

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

April 14, 2014

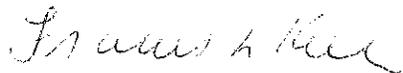
Timothy Ford, Administrator
Springfield Hospital
Po Box 2003
Springfield, VT 05156

Dear Mr. Ford:

The Division of Licensing and Protection completed a survey at your facility on **March 20, 2014**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485. Immediate Jeopardy was determined at that time.

Following the survey, your facility submitted a Plan of Corrections (POC) for the Immediate Jeopardy, which was found to be acceptable on **April 14, 2014**.

Sincerely,



Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
Director State Survey Agency

FK:jl

Enclosure

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471306	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 2003 SPRINGFIELD, VT 05156	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
C 000	<p>INITIAL COMMENTS</p> <p>An unannounced onsite recertification survey was conducted on 3/17/14 - 3/20/14 by the Division of Licensing and Protection. The following regulatory violations were identified:</p> <p>Based on information obtained through staff interviews and record reviews, on 3/19/14 an Immediate Jeopardy situation was determined to exist when the physical health and safety of a patient was jeopardized during a transfer procedure from bed to chair and a failure of the facility to thoroughly investigate the circumstances and sufficiently implement corrective measures to prevent the potential opportunity for further injury and harm.</p> <p>In addition, the Critical Access Hospital (CAH) was determined not to be in compliance with Conditions of Participation for: Provision of Services and Periodic Evaluation and Quality Assurance Review.</p> <p>The jeopardy was removed when the CAH senior management developed an action plan on 3/19/14, to assure the safe, appropriate use of the EZ lift by trained and competent staff, and to prevent the likelihood of a recurrence of the event, which included: evaluation of the EZ lift by the BioMed representative prior to next use; assurance of immediate training and competency for use of the lift for staff on each upcoming shift with plan for ongoing training of all staff to be completed by 4/4/14. Staff were also educated/reminded to remove any equipment involved in patient incidents from use until evaluated by BioMed.</p>	C 000	<p>POC Accepted F. McIntosh / F. Keen 4/19/13 RN RSN UBA</p>
C 270	485.635 PROVISION OF SERVICES	C 270	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

CEO

11 April 2014

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

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C 270	Continued From page 1 Provision of Services This CONDITION is not met as evidenced by: Based on patient/patient representative and staff interviews as well as record review the Condition of Participation for Provision of Services was met as evidenced by: The CAH failed to provide care and services in accordance with established policies and procedures, failed to assure adequate training and competency of staff when using patient equipment and failed to develop and revise a care plan to meet the needs of one patient, whose health and well being was jeopardized because of these failures. Refer to tags C-0271, C-0295 and C-0298	C 270	E-Z Lift Training and Competency All staff working 03 19 2014 will receive training and competency for the E-Z Lift this day. All Staff on the Inpatient Care Unit who utilize the E-Z lift will re-do the training and competency for the lift by April 4, 2014 When moving patients with the E-Z lift the Charge Nurse or the Physical Therapy Assistant will function as the Team Leader for transfer. All Charge Nurses and Physical Therapy Assistant will complete training and competency for the lift by April 4, 2014. Each shift will have a nurse scheduled who has completed their re-education and competency for the lift by April 4, 2014. Monitoring Nursing Education EZ Lift staff training and competency roster completion.	04 14 14
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on interview and record review the nursing staff failed to provide patient care in accordance with the CAH's identified procedure for the use of the EZ Stand Lift. Findings include: Per interview on 3/19/14 with the hospital's Nursing Manager for Patient #2's unit, the hospital's policy on 3/8/14 was to follow the manufacturer's instructions for the EZ lift [a battery powered patient lift]. Instructions include:	C 271	See C 270 485.635 PROVISION OF SERVICES	

