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

November 6, 2023

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

Dear Mr. Adcock:

The Division of Licensing and Protection completed a recertification survey at your facility on **October 4, 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 **November 6, 2023.**

Sincerely,

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 ______	10/04/2023

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 on-site re-certification survey was conducted by the Division of Licensing and Protection on 10/2/23 through 10/4/23 to determine compliance with the Conditions of Participation at 42 CFR Part 485 Subpart F requirements for Critical Access Hospitals (CAH's). As a result of the survey, the following deficiencies were identified.	C 000		
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 observation, interview and record review the CAH failed to provide health care services in accordance with their written policies related to hand hygiene/glove use and testing for efficacy of disinfectant/sterilant in the machine used prior to endoscope/colonoscope (Instruments which can be introduced into the body to give a view of its internal parts.) cleaning. Findings include: 1.) Per observation on 10/4/23 at 10:35 AM of the cleaning of Operating Room (OR) #1, Staff #1 opened one of the doors of the OR with gloves on, left the room with the same gloves to get the mop, re-entered the OR with the same gloves; started to mop the floor; and proceeded to mop and clean other areas of the OR with the same gloves. Per observation on 10/4/23 at 10:40 AM, Staff #2 left the OR area to go into a utility room, removed his/her right glove and without sanitizing his/her hands, touched a cabinet, removed dry cleaning	C1006	1. Hand Hygiene Policies and procedures will be reviewed and revised to ensure best practices are met. 2. Updated educations will be provided to all Operating Room and Environmental Services staff members responsible for cleaning OR rooms. •The education plan will include a return demonstration for competency evaluation. •The updated education training and competency will be added to the new hire orientation and completed annually. •The applicable department manager/director will keep a staff roster. 3 Monitoring of practice and policy adherence will be added to the QA program. •The Director of Environmental Services, Director of Perioperative Services, and/or the Infection Preventionist will observe five (5) cleanings of the OR rooms per month to ensure compliance with policy.	11/01/2023 11/01/2023-12/24/2023 12/01/2023 11/01/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert S. Adcock — TITLE: CEO — (X6) DATE: 11/3/23

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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C1006	Continued From page 1 cloths, and without sanitizing his/her hands, with a contaminated left glove, donned a clean glove on the right hand, applied Virex 256 (Solution used to clean the OR surfaces and floor) to the cleaning cloths and went back into the OR and continued to clean. This process was observed more than once with Staff #2. Per interview on 10/4/23 at approximately 10:40 AM with Staff #1, S/He confirmed that when gloves are removed, you are to sanitize and/or wash your hands prior to donning new ones. S/He also stated that S/He should have removed his/her gloves and donned new gloves prior to entering and exiting the OR. Per interview on 10/4/23 at approximately 12:15 PM with the infection preventionist, S/He confirmed that when gloves are removed hands should be washed and/or sanitized prior to donning new gloves. Per review of the policy "Hand Hygiene" approved 1/31/23, it states, "1. Indications for Hand Hygiene 1.4 Before donning sterile or non-sterile gloves 1.5 After removing sterile or non-sterile gloves". 2.) Per observation of the cleaning of a colonoscope on 10/3/23 at approximately 11:30 AM, a bottle of Rapicide PA strips (Test strips used to test the efficacy of high-level disinfection.) was noted to be on the DSD Edge (Machine used to perform high level disinfection of endoscopes and colonoscopes.). There was no date to indicate when the bottle was opened and/or how long the strips were effective. Per interview at that time with an endoscopy tech,	C1006	1. Policies and procedures surrounding Endoscope Reprocessing will be reviewed and revised to ensure best practices and to include the management of " outdates : " Multiple dose test strips, reagents, or disinfectant containers must be dated with the expiration date of 28 days after opening or by the manufacturer's expiration date, whichever occurs sooner." 2. All staff will review new policies or procedures and receive education on the established process. •The management of outdates and use of check list methodology will be added to education and training of staff. •The applicable department manager/director will keep a staff roster. 3. A cleaning checklist will be used for each scope during the learning process. This will include documenting outdates. 3. A QA process will be implemented to ensure compliance with outdated documentation. This will include: 1. The Department Director will observe five scope cleans a week for one month and then complete five random observation audits a month. 2. All monitoring will be added to the department Quality plan.	11/01/2023- 12/24/2023 12/01/2023

