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

April 30, 2021

Dr. Stephen 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 12, 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 April 29, 2021.

Sincerely,

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

cc: Carol Muzzy, UVMMC

Enclosure

THE
University of Vermont
MEDICAL CENTER

Jeffords Institute for Quality
Accreditation and Regulatory Affairs Department
111 Colchester Avenue
Burlington, VT 05401

April 26, 2021

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

Northeast Division of Survey & Certification

Re: CMS Certification Number (CCN): 470003
Survey ID: WUD11 01/12/2021

Dear Nancy Hannah,

Please find the attached Plan of Correction and form CMS-2567 in response to the Statement of Deficiencies and Findings in regards to survey number 470003.

The University of Vermont Medical Center is committed to continuously improving the quality of services we provide to respond to the regulatory deficiencies that were cited.

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
111 Colchester Avenue
Burlington, VT 05401
Telephone: 802-847-5007
Fax: 802847-6274
Carol.Muzzy@UVMHealth.org

Cc: Dr. Patrick Bender, Chief Quality Officer
Suzanne Leavitt, Assistant Division Director, Director State Survey Agency

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: WUD11 01/12/2021

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Dear Dr. Leffler:

To participate in the Medicare program, a hospital must meet the requirements established under title XVIII of the Social Security Act (the Act) and the regulations established by the Secretary of Health and Human Services under the authority contained in Section 1861(e) and Section 1867 of the Act. Section 1866(b) of the Act authorizes the Secretary to terminate the provider agreement of a hospital that fails to meet these provisions. The regulation at 42 CFR §489.53(b) specifically authorizes the termination of a hospital that violates the provisions of 42 CFR §489.20 or 42 CFR §489.24 (l), (m), (q), and/or (r) the regulatory provisions for the enforcement of Section 1867 of the Act, also known as the Emergency Treatment and Active Labor Act (EMTALA).

On January 12, 2021, the Vermont Division of Licensing and Protection (VT State Survey Agency) completed an investigation survey of an allegation of noncompliance with the requirements of *42 C.F.R. §489.24 Responsibilities of Medicare Participating Hospitals in Emergency Cases*. After a careful review of the findings, we have determined that your hospital violated the requirements of 42 C.F.R. §489.24, which are detailed on the enclosed form CMS-2567, Statement of Deficiencies and Plan of Correction.

Under 42 CFR 489.53, a hospital that violates the provisions of 42 CFR 489.24 may be subject to termination of its provider agreement. This preliminary determination letter serves to notify you of the violation. The projected date on which your Hospital's participation in the Medicare program may terminate is on or about **July 15, 2021**.

You may avoid termination action and notice to the public either by providing a credible allegation of correction of the deficiencies or by successfully proving that the deficiencies did not exist prior to the projected public notification date. In either case, the information must be furnished to this office within 10 days of receipt of this notice. A credible allegation of correction by the hospital requires a resurvey to ensure the Plan of Correction (POC) has been implemented and no new deficiencies have occurred. If we verify your corrective action or determine that you successfully refuted the findings contained in this letter by proving the allegations were in error, your possible termination from the Medicare program will be rescinded.

Please address the following in the construction of the Plan of Correction:

1. Include the main points of the plan of correction on the Statement of Deficiencies form and reference an attachment to include additional information.

2. Include how and when Quality Assurance (QA) monitoring will be done and identify the staff responsible for the monitoring to minimize the occurrence of a future EMTALA violation.

3. Provide evidence of EMTALA in-service training has been provided for all professional staff, as well as clerical staff and "float staff" that may work in the emergency department. Please include a copy of the training material that will be utilized for EMTALA training.

4. Also, please verify that dates of completion are clearly included for each corrective activity.

Please submit your plan of correction within 10 days of receipt of this letter to the Vernont State Survey Agency via email to Suzanne Leavitt at: Suzanne.Leavitt@vermont.gov with a copy to Nancy Hannah, CMS, Northeast Acute & Continuing Care Branch, via email at: Nancy.Hannah@cms.hhs.gov .

