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

Shame Eherth

Assistant Director, Division of Licensing & Protection

cc: Carol Muzzy, UVMMC

Enclosure

University of Vermont

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 a 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, They the

Nancy Hannah, RN-BC, LCSW

Northeast Acute and Continuing Care

Branch

Enclosure: CMS-2567

cc: VT State Survey Agency

PRINTED: 04/16/2021 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 01/12/2021	
	NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF VERMONT MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401			
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A 000	complaint #19459 v through 1/12/21 by Protection as author Medicare and Medi Care Hospital's con (Emergency Medicare	on-site investigation of was conducted on 1/6/21 the Division of Licensing and virzed by the Centers for caid to determine the Acute npliance with the EMTALA at Treatment and Labor Act) illowing regulatory violations	A 000			
A2408	(1) In the case of a emergency department eligible for M regardless of ability emergency department (b) of this section, ti (i) Provide an approximation within emergency department, to dete emergency medical examination must b individual(s) who is hospital bylaws or meets the requirem concerning emerged direction; and (ii) If an emergency determined to exist, stabilizing treatment of this section, or an defined in paragraph	s 489.24(c) provisions of this section. hospital that has an ment, if an individual (whether edicare benefits and to pay) "comes to the ment", as defined in paragraph he hospital must-priate medical screening the capability of the hospital's nent, including ancillary vallable to the emergency emine whether or not an condition exists. The	A2406	Se auschid	Stake	
		INSUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(XS) DATE	

Any deficiency statement indical with an asterisk (*) denotes a deficiency which the institution may be accused from cortection broviding it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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PRINTED: 04/16/2021 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	this section ends, of this section. (2)(i) When a waive accordance with seincludes a waiver and Act, sanctions und inappropriate trans relocation of an incoreening at an alto a hospital with a department if the fick (A) The transfer is circumstances of the emergency area do (B) The direction or receive medical sor is pursuant to an appreparedness planhealth emergency to infectious disease, praparedness planhealth of the section 1 (E) There has been of sanctions is necessanctions is necessanctions in section 1 (E) There has been of sanctions is necessanctions in section 1 (E) There has been of sanctions in necessanctions in section 1 (E) There has been of sanctions in necessanctions in necessanctions in necessanctions in necessanctions in necessanctions in necessanctions in necessance	the hospital's obligation under as specified in paragraph (d)(2) er has been issued in action 1135 of the Act that under section 1135 (b)(3) of the er this section for an after or for the direction or dividual to receive medical emate location do not apply to adicated emergency oblowing conditions are met: necessitated by the ne declared emergency in the uring the emergency period. It relocation of an individual to reening at an alternate location oppropriate State emergency or, in the case of a public that involves a pandemic pursuant to a State pandemic es not discriminate on the tal's source of payment or located in an emergency area cy period, as those terms are 135(g)(1) of the Act. a determination that a waiver issary.	A2406	Si or or or		Strek	

FORM CMS-2567(00-96) Previous Versions Obsolets

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Facility ID: 470003

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	public health emer section 1135(e)(1) (c) Use of dedicate nonemergency set a hospital's dedicate a request is made examination or tree but the nature of the medical conditionature, the hospital such screening as individual presentir that the individual condition. This STANDARD is Based on interview hospital failed to present failed t	gency, as provided under	A2406	Son Sec.	Zule

FORM CMS-2567(02-99) Previous Versions Obsolete

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	S/He was admitted complaint of a "La discharged home: came back to the it psychiatric (mentited discharged home: S/He was admitted complaint of a "La at 2:30 PM; and at with a chief complaint of a "La at 2:30 PM; and at with a chief complainjury" and was dis 12/26/20, On 12/2: presented to the E overdose and substitute of the E	d at 10:04 AM with a chief ceration (deep cut)" and was at 10:54 AM; and at 5:32 PM ED with a chief complaint of al) evaluation" and was at 11:29 PM. On 12/25/20, d at 11:10 AM with a chief ceration" and discharged home is 22 PM came back to the ED aint of a self-inflicted "arm scharged home at 12:38 AM on 7/20 at 6:35 PM, Patient #1 D unresponsive after a drug sequently died on 12/28/20. Invider's note from 12/23/20, ed to the ED for self-injury. Per a the self-mutilation was identity. This personality and cut him/her-self and attons across the left forearm. physical exam, Patient #1 had be left forearmAll lacerations in other". S/He was "alert and tho agitation or thought ther review of the provider's lose have a care plan in place er may consult crisis for new by treat lacerations as y". The patient had "seven is40 sutures total". At 10:35 who evaluated the patient". ently moved from a crowded here staff constantly checked in isolated hotel room. Crisis red" him/her-self "again given lause" s/he "was isolated. le with discharge because"services soon". "The	A2406	State of	à	cuki

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WUDI11

Facility ID: 470003

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	instructions to foliophysician and out physician and out PM, Patient #1 reps/he was moved fi because the newer increased supervirulter personality whad told Patient #1 hotel. Patient #1 hotel. Patient #1 are bought razors; and his/her after cut his had been about a episode of self-har was the first time to Patient #1 reported anxious" and that whis/her medication alone". S/He state insurance until the have access to a cos/He expressed the from the pharmacy would use them to Clinician's mental of was "Well-groome Oriented" with "Fail Per the Crisis Clinie #1 as him/her-self suicide or self-harm caused harm to him past had also causiacarations, which redical admission, also had a history of the suicide of the product of the physical patients of the physical patie	arged home" and was provided ow up with his/her primary patient mental health provider. Isis note from 12/23/20 at 11:19 ported to the Crisis Clinician that from one residence to another ir residence (a hotel) had sion. S/He stated that his/her ras "mad" about moving and 1 that s/he would "die" at the	A2406	Sparakached Sparached		Strake