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C1006	Continued From page 2 S/He confirmed that there was no date and did not know when the bottle was opened and/or how long the strips were effective. Per review of the policy "Endoscope Reprocessing Procedure" reviewed 3/4/20, it states, "G. High Level Disinfection ...Follow disinfectant/sterilant manufacturer's recommendations to achieve high-level disinfection of endoscopes. 1. Prepare the product according to disinfectant/sterilant manufacturer's label instructions. 2. Test the product for the MEC (Minimum Effective Concentration) according to the label on the test strip container. Note that: including, but not limited to, dilution, time/temperature, and number of uses. It is essential that the level of active ingredient be at or above that required to kill and/or inactivate the desired microorganisms (AAMI, 2006;2010). 4. Use a product-specific test strip and keep a log of the test results (Rutala et al., 2008)."	C1006	**Tag C1006 POC accepted on 11/6/23 by D. Wideawake/S. Leavitt**	
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 the use of bed rails was	C1046	1. Review of all current policies and practices relative to fall risk assessment and side rail utilization. 2. All nursing staff on the IPCU will read and review updated policies/procedures for fall assessment and associated interventions including use of side rails. 3. All IPCU nursing staff will receive education on new policies, practices, and documentation requirements. •The correlating updated policy and practices, education and competency will be added to the new hire orientation and completed annually as part of " restraint training" •The applicable department manager/director will keep a staff roster. 4. Monitoring of practice and policy adherence will be added to the IPCU QA program. Concurrent practice and documentation review	11/01/2023 11/01/2023-12/24/2023

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C1046	Continued From page 3 provided in accordance with the needs of the patient and per facility policy for 1 applicable patient (Patient # 7). Findings include: Based on record review, Patient #7 was admitted with dementia, deconditioning, and was assessed to be a falls risk. Per review of nursing notes, bed rails were positioned in the up position for Patient #7 on the following dates: Nursing notes dated 10-1-2023 indicate that two bed rails were raised during some hours of the night, and that three bed rails were raised during some hours of the night. A nursing note that evening also indicated that Patient #7 was restless and anxious as evident by crawling over side rails and getting out of bed frequently. Nursing notes dated 10-2-2023 indicate that two bed rails were raised during the evening and overnight hours. Nursing notes dated 10-3-2023 indicate that two bed rails were raised during some portions of the evening and early morning hours, and that three bed rails were raised during the overnight hours. Nursing notes dated 10-4-2023 indicate that two bed rails were raised during portions of the night, that four bed rails were raised during some portion of the night. Based on review of the "Patient Fall and Activity Policy for Inpatient Unit" approved on 12/16/2022; states "IV. Interventions-Guidelines for fall risk interventions: a. Universal environmental safety includes; x. Consider use of top side rails if appropriate per side rails assessment and policy". Based on review of the facility policy "Clinical Guidance for the Assessment and Implementation of Side Rails" approved	C1046	will be completed each shift on all patients for one week, then all IPCU patients one day a month, monthly . **Tag C1046 POC accepted on 11/6/23 by D. Wideawake/S. Leavitt**	

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C1046	Continued From page 4 4/12/2023, Under "Policy Considerations: "Use of side rails should be based on the patients' assessed medical needs and should be documented clearly and approved by the interdisciplinary team. Side rail effectiveness should be reviewed on a regular basis. The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient". Per observation and during an interview at approximately 11:00 AM on 10-4-2023, Patient #7 presented as not oriented to time or person, and was unable to answer questions about the side rails on their bed. Per interview with the Special Projects Registered Nurse on 10-4-2023 at 12;10 PM, they confirmed that there was no evidence of a side rail assessment, nor a risk-benefit assessment done for Resident #7. Additionally, there was no evidence that the use of side rails was approved by the interdisciplinary team.	C1046		
C1110	RECORDS SYSTEM CFR(s): 485.638(a)(4)(i) For each patient receiving health care services, the CAH maintains a record that includes, as applicable-- (i) Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;	C1110		