Copies of the Form CMS-2567, including copies containing the facility's PoC, are releasable to the public in accordance with the provisions of Section 1864(a) of the Act and 42 C.F.R. § 401.133(a). As such, the PoC should not contain personal identifiers, such as patient names, and you may wish to avoid the use of staff names. It must, however, be specific as to what corrective action the hospital will take to achieve compliance, as indicated above.

If you have any questions, please email Nancy Hannah at nancy.hannah@cms.hhs.gov .

Sincerely,

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

Enclosure: CMS-2567
cc: VT State Survey Agency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470003	A. BUILDING _____ B. WING _____	C 01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF VERMONT MEDICAL CENTER	111 COLCHESTER AVE BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS An unannounced on-site 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. The following regulatory violations were identified.	A 000		
A2406	MEDICAL SCREENING EXAM CFR(s): 489.24(a) & 489.24(c) (a) Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must- (i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for	A2406	See attached POC-CM	5/24/21

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

Director of Laboratory | April 26, 2021

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.

POC accepted 4/29/21 D. Wiedenbeck RN

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A2406	Continued From page 1 further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section. (2)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met: (A) The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period. (B) The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan. (C) The hospital does not discriminate on the basis of an individual's source of payment or ability to pay. (D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act. (E) There has been a determination that a waiver of sanctions is necessary. (ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a	A2406	See attached POC-CM 5/26/21	

POC accepts
4/29/21
D. Wisdeark RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2406	Continued From page 2 public health emergency, as provided under section 1135(e)(1)(B) of the Act. (c) Use of dedicated emergency department for nonemergency services. If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition. This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services (psychiatry) for 1 of 20 applicable patients (Patient #1). 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,	A2406	See CorrectCheck POC-CAL 5/24/21	

POC accepted
4/29/21
D. Widenhorn RN

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A2406	Continued From page 3 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	A2406	Suggested POC. CM 5/24/21	

POC accepted
4/29/21
D. McCrackin

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A2406	Continued From page 4 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	A2406	Suboxone POC-OM Steph	

POC accepted
4/29/21
D. Underwood RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2406	Continued From page 5 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,	A2406	See attached POC - CM Stanley	

POC accepted
4/29/21
D. Wideawake RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2406	Continued From page 6 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	A2406	See corrected POC-CM 4/29/21	

POC accepted
4/29/21
D. Wideawake RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2406	Continued From page 7 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	A2406	Su Obtained POC-CM 4/26/21	

POC Completed
4/29/21
D. Widenhorn RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2406	Continued From page 8 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'". S/He "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	A2406	See attached POC - CM 5/24/21	

POC accepted
4/29/21
D. Widenhorn RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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UNIVERSITY OF VERMONT MEDICAL CENTER	111 COLCHESTER AVE BURLINGTON, VT 05401

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A2406	Continued From page 9 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	A2406	See attached POC-CH 5/24/21	

POC accepted
4/29/21
D. Wiedenmeier RN

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A2406	Continued From page 10 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, 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	A2406	See attached POC-CU 4/6/21	

POC accepted
4/29/21
D. Winchenbach RN

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A2406	Continued From page 11 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	A2406	See attached POC-CM 4/26/21	

POC accepted
4/29/21
D. McCormick RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2406	Continued From page 12 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 and 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	A2406	See attached POC	3/26/21

POC accepted
4/29/21
D. Widdowson RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2406	Continued From page 13 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	A2406	See attached POC. 04	4/29/21

POC accepted
4/29/21
D. Underwood, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2406	Continued From page 14 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	A2406	See attached POC-CM 5/4/21	

POC accepted
4/29/21
D. Widenhorn RN

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A2406	Continued From page 15 "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".	A2406	See attached POC-CM 5/24/21	