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C 271	<p>Continued From page 2</p> <p>"For safe operation of the EZ Way Smart Stand®, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients."</p> <p>On 3/8/14 the EZ lift stand lift was used incorrectly to transfer Patient #2 from the bed to a chair resulting in an emergency situation and the patient suffering acute respiratory difficulty requiring a code to be called.</p> <p>Per interview, on 3/19/14, RN #3 was assigned as Patient #2's primary nurse on 3/18/14. RN #3 stated s/he had received the initial training on the EZ lift in July 2013, but had not had any retraining regarding the lift since. RN #3 reported s/he had not reviewed the EZ lift video and had not completed a training checklist since the incident on 3/8/14. RN #3 also reported 3/18/14 was his/her first day assigned to Patient #2, and s/he had not used the EZ lift on Patient #2 since the patient's admission on 3/6/14.</p> <p>Per interview on 3/19/14 at 9:15 A.M. the primary nurse assigned to Patient #2 that day, RN #4, stated regarding the EZ lift: "I haven't used it with [Patient #2]. I practiced on it when they first got it [July 2013]. I certainly could use a refresher course." RN #4 reported s/he had not received any retraining on the EZ lift since the incident on 3/8/14, had not reviewed the video available, and had not completed a training checklist. RN #4 stated s/he had seen some nursing staff being trained on the EZ lift on 3/18/14, "but I was not involved in that."</p> <p>Per record review and confirmed by interview with the hospital's Professional Development staff on 3/19/14, 7 staff members were trained and had</p>	C 271		
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C 271	Continued From page 3 completed the manufacturer's competency checklist when the EZ lift was first purchased in July 2013. None of the staff members who had received the training participated in the use of the lift the day of the incident on 3/8/14. As of 3/19/14, 4 nursing staff had received training since the incident on 3/8/14, none of whom had been assigned as the primary nurse for Patient #2 since the training.	C 271		
C 295	485.635(d)(1) NURSING SERVICES A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. This STANDARD is not met as evidenced by: Based on interviews with patient, patient representative and facility staff, as well as record review, the CAH failed to assure that all staff were adequately trained and competent in the safe use of a patient lift (EZ Lift) to transfer one patient, resulting in a failure to safely transfer the patient who then suffered an episode of acute respiratory distress requiring medical intervention. (Patient #2). Findings include: Per patient and family interview, staff interview, and record review, on Saturday 3/8/14 at 8:45 A.M an EZ lift patient lift was used to transfer Patient #2 from the bed to a chair resulting in an emergency situation and the patient suffering acute respiratory difficulty. Per interview on 3/19/14 at 10:23 A.M Patient #2 and the patient's daughter reported that on 3/8/14	C 295	See C 270 485.635 PROVISION OF SERVICES	

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C 295	Continued From page 4 RN #1 and three other nursing staff placed the lift's harness around the back of the patient, and hooked the harness straps to the lift. The lift was turned on, and the patient was raised off the bed. The EZ lift, with the patient standing on it, was then pivoted toward a reclining chair. Per record review, a Nurse Practitioner [NP] note, dated 3/8/14, indicated the NP had been present during the transfer process and stated, "...there were some logistical problems utilizing the lift chair. The canvas wrap seemed to constrict [his/her] breathing a bit, and [s/he] did have an episode of acute respiratory insufficiency while in the canvas wrap. [S/he] had to be immediately eased to the floor and the wrap removed in order for [his/her] breathing pattern to return to normal. S/he did require high-flow oxygen ..." An electronic Incident Report filed at 2:25 P.M., on 3/8/14, by the Charge Nurse who was present during the incident, cited, "device failure: would not raise patient high enough." 'Additional Information' in the report states "...[his/her] abdomen pushed up so [s/he] was unable to expand [his/her] lungs. [s/he] turned purple and had agonal breathing [an inadequate pattern of breathing associated with extreme physiological distress]. While attempting to pull [him/her] into chair, device securing patient under [his/her] buttocks slipped out ..." Per interview, on 3/19/14 at 3:25 P.M., RN #2 indicated the lift was unable to raise the patient high enough to meet the seat of the recliner chair to facilitate smooth transfer of the patient to the chair. "Something was wrong with the [EZ lift] battery. Someone said the battery was dead ...it was chaotic." RN #1 stated, during interview on 3/19/14, that during the incident on 3/8/14 Patient #2 turned blue, slumped forward, head down, "probably passed out." The NP stated, during interview on 3/19/14, "I knew [s/he] was blue ..."	G 295			