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	self-harm; however, denied any safety of "agreeable and able Patient #1 "has hist admission due to se increase in severity upon d/c, therefore Patient #1 "not be s admission at this tim was to discharge frowith his/her "provide plan". S/He would b medications"; s/he "dispose of razors"; a staff about checking Per review of a psychological plan created in collar Consult Service", ou provider, "Ethics, and "4/12/2020 hospital a psychiatrist's assess s/he was "in agreemassessment and plan assessment and plan 12/23/20. Per interview on 1/7/2 Provider #1, s/he state presented with self-hout on (suicide) "precout what was going of screening would be divere cleared medical counselor to evaluate	at Patient #1's alters severely patient #1 as him/her-self concerns. Patient #1 was to properly safety plan". corically shown that inpatient elf harm only causes and and frequency of self harming it is recommended that" supported through inpatient ne". The plan for Patient #1 om the ED and to follow-up er" and "outpatient safety e provided a "lock box for felf" that s/he was "able to and was "agreeable to talk to in twice daily". chiatry update note from M, "Psychiatry did not formally int tonight due to a previously and extensively documented boration with the Psychiatry tipatient mental health d Surgery during" Patient #1's admission". The ment and plan revealed that ent with the Crisis Clinician's in" for Patient #1 from	A240	Su conscional		dans.

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Event ID: WUDIT1

Facility ID: 470003

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	and that in his/her of release and typi lacerations. In this were deep and wh #1 for suicidality si ideation flatty". S/r-personalities eng: Provider #1 stated visitor to the ED" a plan that said the pepisodes when dis S/r-le stated that or things were getting outpatient, and that sending" him/her "Patient #1 was "remutiple times" duri Provider #1 stated "ancillary services" have the time to ap course of action and emergency and that the experts to help. Per review of a provider #1 stated in this was his/her "this self-mutilation by our this was his/her "this his/her" this his/her "this was unan remembered going is laceration on his/her morning. Patient #1 object was used to is shared with the provisuicidal as of late, this presumed to be a	istory of self-harm behavior experience, cutting was a form ically did not involve deep case, Patient #1's lacerations en s/he had assessed Patient fhe "denied any suicidal fe stated that "one of" his/her aged in these behaviors". ED that Patient #1 was a "frequent and that s/he had "read a care satient would have these acute charging would get worse". Isis had seen the patient, a set up for him/her as an at they "were comfortable frome". S/He stated that assessed for suicidality ang his/her time in the ED. ED that S/He often involved as s/he expressed, we "do not end" discerning the best d/or treatment for a psychiatric at crisis and psychiatry were	A2406	So constant		Strates.

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Event ID: WUDI11

Facility ID: 470003

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POC accepted 4/20121 D. Wideaerska Por

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DA	TE SURVEY		
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	cm linear laceration the dermis". The povert thought diso if Patient #1 had a episodes of self-mhas been pretty sustated that s/he "is reported that s/he could follow up wit was repaired, and instructions to follow utpatient counsel instructions regard control. The patienre physician immedia "improved sympton Discharged with a follow-up". Per review of a pro 7:10 PM, Patient # psychiatric evaluation the last 24 hours right forearm and le extensive repair. So last night and "ultim safety concern and ED on both occasic ED and stated that s/he would "cut to le his/her outpatient so referred him/her to Patient #1 reported feeling safe". Per the was "alert and orient thought disorder". To Crisis and the "Crisis behaviors were like	age 7 In to the left lower leg through batient had "no agitation or reder". The physician had asked plan in place for future sutilation and s/he stated "he' suicidal"; however, Patient #1 is not suicidal". The patient also had outpatient counseling and them. Patient #1's laceration s/he was discharged with ow-up with his/her doctor and oor. S/He was also given ling wound care and pain int was re-evaluated by the tely prior to discharge with ms, normal vital signs clear plan for outpatient In presented to the ED for a sion. S/He had been seen twice is with several lacerations on aft lower leg both needing laterations on aft lower leg both needing laterations on a lateration was discharged in the ons". S/He came back to the his/her alter told him/her that cill". Patient #1 contacted support program and they the ED for an evaluation. It to the provider's exam, the patient was evaluated by its Clinician felt that the patient ly result of recent move from a re support staff and more	A2406	Sed cur		3ce/s	

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Event ID: WUDI11

Facility ID: 470003

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
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UNIVERS	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER ATOMOS AME OF PROVIDER OR SUPPLIER NIVERSITY OF VERMONT MEDICAL CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A2406 Continued From page 8 people around to a place there is more isolated deson 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 moming 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 Orlented" 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		111	EET ADDRESS, CITY, STATE, ZIP CODE COLCHESTER AVE RLINGTON, VT 05401		01/12/2021	
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE	
	people around to a Patient #1 was als "does not need ho "will be discharged living arrangement s/he "is agreeable Per review of a cric PM, Patient #1 had later than when the had encouraged hi with two packed be Clinician that s/he s/he needed but st "makes threats foll was a warning" an "either another OD that the other perse "destroy the body" alive". S/He "reporting to happen" fromental status exam groomed", "Cooper with "Fair" insight ("suggestions, recom "Fair" judgement ("or Per the Crisis Clinic regarding suicidality disposed of razors it ocut" him/her-self with certainty that" Ias soon as is a interpretation was ti "engaging in deep sof dissatisfactory he again tomorrow and "initially seemed to it."	a place there is more isolated". to evaluated by psychiatry and spitalization at this time". S/He of back to "his/her "established it. I discussed with patient" and to this plan". It is note from 12/24/20 at 8:15 dipresented to the ED hours to outpatient counseling service m/her to do so and had arrived ags. S/He had told the Crisis was not sure what type of help ated that when his/her alter lows through ""this morning did that s/he would expect or more deep cutting". And onality's goal was allegedly to as s/he "doesn't want to be ted being scared of the next on his/her alter. Patient #1's in showed that s/he was "Well artive", "Alert and Orlented" "puts up barriers to immendations to help") and cutting is excessively deep"). It is risk assessment to y, Patient #1 "reportedly but found something this am "with". "At this time, states	A2406	3 Correction Contraction		Skurzi	