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C1110	Continued From page 5 This STANDARD is not met as evidenced by: Based on interview and record review the CAH failed to show evidence that an informed consent was complete prior to a surgical procedure for three of four records reviewed (Patient #11, Patient #20, and Patient #21). Findings include: 1.) Per record review Patient #11 presented to the Emergency Department (ED) on 9/9/23 after a fall. S/He was found to have a right femur (leg) fracture (break); and was admitted to the hospital on the same day. On 9/10/23, Patient #11 underwent surgery to repair the fracture. Per review of the "Consent for Operation or Invasive Procedure" form, there was no time documented when this consent was reviewed with the patient. 2.) Per record review Patient #20 presented to the ED on 6/2/23 after a fall. S/He was found to have left femur fracture; and underwent surgery to repair the fracture later that same day. Per review of the "Consent for Operation or Invasive Procedure" form, there was no time documented when this consent was reviewed with the patient. 3.) Per record review Patient #21 has a history of hypertension, hypothyroidism (low thyroid hormone) and osteopenia (A condition that occurs when the body doesn't make new bone as quickly as it reabsorbs old bone.). On 10/2/23, S/He was admitted to the hospital and underwent an elective Left Total Knee replacement. Per review of the Consent for Operation or Invasive Procedure" form, there was no time documented when this consent was reviewed with the patient. Per interview on 10/3/23 at approximately 11:30 AM with the Director of the Perioperative Services, S/He confirmed that the "Consent for	C1110	1. Review of all current policies and practices relative to obtaining patient consent. 2. All Operating Room staff to include Providers will read and review updated policies/procedures for obtaining patient consent. 3. All Operating Room staff to include providers will receive education on new policies, practices, and documentation requirements. •The correlating updated policy and practices,and education will be added to the new hire orientation and completed during annual training. •The applicable department manager/director will keep a staff roster. 4. Monitoring of policy compliance will be added to the Hospital Quality Plan and tracked on the Quality and Risk Dashboard. • For the first 30 days, all surgical consents for all providers will be reviewed. • Then monitoring will transition to 5 OR patient chart reviews per provider for the next two months. • Then monitoring will transition to 5 OR patient chart reviews per provider quarterly." **Tag C1110 POC accepted on 11/6/23 by D. Wideawake/S. Leavitt**	11/01/2023 11/01/2023-12/24/2023

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C1110	Continued From page 6 Operation or Invasive Procedure" should be timed when reviewed with the patient.	C1110		
C1120	PROTECTION OF RECORD INFORMATION CFR(s): 485.638(b)(1) The CAH maintains the confidentially of record information and provides safeguards against loss, destruction, or unauthorized use. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure patients medical records/information were protected from unauthorized access for 11 of 11 patients sampled. Findings include: During tour on 10/3/23 at approximately 10:15 AM, with the Unit Director on the patient medical unit, an open laptop was observed in the hallway outside a patient's room. The laptop was in the open position with the laptop screen revealing the names of all the patients currently on the unit and no staff presence at the laptop. Interview on 10/3/23 at approximately 10:15 AM, with the Unit Director, they confirmed the open laptop with patient information was visually accessible to passersby. The Unit Director addressed this issue with the staff member (Respiratory Therapist) who immediately exited the patient's room and lowered the laptop screen, however, the information was still visible/accessible to passersby. The Unit Director proceeded to lock the laptop screen and confirm that this is the expectation when staff are not present at the laptops to protect patients' rights to privacy.	C1120	1. Current policies relative to patient privacy and HIPAA will be reviewed. 2. All Respiratory Therapy staff members will read and review policy for patient privacy and HIPAA. 3. All Respiratory Therapy staff members will receive HIPAA education. * The Quality/ Compliance Department will keep a staff roster. 4. A member of the Quality Department will attend environmental rounds monthly to monitor and observe the number of computers left unattended. This metric will be added to the Hospital Quality Plan and tracked through the Quality and Risk Dashboard. **Tag C1120 POC accepted on 11/6/23 by D. Wideawake/S. Leavitt**	11/01/2023 11/01/2023-12/24/2023
C1144	ANESTHETIC RISK AND EVALUATION CFR(s): 485.639(b)(1), 485.639(b)(2), 485.639(b)	C1144		