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C 295	Continued From page 5 didn't need the O2 sat [oxygen saturation level] to tell me [s/he] wasn't breathing." The NP also stated that the EZ lift was not used the following day, 3/9/14, as s/he did not want the lift used until people who were comfortable using it were available. Per interview, at 9:30 AM on 3/19/14, the unit Nurse Manager stated that s/he had been notified of the incident, on the afternoon of 3/8/14. S/he stated the decision was to not use the lift until it could be reviewed on Monday, 3/10/14. S/he further stated that following his/her review of the incident it was determined that there was not an issue with the equipment, " it was a training issue, it was failure of use of the equipment, not failure of the equipment." The Nurse Manager also stated that, because the hospital had not yet approved a formal policy and procedure regarding use of the EZ lift at the time of the incident, the CAH's policy, as of 3/8/14, was to follow the manufacturer's instructions. Per observation on 3/18/14, a copy of the manufacturer's instructions was attached to the handle of the EZ lift. Instructions in the manual include " For safe operation of the EZ Way Smart Stand®, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients. " Per record review and confirmed during interview with the hospital's Chief of Quality and Systems Improvement on 3/19/14, the follow up to the event report for the 3/8/14 incident indicated the " Immediate Action taken: EZ lift device, lift pad evaluated the following Monday " (3/10/14). The report also includes ' recommendations on what needs to be done as a result of this event: Staff education and training on use of lift was reviewed and commenced to include all staff yet to be	C 295	Equipment Evaluation Staff will be educated to remove equipment from service if there has been an event involving such equipment. An event report will be filed in the Safety Event Management system and the BioMed department will be notified of all equipment failures or any question of failure. Equipment will not be returned to service until such time that BioMed deems the equipment safe for operation. Monitoring Review of event reporting, investigation and completion of Bio Med equipment reviews. Follow up Use of Equipment will be monitored for safe use. Failure to report or remove from service any equipment considered at risk for safe use will be followed by staff re-education and removal of that equipment from service until certified safe for operation by Bio Med.	04 04 14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2014
FORM APPROVED
OMB NO. 0938-0391

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C 295	<p>Continued From page 6</p> <p>signed off. EZ lift video available on computer at nurses station and training checklist to be reviewed/completed by each staff prior to assisting current patient. The follow up report is marked as completed 3/18/14 at 11:25 A.M. Per interview, on 3/19/14 at 8:29 A.M., the CAH Biomed representative confirmed that his/her department is responsible for evaluating and maintaining safe functionality of the CAH's patient care equipment, including the EZ lift. The representative confirmed that the EZ lift had not been evaluated by the Biomed department following the incident on 3/8/14, until inquiry by the survey team on 3/19/14.</p> <p>Per record review and confirmed by interview with the hospital's Professional Development staff on 3/19/14 there was no evidence that any of the staff members using the lift on 3/8/14 had ever received adequate training or assurance of competency for the lift. As of 3/19/14, only 4 nursing staff had received training since the incident on 3/8/14, none of whom had been assigned as the primary nurse for Patient #2 since the training.</p> <p>Per record review and confirmed on 3/19/14 by the Nurse Manager for the unit, the lift had been used every day since the incident on 3/8/14, and instructions for using the EZ lift on Patient #2 were not revised until 3/14/14. The Nurse Manager stated the incident "was a training issue... As we began training staff with this patient we learned they were not using the belt as you need to". The Nurse Manager further stated between the time of the incident until 3/14/14 [6 days later] "there wasn't training going on." The Nurse Manager reported "Now we're training staff as they're working."</p> <p>Per record review of Nursing Notes from 3/15/14 the nurse reports, "Patient refusing to get out of</p>	C 295		