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: WUDI11

Facility ID: 470003

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	NO. 0938-039 ATE SURVEY MPLETED
		470003	B. WING			C
	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401				1/12/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	chronic risk" to him #1 was to "dischard Provider" and for th follow-up with house Per review of a psy 10:27 PM, the psyc Crisis Clinician had self-mutilation were time the alter would expressed to the ps want to go to a high care/support and/or Patient #1 was "caldemonstrated obto and help seeking he review of the psychic Patient #1, s/he war mood was "neutral, social reactivity"; or with "fair" insight an review of the psychic been previously est Consult Service, Ett health provider "(du hospitalization)" that from inpatient psych fact demonstrates w discharge. The patie involuntary hold W be considered termi persistently high bas self-mutilation" S/He symptoms of borderand should be alloo the ED, knowing tha recur".	/her-self. The plan for Patient ge from the ED to Follow Up the outpatient crisis center to sing about changing units. Inchiatry note from 12/24/20 at chiatrist confirmed what the reported that the incidents of a "just warnings" and that next I "cut to kill". Patient #1 sychiatrist that s/he did not the level of outpatient at stay in the ED overnight. Inchi, linear, organized,	A2406	Secretary of the secret		Kala

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POCaccepted 4/29/21 D. W. Seawelle Por

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		C 01/12/2021	
	ROVIDER OR SUPPLIER	EDICAL CENTER	111	EET ADDRESS, CITY, STATE, ZIP CODE COLCHESTER AVE RLINGTON, VT 05401	VIIIZZZZZ	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
	Provider #2, s/he s components to a s would be "medical be a "safety" plant there would be a "stated that determine be "case-by-case" teams were heaviful determination for p S/He stated that reseen him/her on 12 in helping to repair Patient #1 had prefollowing day, 12/2 to crisis. ED Provito psychiatry and of Patient #1 was at hot need "hospitalitiescalate when more stated that there we for Patient #1 and not warrant a crisis plan was for Patient #1 and not warrant a crisis plan was for Patient #1's president #	stated that there were several safe discharge; the patient lay stable to leave", there would to mitigate "self-harm risk", and safe place to stay". S/He ining a patient's capacity would and that crisis and psychiatry lay relied upon to help make the satients if there was a question. It is a question lay a garding Patient #1 s/he had 2/23/20 and was only involved of the patient's lacerations. It is sented to the ED on the 1/4/20, and had wanted to speak der #2 stated that s/he spoke crisis on that date and that her "baseline" and that s/he did later "baseline" and that s/he spoke crisis on that date and that s/he spoke crisis on that s/he spoke crisis on that s/he spoke crisis on that date and that s/he spoke crisis on that date and that s/he spoke crisis on the solution.	A2406	Golden Col	Hale	

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1/29/21 1/29/21 1. Un democia RN

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTR	RUCTION	(X3)	DATE SURVEY COMPLETED	
		470003 B. WING		NG			С	
	ROVIDER OR SUPPLIER			111 COLC	DDRESS, CITY, STATE, ZIP CODE HESTER AVE GTON, VT 05401		01/12/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	and that all these paperoved by an At who has complete medicine in a clinic the psychiatry send after they had bee Clinician. S/He stawas based on their whether the patien medical decision". heard about Patier On 12/24/20, s/he s/he was "very well his/her "hair done" clothes". S/He had thinking". S/He "de wanted to go home Director of ED Psychistorically when Psychistorically when Psyches was not suicid S/He stated that who supports his/her cowas "not able to be when s/he was discus a dangerous degrethat "further hospita for the patient". S/He would typically press a "little escalation" a taper off, referring to S/He stated that s/he very bad wounds". The worse s/he "did care plans were alwelling that they come in; the stated that in April of stated that sin April of stated that in April of stated that sin April of state	admit, and discharge patients; processes were evaluated and tending Physician (A physician d residency and practices or hospital). S/He stated that vice only evaluated patients in assessed by a Crisis ted that a patient's capacity in mental status exam and it was able to make a "single S/He stated that s/he had first in the system of th	A24	106	Sy Color		- Sept.	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DA	ATE SURVEY MPLETED C
	PROVIDER OR SUPPLIER	470003 EDICAL CENTER	B. WING	STREET ADDRESS, CITY, STATE 111 COLCHESTER AVE BURLINGTON, VT 05401		01/12/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PL (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
	discuss whether to #1 to receive furth have a way to kee offer the patient". Soverall nothing had did not change the There was an "ove self-lacerations". Per review of a produce a produ	age 12 of involuntarily commit Patient er treatment. "They did not up" him/her "safe". "Nothing to S/He stated that "Because did changed globally, ultimately to treatment recommendations". They did not understand that "Because did changed globally, ultimately to treatment recommendations". The statement recommendations of the statement recommendation of the statement recomm	A24	of State of the St	ş.C.	Mark States

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Pocacceptes 4/29/21 D. W. deauskers

