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

January 7, 2022

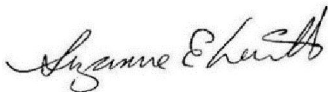
Robert Adcock, CEO
Springfield Hospital
Po Box 2003
Springfield, VT 05156-2003

Dear Mr. Adcock:

The Division of Licensing and Protection completed an investigation at your facility on **December 6, 2021**. 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 **January 5, 2022.**

Sincerely,



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

Enclosure

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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 12/06/2021

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

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C 000	INITIAL COMMENTS An unannounced on-site investigation of complaint #20342 was conducted on 12/2/21 through 12/6/21 by the Division of Licensing and Protection to determine compliance with the Conditions of Participation for Critical Access Hospitals (CAH) at 42 CFR. Part 485, Subpart F and for excluded inpatient psychiatric services in a distinct part unit of the CAH. The following regulatory violations were identified:	C 000	**Plan of Correction: (C 508)** As a result of the December 6, 2021, survey, the Utilization Review process for the Windham Center was reviewed and revised. The utilization review (UR) process for the Windham Center will be formalized by January 30, 2022. This will include, but is not limited to: 1. Revision of current utilization review (UR) policy. 2. Continued use of InterQual and LOCUS materials to guide clinical needs for admission and treatment plan. 3. Continuation of documentation in CPSI regarding ongoing UR to determine and ensure appropriateness of admission, insurance applicability, medical necessity of continued stay, and the preparations made for the next level of care. Documentation will reveal MD involvement/consultation, and continued oversight. a. This includes the Medical Social Worker, the Treatment Team, the admitting physician, and the client's family, guardian, or other designated party. b. This includes personnel who are qualified to evaluate, assess, and provide treatment to those with mental health needs; additionally, to formulate a written, individualized, and comprehensive treatment plan; provide active treatment measures and engage in discharge planning. 4. This process will be monitored through Chart Review conducted by Windham Center Management & Windham Center Social Worker.	
C 508	UTILIZATION REVIEW CFR(s): 485.647(a)(1) [...the services furnished by the distinct part unit must comply with ...§412.25(a)(2) through (f) of Part 412 ... Basis for exclusion (§412.25(a)): "In order to be excluded from the prospective payment systems ...a psychiatric ...unit must meet the following requirements.] (6) Have utilization review standards applicable for the type of care offered in the unit." This STANDARD is not met as evidenced by: Based on interview and policy review there was a failure of the excluded PPS (Prospective Payment Systems) psychiatric unit to show evidence that utilization review was being done for the types of care being offered in the unit. Findings include: Per document review there was no evidence that the unit was performing any utilization review of the types of care provided and/or had a specific policy related to this.	C 508		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert M Co
TITLE: CEO
(X6) DATE: 1/4/22

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.