POC accepted
4/29/21
Dianne Wheeler RN

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A2406	Continued From page 16 The above documentation demonstrates that Patient #1 had an emergency medical condition. S/He presented to the ED 5 times over the course of 3 days with suicidal ideations and significant self-harm injures. S/He had a change in housing, was living alone with limited supervision, had no health insurance, and a lack of appropriate medications. During numerous interviews and review of Patient #1's record, the providers continued to refer to a discussion that had taken place approximately eight months ago (April 2020) with a multidisciplinary group regarding the patient's care. There was no evidence that the patient's status was reassessed and no evidence of a written care plan and/or evidence of the patient's involvement in that plan during any of his/her visits to the ED on 12/23/20 through 12/26/20. 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. As such, the evaluation of Patient #1's emergency medical condition was incomplete by psychiatry. Per review of the hospital policy "EMTALA-Medical Screening Examination & Stabilization Policy"-effective 1/1/2019, it states, "Emergency Medical Condition means: 1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in: (A) Placing the health of the individual (...) in serious jeopardy, (B) Serious impairment of bodily functions, or (C) Serious dysfunction of any bodily organ or part..... Medical Screening Examination is the process required to determine with reasonable clinical confidence that	A2406	See attached POC-CM 4/29/21	

POC accepted
4/29/21
D. Widenhouse RN

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A2406	Continued From page 17 an emergency medical condition exits or a woman is in labor. With respect to an individual with psychiatric symptoms, a medical screening exam consists of both a medical and psychiatric screening. The medical screening examination is an ongoing process and the medical records must reflect continued monitoring based on the individual's needs and must continue until the individual is either stabilized or appropriately transferred."	A2406		
A2407	STABILIZING TREATMENT CFR(s): 489.24(d)(1-3) (1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either- (i) within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition. (ii) For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section. (2) Exception: Application to Inpatients. (i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual (ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency)	A2407	See attached POC - CM Steph	

POC accepted
4/29/21
D. Widawski RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2407	Continued From page 18 diagnosis or treatment. (iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation. (3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both. This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to provide, within the capabilities of the staff and facilities available, stabilizing treatment for an emergency medical condition prior to discharge and/or transfer for 1 of 20 applicable patients (Patient #1). Findings include: Per record review Patient #1 has a history of self-mutilation, pulmonary embolism (blood clot in lung), overdose, hemorrhagic shock (body shuts	A2407	See correction POC-CY 4/29/21	

POC accepted
4/29/21
D. Widegren RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2407	Continued From page 19 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	A2407	See corrected POC_CM 5/6/21	

POC accepted
4/29/21
D. Whitcomb RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2407	Continued From page 20 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 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	A2407	See attached POC - CH 5/4/21	

POC accepted
4/29/21
D. Widenhouse RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470003	A. BUILDING _____ B. WING _____	C 01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A2407	Continued From page 21 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	A2407	See attached POC-CM 5/20/21	

POC accepted
4/29/21
D. McDermott RN

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A2407	Continued From page 22 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	A2407	See attached POC-A4	3/2/21

POC accepted
4/29/21
D. Widenwalk RN

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A2407	Continued From page 23 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	A2407	See attached POC-CH 5/4/21	

POC accepted
4/29/21
D McCormick RN

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A2407	Continued From page 24 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").	A2407	See attached POC-CM	3/26/21

POC accepted
4/29/21
D. Wildermuth RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2407	Continued From page 25 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 notbenefit	A2407	3x attached POC - CM 5/28/21	

POC accepted
4/29/21
D. Widenmark RN

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A2407	Continued From page 26 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	A2407	3u attached POC-CH 5/24/21	

POC accepted
4/29/21
D. Wiseman RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2407	Continued From page 27 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, 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	A2407		

POC accepted
4/29/21
D. Lindenmayer RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2407	Continued From page 28 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".	A2407	See attached POC-CM Stephen	