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C 295	<p>Continued From page 7</p> <p>bed with lift ... because of what happened last weekend. [S/he] is very scared " & from 3/16/14 notes "Patient refused to get out of bed for supper. [S/he] feels unsafe and that staff are not trained with the lift."</p> <p>Per interview with RN #3 and per record review on 3/19/14, RN #3 was assigned as Patient #2's primary nurse on 3/18/14. RN #3 stated s/he had received the initial training on the EZ lift in July 2013, but had not had any retraining regarding the lift since. RN #3 reported s/he had not reviewed the EZ lift video and had not completed a training checklist since the incident on 3/8/14. RN #3 also reported 3/18/14 was his/her first day assigned to Patient #2, and s/he had not used the EZ lift on Patient #2 this admission.</p> <p>On 3/19/14 at 10:23 A.M during an interview with Patient #2 and a family member, they reported that RN #3 and 2 other staff members attempted to place the EZ lift harness on Patient #2 the previous night, 3/18/14, at approximately 6:00 P.M., in order to raise the patient out of a recliner. The family member stated RN #3 asked him/her regarding the lift harness, "how does it go?" The family member stated s/he told RN #3 s/he "had it upside down."</p> <p>Per interview on 3/19/14 at 9:15 A.M. the primary nurse assigned to Patient #2 that day, RN #4, stated regarding the EZ lift: "I haven't used it with [Patient #2]. I practiced on it when they first got it [July 2013]. I certainly could use a refresher course." RN #4 reported h/she had not received any retraining on the EZ lift since the incident on 3/8/14, had not reviewed the video available, and had not completed a training checklist. RN #4 stated s/he had seen some nursing staff being trained on the EZ lift on 3/18/14, "but I was not involved in that".</p> <p>The unit Nurse Manager confirmed, during</p>	C 295	

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C 295	Continued From page 8 interview on 3/19/14, that the identified need for training to prevent a re-occurrence had not been instituted. The CAH's Professional Development staff member confirmed during interview, on 3/19/14, that training on the EZ lift as outlined by facility's policy, had not started until 3/18/14, and staff assigned to Patient #2 on 3/18 & 3/19/14 had not received any training or retraining since the incident. Despite the fact that inappropriate use of the EZ lift, by staff, had resulted in a situation in which Patient #2 suffered a compromised airway and acute respiratory distress, and although the EZ lift had not been evaluated to assure safe functionality, and appropriate training of staff and assurance of competency with use of the EZ lift did not occur, Patient #2 was subjected to ongoing daily use of the lift by untrained staff placing the patient's health and well being in jeopardy.	C 295	
C 298	485.635(d)(4) NURSING SERVICES A nursing care plan must be developed and kept current for each inpatient. This STANDARD is not met as evidenced by: Based on interview and record review, nursing staff failed to update the current patient care plan for Patient #2. Findings include: Per record review Patient #2, whose diagnoses include immobility and pneumonia, was admitted to the hospital on 3/5/14. The patient was assessed as a high fall risk. The patient's care plan on 3/6/14 includes "Potential for Fall" with interventions that include: "gait belt for ambulation" and the goals included "Patient will remain injury free." The care plan did not address	C 298	Nursing Care Plan When a patient is being transferred using the E-Z Lift any specifics related to that patient's transfer will be included on the Medact (Nursing Care Plan), or the Medact will refer to a document in the patient's chart. On the Nursing Care Plan it will be noted that operation of the EZ lift may only occur under the direct supervision of a trained operator. Monitoring Med Act (Nursing Care Plan) will reflect current plan of care and updated to patient patient's preferences and specifics related to the provision of safe services.