Tag C508
POC accepted on 1/5/22
by D. Wdeandler

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C 508	Continued From page 1 Per interview with the Unit Director on 12/3/12 at 12:21 PM, S/He stated that S/He had been monitoring measures that CMS (Centers for Medicare and Medicaid) had expected the facility to review; however, S/He did not have any documentation and/or policies related to quality and/or utilization review for the unit.	C 508	**Plan of Correction: (C 578)** As a result of the December 6, 2021, survey; the policy "Orientation, Departmental Orientation, and Annual Update" was reviewed. Revision and reimplementation of this policy will be completed by February 4th.	
C 578	ADEQUATE TYPES OF PERSONNEL CFR(s): 485.647(a)(1) [...the services furnished by the distinct part unit must comply with ...the additional requirements of §412.27 of Part 412 of this chapter for excluded psychiatric units. Excluded psychiatric units: Additional requirements (§412.27): "...A psychiatric unit must ...] (d)(1) Personnel. The unit must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to- (i) evaluate inpatients; (ii) formulate written, individualized, comprehensive treatment plans; (iii) provide active treatment measures; and (iv) engage in discharge planning." This STANDARD is not met as evidenced by: Based on interview and policy review there was a failure of the excluded PPS psychiatric unit to ensure 3 of 7 (Staff #1, #4 and #7) professional and technical staff were qualified. Findings	C 578	Education related to Annual Training policy will be given to all staff. In anticipation of the formal policy revision, Windham-specific orientation guidelines were updated as of 12/23/2021. Competencies which were deemed no longer applicable were removed and new competencies have been added as appropriate. Annual competencies have been identified and planned. Additionally, there is a certified Basic Life Support (BLS) instructor employed at Windham. Staff who were previously certified but whose certification has expired have been scheduled to recertify. Any other appropriate staff will be scheduled for an initial certification. All full and part-time clinical staff will have current certifications with BLS/CPR as of January 31, 2022. 1. All clinical staff will receive annual training that includes the Haligan Tool, the S-Cut Tool, Patient Sitter Guidelines, and the Involuntary Admission Binder. 2. Records regarding training and competency needs, completion and renewal requirements will be kept in the Director's possession. The Director will hold staff accountable for annual training and timely renewal(s) of certifications and licensure. Staff will be educated regarding this process and be made aware of their responsibilities to adhere to training requirements.	

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C 578	Continued From page 2 include: Per review of several documents provided by the Unit Director on 12/6/21, there was no evidence that Staff #1, #4, and #7 had BLS/CPR (Basic Life Support/Cardiopulmonary Resuscitation) certification and/or that they had completed other necessary training's used in helping to evaluate, assess, and treat the patient population that was served. Per interview with the Unit Director on 12/6/21 at 11:22 AM, S/He stated that the expectation was that staff were BLS/CPR certified prior to being hired and that S/He was currently working to ensure all staff were trained on unit specific policies and procedures.	C 578	3. To ensure educational requirements and certifications are met, documentation of completed trainings will also be forwarded to Human Resources as applicable. Tag C578 POC accepted 1/5/22 by D Wickersham RN	
C1006	PATIENT CARE POLICIES CFR(s): 485.635(a)(1) (1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on interview and record review the Community Access Hospital (CAH) failed to deliver health care services according to their policies for patient rights & responsibilities and code of conduct for 1 applicable patient (Patient #1); and prevention of patient abuse and neglect through screening for 5 of 7 staff members (Staff #1, 2, 4, 6, 7). Findings include: 1.) Per review of nursing admission note from 11/18/21, Patient #1 arrived at the facility via ambulance from an area Emergency Department. Prior to this admission, the patient was at a	C1006	**Plan of Correction: (C1006)** As a result of the December 6, 2021, survey it was determined that staff re-education related to the following policies would be completed by February 4, 2022. The below listed policies will also be included in the yearly education requirement. The formalization of the yearly education requirement will be completed by February 4, 2022. 1. Patients' Rights and Responsibilities 2. Ethical Code of Conduct 3. Prevention of Abuse and Neglect of Patients by Staff 4. Abuse and Neglect and Exploitation of Vulnerable Adults Additionally, The Windham Center Contraband policy will be revised and added to the new orientation and yearly educational requirement. Documentation of all requirements will be filed in the staff's personnel file.	

