Division of Licensing and Protection
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Waterbury VT 05671-2060
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Survey and Certification Voice/TTY (802) 241-0480
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Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 3, 2021

Dr. Steven Leffler Ceo
University Of Vermont Medical Center
111 Colchester Ave
Burlington, VT 05401

Provider ID #: 470003

Dear Dr. Leffler:

The Division of Licensing and Protection completed a survey at your facility on **January 11, 2021**. The purpose of the survey was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **February 24, 2021**.

On January 20, 2021, the CMS Center for Clinical Standards and Quality released a policy memorandum to ensure quality of care oversight, while providing hospitals the ability to focus on serving their patients and communities during the continuing Public Health Emergency. This memorandum was revised on February 18, 2021 extending the hospital survey limitations until March 22, 2021. As such, following the expiration of the memorandum, or unless otherwise specified, the hospital will have up to 60 days to demonstrate compliance with any outstanding deficiencies.

Sincerely,

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

Enclosure

THE
University of Vermont
MEDICAL CENTER

February 19, 2021

Department of Health & Human Services
Centers for Medicare and Medicaid Services
JFK Federal Building Government Center
Room 2325
Boston, MA 02203

ATTN: Nancy Hannah

Re: CMS Certification Number (CCN): 47003
Survey ID: 4SN411, 01/11/2021

Dear Ms. Nancy Hannah,

Please find the attached Plan of Corrections and form CMS-2567 in response to the Statement of Deficiencies and Findings in regards to the survey conducted on 1/11/2021 at the University of Vermont Medical Center.

If you have questions regarding the attached Plan of Correction or require further clarification, please do not hesitate to contact me.

Sincerely,

Carol Muzzy, Director
Accreditation & Regulatory Affairs
The University of Vermont Medical Center
Telephone: 802-847-5007
Fax: 802-847-5462
Carol.Muzzy@UVMHealth.org

Enclosures:
Plan of Corrections
Form CMS-2567

cc: Dr. Stephen Leffler, M.D. President and CEO
cc: Dr. Stephen Bender, MD Vice President of Quality and Operational Effectiveness
cc: Suzanne Leavitt, RN MS, Director, Survey and Certification

Plan of Correction

A000 Initial Comments

An unannounced on-site investigation of complaint #19459 was conducted on 1/6/21 through 1/12/21 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. During the EMTALA investigation on 1/7/21 and 1/11/21, the survey agency was authorized by the Centers for Medicare and Medicaid to review the following Conditions of Participation for Acute Care Hospitals: Patient Rights, Emergency Services, and Quality Assessment and Performance Improvement Program (for complaint #19468). The following regulatory violations were identified.

Based on the information gathered, it was determined that the hospital was not in compliance with the following Federal Conditions of Participation (CoP) for Acute Care Hospitals: Patient Rights and Emergency Services.

A115 PATIENT RIGHTS CFR(s): 482.13

A hospital must protect and promote each patient's rights.

This CONDITION is not met as evidenced by: Based on interviews and record reviews, the Condition of Participation: Patient Rights was not met as evidenced by the hospital's failure to provide sufficient interventions and treatments for 1 of 20 applicable patients (Patient #1) to ensure that patients' rights were protected and promoted. Findings include Refer to A-130

- University of Vermont Medical Center is responding to this condition-level deficiency through the standard level action plans.

A130 PATIENT RIGHTS: PARTICIPATION IN CARE PLANNING CFR(s): 482.13(b)(1)

The patient has the right to participate in the development and implementation of his or her plan of care.

This STANDARD is not met as evidenced by: Based on interviews and record reviews the hospital failed to include 1 of 20 applicable patients (Patient #1) in the development, implementation, and revision of his/her plan of care to meet his/her physical, emotional, and psychological needs. Findings include

Per record review Patient #1 has a history of self-mutilation, pulmonary embolism (blood clot in lung), overdose, hemorrhagic shock (body shuts down due to blood loss), dissociative identity disorder (A disorder characterized by the presence of two or more distinct personality states.), depression, borderline personality disorder (A mental disorder characterized by unstable moods, behavior, and relationships.), anxiety, and anemia (deficiency of red blood cells). Patient #1 was admitted and discharged from the Emergency Department (ED) five times over a period of three days from 12/23/20 to 12/26/20. On 12/23/20, S/He was admitted at 4:12 PM with a chief complaint of "Self Injury" and was discharged home at 11:39 PM. On 12/24/20, S/He was admitted at 10:04 AM with a chief complaint of a "Laceration (deep cut)" and was discharged home at 10:54 AM; and at 5:32 PM came back to the ED with a chief complaint of "psychiatric (mental) evaluation" and was discharged home at 11:29 PM. On 12/25/20, S/He was admitted at 11:10 AM with a chief complaint of a "Laceration" and discharged home at 2:30 PM; and at 8:22 PM came back to the ED with a chief complaint of a self-inflicted "arm injury" and was discharged home at 12:38 AM on 12/26/20. On 12/27/20 at 6:35 PM, Patient #1 presented to the ED unresponsive after a drug overdose and subsequently died on 12/28/20

Per review of a provider's note from 12/23/20, Patient #1 presented to the ED for self-injury. Per the patient's report, the self-mutilation was caused by another identity. This personality found a razor blade and cut him/her-self and caused eight lacerations across the left forearm. Per the physician's physical exam, Patient #1 had "7 lacerations on the left forearm all lacerations are parallel to each other". S/He was "alert and oriented" and had "no agitation or thought disorder". Upon further review of the provider's note, "The patient does have a care plan in place which states

Dawn Deerwater RN
1/24/21

provider may consult crisis for new concerns, but to only treat lacerations as medically necessary". The patient had "seven lacerations repaired 40 sutures total". At 10:35 PM "Spoke to crisis who evaluated the patient".

Patient #1 was "recently moved from a crowded homeless shelter where staff constantly checked up on" him/her "to an isolated hotel room. Crisis feels that" s/he "injured" him/her-self "again given the opportunity because" s/he "was isolated.

They are comfortable with discharge because" s/he "will have full services soon". "The patient was discharged home" and was provided instructions to follow up with his/her primary physician and outpatient mental health provider

Per review of a crisis note from 12/23/20 at 11:19 PM, Patient #1 reported to the Crisis Clinician that s/he was moved from one residence to another because the newer residence (a hotel) had increased supervision. S/He stated that his/her alter personality was "mad" about moving and had told Patient #1 that s/he would "die" at the hotel. Patient #1 reported that s/he "disassociated" and his/her alter went out and bought razors; and "disassociated" again and his/her alter cut his/her forearm seven times. It had been about a month since Patient #1's last episode of self-harm and s/he remarked that "it was the first time they have really been alone".

Patient #1 reported that s/he felt "depressed and anxious" and that was because s/he was off his/her medications and was "doing everything alone". S/He stated that s/he did not have insurance until the first of the year; however, did have access to a couple of his/her medications. S/He expressed that s/he had not picked them up from the pharmacy because s/he feared the alter would use them to "overdose". The Crisis Clinician's mental exam revealed that Patient #1 was "Well-groomed", "Cooperative", "Alert and Oriented" with "Fair" insight and "Poor" judgment. Per the Crisis Clinician's risk assessment, Patient #1 as him/her-self did not have thoughts of suicide or self-harm; however, his/her alter caused harm to him/her today. The alters in the past had also caused extensive and severe lacerations, which necessitated skin grafting, medical admission, and blood transfusions. S/He also had a history of a drug overdose in 2018 and in the spring of 2020. The crisis clinician's clinical impression was that Patient #1's alters severely self-harm; however, Patient #1 as him/her-self denied any safety concerns. Patient #1 was "agreeable and able to properly safety plan".

Patient #1 "has historically shown that inpatient admission due to self-harm only causes and increase in severity and frequency of self-harming upon d/c, therefore it is recommended that" Patient #1 "not be supported through inpatient admission at this time". The plan for Patient #1 was to discharge from the ED and to follow-up with his/her "provider" and "outpatient safety plan". S/He would be provided a "lock box for medications"; S/He "felt" that s/he was "able to dispose of razors"; and was "agreeable to talk to staff about checking in twice daily".

Per review of a psychiatry update note from 12/23/20 at 10:53 PM, "Psychiatry did not formally consult on this patient tonight due to a previously established explicit and extensively documented plan created in collaboration with the Psychiatry Consult Service", outpatient mental health provider, "Ethics, and Surgery during" Patient #1's "4/12/2020 hospital admission". The psychiatrist's assessment and plan revealed that s/he was "in agreement with the Crisis Clinician's assessment and plan" for Patient #1 from 12/23/20.