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C 298	<p>Continued From page 9</p> <p>the use of an EZ lift to assist in patient transfers, or the need for staff to receive instruction prior to its use.</p> <p>Per interview on 3/19/14 with the Nurse Manager for the unit on which Patient #2 resided, the CAH's policy at that time was to follow the manufacturer's instructions for the EZ lift. Instructions include, "For safe operation of the EZ Way Smart Stand®, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients."</p> <p>On 3/7/14 an EZ lift stand lift (a battery powered patient lift) was used for the first time during this admission to transfer Patient #2 from the bed to a chair, and later from the chair back to bed. On 3/8/14 the patient lift was used again, resulting in an emergency situation and the patient suffering acute respiratory difficulty.</p> <p>Per record review and confirmed during an interview on 3/19/14 with the Nurse Manager the EZ lift continued to be used on Patient #2 daily for 6 days after the incident, with no review or revision to the patient's care plan to reflect use of the lift, until 3/14/14. The Nurse Manager stated during the 6 days after the emergency situation "there wasn't training going on."</p>	C 298		
C 330	<p>485.641 PERIODIC EVALUATION & QA REVIEW</p> <p>Periodic Evaluation and Quality Assurance Review</p>	C 330		

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C 330	Continued From page 10 This CONDITION is not met as evidenced by: Based on observation, interview and record review, the Condition of Participation: Periodic Evaluation and Quality Assurance was not met as evidenced by: The Quality Assurance Program failed to thoroughly investigate in a timely manner the circumstances of an event resulting in respiratory compromise for a patient and the failure of the Quality Assurance Program to sufficiently implement corrective measures to prevent further opportunity of harm and/or injury for all patients. Refer to Tag: C-0342	C-330	Event reporting management Safety events either directly or potentially causing risk to a patients' safety will be reported and investigated thoroughly, and actions will be identified for immediate implementation to protect that patient's safety. Special emphasis is place on assuring staff training and competency is complete and that educational resources are readily available. Any equipment noted by event reporting that has been involved in a safety event either directly or potentially causing harm will removed from service until a biomedical device review is complete and the equipment is deemed safe for operation.	04 14 14
C 336	485.641(b) QUALITY ASSURANCE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that – This STANDARD is not met as evidenced by: Based on observation, interview and record review, the CAH Quality Assurance Program failed to fully assess the events leading up to a significant patient event and failed to take appropriate remedial action to address the event in an effort to avoid the re-occurrence of like events. Based on record review and confirmed through staff interviews the CAH Quality Assurance Program failed to implement, in a timely manner, corrective actions for a deficient practice	C-336	Quality Assurance Actual and potential events are reported through the electronic event reporting system. All events are reviewed 100% by the Chief of Quality and Division Head over which department such events occurred. Events are assigned to the Department Manager for investigation and development of a response and resolution plan. Action plans are reviewed by the department's Division Head and Chief of Quality for appropriateness. As needed, debriefing sessions are requested to gain further understanding of situations reported and to further identify performance improvement areas which may involve communication needs, staff educational needs, staffing, equipment maintenance etc. Improvement plans are developed and then communicated to the staff and implemented. Oversight of recommended actions and identifying system quality metrics are overseen for completion by the Department Manager and monitored by the Department's Division Head and the Chief of Quality. The plan of correction is integrated into the quality assurance system.	04 04 14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471308	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 2003 SPRINGFIELD, VT 05156	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