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C1006	Continued From page 3 treatment facility which caused him/her "a great deal of stress and suicidal ideation". During a physical assessment, it was noted that S/He had a "small pick mark" on his/her left hand. S/He was well known to the staff and stated S/He was "feeling safe" and "denies urge to SH (self-harm)". Per review of a nursing note from 11/19/21 at 8:39 PM, "Pt appears anxious ...pt states feeling anxious and tired". S/He "reports being woken up several times and feels screaming triggered PTSD (post-traumatic stress disorder) d/t peer on unit". S/He "states urge to s/h early in day after poor sleep and anxiety ...denies S/I (suicidal ideation), H/I (homicidal ideation) and safety concerns". Per review of a provider's history and physical note from 11/19/21, Patient #1 had a history of depression, anxiety, post-traumatic stress, and alcohol abuse. S/He had previously been admitted to the facility on 10/12/21. Upon evaluation, the patient "continues to report decreased ability to sleep, feelings of hopelessness, worthlessness, increasing depressive thoughts and increased thoughts of self-harm without a plan". "Plan for a short hospital stay. The patient became very comfortable here during prolonged admission last time". Per a nursing note from 11/20/21 at 5:25 AM, "Slept all night ...6.5 hours for this shift". At 7:30 AM, "attempted blood draw ...in both arms, unsuccessfully". At 10:49 AM, the patient reported "'Having a hard day' .... experiencing 'lots of triggers' ...Affect flat ...Denies any urges to SH ...Contracts verbally for safety". At 2:29 PM, "Pt tearful when sharing that one of the staff 'triggered her' ...the staff had "wanted" him/her to "rap to a song" S/He "found inappropriate ...and made comments about" his/her appearance".	C1006	Education will be pushed out to staff via the Director of the Windham Center. To ensure educational requirements are met, documentation of completed trainings will be forwarded to HR as applicable. **Plan of Correction: (C1006) (continued)** As a result of the December 6th, 2021, survey; the current policy entitled, "Background Checks" was reviewed. A staff in service was provided for the Human Resources Department on 12/23/21, and a process to ensure the Vermont Abuse Registry was enacted on this same date. Additionally, the Human Resources Department initiated a file audit to ensure that all current staff members have the necessary documentation within their Employment File. This process will be broken down into two phases. Phase 1 is an audit of all current employees against the Vermont Abuse Registry, to include printing documentation of the search in the employee file. This will be completed by February 4, 2022. Phase 2 will consist of an audit of all employees Human Resource Employee Files who were hired within the previous five (5) years to ensure completion.	

Tag C1006
POC accepted on 1/5/22
by D. Wickerson

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C1006	Continued From page 4 The patient was "shaking and crying when sharing" his/her experience". The patient "notes" that S/He "does not feel safe" when the staff member is working. Per a provider's note from 11/20/21, the patient "had difficulty engaging with treatment team ...was violently shaking this am". S/He would not disclose what had happened; however, later stated that a staff member was making "inappropriate sexual jokes and being flirtatious". S/He "attempted to scratch herself on the arm but states that" S/He "is not suicidal". Per a nursing note from 11/21/21 at 5:38 AM, the patient had "Mid cycle awakening ...Appears to have slept 5.5 hours this shift". At 9:33 AM, the patient had "no feeling of SH but 'scared ...do not want retaliation'". At 10:18 PM, "Pt appeared tired and irritable ...had a phone call" from a family member. "Pt went to" his/her "room and napped for a few hours. Denies SI". On 11/22/21 at 10:21 AM, "Affect sad, sits with hands clenched ...Pt prefers to stay" at the facility. "Pt reports feeling safe ... as there are staff" S/He "knows will keep" him/her "safe". On 11/24/21. "Pt appeared depressed and tearful ...Pt concerned about possibly staying at a motel as a short stay until more stable housing ...is not ready ... and 'do not want to be kicked out'". Per interview on 12/3/21 at 10:44 with Patient #1, S/He stated that "most staff" were "supportive"; S/He had an issue with a night shift nurse who was making "inappropriate comments". S/He stated that the staff member had attempted to draw blood and "stood over" him/her and S/He felt "very vulnerable". The staff member further commented "how beautiful" S/he "was and that" S/He "deserved to have" his/her "feet rubbed ...and any man" ... "was lucky to have" him/her. The staff member also made "inappropriate	C1006		