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STATEMENT AND PLAN O	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
		470003	B. WING			C 1/12/2024
	PROVIDER OR SUPPLIER		111	EET ADDRESS, CITY, STATE, ZIP CODE COLCHESTER AVE RLINGTON, VT 05401	0	1/12/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Patient #1 a "num s/he "can't think of present without the Patient #1 was "ac ED Provider #3 st. crisis while Patient "did not feel that the ED Provider #3 ha at home. S/He star psychiatry advised discharged. They reasonable plan". looking at previous that Patient #1 did hospitalization. Per review of a prosection with patient #1 did hospitalization. Per review of a prosection with patient #1 did hospitalization. Per review of a prosection with patient #1 did hospitalization. Per review of a prosection with patient #1 did hospitalization. Per review of a prosection with patient #1 did hospitalization. Per review of a prosection with patient #1 well as times yesterday for "kill" and that s/he him/her-self. Per the him/her-self. Per the him/her-self. Per the him/her-self. Per the patient #1 reported "injuries have been alone must be a lone must be limited at baseline do not acutely worse".	ber of times". S/He stated that f a time that" Patient #1 "did not e same complaint"; and that damant" s/he "was not suicidal". ated that s/he had spoken to t #1 was in the ED and that they ney needed to see" him/her. Id asked crisis to call the patient ted that both crisis and If that Patient #1 was "ok" to be "all agreed that it was a S/He stated that s/he "knew is psychiatry documentation"	A2406	State of the state		King

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470003		B. WING		01/12/2021
	ROVIDER OR SUPPLIER	EDICAL CENTER	11	REET ADDRESS, CITY, STATE, ZIP CODE 1 COLCHESTER AVE JRLINGTON, VT 05401	01/12/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRI REGULATORY OR LSC IDENTIFYING INFORMATION) T/		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
	patient, discussed that the patient was d suture removal an worsening sympto. Per review of a cri. AM, Patient #1 ext that his/her "behavione of" his/her "behavione of" his/her "alti to be dead' and or resignation and he "does not have the "intent". Patient #1 appointment with It manager on 12/28 1/12/20. Patient #1 control" and that sand dose not evide reported that his/hibecause "they cou "Earlier in the year Psychiatry", Outpat to discuss protocol patients "level of seneed for medically had decided to treamore medically bas crisis clinician consinclude the attendir felt that discharge fourse of action". "daily phone checks s/he "meets with Cencouraged to seel needed which to dawith". Per review of status exam, Patier	with psychiatry, and agreed as appropriate for discharge". ischarged with instructions for id to "return for any new or	A2406	Se Cu	- Skulzi

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STATEMENT AND PLAN C	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) D	NO. 0938-039 ATE SURVEY OMPLETED
		470003	B. WING		С	
	PROVIDER OR SUPPLIER		111	EET ADDRESS, CITY, STATE, ZIP CODE COLCHESTER AVE RLINGTON, VT 05401		01/12/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
	"Poor" judgment." assessment revea was "High for cont however no currer The Clinician's interplace of the content of the conte	age 15 The Crisis Clinician's risk led that Patient #1's suicidality inuing acts of self-harm at stated Intent or intent to die". Parpretation was that "past it treatment states that inpatient ensive OP (outpatient)therapy roductive for Patient #1 Historically Patient #1 "has sed medical care as needed with psychiatry, it is it Patient #1 "discharge to bilished treatment team". 7/21 at 3:11 PM with ED tated that when a patient D with self-harm, a medical e done to identify any acute ce the medical issues were eased, a psychiatric evaluation le stated that Patient #1 D with a "left arm laceration". Alm" and s/he "answered and other lacerations on the is on both legs. ED Provider closed the laceration, and that other medical issues. S/He the crisis person involved"; at was unusual, crisis person Patient #1 "was a pallilative that s/he had been an ED rs" and had "never heard that sychlatric case before". S/He crisis had spoken to the land "together made a diemergency hospitalization". The patient was ok to be	A2406	Sel Col		Skrikel

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STATEMENT AND PLAN O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O	CONSTRUCTION	(X3) DA	O. 0938-039 TE SURVEY
		470003	A. BUILDING			C
	AZ406 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	STR	REET ADDRESS, CITY, STATE, ZIP CODE COLCHESTER AVE RLINGTON, VT 05401	0	1/12/2021	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	The above documination of 3 days with suice self-harm injures. So was living alone with health insurance, a medications. During review of Patient # continued to refer to place approximated 2020) with a multide patient's care. The patient's care. The patient's review of a written care place approximate insurance of a written care place patient's involvement in the insurance of a written care place patient's involvement in the insurance of the in	entation demonstrates that emergency medical condition. the ED 5 times over the course idal ideations and significant S/He had a change in housing, the limited supervision, had no and a lack of appropriate g numerous interviews and 1's record, the providers to a discussion that had taken by eight months ago (April disciplinary group regarding the re was no evidence that the ser reassessed and no evidence an and/or evidence of the ent in that plan during any of ED on 12/23/20 through the salso no further updated the plan for Patient #1 that its stability and/or safety from the evaluation of Patient #1's I condition was incomplete by	A2406	Se Color		Xula

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		MPLETED
		470003	B. WING			C 01/12/2021
	NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF VERMONT MEDICAL CENTER (XA) ID SUMMARY STATEMENT OF DESICIENCIES			STREET ADDRESS, CITY, STATE, ZIP 111 COLCHESTER AVE BURLINGTON, VT 05401		11/12/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	an emergency mewoman is in labor. with psychiatric sy exam consists of the screening. The mean ongoing process must reflect continuindividual's needs individual is either transferred." STABILIZING TRECFR(s): 489.24(d)(1) General. Subjet paragraph (d)(2) of (whether or not elignomes to a hospital that the individual is condition, the hospical that the individual is examination and treatmedical facility in according for transfer of this section. (2) Exception: Application of this section. (2) Exception: Application of this section.	dical condition exits or a With respect to an individual imptoms, a medical screening to the amedical and psychlatric adical screening examination is as and the medical records used monitoring based on the and must continue until the stabilized or appropriately ATMENT (1-3) ct to the provisions of this section, if any individual gible for Medicare benefits) and the hospital determines has an emergency medical ital must provide either-ilities of the staff and facilities expital, for further medical eatment as required to stabilize for. of the individual to another excordance with paragraph (e) ication to Inpatients. icareened an individual under a section and found the memergency medical its that individual as an thin order to stabilize the condition, the hospital has responsibilities under this	A2406	September 1		Start