C 336	<p>Continued From page f1</p> <p>involving the use of an EZ Stand Lift for Patient #2, who experienced acute respiratory distress as the result of inappropriate use of the lift by staff. Although an investigation of the event, by nursing management, identified the need to assure staff training and competency evaluation in the use of the lift, to assure no re-occurrence of like incidents, prior to continued use of the EZ lift, the training was not completed by all staff who continued to use the EZ lift with Patient #2.</p> <p>Per interview on 3/19/14 at 10:23 A.M. Patient #2 and the patient's daughter reported that on 3/8/14 RN #1 and three other nursing staff placed the lift's harness around the back of the patient, and hooked the harness straps to the lift. The lift was turned on, and the patient was raised off the bed. The EZ lift, with the patient standing on it, was then pivoted toward a reclining chair. Per record review, a Nurse Practitioner (NP) note, dated 3/8/14, indicated the NP had been present during the transfer process and stated, "...there were some logistical problems utilizing the lift chair. The canvas wrap seemed to constrict [his/her] breathing a bit, and [s/he] did have an episode of acute respiratory insufficiency while in the canvas wrap. [S/he] had to be immediately eased to the floor and the wrap removed in order for [his/her] breathing pattern to return to normal. S/he did require high-flow oxygen ..." An electronic Incident Report filed at 2:25 P.M., on 3/8/14, by the Charge Nurse who was present during the incident, cited, "device failure: would not raise patient high enough." Additional information in the report states "...[his/her] abdomen pushed up so [s/he] was unable to expand [his/her] lungs. [s/he] turned purple and had agonal breathing [an inadequate pattern of breathing associated with extreme physiological distress]. While attempting</p>	C 336	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 3003 SPRINGFIELD, VT 05156		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 336	<p>Continued From page 12</p> <p>to pull [him/her] into chair, device securing patient under [his/her] buttocks slipped out ...</p> <p>Per interview, on 3/19/14 at 3:25 P.M., RN #2 indicated the lift was unable to raise the patient high enough to meet the seat of the recliner chair to facilitate smooth transfer of the patient to the chair. "Something was wrong with the [EZ lift] battery. Someone said the battery was dead ... it was chaotic." RN #1 stated, during interview on 3/19/14, that during the incident on 3/8/14 Patient #2 turned blue, slumped forward, head down, "probably passed out." The NP stated, during interview on 3/19/14, "I knew [s/he] was blue ... I didn't need the O2 sat [oxygen saturation level] to tell me [s/he] wasn't breathing." The NP also stated that the EZ lift was not used the following day, 3/9/14, as s/he did not want the lift used until people who were comfortable using it were available.</p> <p>Per interview, at 9:30 AM on 3/19/14, the unit Nurse Manager stated that s/he had been notified of the incident, on the afternoon of 3/8/14. S/he stated the decision was to not use the lift until it could be reviewed on Monday, 3/10/14. S/he further stated that following his/her review of the incident it was determined that there was not an issue with the equipment. "it was a training issue, it was failure of use of the equipment, not failure of the equipment." The Nurse Manager also stated that, because the hospital had not yet approved a formal policy and procedure regarding use of the EZ lift at the time of the incident, the CAH's policy, as of 3/8/14, was to follow the manufacturer's instructions, which included: "For safe operation of the EZ-Way Smart Stand®, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients."</p>	C 336		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2014
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 2003 SPRINGFIELD, VT 05156
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C 336	<p>Continued From page 13</p> <p>Per record review and confirmed during interview with the hospital's Chief of Quality and Systems Improvement on 3/19/14, the follow up to the event report for the 3/8/14 incident indicated the "Immediate Action taken: EZ lift device, lift pad evaluated the following Monday" [3/10/14]. The report also includes recommendations on what needs to be done as a result of this event. Staff education and training on use of lift was reviewed and commenced to include all staff yet to be signed off. EZ lift video available on computer at nurses station and training checklist to be reviewed/completed by each staff prior to assisting current patient." The follow up report is marked as completed 3/18/14 at 11:25 A.M. Per interview, on 3/19/14 at 8:29 A.M., the CAH BioMed representative confirmed that his/her department is responsible for evaluating and maintaining safe functionality of the CAH's patient care equipment, including the EZ lift. The representative confirmed that the EZ lift had not been evaluated by the BioMed department following the incident on 3/8/14, until inquiry by the survey team on 3/19/14.