Per interview on 1/7/21 at 4:34 PM with ED Provider #1, s/he stated that if a patient presented with self-harm, the patient would be put on (suicide) "precautions" until s/he figured out what was going on with the patient. A medical screening would be done and then if the patient were cleared medically, a consult for a crisis counselor to evaluate the patient would be made. Regarding the case with Patient #1 on 12/23/20

Patient #1 had a history of self-harm behavior and that in his/her experience, cutting was a form of release and typically did not involve deep lacerations. In this case, Patient #1's lacerations were deep and when s/he had assessed Patient #1 for suicidality, s/he "denied any suicidal ideation flatly". S/He stated that "one of" his/her "personalities engaged in these behaviors". ED Provider #1 stated that Patient #1 was a "frequent visitor to the ED" and that s/he had "read a care plan that said the patient would have these acute episodes when discharging would get worse". S/He stated that crisis had seen the patient, things were getting set up for him/her as an outpatient, and that they "were comfortable sending" him/her "home". S/He stated that Patient #1 was "re-assessed for suicidality multiple times"

D. Widdowson
2/2/21

during his/her time in the ED. ED Provider #1 stated that s/he often involved "ancillary services" as s/he expressed, we "do not have the time to spend" discerning the best course of action and/or treatment for a psychiatric emergency and that crisis and psychiatry were the experts to help guide that process.

Per review of a provider's note from 12/24/20 at 10:16 AM, Patient #1 presented to the ED for a laceration. The patient had a significant history of self-mutilation by cutting requiring repairs, and this was his/her "third presentation in three days". Patient #1 was unaware of what happened, s/he remembered going to bed and noticed a large laceration on his/her left lower leg at 9:30 this morning. Patient #1 did not know what type of object was used to inflict the injury. Patient #1 shared with the provider that "'he' has been very suicidal as of late, this 'he'" Patient #1 "speaks of is presumed to be a dissociative identity". The physician's exam revealed that there was a "25 cm linear laceration to the left lower leg through the dermis". The patient had "no agitation or overt thought disorder". The physician had asked if Patient #1 had a plan in place for future episodes of self-mutilation and s/he stated "'he' has been pretty suicidal"; however, Patient #1 stated that s/he "is not suicidal". The patient also reported that s/he had outpatient counseling and could follow up with them. Patient #1's laceration was repaired, and s/he was discharged with instructions to follow-up with his/her doctor and outpatient counselor. S/He was also given instructions regarding wound care and pain control. The patient was re-evaluated by the physician immediately prior to discharge with "improved symptoms, normal vital signs discharged with a clear plan for outpatient follow-up".

Per review of a provider's note from 12/24/20 at 7:10 PM, Patient #1 presented to the ED for a psychiatric evaluation. S/He had been seen twice in the last 24 hours with several lacerations on right forearm and left lower leg both needing extensive repair. S/He had a crisis consultation last night and "ultimately felt like this was not a safety concern and patient was discharged in the ED on both occasions". S/He came back to the ED and stated that his/her alter told him/her that s/he would "cut to kill". Patient #1 contacted his/her outpatient support program and they referred him/her to the ED for an evaluation.

Patient #1 reported to the provider that s/he "is feeling safe". Per the provider's exam, the patient was "alert and oriented. No agitation or overt thought disorder". The patient was evaluated by Crisis and the "Crisis Clinician felt that the patient behaviors were likely result of recent move from a shelter that had more support staff and more people around to a place there is more isolated". Patient #1 was also evaluated by psychiatry and "does not need hospitalization at this time". S/He "will be discharged back to" his/her "established living arrangement. I discussed with patient" and s/he "is agreeable to this plan".

Per review of a crisis note from 12/24/20 at 8:15 PM, Patient #1 had presented to the ED hours later than when the outpatient counseling service had encouraged him/her to do so and had arrived with two packed bags. S/He had told the Crisis Clinician that s/he was not sure what type of help s/he needed but stated that when his/her alter "'makes threats follows through'" "'this morning was a warning'" and that s/he would expect "either another OD or more deep cutting". And that the other personality's goal was allegedly to "'destroy the body'" as s/he "'doesn't want to be alive'". "She reported being scared of the next thing to happen" from his/her alter. Patient #1's mental status exam showed that s/he was "Well groomed", "Cooperative", "Alert and Oriented" with "Fair" insight ("puts up barriers to suggestions, recommendations to help") and "Fair" judgement ("cutting is excessively deep"). Per the Crisis Clinician's risk assessment regarding suicidality, Patient #1 "reportedly disposed of razors but found something this am to cut" him/her-self "with". "At this time, states with certainty that" his/her "alter will cut to kill .as soon as .is alone". The Crisis Clinician's interpretation was that Patient #1 had been "engaging in deep self-harm cutting in the context of dissatisfactory housing with noisy roommate and less staffing". Patient #1 "may very well cut again tomorrow and end up in the ED". S/He "initially seemed to be seeking admission by coming with two packed bags. Remains at chronic risk" to him/her-self. The plan for Patient #1 was to "discharge from the ED to Follow up Provider" and for the outpatient crisis center to follow-up with housing about changing units

Per review of a psychiatry note from 12/24/20 at 10:27 PM, the psychiatrist confirmed what the Crisis Clinician had reported that the incidents of self-mutilation were "just warnings" and that next time the alter would "cut to kill".

D. Widenka RN
2/24/21

Patient #1 expressed to the psychiatrist that s/he did not want to go to a higher level of outpatient care/support and/or stay in the ED overnight.

Patient #1 was "calm, linear, organized, but demonstrated obvious black-and-white thinking and help seeking help rejecting behavior". Per review of the psychiatrist's mental status exam for Patient #1, s/he was "cooperative and apathetic"; mood was "neutral, mildly restricted, appropriate social reactivity"; oriented to "person, place, time"; with "fair" insight and "poor" judgment. Per review of the psychiatrist's assessment, "It has been previously established by the Psychiatry Consult Service, Ethics" and outpatient mental health provider "(during 4/12-4/20/20 hospitalization)" that Patient #1 "does not benefit from inpatient psychiatric hospitalization and in fact demonstrates worsened self-mutilation after discharge. The patient will not be placed on an involuntary hold while the patient has what can be considered terminal psychiatric illness and has persistently high baseline risk of death by self-mutilation" s/he "clearly demonstrates symptoms of borderline personality disorder and should be allowed to discharge home from the ED, knowing that" his/her "self-mutilation will recur".

Per interview on 1/7/21 at 1:18 PM with ED Provider #2, s/he stated that there were several components to a safe discharge; the patient would be "medically stable to leave", there would be a "safety" plan to mitigate "self-harm risk", and there would be a "safe place to stay". S/He stated that determining a patient's capacity would be "case-by-case" and that crisis and psychiatry teams were heavily relied upon to help make the determination for patients if there was a question. S/He stated that regarding Patient #1 s/he had seen him/her on 12/23/20 and was only involved in helping to repair the patient's lacerations.

Patient #1 had presented to the ED on the following day, 12/24/20, and had wanted to speak to crisis. ED Provider #2 stated that s/he spoke to psychiatry and crisis on that date and that Patient #1 was at her "baseline" and that s/he did not need "hospitalization". Patient #1 "tended to escalate when more services were added". S/He stated that there was an "ED care plan" in place for Patient #1 and that "unless new change would not warrant a crisis clinician evaluation". The plan was for Patient #1 was to be discharged from the ED and for him/her to go back to the hotel s/he was residing in. ED Provider #2 stated that Patient #1's presentation was like times when s/he had presented to the ED in the past. Upon his/her evaluation of Patient #1 on 12/24/20, s/he was "calm, cooperative, pleasant, and reasonable".

S/He had a "linear thought pattern, did not seem off" his/her "baseline from when I had met" him/her "previously". S/He stated that for Patient #1, it was "up to the provider's discretion whether or not crisis was called"

Per interview on 1/7/21 at 2:31 PM with a Second Year Resident Physician (A stage of graduate medical education.), s/he stated that his/her role was to evaluate patients, write notes, make recommendations, admit, and discharge patients; and that all these processes were evaluated and approved by an Attending Physician (A physician who has completed residency and practices medicine in a clinic or hospital). S/He stated that the psychiatry service only evaluated patients after they had been assessed by a Crisis Clinician. S/He stated that a patient's capacity was based on their mental status exam and whether the patient was able to make a "single medical decision". S/He stated that s/he had first heard about Patient #1 on 12/23/20 from crisis. On 12/24/20, s/he evaluated Patient #1 and that s/he was "very well put together". S/He had his/her "hair done" and was dressed in "casual clothes". S/He had exhibited "linear, organized thinking". S/He "denied suicidal ideations, wanted to go home".