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003 NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF VERMONT MEDICAL CENTER			(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		470003	B. WING			1/12/2021
		EDICAL CENTER		STREET ADDRESS, CITY, STATE, 2 111 COLCHESTER AVE BURLINGTON, VT 05401		1112121
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
	diagnosis or treatm (iii) A hospital is re participation for ho chapter to provide accordance with th (3) Refusal to cons A hospital meets ti (d)(1)(i) of this sect individual if the hos further medical exa described in that pa individual (or a pen behalf) of the risks of the examination individual (or a pen behalf) does not co treatment. The med description of the e if applicable, that w the individual. The ir reasonable steps to informed refusal (or his or her behalf). T indicate that the pen risks and benefits o treatment, or both. This STANDARD is Based on Interview hospital failed to pro the staff and facilitie treatment for an em prior to discharge ar applicable patients (Per record review Pe self-mutilation, pulm	nent. quired by the conditions of spitals under Part 482 of this care to its inpatients in lose conditions of participation.	A24	TOT SECRETARIAN SE		Keek

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) D	ATE SURVEY
		470003	B. WING			C
	PROVIDER OR SUPPLIER	EDICAL CENTER	111	EET ADDRESS, CITY, STATE, ZIP CODE COLCHESTER AVE RLINGTON, VT 05401		01/12/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	down due to blood disorder (A disorder (A disorder presence of two or states.), depressio disorder (A mental unstable moods, b anxiety, and anem cells). Patient #1 w from the Emergence over a period of the 12/26/20. On 12/23 4:12 PM with a chie was discharged home a came back to the E "psychiatric (menta discharged home a S/He was admitted complaint of a "Lac at 2:30 PM; and at with a chief complaint of a "Lac at 2:30 PM; and at with a chief complain injury" and was disc12/26/20. On 12/27 presented to the EE overdose and subserved search with a chief complaint of a proventient #1 presented to the patient #1 presented presented by another if found a razor blade caused eight laceral Per the physician's p "7 lacerations on the parallel to each oriented" and had "n presented" and had "n presented" and had "n parallel to each oriented" and had "n	age 19 loss), dissociative identity or characterized by the more distinct personality in, borderline personality disorder characterized by ehavior, and relationships.), ia (deficiency of red blood was admitted and discharged by Department (ED) five times ree days from 12/23/20 to 3/20, S/He was admitted at aff complaint of "Self Injury" and me at 11:39 PM. On 12/24/20, at 10:04 AM with a chief complaint of (deep cut)" and was at 10:54 AM; and at 5:32 PM in the complaint of (deep cut) and was at 11:29 PM. On 12/25/20, at 11:10 AM with a chief ceration" and discharged home 8:22 PM came back to the ED int of a self-inflicted "arm charged home at 12:38 AM on (20 at 6:35 PM, Patient #1 of unresponsive after a drug equently died on 12/28/20. Alder's note from 12/23/20, died to the ED for self-injury. Per the self-mutilation was dentity. This personality and cut him/her-self and the considering across the left forearm. Onlysical exam, Patient #1 had be left forearmAll lacerations other". S/He was "alert and to agitation or thought her review of the provider's	A2407	The state of the s		Special

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURV	VEY
	470003		B. WING		C	
	NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF VERMONT MEDICAL CENTER		11	REET ADDRESS, CITY, STATE, ZIP CODE 1 COLCHESTER AVE URLINGTON, VT 05401	01/12/20	021
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COM	(X5) MPLETION DATE
	which states provice concerns, but to a medically necessal acerations repaire PM "Spoke to crisis Patient #1 was "re homeless shelter vup on" him/her "to feels that" s/he "inj the opportunity bet They are comfortal s/he "will have full patient was dischal instructions to follo physician and outp Per review of a cris PM, Patient #1 reps/he was moved frobecause the newer increased supervisalter personality was had told Patient #1 redisassociated" and bought razors; and his/her alter cut his had been about an episode of self-harm was the first time the Patient #1 reported anxious" and that whis/her medications alone". S/He stated insurance until the finave access to a cos/He expressed tha	does have a care plan in place der may consult crisis for new only treat lacerations as ary". The patient had "seven ad40 sutures total". At 10:35 as who evaluated the patient". Cently moved from a crowded where staff constantly checked an isolated hotel room. Crisis ured" him/her-self "again given cause" S/He "was isolated. ble with discharge because"services soon". "The rged home" and was provided we up with his/her primary patient mental health provider. Sis note from 12/23/20 at 11:19 ported to the Crisis Clinician that form one residence to another residence (a hotel) had alon. S/He stated that his/her as "mad" about moving and that s/he would "die" at the	A2407	Of Contract of Con	Zen	la l

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		470003	B. WING	B. WING		
	NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF VERMONT MEDICAL CENTER		111	EET ADDRESS, CITY, STATE, ZIP CODE COLCHESTER AVE RLINGTON, VT 05401	01/12/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLET	
	would use them to Clinician's mental was "Well-groomed oriented" with "Fal Per the Crisis Clinil #1 as him/her-self suicide or self-harm caused harm to him past had also caus lacerations, which is medical admission, also had a history of in the spring of 202 impression was that self-harm; however denied any safety of "agreeable and able Patient #1 "has hist admission due to se increase in severity upon d/c, therefore Patient #1 "not be sadmission at this tin was to discharge frowith his/her "provide plan". S/He would be medications"; S/He dispose of razors"; a staff about checking Per review of a psychological plan created in collal Consult Service", our orovider, "Ethics, and "4/12/2020 hospital as "4/12/2020 hospital as "as him provider," Ethics, and "4/12/2020 hospital as "4/12	"overdose". The Crisis exam revealed that Patient #1 d", "Cooperative", "Alert and r" insight and "Poor" judgment. clan's risk assessment, Patient did not have thoughts of in; however, his/her alter in/her today. The alters in the ed extensive and severe necessitated skin grafting, and blood transfusions. S/He of a drug overdose in 2018 and 0. The crisis clinician's clinical at Patient #1's alters severely patient #1 as him/her-self concerns. Patient #1 was at the properly safety plan". Orically shown that inpatient elf harm only causes and and frequency of self harming it is recommended that" upported through inpatient me". The plan for Patient #1 om the ED and to follow-up er" and "outpatient safety e provided a "lock box for "felt" that s/he was "able to and was "agreeable to talk to in twice daily". This this ty update note from M, "Psychiatry did not formally and extensively documented boration with the Psychiatry thatient mental health disurgery during" Patient #1's	A2407	Section of the sectio	Scela	