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C1144	Continued From page 7 (3) (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed. (2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia. (3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on interview and record review the CAH failed to ensure that surgical patients prior to discharge were evaluated for proper anesthesia recovery regarding cardiopulmonary status, level of consciousness, follow-up care/observations, and complications for three of four records reviewed (Patient #3, Patient #11, and Patient #20). Findings include: 1.) Per record review Patient #3 has a history of high blood pressure, insomnia, and macular degeneration (loss in the center of the field of vision). S/He was admitted to the hospital with a right hip fracture on 10/2/23 and underwent surgery the same day. Per review of the "Post Anesthesia Note" from 10/2/23 at 1600 (4:00 PM), it states "VSS" (Vital Signs Stable); and able to be easily awakened. 2.) Per record review Patient #11 has a history of smoking, high cholesterol, and peripheral vascular disease (condition where narrowed	C1144	1. Current policies and practices relative to post anesthesia evaluation will be reviewed and revised. 2. Anesthesia medical record forms will be amended to reflect any/all changes. 3. Reeducation of the OR staff members to include the Anesthesia team, and the Medical Staff will be conducted to include sign off on new policy and documentation practices. •The applicable department manager/director will keep a staff roster. 4. Monitoring of anesthesia recovery documentation practices and policy adherence will be added to the Anesthesia QA program. • Initially 5-OR patient chart reviews will be completed on each provider in the first month. • Then monitoring will transition to 5-OR patient chart reviews per provider quarterly. **Tag C1144 POC accepted on 11/6/23 by D. Wideawake/S. Leavitt**	11/01/2023 11/01/2023-12/24/2023 11/01/2023-12/24/2023

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C1144	Continued From page 8 blood vessels affect blood flow to the limbs). S/He was admitted on 9/9/23 after a fall with a right femur fracture and underwent surgery on 9/10/23. Per review of the "Post Anesthesia Note" from 9/10/23 at 1211, it states "VSS. Pt awake and alert. No apparent anesthesia complications". 3.) Per record review Patient #20 has a history of smoking, high blood pressure, and chronic obstructive pulmonary disease (lung disease that affects breathing). S/He was admitted on 6/2/23 with a left femur fracture and underwent surgery the same day. Per review of the "Post Anesthesia Note" from 6/2/23 at 1605 (4:05 PM), it states, "VSS"; and easy to wake up. Per review of the policy "Post-anesthesia evaluation", reviewed 2/23/21, it states, " A post-anesthesia evaluation must be completed by an individual qualified to administer anesthesia ....The anesthesia recovery note must be based on an evaluation of the patient as outlined in the CMS Conditions of Participation ....The elements of an adequate post-anesthesia evaluation should be clearly documented and include: Respiratory function, including respiratory rate, airway patency, and oxygen saturation (level of oxygen in the blood); Cardiovascular function, including pulse rate, and blood pressure; Mental status; Pain; Nausea and vomiting; Post operative hydration." Per interview on 10/3/23 at approximately 12:00 PM with the Director of Perioperative Services, S/He confirmed that the above post anesthesia evaluations do not follow the facility's policy and/or contain the required regulatory elements.	C1144		

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E 000	Continued From page 9	E 000		
E 000	Initial Comments During an unannounced on-site re-certification survey from 10/2/23 through 10/4/23, the Division of Licensing and Protection conducted a survey of the Critical Access Hospital's (CAH's) Emergency Preparedness Program to determine compliance with Conditions of Participation at §485.625, the Emergency Preparedness requirements for CAH's. As a result of this survey, the CAH was found to be in substantial compliance with these requirements.	E 000		