During an interview at that time with the Medical Director of ED Psychiatry, s/he stated that historically when Patient #1 presented to the ED s/he was not suicidal, his/her "alter" was suicidal. S/He stated that when Patient #1 had increased supports his/her condition had "worsened". S/He was "not able to be kept safe as an inpatient" and when s/he was discharged, s/he had "escalated to a dangerous degree of self-harm". S/He stated that "further hospitalizations would be dangerous for the patient". S/He stated that the patient would typically present several days in a row with a "little escalation" and then the behavior would taper off, referring to this as an "extinction burst". S/He stated that s/he "came in all the time with very bad wounds". The "more support" s/he "got the worse" s/he "did". S/he stated that patients care plans were always "in flux" and that "every time they come in; they are re-assessed". S/He stated that in April of 2020 a multidisciplinary team (to include Ethics) meeting was held to discuss whether to

D. Wickenhauser
1/24/21

involuntarily commit Patient #1 to receive further treatment. "They did not have a way to keep" him/her "safe". "Nothing to offer the patient". S/He stated that "Because overall nothing had changed globally, ultimately did not change the treatment recommendations". There was an "overall chronic risk in death by self-lacerations

Per review of a provider's note from 12/25/20 at 12:21 PM, Patient #1 presented to the ED with a nine (cm) centimeter laceration with six branching lacerations, one-centimeter perpendicular to the main laceration: and 4 cm, 3 cm, and 2 cm lacerations on his/her right ankle. Patient #1 reported that s/he took an Uber to the ED and that s/he "disassociated and cut" him/her-self. S/he denied any "current SI (suicidal ideation) but states that" his/her "'other person' desires to hurt her". Per the provider's physical exam, Patient #1 was "alert and oriented, appears comfortable".

The provider contacted Crisis and they stated that Patient #1 would not be accepted to the higher level of outpatient care and that the "patient declined any further assessment from crisis.

Crisis agreed to do a phone check later today". The patient's condition at departure from the ED was "Stable". Per interview on 1/7/21 at 3:27 PM with ED Provider #3, s/he stated that when a patient presents as suicidal and/or with self-harm, the main goal was to "assess risk to harm to self or others". If it is "determined" that there is a risk of harm to self and/or others, then s/he would "get crisis involved". S/He further stated that a safe discharge plan would reflect how the patient could be discharged safely and that "everyone is on the same page". S/He stated that s/he had seen Patient #1 a "number of times". S/He stated that s/he "can't think of a time that" Patient #1 "did not present without the same complaint"; and that Patient #1 was "adamant" s/he "was not suicidal". ED Provider #3 stated that s/he had spoken to crisis while Patient #1 was in the ED and that they "did not feel that they needed to see" him/her.

ED Provider #3 had asked crisis to call the patient at home. S/He stated that both crisis and psychiatry advised that Patient #1 was "ok" to be discharged. They "all agreed that it was a reasonable plan". S/He stated that s/he "knew looking at previous psychiatry documentation" that Patient #1 did not "benefit" from hospitalization

Per review of a provider's note from 12/25/20 at 8:25 PM, Patient #1 presented to the ED via Emergency Medical Service for an arm injury. S/he has been seen in the ED multiple times in the past as well as earlier today and multiple times yesterday for self-inflicted wounds. Patient #1 reported that his/her "alter" was threatening to "kill" and that s/he "disassociated" and cut him/her-self. Per the physician's physical exam, Patient #1 was "Well appearing, in no acute distress"; his/her skin was with "multiple injuries in various stages of healing"; and s/he had "Normal speech, gait wnl (within normal limits), strength and sensation to light touch wnl".

Patient #1 reported to the physician that his/her "injuries have been increasing lately because has been alone more often, which allows other personalities to injure more often". Upon exam his/her "tendon is clearly visible, no tendon injury and range of motion though limited at baseline due to multiple injuries, is not acutely worse". His/her wound was repaired, and crisis was consulted. "Crisis met with the patient, discussed with psychiatry, and agreed that the patient was appropriate for discharge". The patient was discharged with instructions for suture removal and to "return for any new or worsening symptoms".

Per review of a crisis note from 12/26/20 at 12:23 AM, Patient #1 explained to the Crisis Clinician that his/her "behaviors of late as being driven by one of" his/her "alters". And that the alter "'wants to be dead' and on some level there is a sense of resignation and hopelessness that" Patient #1 "does not have the capacity to subdue" their "intent". Patient #1 was scheduled to have an appointment with his/her outpatient case manager on 12/28/20 and then a psychiatrist on 1/12/20. Patient #1 reported that s/he was in "full control" and that s/he "denies current suicidality and dose not evidence plan or intent". S/He reported that his/her housing had changed because "they could not keep" his/her "safe". "Earlier in the year a treatment team from Psychiatry", Outpatient provider, and "ethics met to discuss protocol for ongoing care" due to the patients "level of self-harm that has led to the need for medically based admissions the team had decided to treat further occurrences in a more medically based palliative manner" The crisis clinician consulted with on-call psychiatry to include the attending physician, and "both doctors felt that discharge from the ED was appropriate course of action". "This writer will schedule twice daily phone checks over the next two days until" s/he "meets with Case Manager". S/He "is also encouraged to seek medical care at the ED if as needed

D. Widawski RN
2/12/21

which to date" s/he "has followed through with". Per review of the Crisis Clinician's mental status exam, Patient #1 was "Well groomed", "Alert and oriented", with "Poor" insight and "Poor" judgment. The Crisis Clinician's risk assessment revealed that Patient #1's suicidality was "High for continuing acts of self-harm however no current stated intent or intent to die". The Clinician's interpretation was that "past history and current treatment states that inpatient admission and intensive OP (outpatient)therapy appears counter-productive for" Patient #1 "moving forward Historically" Patient #1 "has sought and accessed medical care as needed in consultation with psychiatry it is recommended that" Patient #1 "discharge to follow up with established treatment team"

Per interview on 1/7/21 at 3:11 PM with ED Provider #4, s/he stated that when a patient presented to the ED with self-harm, a medical evaluation would be done to identify any acute medical issues. Once the medical issues were identified and addressed, a psychiatric evaluation would be done. S/He stated that Patient #1 presented to the ED with a "left arm laceration". The patient was "calm" and s/he "answered questions". S/He had other lacerations on the same arm as well as on both legs. ED Provider #4 stated that s/he closed the laceration, and that Patient #1 had no other medical issues. S/He stated that s/he "got the crisis person involved"; and stated that "what was unusual, crisis person told" him/her "that" Patient #1 "was a palliative case". S/He stated that s/he had been an ED provider for "27 years" and had "never heard that term applied to a psychiatric case before". S/He further stated that "crisis had spoken to the psychiatric resident" and "together made a decision did not need emergency hospitalization". "Everyone felt that the patient was ok to be discharged Per review of an Ethics Service Consult note from 4/15/20 at 2:44 PM, a question was posed "What are our obligations to a patient with a history of severe self-harm who has been newly stabilized from" his/her "most recent instance of self-harm and thus is likely to be discharged soon?" There were concerns amongst the group of providers (Surgery, Outpatient Mental Health, Psychiatry, and Social Work) about "escalation in behavior and risk of self-harm in the future," as "there has been a pattern of exacerbation particularly in response to escalation of services. Post-discharge high risk of repeat self-harm". The team discussed the definition of goals for the patient that were achievable. One of the psychiatrist's asked "if the patient could be considered 'terminal' and if this conception of" his/her "prognosis affect goals of care". A question of decision-making capacity was also brought up in the discussion. The note further read, "Beneficence is a core value in bioethics. We should try to do the right thing. To help. To heal. To cure when possible. This translates to a duty to render the standard care, and to attempt to achieve the best results possible. The nature of the standard of care depends on patient decision-making capacity. For adults with decision-making capacity, our professional obligation is to offer the standard interventions and then let the patient decide which she will or will not allow, engage or thwart. Here, decision making capacity is in question, and next steps hinge on it". The ethicist recommended that it was appropriate to stabilize the patient acutely and as surgical repair was needed; to "engage an outside psychiatric expert" to "weigh in on whether the patient does or does not have decision making capacity"; and then the "Next steps in care can proceed from there