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Event ID: WUDI11

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		470003	B. WING			C
	NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF VERMONT MEDICAL CENTER (VALID SUPPLIES OF DESCRIPTIONS OF DESCRIP		111	REET ADDRESS, CITY, STATE, ZIP CODE I COLCHESTER AVE RLINGTON, VT 05401		1/12/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	s/he was "in agree assessment and p 12/23/20. Per interview on 1. Provider #1, s/he spresented with selput on (suicide) "p out what was going screening would be were cleared medicounselor to evalue Regarding the case Patient #1 had a hand that in his/her of release and typical lacerations. In this were deep and whe #1 for suicidality s/ldeation flatty". S/he "personalities engate Provider #1 stated visitor to the ED" applant that said the perisodes when discontained the sending him/her "heatient #1 was "remultiple times" during Provider #1 stated is "ancillary services" have the time to specurse of action and emergency and that the experts to help is the sending of the service where the specurse of action and emergency and that the experts to help is the service of action and emergency and that the experts to help is the service of action and emergency and that the experts to help is the service of action and emergency and that the experts to help is the service of action and emergency and that the service of action and	ement with the Crisis Clinician's plan" for Patient #1 from ////21 at 4:34 PM with ED stated that if a patient if-harm, the patient would be recautions" until s/he figured g on with the patient. A medical e done and then if the patient ically, a consult for a crisis pate the patient would be made. We with Patient #1 on 12/23/20, listory of self-harm behavior experience, cutting was a form cally did not involve deep case, Patient #1's lacerations en s/he had assessed Patient in denied any sulcidal le stated that "one of" his/her aged in these behaviors". ED that Patient #1 was a "frequent at that s/he had "read a care patient would have these acute charging would get worse". Isis had seen the patient, is set up for him/her as an at they "were comfortable home". S/He stated that assessed for suicidality ing his/her time in the ED. ED that s/he often involved as s/he expressed, we "do not end" discerning the best di/or treatment for a psychiatric trisis and psychiatry were	A2407	Spaceur		Zeik

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Event ID: WUDI11

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED C
		470003	B. WING			1/12/2021
	PROVIDER OR SUPPLIER	EDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 111 COLCHESTER AVE BURLINGTON, VT 05401		11/12/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	laceration. The pa self-mutilation by this was his/her "the Patient #1 was un remembered going laceration on his/hemoming. Patient #0 object was used to shared with the produced with the produ	#1 presented to the ED for a tient had a significant history of cutting requiring repairs, and hird presentation in three days". aware of what happened, s/he is to bed and noticed a large er left lower leg at 9:30 this in did not know what type of a inflict the injury. Patient #1 ovider that "he' has been very this 'he'" Patient #1 "speaks of a dissoclative identity". The evealed that there was a "25 in to the left lower leg through attent had "no agitation or der". The physician had asked plan in place for future utilation and s/he stated "he' icidal"; however, Patient #1 not suicidal". The patient also had outpatient counseling and in them. Patient #1's laceration is/he was discharged with w-up with his/her doctor and or. S/He was also given nig wound care and pain it was re-evaluated by the ely prior to discharge with his, normal vital signs	A240	Se Contract		Stake

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second s	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	470003		470003 B. WING			C 04/43/2024
UNIVERSITY OF VERMONT MEDICAL CENTER (YALID SUMMARY STATEMENT OF DESIGNATIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401			01/12/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	ED on both occasi ED and stated that s/he would "cut to his/her outpatient serierred him/her to Patient #1 reported feeling safe". Per the was "alert and orie thought disorder". Crisls and the "Cris behaviors were like shelter that had mo people around to a Patient #1 was also "does not need hos "will be discharged living arrangement. s/he "is agreeable to "will be discharged living arrangement. s/he "is agreeable to "will be discharged living arrangement. s/he "is agreeable to "make the that had alater than when the had encouraged him with two packed ba Clinician that s/he v s/he needed but sta "makes threats follow was a warning" and "either another OD that the other perso "destroy the body" alive". "She reporte thing to happen" fro mental status exam groomed", "Coopera with "Fair" insight ("groupgestions, recomi	d patient was discharged in the ons". S/He came back to the this/her alter told him/her that kill". Patient #1 contacted support program and they the ED for an evaluation. If to the provider that s/he "is the provider's exam, the patient ented. No agitation or overt of the patient was evaluated by sis Clinician felt that the patient ely result of recent move from a pre support staff and more place there is more isolated". It is time. S/He back to "his/her "established of this plan". It is note from 12/24/20 at 8:15 presented to the ED hours outpatient counseling service m/her to do so and had arrived gs. S/He had told the Crisis was not sure what type of help the that when his/her alter ows through" "this moming if that s/he would expect or more deep cutting". And nality's goal was allegedly to as s/he "doesn't want to be do being scared of the next m his/her alter. Patient #1's showed that s/he was "Well attive", "Alert and Oriented"	A2407	St. Ch.		Ship