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C1006	Continued From page 5 jokes". S/He stated that the Nurse Practitioner did question him/her about whether S/He felt safe in the facility. S/He stated that S/He did not want to leave the facility; however, S/He didn't "feel safe at night ...really not the way" S/He "used to", and that S/He "did not have any further contact" with Staff #4. S/He also stated that S/He "felt like, since the incident they are pushing" him/her "out the door". Per interview on 12/6/21 at 10:36 AM with Staff Nurse #4, S/He stated that the unit expectation for drawing blood was that it would be done early in the morning, before morning report. On 11/20/21, S/He went to draw Patient #1's blood, it was unsuccessful, and S/He asked the other nurse on duty to try, and S/He also was unsuccessful. Staff Nurse #4 stated that S/He had asked Patient #1 if S/He had a "dad joke for the day". S/He stated that Patient #1 "told an inappropriate joke". And then S/He "told two inappropriate jokes". S/He stated S/He didn't "know if" S/He "said anything about how the patient looked". S/He further stated that S/He "did say two dirty jokes and don't know why ...not proud of this ...don't have any reason why". S/He further stated that S/He remembered signing the facility's code of conduct and that the code meant to "dress neatly, be professional, take care of patients". Per review of the policy "Patient Rights & Responsibilities"-approved 4/16/2021, it states, "While You are a Patient in This Hospital, You Have the Right to: Respect for your personal privacy, dignity and comfort. Receive care in a safe setting". Per review of the policy "Code of	C1006		

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C1006	Continued From page 6 Conduct"-approved 1/21/2020 it states, "to provide quality care to our patients. As part of this, we strive to ensure an ethical and compassionate approach to healthcare delivery and management. We must demonstrate consistently that we act with absolute integrity in the way we do our work and they way we live our lives ...Patients are treated in a manner that preserves their dignity, autonomy, self-esteem, civil rights, and involvement in their own care ...colleagues will receive training about patient rights in order to clearly understand their role in supporting them". The facility "requires all colleagues to sign an acknowledgement confirming they have received the Code and understand it represents mandatory policies of" the facility. "New colleagues will be required to sign this acknowledgement as a condition of employment". 2.) Per review of personnel files for Staff Members #1, 2, 4, 6, 7 there was no evidence that the state child and adult abuse checks were done. Per interview on 12/6/21 at 12:20 PM with the Human Resources Manager, S/He stated that the facility policy was to perform background checks upon hire and that those checks included state child and adult abuse. Per interview on 12/6/21 at 2:09 PM with the Director of Quality/Risk and the Chief Nursing Officer they confirmed that state child and adult abuse checks were not done and/or that there was no record of them being done for the above staff members.	C1006		

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C1006	Continued From page 7 Per review of the policy "Prevention of Abuse and Neglect of Patients by Staff" -approved 10/14/2020 it states, "Each patient has the right to be free from abuse, corporal punishment, and involuntary seclusion. Patients must not be subjected to abuse by anyone, including but not limited to, facility staff, other patients, consultants of volunteers, staff of other agencies serving the patient, family members or legal guardians, friends, or other individuals ...Procedure A. Screening of Employees- All individuals who have applied for employment at" the facility "will be screened for a history of abuse, neglect, mistreating of patient's as defined above ...The Human Resources Department, upon any substantiated abuse complaint will report the individual to the state officials, including the state survey and certification agencies, in accordance with state law within 48 hours of occurrence".	C1006		
C1046	NURSING SERVICES CFR(s): 485.635(d)(1) Nursing services must meet the needs of patients. (1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. This STANDARD is not met as evidenced by: Based on interview and record review, the CAH failed to ensure that nursing staff were adequately trained, competent, and their clinical activities were evaluated for 5 of 5 staff reviewed.	C1046	**Plan of Correction: (C 1046)** As a result of the December 6th, 2021, survey, the orientation program for the Windham Center was reviewed. It was determined that the current program needed revision. Formal revision of the program will be completed by February 4, 2022. Immediate changes include the following: 1. BLS training and certification are scheduled and will be completed by January 31, 2022. 2. All full and part-time clinical staff at the Windham Center will be current with both BLS/CPR and Crisis Prevention Institute (CPI) training by January 31, 2022. 3. Phlebotomy training needs will be assessed, and training scheduled as appropriate. 4. Previous orientation guidelines and checklists are being reviewed and edited by the Windham leadership team. They will include Windham-specific training such as phlebotomy, EKG competency, and obtaining urine samples from patients/clients; training on the Haligan Tool, S-Cut Tool, Patient Sitter Guidelines, and the Involuntary Admission Binder. 5. All full and part-time clinical staff at the Windham Center will complete and be current with these competencies by February 4, 2022. 6. The previously mentioned policies will be reviewed at the next staff meeting and with all new hires. 7. Ongoing training regarding abuse and neglect will be carried out according to policy. This will include:	