Per review of a Psychiatric Consult note from 4/16/20 at 12:54 PM, the psychiatrist met with Patient #1 on this date via video conference and discussed the outcomes and recommendations from the ethic's consultation from 4/15/20. Also during the consultation, a "decision that a competency evaluation should be performed" for Patient #1 was made. The note also read, "based on the ethics consultant's findings, itmight be the only viable option for us to discharge" him/her "under" his/her "own care and supervision while we are waiting a capacity evaluation given that" s/he "would be considered competent to care for" him/her-self "until deemed incompetent by a judge and because" s/he "currently is being declined for admission on multiple inpatient psychiatry units, including ours, because it is felt that inpatient psychiatric admissions had not been helpful orproductive

Per review of a Psychiatry Attending Note from 4/17/20 at 10:04 AM, it read, "The patient was evaluated for the decision-making capacity regarding: 'Does the patient have the capacity to keep" him/her-self "safe". The provider's assessment revealed that "based on the assumption" that the "diagnosis of Dissociative Identity Disorder (DID) is accurate, the patient does not want to self-harm but apparently cannot avoid doing so because a 'different self' is the one harming the patient". If Patient #1 "has an alternate personality, does it have the right to self-harm? This scenario raises questions about whether it is safe to discharge" him/her "without supervision. I would support seeking of guardianship through the court and having extensive supervision for the patient". Also if Patient #1 "does not have capacity to keep" him/her-self "safe due to the presence of 'another self' would create a very difficult clinical scenario by which the patient would have to be considered to not have capacity for ANY medical decision, since the 'other' may

D. Widdecke
2/24/21

not want those decisions ....If we are going to deem" Patient #1 "to lack capacity we would need to factor that the alternate personality would decide in EVERY clinical scenario. This is the definition of competency, which falls upon courts to decide .At this time it is my clinical opinion that the patient HAS decision making capacity to keep" him/her-self "safe".

Per record review, Patient #1 was admitted to the hospital on 5/5/20 with bilateral pulmonary embolisms. Per review of a Spiritual Care Note from 5/15/20 at 6:00 PM, the Chaplin met with Patient #1 as s/he was waiting for information from his/her care team about options for treatment. During a prior admission, a recommendation was made for the patient to stay in the hospital for 3 months for treatment. Patient #1 "felt" it "was not feasible on an emotional/psychological level." Patient #1 expressed that his/her current concerns were a "24/7 sitter, limited access to support network due to Covid restrictions, and being in hospital clothing". S/He was able to "articulate an understanding of the teams concerns ('if I take blood thinners at home and cut myself, I might die') but kept returning to, 'they don't know me; they only see me here'". "Ultimately" Patient #1 "feels abandoned". Patient #1 shared with the Chaplin the following: "'Psychiatry said I can't come back here to get treatment. For the last two years or so, they won't even take me inpatient .If I don't get this treatment, I'll die. But I can't commit to being here for three months, so they say I can't get any treatment at all They told me they think my psychiatric illness is terminal so they don't have to treat it anymore I feel like everyone's giving up on me'". The Chaplin recommended that "In the future it may be helpful for" Patient #1 "to have a trusted support person present for medical conversations

Per interview on 1/11/20 at 2:06 PM with the Medical Director of ED Psychiatry, s/he clarified that there were flags in Patient #1's record that alerted providers to how the patient presented but that did not "mean it's the ED Care Plan". Patient #1 had left the state during the summer of 2020 to receive treatment. S/He came back to the state in the fall of 2020 and at that time, the hospital "had maintained the same care plan, recommendation-not to hospitalize" and if Patient #1 were to come in and his/her presentation was "not new" the providers would "not need to consult crisis". S/He stated that they "did not have an official care plan" for Patient #1 and that, "multidisciplinary teams were consulted". When asked to explain the criteria for an involuntary admission, s/he stated that a patient needed to be "at risk of death to self or another person and that risk has to be due to a major mental illness, Borderline Personality Disorder not considered major mental illness". S/he stated that if Patient #1 as him/her-self stated s/he was suicidal, was self-harming and would not go to the hospital, the hospital could involuntarily admit him/her.

However, s/he as him/her-self did not present as suicidal, his/her "alter" was. When asked to define whether a psychiatric patient could be palliative and/or terminal, s/he stated that the term "palliative psychiatry was not accepted".

S/He stated that a psychiatric illness could be "terminal" and that they do "everything in power to change the course". However, it was "not accepted in the U.S. to deem someone terminal" with a "psychiatric" illness. S/He stated that for this patient "every time need to be revisiting" whether or not the patient "needs to be admitted". When asked why the plan for the patient had not changed and or the patient re-assessed, s/he stated that the "pathology of the patient did not change, life circumstances changed, was not a change from baseline path

Per interview on 1/12/21 at 11:26 AM with the Director of Ethics, s/he stated that ethics was often consulted when difficult issues arose regarding patients care like conflicts at end of life and/or helping clinician's deal with violent/non-compliant patients. S/He stated that the hospital clinicians consulted ethics for Patient #1's care. S/He stated that the team was "distressed that" his/her "mental illness was leading" him/her "to self-injure in life threatening ways" and were "worried treatment" was not "changing the path". They "did not want to make" his/her "condition worse". S/he stated that to be able to keep Patient #1 safe, s/he would have to have "lifelong 24/7 observation". There were several obstacles with this as Patient #1 "did not want" this and that there was "no facility willing to accept and/or provide" this type of care. It appeared that what the hospital "could do was not working" and "there were no other options". S/He stated that part of his/her role was to "try to help them be advocates for" him/her and "think of a new way" to treat him/her. When asked about Patient #1 being palliative/terminal s/he stated that the "judgement is outside" his/her "clinical expertise". S/He stated that the terms were "ordinarily" an "uncommon designation". And that "typically for psychiatric illnesses" patients were either "incapacitated" and were "a ward of

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the state" and/or they were able to "access some service line" to be able "to live in" an "outpatient setting". S/He stated that "health care providers can assess capacity related to conditions". And that a determination of "competency" a "judge needs to make". S/He stated that Patient #1 was "able to demonstrate capacity". S/He was "bright and could tell you pros/cons and could give a rationale" and his/her "reasoning was sound". S/He stated that "one of the challenges with this" is that "when someone is self-injurious", they "can still have decision making capacity". Patient #1 had times that s/he "admitted" to being suicidal and that would warrant a hospital admission.

However, at times after hospitalization(s) his/her condition would decline. "The challenge with" Patient #1 was that s/he "was so determined" to "hurt" him/herself and that what "would ordinarily be helpful would not be in this patient's case". Based on the above interviews and record reviews it was not evident that Patient #1 was involved in developing, participating, and/or revising his/her plan of care during any of his/her visits to the ED on 12/23/20 through 12/26/20.

There was no evidence that the hospital further explored guardianship; and whether the patient was competent to make decisions regarding his/her psychiatric care, especially in times of crisis. There was also no further updated safety and/or treatment plan for Patient #1 that ensured Patient #1's stability and/or safety from self-harm. And it was not clear after the Ethics and Psychiatry Consultations from April of 2020, if the hospital had made attempts and exhausted all possibilities to refer and pursue treatment for Patient #1 within the system of care.

Action Plan

- Prior to the review by the Division of Licensing and Protection on January 11, 2021, it is important to note that the referenced case was under review through University of Vermont Medical Center Quality Review Process by the Quality Chairs for the Department of Ethics, Emergency Medicine and Psychiatry.

- This case was the focus of a multidisciplinary Grand Round Session with representation from Psychiatry, Emergency Medicine, Intensive Care and Ethics on 1/7/21. In addition this case was reviewed at the Safety Adjudication Committee Meeting chaired by the Chief Medical Officer and Vice President for the Institute for Quality.

- A thorough review of University of Vermont Medical Center Emergency Department multi visit care delivery process was led by Assistant Division Chief, Emergency Medicine/ Associate Chief Medical Officer for Medical Staff Affairs, Quality Director Emergency Medicine/ Education Director Emergency Medicine Residency Program, Network Director of Case Management and Emergency Department Nursing Director/ Manager. As a result of this review, opportunities were identified to improve the care coordination process and infrastructure. In order to ensure a standardized process, a policy titled: Emergency Department Care Plan and Approval Procedure was created. Electronic medical record modifications to support the procedure were also created. The procedure provides a guideline for development, review and approval of Emergency Department care plans for patients who are high utilizers of Emergency Department services and/ or have complex care needs.