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING		(X3) DA	NO. 0938-039 ATE SURVEY OMPLETED
		470003	B. WING			01/12/2021
	ROVIDER OR SUPPLIER	EDICAL CENTER	111	EET ADDRESS, CITY, STATE, ZIP CODE COLCHESTER AVE RLINGTON, VT 05401		1712021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Per the Crisis Clin regarding suicidali disposed of razors to cut" hlm/her-sel with certainty that"as soon asis interpretation was "engaging in deep of dissatisfactory hand less staffing". again tomorrow an "initially seemed to coming with two pachronic risk" to him #1 was to "dischan Provider" and for the follow-up with house the provider and for the follow-up with house the alter would expressed to the pachronic risk to the pachronic risk to pachronic risk to him #1 was to "dischan Provider" and for the follow-up with house the alter would expressed to the pachronic risk to go to a high care/support and/or Patient #1 was "caldemonstrated ob and help seeking heview of the psych patient #1, s/he wa mood was "neutral, social reactivity"; or with "fair" insight ar review of the psych been previously est Consult Service, Ethealth provider "(du	ician's risk assessment ty, Patient #1 "reportedly but found something this am f "with". "At this time, states his/her "alter will cut to kill alone". The Crisis Clinician's that Patient #1 had been self harm cutting in the context tousing with noisy roommate Patient #1 "may very well cut d end up in the ED". S/He be seeking admission by acked bagsRemains at u/her-self. The plan for Patient ge from the ED to Follow Up ne outpatient crisis center to sing about changing units. Achiatrist confirmed what the d reported that the incidents of a "just warnings" and that next d "cut to kill". Patient #1 sychiatrist that s/he did not ner level of outpatient or stay in the ED overnight. m, linear, organized, but vious black-and-white thinking elp rejecting behavior". Per latrist's mental status exam for s "cooperative and apathetic"; mildly restricted, appropriate liented to "person, place, time"; id "poor" judgment. Per latrist's assessment, "It has ablished by the Psychiatry hics" and outpatient mental	A2407	Su consciul		Spara

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Polarytes 4/29/21 D. Widerwick PN

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DAT	E SURVEY	
	470003		B. WING			01/12/2021	
	ROVIDER OR SUPPLIER	EDICAL CENTER	1	TREET ADDRESS, CITY, STATE, ZIP COD 11 COLCHESTER AVE URLINGTON, VT 05401		1/12/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	fact demonstrates discharge. The par Involuntary hold be considered terr persistently high b self-mutilation" s/h symptoms of borde and should be all the ED, knowing	age 26 chiatric hospitalization and in worsened self-mutilation after tient will not be placed on an While the patient has what can minal psychiatric illness and has aseline risk of death by e "clearly demonstrates erline personality disorder lowed to discharge home from nat" his/her "self-mutilation will with the patient y stable to leave", there would no mitigate "self-harm risk", and safe place to stay". S/He ming a patient's capacity would and that crisis and psychiatry or relled upon to help make the attents if there was a question. If years a question was a question of the patient is fithere was a question. If there was a question was a patient's lacerations. Sented to the ED on the patient's lacerations. Solve the patient's lacerations. The patient #1 "tended to be services were added". S/He as an "ED care plan" in place that "unless new change would clinician evaluation". The place the provider #2 stated sentation was like times when	A2407	Secretary of the secret		Spale	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			IO. 0938-039 TE SURVEY MPLETED C
NAME OF F	PROVIDER OR SUPPLIER	470003	B. WING			1/12/2021
	ITY OF VERMONT MI	EDICAL CENTER	111	REET ADDRESS, CITY, STATE, ZIP COD 1 COLCHESTER AVE JRLINGTON, VT 05401	E	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	his/her evaluation was "calm, cooper S/He had a "linear off" his/her "basell him/her "previous! #1, it was "up to the or not crisis was calmed the property of the or not crisis was calmed the property of the or not crisis was calmed the property of the or not crisis was calmed the property of the prop	d to the ED in the past. Upon of Patient #1 on 12/24/20, s/he rative, pleasant, reasonable". Thought pattern, did not seem ne from when I had met" y". S/He stated that for Patient the provider's discretion whether alled". 77/21 at 2:31 PM with a Second relician (A stage of graduate colors), s/he stated that his/her role stients, write notes, make admit, and discharge patients; processes were evaluated and tending Physician (A physician diresidency and practices or hospital). S/He stated that rice only evaluated patients in assessed by a Crisis ted that a patient's capacity mental status exam and the was able to make a "single S/He stated that s/he had first at #1 on 12/23/20 from crisis. Evaluated Patient #1 and that put together". S/He had and was dressed in "casual exhibited "linear, organized nied suicidal Ideations,	A2407	Syldraduck Social		John

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		470003	B. WING			C
UNIVERSITY OF VERMONT MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401			01/12/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
	a dangerous degrithat "further hospit for the patient". S/ would typically pre a "little escalation" taper off, referring S/He stated that savery bad wounds" the worse" s/he "dicare plans were al time they come in; stated that in April team (to include Eidiscuss whether to #1 to receive further have a way to keep offer the patient". Soverall nothing had did not change the There was an "ove self-lacerations". Per review of a pro 12:21 PM, Patient in line (cm) centimete lacerations, one cemain laceration: an laceration on his/her reported that s/he that s/he "disassoci S/he denied any "cu states that" his/her ther". Per the providwas "alert and orien The provider contact patient #1 would no level of outpatient catellined any further declined any further	ee of self-harm". S/He stated talizations would be dangerous He stated that the patient sent several days in a row with and then the behavior would to this as an "extinction burst". //he "carne in all the time with. The "more support" s/he "got id". S/he stated that patients ways "in flux" and that "every they are re-assessed". S/He of 2020 a multidisciplinary thics) meeting was held to involuntarily commit Patient for treatment. "They did not on him/her "safe". "Nothing to s/He stated that "Because in changed globally, ultimately treatment recommendations". It is also that the presented to the ED with a ser laceration with six branching intimeter perpendicular to the did 4 cm, 3 cm, and 2 cm ser right ankle. Patient #1 pok an Uber to the ED and ated and cut" him/her-self. Jurrent SI (suicidal ideation) but "other person' desires to hurt er's physical exam, Patient #1 ted, appears comfortable". It ted Crisis and they stated that the accepted to the higher are and that the "patient assessment from crisis. It is phone checklater today".	A2407	Secretary of the secret		Krist

