview and record review, the CAH failed to assure that all hospital policies and procedures included consistent definitions related to emergency treatment for patients exhibiting self-harming and/or other types of behavior. This practice had the potential to affect applicable patients in inpatient units and the ED (emergency department). There was also a failure by staff to provide services in accordance with existing policies and procedures. Findings include:	{C 271}	**C271** Revision of policy and procedure to pull information and content to include consistent definitions and terms related to emergency treatment for patients exhibiting self-harm and/ or other types of behaviors. The glossary will contain organizational definitions for: - Attending Physician/PA/NP - 1:1 monitoring with continuous visual observation - Non-Violent physical crisis intervention trained staff - Contraband - De-escalation strategies - Drug used as a restraint - Earliest possible time - Frequent observation - Intermittent observation - Restraint or seclusion - Medically necessary treatment - Multidisciplinary team discussion - Verification	Completion Date: 5/24/2019 Responsible Party: Nursing Director of Emergency Department

tag C-271 POC accepted 5/16/19 SS/MB

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{C 271}	Continued From page 2 1. Per review of hospital policies and procedures related to treatment of patients with mental health issues, including self harming/risk of harming others, and violent, aggressive actions, hospital policies were not consistent with definitions related to frequency of observations and documentation in related policies and procedures. This failure resulted in staff inconsistency of documentation of care and treatments regarding some Emergency Department patients who were restrained and or secluded . Examples of 2 reviews related to the inconsistent implementation of the policy/procedure processes are included as follows: a. Per interview with the security staff providing monitoring for 2 patients in the seclusion area on 4/23/19 at 1:30 PM, the staff member stated that every 15 minutes, they have 'eyes on' (visualize) the patients in the room (s) in that area. On 4/23/19, both rooms had patient occupants, both had the window blinds closed. For 1 room (rm. #6), the patient was alone in the room at the time of the observation. The security staff demonstrated that they could open the window blinds to observe the patient in the room every 15 minutes, and document the safety check on the Constant Observation Log Flow Sheet. The hospital nursing policy entitled Restraint and Seclusion Policy, approval date of 3/11/19, stated on Pg. 4, under DEFINITIONS, "Continuous Monitoring, staff will maintain the ability to appreciate the activities of the patient at all times while also maintaining proximity and access to the patient to allow immediate physical	{C 271}	In addition to the revision of the policy, we adopted a validated screening tool to provide a risk assessment for each patient that will correlate with the 3 levels of observation status we can provide for patient safety. The 3 levels of observation (Continuous, frequent, or Intermittent) can be changed according to the behaviors of the patient and the result of the multidisciplinary team discussion at any point in time during the course of the patients stay. The review and education of these revised/ adopted policies will be completed by May 24,2019. The policy and education will be signed and dated by staff members, as well as Hunter North Security on the levels of observation, and policy review. 100% of behavior health patient charts are being reviewed by a designated charge nurse. Data is compiled from these records. The data is presented to the Medical and Nursing Directors of the Emergency Department. The data review will include compliance with the approved definitions and observation levels, the level of staff assigned to the patient (i.e. security, LNA, mental health worker, LPN, RN) Annual review of the policies and procedures related to behavioral health patients within the organization will be reviewed by the Emergency Department, Policy and Procedure Committee with representation from our Quality Department. Meeting minutes will reflect compliance. Failure to comply with organizational policy and practice will result in documented counseling, reeducation, and/or corrective action.	Completion Date: 5/24/2019 Responsible Party: Nursing Director of Emergency Department

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{C 271}	Continued From page 3 intervention if necessary." On Pg. 2, it stated under DOCUMENTATION, "shall include" at "(4) ongoing monitoring by trained staff;" It was not clear based on the policy definitions and the Constant Observation Log Flow Sheet whether patients should have 'eyes on' continuously or only every 15 minutes, per the documentation log reviews. A nurse interviewed on 4/24/19 indicated that if patients were restrained or in seclusion, then the patient would always be on continuous 1:1 observation. Although the security staff indicated that s/he could open the blinds to see into the patient room as needed, the fact that the blinds were closed at the time of the observation, was not in accordance with the policy. The lack of clarity regarding the specific monitoring requirements for patients in restraints or in seclusion was confirmed during interviews with the RN ED Director of Clinical Operations and the ED Charge RN on 4/24/19 at 12:55 PM. b. Per record reviews, ED nursing staff also failed to adhere to the ED policy entitled Patients with Potential for Self-Harm, Suicide, or Harm of Others in the ED. Patient #1 arrived in the ED on 4/21/19 at 23:03 with chief complaint of depression and suicidal thoughts. Per review, The Self-Harm Assessment performed by ED nurse at the time of triage noted the following: Patient ...answered "yes" to questions related to being depressed; hopeless; and having thoughts of killing himself/herself. Patient consented to changing into hospital gown and was placed in a "Safe room" after a safety sweep of the room was performed by staff. Patient #1 informed the ED provider that s/he wanted to commit suicide and the plan would be to overdose on medications or drive or jump into	{C 271}		

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{C 271}	Continued From page 4 a dam. Per review, a nurses progress note stated: Suicide precautions initiated and " ...continuous one on one supervision, checks performed every 15 minutes ..." Per review, the Policy and Procedure Patients with Potential for Self-Harm, Suicide, or Harm of Others in the ED, approved on 3/1/19, stated that patients with increased risk for harm will be placed on 1:1 "continuous" visual observation .....". It further stated "F. If the PA-C/MD, after assessing the patient decides that there is not a risk for harm and there has been no sign of escalation of behavior, the continuous observation status may be discontinued." Per review, the Crisis Screener Emergency Services Progress Note/Evaluation of 4/22/19 stated related to Suicidal ideation, that Patient #1: " ...has access to his/her car and medications and clear intent to carry out his/her plan to take his/her life". On 4/23/19 at 1:45 PM a security guard was observed sitting in the entry of the hallway between rooms #5 & #6. During interview, the security guard confirmed that once every 15 minutes s/he checks on Patient #1, (located in Room #6) however, "continuous observations" were not being followed. There was also no documented evidence in the medical record that the ED provider had made a change in the determination of suicide precautions and the level of observation since admission.	{C 271}		

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