- The referenced policy will be presented at the March 4th, 2021 Medical Executive Committee by the Assistant Division Chief, Emergency Medicine/ Associate Chief Medical Officer for Medical Staff Affairs for awareness within the Medical Staff at large.

- Under the direction of the Emergency Department Director and Medical Director, the Emergency Department Staff and Providers will be educated on the Emergency Department Care Plan and Approval Procedure through a combination of learning modules, meetings and electronic communication.

- Under the direction of the Network Director of Case Management and Social Work, an Emergency Department Case Manager High Utilizer Report will be reviewed monthly by the Case Manager to ensure patients who would benefit from an Emergency Department Care Plan are identified.

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- Documentation will be reviewed monthly for concordance with the Emergency Department Care Plan Policy for the development, review and approval of the Emergency Department Care_Plan by the Case Manager and RN Clinical Analyst. Performance Data will be shared as appropriate with the Emergency Department Leaders.

- All actions will be complete by 3/25/21.

PBC accepted 2/24/21
D. Widerkehr

A1100 EMERGENCY SERVICES CFR(s): 482.55

The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.

This CONDITION is not met as evidenced by: Based on interviews and record reviews, the Condition of Participation: Emergency Services was not met as evidenced by the failure of the hospital to ensure that the emergency needs of behavioral health patients were met due to the failure of the hospital to protect and prevent 1 of 20 applicable patients (Patient #1) from injury and/or self-harm. Findings include

University of Vermont Medical Center is responding to this condition-level deficiency through the standard level action plans.

Per record review, Patient #1 has a history of Self-mutilation, pulmonary embolism (blood clot in lung), overdose, hemorrhagic shock (body shuts down due to blood loss), dissociative identity disorder (A disorder characterized by the presence of two or more distinct personality states.), depression, borderline personality disorder (A mental disorder characterized by unstable moods, behavior, and relationships.), anxiety, and anemia (deficiency of red blood cells). Patient #1 was admitted and discharged from the Emergency Department (ED) five times over a period of three days from 12/23/20 to 12/26/20. On 12/23/20, S/He was admitted at 4:12 PM with a chief complaint of "Self Injury" and was discharged home at 11:39 PM. On 12/24/20, S/He was admitted at 10:04 AM with a chief complaint of a "Laceration (deep cut)" and was discharged home at 10:54 AM; and at 5:32 PM came back to the ED with a chief complaint of "psychiatric (mental) evaluation" and was discharged home at 11:29 PM. On 12/25/20, S/He was admitted at 11:10 AM with a chief complaint of a "Laceration" and discharged home at 2:30 PM; and at 8:22 PM came back to the ED with a chief complaint of a self-inflicted "arm injury" and was discharged home at 12:38 AM on 12/26/20. On 12/27/20 at 6:35 PM, Patient #1 presented to the ED unresponsive after a drug overdose and subsequently died on 12/28/20.

Per review of a provider's note from 12/23/20, Patient #1 presented to the ED for self-injury. Per the patient's report, the self-mutilation was caused by another identity. This personality found a razor blade and cut him/her-self and caused eight lacerations across the left forearm. Per the physician's physical exam, Patient #1 had "7 lacerations on the left forearm all lacerations are parallel to each other". S/He was "alert and oriented" and had "no agitation or thought disorder". Upon further review of the provider's note, "The patient does have a care plan in place which states provider may consult crisis for new concerns, but to only treat lacerations as medically necessary". The patient had "seven lacerations repaired ...40 sutures total". At 10:35 PM "Spoke to crisis who evaluated the patient".

Patient #1 was "recently moved from a crowded homeless shelter where staff constantly checked up on" him/her "to an isolated hotel room. Crisis feels that" s/he "injured" him/her-self "again given the opportunity because" s/he "was isolated. They are comfortable with discharge because" s/he "will have full services soon". "The patient was discharged home" and was provided instructions to follow up with his/her primary physician and outpatient mental health provider.

Per review of a crisis note from 12/23/20 at 11:19 PM, Patient #1 reported to the Crisis Clinician that s/he was moved from one residence to another because the newer residence (a hotel) had increased supervision. S/He stated that his/her alter personality was "mad" about moving and had told Patient #1 that s/he would "die" at the hotel. Patient #1 reported that s/he "disassociated" and his/her alter went out and bought razors; and "disassociated" again and his/her alter cut his/her forearm seven times. It had been about a month since Patient #1's last episode of self-harm and s/he

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remarked that "it was the first time they have really been alone". Patient #1 reported that s/he felt "depressed and anxious" and that was because s/he was off his/her medications and was "doing everything alone". S/He stated that s/he did not have insurance until the first of the year; however, did have access to a couple of his/her medications. S/He expressed that s/he had not picked them up from the pharmacy because s/he feared the alter would use them to "overdose". The Crisis Clinician's mental exam revealed that Patient #1 was "Well-groomed", "Cooperative", "Alert and Oriented" with "Fair" insight and "Poor" judgment. Per the Crisis Clinician's risk assessment, Patient #1 as him/her-self did not have thoughts of suicide or self-harm; however, his/her alter caused harm to him/her today. The alters in the past had also caused extensive and severe lacerations, which necessitated skin grafting, medical admission, and blood transfusions. S/He also had a history of a drug overdose in 2018 and in the spring of 2020. The crisis clinician's clinical impression was that Patient #1's alters severely self-harm; however, Patient #1 as him/her-self denied any safety concerns. Patient #1 was "agreeable and able to properly safety plan".

Patient #1 "has historically shown that inpatient admission due to self-harm only causes and increase in severity and frequency of self-harming upon d/c, therefore it is recommended that"

Patient #1 "not be supported through inpatient admission at this time". The plan for Patient #1 was to discharge from the ED and to follow-up with his/her "provider" and "outpatient safety plan". S/He would be provided a "lock box for medications"; S/He "felt" that s/he was "able to dispose of razors"; and was "agreeable to talk to staff about checking in twice daily".

Per review of a psychiatry update note from 12/23/20 at 10:53 PM, "Psychiatry did not formally consult on this patient tonight due to a previously established explicit and extensively documented plan created in collaboration with the Psychiatry Consult Service", outpatient mental health provider, "Ethics, and Surgery during" Patient #1's "4/12/2020 hospital admission". The psychiatrist's assessment and plan revealed that s/he was "in agreement with the Crisis Clinician's assessment and plan" for Patient #1 from 12/23/20.

Per interview on 1/7/21 at 4:34 PM with ED Provider #1, s/he stated that if a patient presented with self-harm, the patient would be put on (suicide) "precautions" until s/he figured out what was going on with the patient. A medical screening would be done and then if the patient were cleared medically, a consult for a crisis counselor to evaluate the patient would be made. Regarding the case with Patient #1 on 12/23/20,

Patient #1 had a history of self-harm behavior and that in his/her experience, cutting was a form of release and typically did not involve deep lacerations. In this case, Patient #1's lacerations were deep and when s/he had assessed Patient #1 for suicidality, s/he "denied any suicidal ideation flatly". S/He stated that "one of" his/her "personalities engaged in these behaviors". ED Provider #1 stated that Patient #1 was a "frequent visitor to the ED" and that s/he had "read a care plan that said the patient would have these acute episodes when discharging would get worse".

S/He stated that crisis had seen the patient, things were getting set up for him/her as an outpatient, and that they "were comfortable sending" him/her "home". S/He stated that Patient #1 was "re-assessed for suicidality multiple times" during his/her time in the ED. ED Provider #1 stated that s/he often involved "ancillary services" as s/he expressed, we "do not have the time to spend" discerning the best course of action and/or treatment for a psychiatric emergency and that crisis and psychiatry were the experts to help guide that process

Per review of a provider's note from 12/24/20 at 10:16 AM, Patient #1 presented to the ED for a laceration. The patient had a significant history of self-mutilation by cutting requiring repairs, and this was his/her "third presentation in three days". Patient #1 was unaware of what happened, s/he remembered going to bed and noticed a large laceration on his/her left lower leg at 9:30 this morning. Patient #1 did not know what type of object was used to inflict the injury. Patient #1 shared with the provider that "'he' has been very suicidal as of late, this 'he'" Patient #1 "speaks of is presumed to be a dissociative identity". The physician's exam revealed that there was a "25 cm linear laceration to the left lower leg through the dermis". The patient had "no agitation or overt thought disorder". The physician had asked if Patient #1 had a plan in place for future episodes of self-mutilation and s/he stated "'he' has been pretty suicidal"; however, Patient #1 stated that s/he "is not suicidal". The patient also reported that s/he had outpatient counseling and could follow up with them. Patient #1's laceration was repaired, and s/he was discharged with

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instructions to follow-up with his/her doctor and outpatient counselor. S/He was also given instructions regarding wound care and pain control. The patient was re-evaluated by the physician immediately prior to discharge with "improved symptoms, normal vital signs discharged with a clear plan for outpatient follow-up".