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003 NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF VERMONT MEDICAL CENTER		IDENTIFICATION NUMBER:	ENTIFICATION NUMBER: A. BUILDIN		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		STREET ADDRESS, CITY, STATE, ZIP CODE				01/12/2021	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	4	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
- 4	was "Stable". Per interview on 1 Provider #3, s/he is presents as suicid main goal was to others". If it is "detharm to self and/o crisis involved". S/discharge plan wo be discharged safe same page". S/He Patient #1 a "numis/he "can't think of present without the Patient #1 was "ac ED Provider #3 stacrisis while Patient "did not feel that the ED Provider #3 ha at home. S/He star psychiatry advised discharged. They treasonable plan". Ilooking at previous that Patient #1 did hospitalization. Per review of a prosection of the provider #3 provider #3 provider #3 provider #3 provider #4 pro	dition at departure from the ED ////21 at 3:27 PM with ED stated that when a patient lal and/or with self-harm, the "assess risk to harm to self or termined" that there is a risk of or others, then s/he would "get //He further stated that a safe uld reflect how the patient could ely and that "everyone is on the o stated that s/he had seen ber of times". S/He stated that if a time that" Patient #1 "did not oe same complaint"; and that damant" s/he "was not suicidal". ated that s/he had spoken to t #1 was in the ED and that they ney needed to see" him/her. d asked crisis to call the patient ted that both crisis and I that Patient #1 was "ok" to be "all agreed that it was a S/He stated that s/he "knew is psychiatry documentation"	A2-	407	Secretary Secret		Spare

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POCALLADAS 4/29/21 D. W. denester

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
NAME OF E	NAME OF PROVIDER OR SUPPLIER		B. WING			01/12/2021
	ITY OF VERMONT ME	DICAL CENTER		STREET ADDRESS, CITY, STATE, 111 COLCHESTER AVE BURLINGTON, VT 05401	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
	distress"; his/her si in various stages o "Normal speech, gi strength and sensa Patient #1 reported "injuries have beenhas been alone inother personalitie Upon exam his/her tendon injury and rollimited at baselline of acutely worse". and crisis was conspatient, discussed worsening symptom Per review of a cris AM, Patient was dissuture removal and worsening symptom Per review of a cris AM, Patient #1 explication and hop "does not have the limitent". Patient #1 appointment with his manager on 12/28/21/12/20. Patient #1 control" and that s/hand dose not eviden reported that his/her because "they could "Earlier in the year a Psychiatry", Outpatie to discuss protocol for patients "level of self-	kin was with "multiple injuries of healing"; and s/he had alt wnl (within normal limits), ation to light touch wnl". If to the physician that his/her or increasing lately because more often, which allows to to injure more often". Intendon is clearly visible, no ange of motion though due to multiple injuries, is His/her wound was repaired, sulted. "Crisis met with the with psychiatry, and agreed appropriate for discharge". Scharged with instructions for to "return for any new or	A24	407 State of the		Stores

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		RRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		O. 0938-0391 SURVEY PLETED
		470003	B. WING		C 12/2021	
UNIVERS	ROVIDER OR SUPPLIER ITY OF VERMONT ME		1	STREET ADDRESS, CITY, STATE, ZIP CO 11 COLCHESTER AVE SURLINGTON, VT 05401		12/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	had decided to treamore medically base crisis clinician consinclude the attendir felt that discharge course of action". "daily phone checks s/he "meets with C encouraged to see needed which to dawith". Per review of status exam, Patter "Alert and Oriented "Poor" judgment. T assessment reveal was "High for contain however no current The Clinician's internistory and current admission and internistory and current admission and internistory and accesses	age 31 at further occurrences in a sed palliative manner*. The sulted with on-call psychiatry to no physician, and "both doctors from the ED was appropriate This writer will schedule twice sover the next two days until" ase Manager*. S/He "is also k medical care at the ED if as ate "s/he "has followed through the Crisis Clinician's mental nt #1 was "Well groomed", ", with "Poor" insight and the Crisis Clinician's risk ed that Patient #1's suicidality nuing acts of self-harm a stated intent or intent to die". In treatment states that inpatient the sive OP (outpatient) therapy oductive for Patient #1 "has ed medical care as needed the psychiatry, it is "Patient #1 "discharge to alished treatment team". If you at 3:11 PM with ED ated that when a patient with self-harm, a medical care as needed that when a patient with self-harm, a medical care that including the stated that when a patient with self-harm, a medical care that when a patient at all the with self-harm, a medical care that when a patient with self-harm, a medical care that when a patient at all the with a "left arm laceration". It with a "left arm laceration". It with a "left arm laceration" and s/he "answered dother lacerations on the stop both legs. ED Provider slosed the laceration, and that	A2407	Signal of the state of the stat		Spir

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POC alugates 4/29/21 D. Wideawalara

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		470003	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 111 COLCHESTER AVE BURLINGTON, VT 05401		01/12/2021	
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WUDI11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/16/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C			
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WUDI11

Facility ID: 470003

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POCAUCPTES 1/21/21 D. Linderweller

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 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 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,

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 reevaluated 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 reassessed". 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 4129121 D. Lin Scawelle 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-bycase" 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". SHe 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. She 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 ...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 inputient 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 an 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.

POLAKUPTES YMAZI Dindunura

- 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.

Polarepted 4/29/21 Di wi dewale RN