POC accepted
4/29/21
D. Wiedenmeier RN

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A2407	Continued From page 29 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	A2407	See attached POC-CU 5/24/21	

POC accepted
4/29/21
D. Widenhorn RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2407	Continued From page 30 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	A2407	Su attached POC-CM 5/24/21	

POC accepted
4/29/21
D. Whitcomb RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A2407	Continued From page 31 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	A2407	Su attached POC-CM 5/26/21	

POC accepted
4/29/21
D. Widenwolka RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470003	A. BUILDING _____ B. WING _____	C 01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF VERMONT MEDICAL CENTER	111 COLCHESTER AVE BURLINGTON, VT 05401

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A2407	Continued From page 32 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". The above documentation demonstrates that the patient had a change in status and was not stabilized. S/He presented to the ED 5 times over the course of 3 days with significant self-harm injures. S/He had a change in housing, was living alone with limited supervision, had no health insurance, and a lack of appropriate medications. During numerous interviews and review of Patient #1's record, the providers continued to refer to a discussion that had taken place approximately eight months ago (April 2020) with a multidisciplinary group regarding the patient's care. There was no evidence that the patient's status was reassessed and no evidence of a written care plan and/or evidence of the patient's involvement in that plan during any of his/her visits to the ED on 12/23/20 through 12/26/20. 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. Per review of the hospital policy "EMTALA-Medical Screening Examination & Stabilization Policy"-effective 1/1/2019, it read, "Stabilization of Psychiatric Emergencies: If an	A2407	See attached POC-04 5/24/21	

POC accepted
4/29/21
D. Wiedenkeller

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470003	A. BUILDING _____ B. WING _____	C 01/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF VERMONT MEDICAL CENTER	111 COLCHESTER AVE BURLINGTON, VT 05401

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A2407	Continued From page 33 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".	A2407	See attached POC_CM	5/26/21

POC accepted
4/29/21
D. Linderman RN

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. The following regulatory violations were identified.

A2406 MEDICAL SCREENING EXAM CFR(s): 489.24(a) & 489.24(c)

(a) Applicability of provisions of this section.

(1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph

(b) of this section, the hospital must-

(i)Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction and. If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

(2)(i) When a waiver has been issued in accordance with section 1135 of the Act that includes a waiver under section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department if the following conditions are met:

(A)The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergencyperiod.

(B)The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency, that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.

(C)The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.

(D) The hospital is located in an emergency area during an emergency period, as those terms are defined in section 1135(g)(1) of the Act.

(E)There has been a determination that a waiver of sanctions is necessary.

(ii) A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under section 1135(e)(1)(B) of the Act.

(c) Use of dedicated emergency department for nonemergency services. If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services (psychiatry) for 1 of 20 applicable patients (Patient #1). 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. On12/24/20,

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 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 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'". S/He "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, and 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 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 and 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 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". The above documentation demonstrates that Patient #1 had an emergency medical condition. S/He presented to the ED 5 times over the course of 3 days with suicidal ideations and significant self-harm injures. S/He had a change in housing, was living alone with limited supervision, had no health insurance, and a lack of appropriate medications. During numerous interviews and review of Patient #1's record, the providers continued to refer to a discussion that had taken place approximately eight months ago (April 2020) with a multidisciplinary group regarding the patient's care. There was no evidence that the patient's status was reassessed and no evidence of a written care plan and/or evidence of the patient's involvement in that plan during any of his/her visits to the ED on 12/23/20 through 12/26/20. 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. As such, the evaluation of Patient #1's emergency medical condition was incomplete by psychiatry.