Per review of a provider's note from 12/24/20 at 7:10 PM, Patient #1 presented to the ED for a psychiatric evaluation. S/He had been seen twice in the last 24 hours with several lacerations on right forearm and left lower leg both needing extensive repair. S/He had a crisis consultation last night and "ultimately felt like this was not a safety concern and patient was discharged in the ED on both occasions". S/He came back to the ED and stated that his/her alter told him/her that s/he would "cut to kill". Patient #1 contacted his/her outpatient support program and they referred him/her to the ED for an evaluation.

Patient #1 reported to the provider that s/he "is feeling safe". Per the provider's exam, the patient was "alert and oriented. No agitation or overt thought disorder". The patient was evaluated by Crisis and the "Crisis Clinician felt that the patient behaviors were likely result of recent move from a shelter that had more support staff and more people around to a place there is more isolated". Patient #1 was also evaluated by psychiatry and "does not need hospitalization at this time". S/He "will be discharged back to" his/her "established living arrangement. I discussed with patient" and s/he "is agreeable to this plan".

Per review of a crisis note from 12/24/20 at 8:15 PM, Patient #1 had presented to the ED hours later than when the outpatient counseling service had encouraged him/her to do so and had arrived with two packed bags. S/He had told the Crisis Clinician that s/he was not sure what type of help s/he needed but stated that when his/her alter "'makes threats follows through'" "'this morning was a warning'" and that s/he would expect "either another OD or more deep cutting". And that the other personality's goal was allegedly to "'destroy the body'" as s/he "'doesn't want to be alive'". "She reported being scared of the next thing to happen" from his/her alter. Patient #1's mental status exam showed that s/he was "Well groomed", "Cooperative", "Alert and Oriented" with "Fair" insight ("puts up barriers to suggestions, recommendations to help") and "Fair" judgement ("cutting is excessively deep"). Per the Crisis Clinician's risk assessment regarding suicidality, Patient #1 "reportedly disposed of razors but found something this am to cut" him/her-self "with". "At this time, states with certainty that" his/her "alter will cut to kill as soon as is alone". The Crisis Clinician's interpretation was that Patient #1 had been "engaging in deep self-harm cutting in the context of dissatisfactory housing with noisy roommate and less staffing". Patient #1 "may very well cut again tomorrow and end up in the ED". S/He "initially seemed to be seeking admission by coming with two packed bags ...Remains at chronic risk" to him/her-self. The plan for Patient #1 was to "discharge from the ED to Follow up Provider" and for the outpatient crisis center to follow-up with housing about changing units

Per review of a psychiatry note from 12/24/20 at 10:27 PM, the psychiatrist confirmed what the Crisis Clinician had reported that the incidents of self-mutilation were "just warnings" and that next time the alter would "cut to kill". Patient #1 expressed to the psychiatrist that s/he did not want to go to a higher level of outpatient care/support and/or stay in the ED overnight. Patient #1 was "calm, linear, organized, but demonstrated obvious black-and-white thinking and help seeking help rejecting behavior". Per review of the psychiatrist's mental status exam for Patient #1, s/he was "cooperative and apathetic"; mood was "neutral, mildly restricted, appropriate social reactivity"; oriented to "person, place, time"; with "fair" insight and "poor" judgment. Per review of the psychiatrist's assessment, "It has been previously established by the Psychiatry Consult Service, Ethics" and outpatient mental health provider "(during .4/12-4/20/20 hospitalization)" that Patient #1 "does not benefit from inpatient psychiatric hospitalization and in fact demonstrates worsened self-mutilation after discharge. The patient will not be placed on an involuntary hold while the patient has what can be considered terminal psychiatric illness and has persistently high baseline risk of death by self-mutilation" s/he "clearly demonstrates symptoms of borderline personality disorder and should be allowed to discharge home from the ED, knowing that" his/her "self-mutilation will recur".

Per interview on 1/7/21 at 1:18 PM with ED Provider #2, s/he stated that there were several components to a safe discharge; the patient would be "medically stable to leave", there would be a "safety" plan to mitigate "self-harm risk", and there would be a "safe place to stay". S/He stated that determining a patient's capacity would be "case-by-case" and that crisis and psychiatry teams were heavily relied upon to help make the determination for patients if there

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was a question. S/He stated that regarding Patient #1 s/he had seen him/her on 12/23/20 and was only involved in helping to repair the patient's lacerations Patient #1 had presented to the ED on the following day, 12/24/20, and had wanted to speak to crisis. ED Provider #2 stated that s/he spoke to psychiatry and crisis on that date and that Patient #1 was at her "baseline" and that s/he did not need "hospitalization". Patient #1 "tended to escalate when more services were added". S/He stated that there was an "ED care plan" in place for Patient #1 and that "unless new change would not warrant a crisis clinician evaluation". The plan was for Patient #1 was to be discharged from the ED and for him/her to go back to the hotel s/he was residing in. ED Provider #2 stated that Patient #1's presentation was like times when s/he had presented to the ED in the past. Upon his/her evaluation of Patient #1 on 12/24/20, s/he was "calm, cooperative, pleasant, and reasonable". S/He had a "linear thought pattern, did not seem off" his/her "baseline from when I had met" him/her "previously". S/He stated that for Patient #1, it was "up to the provider's discretion whether or not crisis was called".

Per interview on 1/7/21 at 2:31 PM with a Second Year Resident Physician (A stage of graduate medical education.), s/he stated that his/her role was to evaluate patients, write notes, make recommendations, admit, and discharge patients; and that all these processes were evaluated and approved by an Attending Physician (A physician who has completed residency and practices medicine in a clinic or hospital). S/He stated that the psychiatry service only evaluated patients after they had been assessed by a Crisis Clinician. S/He stated that a patient's capacity was based on their mental status exam and whether the patient was able to make a "single medical decision". S/He stated that s/he had first heard about Patient #1 on 12/23/20 from crisis. On 12/24/20, s/he evaluated Patient #1 and that s/he was "very well put together". S/He had his/her "hair done" and was dressed in "casual clothes". S/He had exhibited "linear, organized thinking". S/He "denied suicidal ideations, wanted to go home".

During an interview at that time with the Medical Director of ED Psychiatry, s/he stated that historically when Patient #1 presented to the ED s/he was not suicidal, his/her "alter" was suicidal. S/He stated that when Patient #1 had increased supports his/her condition had "worsened". S/He was "not able to be kept safe as an inpatient" and when s/he was discharged, s/he had "escalated to a dangerous degree of self-harm". S/He stated that "further hospitalizations would be dangerous for the patient". S/He stated that the patient would typically present several days in a row with a "little escalation" and then the behavior would taper off, referring to this as an "extinction burst". S/He stated that s/he "came in all the time with very bad wounds". The "more support" s/he "got the worse" s/he "did". S/he stated that patients care plans were always "in flux" and that "every time they come in; they are re-assessed". S/He stated that in April of 2020 a multidisciplinary team (to include Ethics) meeting was held to discuss whether to involuntarily commit Patient #1 to receive further treatment. "They did not have a way to keep" him/her "safe". "Nothing to offer the patient". S/He stated that "Because overall nothing had changed globally, ultimately did not change the treatment recommendations". There was an "overall chronic risk in death by self-lacerations".

Per review of a provider's note from 12/25/20 at 12:21 PM, Patient #1 presented to the ED with a nine (cm) centimeter laceration with six branching lacerations, one-centimeter perpendicular to the main laceration: and 4 cm, 3 cm, and 2 cm lacerations on his/her right ankle. Patient #1 reported that S/he took an Uber to the ED and that s/he "disassociated and cut" him/her-self. S/he denied any "current SI (suicidal ideation) but states that" his/her "'other person' desires to hurt her". Per the provider's physical exam, Patient #1 was "alert and oriented, appears comfortable".

The provider contacted Crisis and they stated that Patient #1 would not be accepted to the higher level of outpatient care and that the "patient declined any further assessment from crisis. Crisis agreed to do a phone check ...later today". The patient's condition at departure from the ED was "Stable".