</p> <p>Per record review and confirmed by Interview with the hospital's Professional Development staff on 3/19/14 there was no evidence that any of the staff members using the lift on 3/8/14 had ever received adequate training or assurance of competency for the lift. As of 3/19/14, only 4 nursing staff had received training since the incident on 3/8/14, none of whom had been assigned as the primary nurse for Patient #2 since the training.</p> <p>Per record review of Nursing Notes from 3/15/14 the nurse reports; "Patient refusing to get out of bed with lift ...because of what happened last weekend. [S/he] is very scared" & from 3/16/14</p>	C 336		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2014
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 2003 SPRINGFIELD, VT 05156
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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C 336	<p>Continued From page 14</p> <p>notes, "Patient refused to get out of bed for supper. [S/he] feels unsafe and that staff are not trained with the lift."</p> <p>Per interview on 3/19/14, RN #3 was assigned as Patient #2's primary nurse on 3/18/14. RN #3 stated s/he had received the initial training on the EZ lift in July 2013, but had not had any retraining regarding the lift since. RN #3 reported s/he had not reviewed the EZ lift video and had not completed a training checklist since the incident on 3/8/14. RN #3 also reported 3/18/14 was his/her first day assigned to Patient #2, and s/he had not used the EZ lift on Patient #2 this admission.</p> <p>On 3/19/14 at 10:23 A.M during an interview with Patient #2 and a family member, they reported that RN #3 and 2 other staff members attempted to place the EZ lift harness on Patient #2 the previous night, 3/18/14, at approximately 6:00 P.M., in order to raise the patient out of a recliner. The family member stated RN #3 asked him/her regarding the lift harness, "how does it go?" The family member stated s/he told RN #3 s/he "had it upside down."</p> <p>Per interview on 3/19/14 at 9:15 A.M., RN #4, the primary nurse assigned to Patient #2 that day, stated regarding the EZ lift: "I haven't used it with [Patient #2]. I practiced on it when they first got it [July 2013]. I certainly could use a refresher course". RN #4 reported s/he had not received any retraining on the EZ lift since the incident on 3/8/14, had not reviewed the video available, and had not completed a training checklist. RN #4 stated s/he had seen some nursing staff being trained on the EZ lift on 3/16/14, "but I was not involved in that"</p> <p>The unit Nurse Manager confirmed, during interview on 3/19/14, that the identified need for training to prevent a re-occurrence had not been</p>	C 336		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 474306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 2003 SPRINGFIELD, VT 05156		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 336	<p>Continued From page 15</p> <p>Instituted. The CAH's Professional Development staff member confirmed during interview, on 3/19/14, that training on the EZ lift as outlined by hospital policy, had not started until 3/18/14, and staff assigned to Patient #2 on 3/18/14 & 3/19/14, respectively, had not received any training since the incident.</p> <p>Per record review and confirmed on 3/19/14 by the Nurse Manager for the unit, the lift had been used every day since the incident on 3/8/14, and instructions for using the EZ lift on Patient #2 were not revised until 3/14/14. The Nurse Manager stated the incident "was a training issue ... As we began training staff with this patient we learned they were not using the belt as you need to." The Nurse Manager further stated between the time of the incident until 3/14/14 [6 days later] "there wasn't training going on." The Nurse Manager reported "Now we're training staff as they're working."</p> <p>Despite the fact that inappropriate use of the EZ lift was identified by nursing management as a contributing factor in the incident of 3/8/14 in which Patient #2 suffered a compromised airway and acute respiratory distress, the CAH failed to implement the action plan identified for staff training and assurance of competence to use the lift, and failed to evaluate the lift to assure it was functioning safely, and Patient #2 was subjected to ongoing daily use of the lift by untrained staff, through 3/19/14, placing the patient's health and well being in jeopardy.</p>	C 336		

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