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C1046	Continued From page 8 Findings include: Per review Staff #1's personnel file there was no evidence of certification for BLS/CPR, that S/He had received training regarding blood draws, training specific to the patient needs of the PPS psychiatric unit, and no consistent evidence of "ongoing" training for abuse/neglect. Per review of Staff #2's personnel file his/her BLS/CPR certification expiration expired on 3/19/21; and there was no consistent evidence of "ongoing" training for abuse/neglect and no evidence of consistent competency and/or performance evaluations. Per review of Staff #4's personnel file there was no evidence of certification for BLS/CPR, that S/He had received training regarding blood draws, and/or training specific to the patient needs of the PPS psychiatric unit, and no consistent evidence of "ongoing" training for abuse/neglect. Per review of Staff #3 & #5's personnel files there was no evidence of "ongoing" training for abuse/neglect and no evidence of consistent competency and/or performance evaluations. Per interview on 12/3/21 at approximately 5:00 PM with the Director of Quality/Risk, S/He stated that the facility's education and human resources systems were not in line with each other and that there were some "gaps" in the processes. Per interview on 12/6/21 at 11:22 AM with the Unit Director, S/He stated that BLS/CPR was to be completed upon hire and they were currently working on ensuring staff were trained with the	C1046	**Plan of Correction: (C 1046) (continued)** a. What constitutes abuse, neglect, and misappropriation of patients' belongings b. How staff can recognize signs of burnout, frustration, and stress that may lead to abuse, and resources that are available for help (EAP) c. How staff should report their knowledge, related to allegations of abuse without fear of reprisal d. Appropriate interventions to deal with aggressive and/or catastrophic reactions of patients e. How staff will report abuse and to whom f. Records of orientation, and ongoing training programs, will be kept by Windham's Director/Manager 8. Clients/patients will be assessed on a regular basis (determine intervals) as to their comfort with their provider(s) and Treatment Team for early identification and remediation of issues or concerns. 9. Annual performance evaluations will be performed and stored at the Director/ Manager's location. A shared file between HR and the Windham leadership team will be created to facilitate access to these records. 10. Education will be sent out via Director of Windham Center. 11. Documentation of completed training will be forwarded to HR as applicable. Tag C1046 POC accepted on 1/5/22 by D. Wicharzke RN	

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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
C1046	Continued From page 9 skills needed for the psychiatric unit. S/He confirmed that the current "system was disjointed". During an interview on 12/6/21 at 2:09 PM with the Chief Nursing Officer, S/He stated that the facility did not have a definition for "ongoing" as it read in the facility's abuse/neglect policy therefore, S/He was not able to verify how often this training was taking place for staff. Per review Per review of the policy "Prevention of Abuse and Neglect of Patients by Staff" -approved 10/14/2020 it states, "B. Training of Employees-In order to prevent the abuse or neglect of patients and to ensure a safe environment, all staff at" the facility, "in any capacity, will receive training through orientation, and ongoing sessions, on issues related to abuse prevention practices. The content should include: 1. What constitutes abuse, neglect, and misappropriation of patient property. 2. How staff can recognize signs of burnout, frustration, and stress that may lead to abuse, and resources that are available for help. 3. How staff should report their knowledge, related to allegations of abuse, without fear of reprisal. 4. Appropriate interventions to deal with aggressive and/or catastrophic reactions of patients. 5. How staff will report abuse and to whom. Records of orientation, and ongoing training programs, will be kept by the Professional Development Department in the employee's file."	C1046		