Per interview on 1/7/21 at 3:27 PM with ED Provider #3, s/he stated that when a patient presents as suicidal and/or with self-harm, the main goal was to "assess risk to harm to self or others". If it is "determined" that there is a risk of harm to self and/or others, then s/he would "get crisis involved". S/He further stated that a safe discharge plan would reflect how the patient could be discharged safely and that "everyone is on the same page". S/He stated that s/he had seen Patient #1 a "number of times". S/He stated that s/he "can't think of a time that" Patient #1 "did not present

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without the same complaint"; and that Patient #1 was "adamant" s/he "was not suicidal". ED Provider #3 stated that s/he had spoken to crisis while Patient #1 was in the ED and that they "did not feel that they needed to see" him/her.

ED Provider #3 had asked crisis to call the patient at home. S/He stated that both crisis and psychiatry advised that Patient #1 was "ok" to be discharged. They "all agreed that it was a reasonable plan". S/He stated that s/he "knew looking at previous psychiatry documentation" that Patient #1 did not "benefit" from hospitalization

Per review of a provider's note from 12/25/20 at 8:25 PM, Patient #1 presented to the ED via Emergency Medical Service for an arm injury. S/he has been seen in the ED multiple times in the past as well as earlier today and multiple times yesterday for self-inflicted wounds. Patient #1 reported that his/her "alter" was threatening to "kill" and that s/he "disassociated" and cut him/her-self. Per the physician's physical exam, Patient #1 was "Well appearing, in no acute distress"; his/her skin was with "multiple injuries in various stages of healing"; and s/he had "Normal speech, gait wnl (within normal limits), strength and sensation to light touch wnl".

Patient #1 reported to the physician that his/her "injuries have been increasing lately because has been alone more often, which allows other personalities to injure more often". Upon exam his/her "tendon is clearly visible, no tendon injury and range of motion though limited at baseline due to multiple injuries, is not acutely worse". His/her wound was repaired, and crisis was consulted. "Crisis met with the patient, discussed with psychiatry, and agreed that the patient was appropriate for discharge". The patient was discharged with instructions for suture removal and to "return for any new or worsening symptoms".

Per review of a crisis note from 12/26/20 at 12:23 AM, Patient #1 explained to the Crisis Clinician that his/her "behaviors of late as being driven by one of" his/her "alters". And that the alter "'wants to be dead' and on some level there is a sense of resignation and hopelessness that" Patient #1 "does not have the capacity to subdue" their "intent". Patient #1 was scheduled to have an appointment with his/her outpatient case manager on 12/28/20 and then a psychiatrist on 1/12/20. Patient #1 reported that s/he was in "full control" and that s/he "denies current suicidality and dose not evidence plan or intent". S/He reported that his/her housing had changed because "they could not keep" his/her "safe". "Earlier in the year a treatment team from Psychiatry", Outpatient provider, and "ethics met to discuss protocol for ongoing care" due to the patients "level of self-harm that has led to the need for medically based admissions the team had decided to treat further occurrences in a more medically based palliative manner". The crisis clinician consulted with on-call psychiatry to include the attending physician, and "both doctors felt that discharge from the ED was appropriate course of action". "This writer will schedule twice daily phone checks over the next two days until" s/he "meets with Case Manager". S/He "is also encouraged to seek medical care at the ED if as needed which to date" s/he "has followed through with". Per review of the Crisis Clinician's mental status exam, Patient #1 was "Well groomed", "Alert and oriented", with "Poor" insight and "Poor" judgment. The Crisis Clinician's risk assessment revealed that Patient #1's suicidality was "High for continuing acts of self-harm however no current stated intent or intent to die". The Clinician's interpretation was that "past history and current treatment states that inpatient admission and intensive OP (outpatient) therapy appears counter-productive for" Patient #1 "moving forward historically" Patient #1 "has sought and accessed medical care as needed in consultation with psychiatry, it is recommended that" Patient #1 "discharge to follow up with established treatment team".

Per interview on 1/7/21 at 3:11 PM with ED Provider #4, s/he stated that when a patient presented to the ED with self-harm, a medical evaluation would be done to identify any acute medical issues. Once the medical issues were identified and addressed, a psychiatric evaluation would be done. S/He stated that Patient #1 presented to the ED with a "left arm laceration". The patient was "calm" and s/he "answered questions". S/He had other lacerations on the same arm as well as on both legs. ED Provider #4 stated that s/he closed the laceration, and that Patient #1 had no other medical issues. S/He stated that s/he "got the crisis person involved"; and stated that "what was unusual, crisis person told" him/her "that" Patient #1 "was a palliative case". S/He stated that s/he had been an ED provider for "27 years" and had "never heard that term applied to a psychiatric case before". S/He further stated that "crisis had spoken to the psychiatric resident" and "together made a decision did not need emergency hospitalization". "Everyone felt that the patient was ok to be discharged".

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Per interview on 1/11/21 at 1:09 PM with the ED Nurse Manager, s/he stated that his/her role was to ensure that "staff and patients have a safe environment". S/He stated that if a patient presented with suicidal ideation and/or self-harm they were triaged, a suicide screen was done, and then the patient was roomed and was asked to change into paper scrubs. S/He stated that patients who say they were suicidal were immediately placed on constant observation and stayed on this level of observation until the provider released the patient. S/He stated that s/he was aware of Patient #1 but had not taken care of him/her. S/He stated that Patient #1 had come into the ED with "pretty impressive lacerations" that were done by an "alter" ego.

S/He stated that the patient as him/her-self "was not always feeling suicidal". S/He stated that this was "always how" s/he "presented". S/He stated that the staff had come to him/her and "were distressed" by Patient #1's death. S/He stated that was not his/her "history" and/or "trajectory". The "staff were surprised".

Per interview on 1/11/21 at 3:01 PM with the Assistant Division Chief of the ED, s/he said that part of his/her role was directing operations of the ED. S/He stated that when "stuff comes up that needs to be addressed" s/he helps to "problem solve and address it". S/He stated that there was a physician in charge of doing case reviews and that s/he participated and helped to support the process. S/He stated that Patient #1's name was familiar to him/her and that s/he was aware that the patient had "been in the ED for many visits". S/He stated that "lots of people have seen" Patient #1 and that s/he had "pretty extensive needs". And that it was "really sad" that s/he died. S/He stated that "crisis knows patients" like Patient #1 and how they are "functioning in the community better than the physician's do" and that "they become the experts on how best to treat the patient". S/He stated that about determining capacity, "sometimes it's very clear and the physician knows for sure" and other times "crisis and psychiatry" were called to help determine this.

Per interview on 1/12/21 at 10:29 AM with the Director of the ED Quality Program, s/he stated that the quality program was built around "two pillars" with multidisciplinary and non-punitive approaches. It was a unified approach with active participation by nursing, physicians, and technicians. The quality group's role was to review all services provided in the ED. S/He stated that as part of their quality process they screen for patients who return to the ED within 72 hours. S/He stated that Patient #1's case was referred for a quality review via two different ways; by a provider and as part of their 72-hour return screening process. S/He stated that s/he did not think there "were any gaps in the care".

The "group felt" that Patient #1 "was assessed on each visit". S/he had seen crisis on "4/5 visits" and "psychiatry was called for 1-2 visits". S/He stated that what was "interesting about this patient" was that "psychiatry and ethics had met and felt" s/he "was palliative from their standpoint". S/He stated that it "did not alter how" they "managed the patient from" an "ED provider standpoint". S/He stated that s/he had not heard "palliative/terminal" as a "designation for a psychiatric patient before". S/He stated that what s/he understood was that the resources and methods known to exist were "ineffective in treating" Patient #1's illness and that "no treatments left were going to be effective for" him/her. When asked about whether Patient #1 had capacity, s/he stated that providers will often use their time interacting with a patient to get a sense of their decision-making capacity, assessing whether the patient understands the implications of being discharged and the plan.

For Patient #1's case, s/he stated that it was "clearly documented" that s/he "understood" and felt "safe to go back".

Based on the above interviews and record reviews there was a lack of substantial evidence that showed Patient #1's behavioral health needs were met. Patient #1 presented to the ED 5 times over the course of 3 days with significant self-harm injuries. S/He had a change in housing, was living alone with limited supervision, had no health insurance, and a lack of appropriate medications. There was limited evidence that the patient's behavioral health status was adequately reassessed during his/her visits to the ED on 12/23/20 through 12/26/20 and that there was an updated safety and/or treatment plan for Patient #1 that ensured Patient #1's stability and/or safety from self-harm.