Per review of the hospital policy "EMTALA-Medical Screening Examination & Stabilization Policy"-effective 1/1/2019, it states, "Emergency Medical Condition means: 1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in: (A) Placing the health of the individual (.) in serious jeopardy, (B) Serious impairment of bodily functions, or (C) Serious dysfunction of any bodily organ or part Medical

Screening Examination is the process required to determine with reasonable clinical confidence that an emergency medical condition exits or a woman is in labor. With respect to an individual with psychiatric symptoms, a medical screening exam consists of both a medical and psychiatric screening. The medical screening examination is an ongoing process and the medical records must reflect continued monitoring based on the individual's needs and must continue until the individual is either stabilized or appropriately transferred."

ACTION PLAN

- **A thorough review of University of Vermont Medical Center Emergency Department delivery process related to Emergency Medical Treatment and Labor Act Medical Screening Exam and Stabilization 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 training , inclusion of 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 and how it can impact medical screening and decision making, the importance of the patient's role in their own care, 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 included requirements of EMTALA content and learning scenarios specific to medical screening, stabilization and transfer in accordance with 42 C.F.R.489.24. The curriculum was finalized on March 8, 2021 for deployment to Emergency Department all clinical/professional staff, Psychiatry medical staff and contracted community crisis providers with a completion date of 3/25/2021 or before the next scheduled shift. In addition, the curriculum was deployed as part of the annual mandatories to all of the Emergency Department non-professional staff with expected completion date of 5/26/21. 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, which include medical screening and stabilization. Feedback on the audit findings will be communicated on a monthly basis to the appropriate Managers and Medical Directors for required action.**

- **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 5/26/21.**

PEC accepted
4/29/21
D. Linsdeau RN

A2407 STABILIZING TREATMENT CFR(s): 489.24(d)(1-3)

(1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either-

(i)within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

(ii)For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

(2) Exception: Application to inpatients.

(i)If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual

This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.

(iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

(3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to provide, within the capabilities of the staff and facilities available, stabilizing treatment for an emergency medical condition prior to discharge and/or transfer for 1 of 20 applicable patients (Patient #1). 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 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" 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". 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 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 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".

The above documentation demonstrates that the patient had a change in status and was not stabilized. S/He presented to the ED 5 times over the course of 3 days with significant self-harm injures. S/He had a change in

housing, was living alone with limited supervision, had no health insurance, and a lack of appropriate medications. During numerous interviews and review of Patient #1's record, the providers continued to refer to a discussion that had taken place approximately eight months ago (April 2020) with a multidisciplinary group regarding the patient's care. There was no evidence that the patient's status was reassessed and no evidence of a written care plan and/or evidence of the patient's involvement in that plan during any of his/her visits to the ED on 12/23/20 through 12/26/20. 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.

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

- **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 care delivery process related to the Emergency Medical Treatment and Active Labor Act (EMTALA) and related requirements for medical screening and stabilization 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 that supports stabilization and safe disposition. In order to ensure a standardized process, a policy titled: UVMMC Emergency Department Care Planning was created. Electronic medical record modifications to support the procedure were also created to support the process and includes built in safety checks to assure review. 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 Emergency Department Care Multidisciplinary Team review is coordinated by the Case Management and Social Work Team.**

- **An asynchronous online training with content on Patient-centered care that acknowledges potential unconscious emotional and cognitive biases in providers and how it can impact medical screening and decision making, the importance of the patient's role in their own care, 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 included requirements of EMTALA content and learning scenarios specific to medical screening, stabilization and transfer in accordance with 42 C.F.R.489.24. The curriculum was finalized on March 8, 2021 for deployment to Emergency Department all clinical/professional staff, Psychiatry medical staff and contracted community crisis providers with a completion date of 3/25/2021 or before the next scheduled shift. In addition, the curriculum was deployed as part of the annual mandatories to Emergency Department non-professional staff with expected completion date of 5/26/21. Going forward, the online training will be incorporated into onboarding education for the identified populations.**

POC accepted
4/29/21
D. Anderson

- **The referenced policy was 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 and reviewed at the multidisciplinary care plan meeting for action.**

- **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.**

- **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 5/26/21.**

PIC accepted
4/29/21
Dawn Edwards RN