Per review of the hospital policy "Evaluation and Care of Psychiatric Patients in the Emergency Department"- effective 1/12/21 it read, "15. Under Vermont law, a hospital is prohibited from keeping a person in the emergency department, or involuntarily admitting the person for inpatient care, unless they appear to be a danger to self or others

P. Widawski RN
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(Title 18, Vermont Statues Annotated, chapter 179). If the person appears to be a danger to self or others, that law prescribes the process that determines the type of care a person will receive, ranging from a psychiatric evaluation and discharge to involuntary hospitalization and treatment."

Per review of the hospital policy "EMTALA-Medical Screening Examination & Stabilization Policy" effective 1/1/2019, it read, "Stabilization of Psychiatric Emergencies: If an individual is expressing suicidal or homicidal thoughts or gestures and it is determined that he or she presents a danger to themselves or others, he or she is deemed to have an 'emergency medical condition'. Such an individual is stable when he or she is protected or prevented from injuring or harming himself or others stable for discharge. For the purpose of discharging an individual with psychiatric condition(s), the individual is considered to be stable when he or she is no longer considered to be a threat to himself or herself or others".

Action Plan

- A thorough review of University of Vermont Medical Center Emergency Department multi visit care delivery process was led by Assistant Division Chief, Emergency Medicine/ Associate Chief Medical Officer for Medical Staff Affairs, Quality Director Emergency Medicine/ Education Director Emergency Medicine Residency Program, Network Director of Case Management and Emergency Department Nursing Director/ Manager. Through the referenced review, educational opportunities were identified. These opportunities include: uniform EMTALA for a broader audience who provide care in the Emergency Department, including psychiatry residents and contracted staff from community organizations and targeted training for staff who may perform repeated evaluations of patients who present multiple times.

- An asynchronous online training with content on Patient-centered care that acknowledges potential unconscious emotional and cognitive biases in providers, the importance of the patient's role in their own care, and the guidance that is provided by EMTALA, VT law, and UVMMC ED Care Planning policy has been developed under the direction of Psychiatry and the Chief Medical Officer. The curriculum will finalized by March 8, 2021 for deployment to Emergency Department clinical staff, Psychiatry medical staff and contracted community crisis providers with an expected completion date of 3/25/2021 or before the next scheduled shift. Going forward, the online training will be incorporated into onboarding education for the identified populations.

- Approval for a Howard Center Contract amendment to include participation in EMTALA education.

- RN Clinical Analysts for the James Jeffords Institute for Quality will review a sample monthly for documentation that supports the Care Plan Procedure and EMTALA documentation elements. Feedback on the audit findings will be communicated on a monthly basis to the appropriate Managers and Medical Directors for required action.

- All actions will be complete by 3/25/21.

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A112 QUALIFIED EMERGENCY SERVICES PERSONNEL CFR(s): 482.55(b)(2)

There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.

This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to adequately train 6 of 11 applicable staff members in accordance with their written emergency policies. Findings include:

Per document and hospital policy review on 1/12/21 at 7:55 AM, there was no evidence that 5 ED Providers and 1 Registered Nurse (RN) were trained regarding EMTALA regulations. Per interview on 1/12/21 with a Regulation Specialist at that time, s/he confirmed that there was no evidence of the training for the ED staff and that s/he had no explanation as to why they were not trained.

Action Plan

- An asynchronous online training with content on Patient-centered care that acknowledges potential unconscious emotional and cognitive biases in providers, the importance of the patient's role in their own care, and the guidance that is provided by EMTALA, VT law, and UVMMC ED Care Planning policy has been developed under the direction of Psychiatry and the Chief Medical Officer. The curriculum will finalized by March 8, 2021 for deployment to Emergency Department clinical staff, Psychiatry medical staff and contracted community crisis providers with an expected completion date of 3/25/2021 or before the next scheduled shift. Going forward, the online training will be incorporated into onboarding education for the identified populations.

- Under the Direction of the Emergency Room Nurse Manager, a quarterly review of required education will be completed to assure required staff members are current with trainings.

- Under the Direction of the Assistant Division Chief, Emergency Medicine/ Associate Chief Medical Officer for Medical Staff Affairs required EMTALA education will be added to the Ongoing Provider Performances Evaluation Measures reviewed every nine months by the Department Chairs.

- All actions will be complete by 3/25/21.

POC Accepted 2/24/21
Dawn Edwards RN

Department of Health & Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203

Northeast Division of Survey & Certification

February 11, 2021

Via electronic mail: Stephen.Leffler@uvmhealth.org

Dr. Stephen Leffler M.D, President & CEO
University of Vermont Medical Center
111 Colchester Avenue
Burlington, VT 05401

Re: CMS Certification Number (CCN): 470003
Survey ID: 4SN411, 01/11/2021

Dear Dr. Leffler:

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Section 1865 of the Social Security Act and implementing regulations permit a hospital accredited by the Joint Commission (JC) or other applicable Accrediting Organizations to be deemed to meet all of the Medicare Conditions of Participation. 42 U.S.C. § 1395bb; 42 C.F.R. §488.4. Section 1864 of the above Act and the implementing regulation authorize the Secretary of Health & Human Services to conduct, on a selective sampling basis or in response to substantial allegations of non-compliance, surveys of accredited hospitals participating in Medicare as a means of validating the accreditation survey process. 42 U.S.C. § 1395aa; 42 C.F.R. §488.9. If, in the course of such a survey, a hospital is found not to meet one or more of the Medicare Conditions of Participation, the hospital will no longer be deemed to meet any Medicare Conditions of Participation. 42 U.S.C. § 1395bb (c); 42 C.F.R. §488.9. Also, we are required to place the hospital under Medicare State agency survey jurisdiction until it is in compliance with all Medicare Conditions of Participation.

The Vermont Division of Licensing and Protection (VT State Survey Agency) completed a complaint survey of your hospital on January 11, 2021 related to a reportable event. The State Agency's findings are explained in the enclosed Form CMS-2567 (Statement of Deficiencies). CMS concurs with these findings and, as a result, has determined that University of Vermont Medical Center is not in compliance with the following Medicare Conditions of Participation:

42 CFR § 482.13 - Patient's Rights
42 C.F.R. § 482.55 - Emergency Services

These deficiencies have been determined to be of such character as to substantially limit the hospital's capacity to furnish adequate care and/or as to adversely affect the health and safety of patients. In accordance with the federal regulation at 42 C.F.R. § 488.9, we have determined that the University of Vermont Medical Center is no longer deemed to meet the Medicare Conditions of Participation and will be subject to the federal requirements applied to unaccredited hospitals. Consequently, we have further

determined that effective January 11, 2021, University of Vermont Medical Center is under the jurisdiction of the State Agency.

The findings that the University of Vermont Medical Center is not in compliance with the above Conditions of Participation does not affect your hospital's accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. A copy of this letter is being forwarded to the Joint Commission and the VT State Survey Agency. Attached please find the CMS notice and CMS form 2567 findings of the complaint investigation survey conducted by the Vermont State Survey Agency.

On January 20, 2021, the CMS Center for Clinical Standards and Quality released a policy memorandum to ensure quality of care oversight, while providing hospitals the ability to focus on serving their patients and communities during the continuing Public Health Emergency. Consequently, University of Vermont Medical Center is not required to submit an acceptable plan of correction, nor will a revisit survey by the Vermont State Survey Agency be required during the time this memo is in effect through 2/20/2021, or unless otherwise specified. Following the expiration of this memo, the hospital will have up to 60 days to demonstrate compliance with any outstanding deficiencies.

Please note, under Federal disclosure rules, a copy of the findings of this Medicare survey must be available for public disclosure within 90 days of the completion date of the survey. Therefore, you may wish to submit a Plan of Correction (PoC) for the cited deficiencies for inclusion with any public disclosure of this substantial allegation investigation survey.

If you believe this notice of findings that the University of Vermont Medical Center does not comply with the Medicare Conditions of Participation for hospitals is incorrect, you may request an informal reconsideration. If you wish to do so, please write to Nancy Hannah, Centers for Medicare & Medicaid Services, Northeast Acute & Continuing Care Branch, JFK Federal Building, Room #2275, Boston, MA 02203 within 15 days of receipt of this letter. You should state why you consider the finding incorrect, and you should submit any evidence and arguments which you may wish to bring to our attention.

We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. If you have any questions, please contact Nancy Hannah at nancy.hannah@cms.hhs.gov.

Sincerely,

Nancy Hannah, RN-BC, LCSW
Northeast Acute and Continuing Care Branch

cc: VT SA
Joint Commission