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Division of
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Licensing and Protection

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

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471306	A. BUILDING _____ B. WING _____	C 05/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HOSPITAL	PO BOX 2003 SPRINGFIELD, VT 05156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS An unannounced complaint investigation was conducted on 5/13/13-5/14/13 by the Division of Licensing and Protection. The following regulatory violations were identified.	C 000	See attached Plan of Correction.	
C 152	485.608(b) COMPLIANCE WITH STATE & LOCAL LAWS All patient care services are furnished in accordance with applicable State and local laws and regulations. This STANDARD is not met as evidenced by: Based on staff interview and record review, during the provision of care and services in the Emergency Department (ED) staff failed to maintain patient rights in accordance with State statute, Title 18, Chapter 42; Bill of Rights for Hospital Patients; § 1852. 1) The patient has the right to considerate and respectful care at all times and under all circumstances with recognition of his or her personal dignity, for 2 of 10 applicable patients. (Patients #1, #2). Findings include: Per record review the policy, titled Restraint and Seclusion Policy last approved on 1/10/2013 states "....that all patients have the right to the least restrictive alternative for restraint and seclusion and support the fundamental patient right to be free from physical restraint, chemical restraint, and seclusion. Restraint alternatives will be considered prior to restraint and/or seclusion.....It is our responsibility to facilitate the discontinuation of restraint or seclusion as soon as possible.....are committed to preserve the patient's safety and dignity when restraint or seclusion is used."	C 152		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew [signature]	ACTING CEO	06/20/2013

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 152	Continued From page 1 Per record review staff failed to provide care in a respectful and dignified manner by failing to adhere to the CAH's policy for restraint use for Patients #1 and #2, both of whom were phyically restrained during their respective individual treatment in the ED (Emergency Department). Each of the patients had an extended length of stay in the ED, exceeding 24 hours, while awaiting available bed placement for involuntary admission to an inpatient psychiatric unit. Patient #1 was brought to the ED on 10/23/12, in custody of the Sheriff's department with behavioral changes, suicidal thoughts, delusional, paranoid and aggressive, homicidal thoughts. The patient, age 33, was in need of medical clearance to facilitate a involuntary inpatient psychiatric unit admission. Patient #1 remained in the ED for 11 days, during which time restraints were utilized on multiple occasions, with limited documentation to ensure least restrictive alternatives were attempted or evidence of appropriate medical staff orders for the use of restraints and reassessment for continuation or discontinuation of restraints. During a period of restraint use, staff failed to preserve Patient #1's dignity. On 10/24/12 at 15:44 a nurses note states the patient requested to stand to void (a bladder scan confirmed 662 ML of urine), however the patient was not permitted to stand and remained restrained on a stretcher. At 16:13 Patient #1 became incontinent of urine and was then placed in disposable briefs and continued to be held in 4 point restraints. On 10/26/12 at 09:01 Patient #1 was described as "calm....restraints released for 20 minutes...Cooperative the entire time..." the patient was not kept out of restraints	C 152		

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C 152	Continued From page 2 but provided the option of which two restraints s/he wanted applied. Later in the evening and night of 10/26/12 the patient slept while two guards remained outside Patient #1's room, yet restraints were not reduced or removed. Per record review, Patient #2 was brought to the ED on 3/13/13 at 16:49 with a chief complaint of being anxious and depressed with a diagnosis of Schizophrenia. Although the patient was cooperative upon arrival, a nursing note timed 17:47 states " The patient was taken to room #5 s/he was cooperative and undressed putting on pt gown and pants. I discussed his/her earlier behavior and stated I wanted to put him/her into 4 pt (point) restraints. We talked about starting with 3 pt both legs and his/her left wrist. he is doing well with this." Without any evidence of immediate threat to himself/herself or others restraints were initiated. At 23:20 on 3/13/13 Patient #2 was released from restraints, walked to the bathroom and then placed back in 3 point restraints. Despite no evidence of violent behavior or threats and without an assessment for the reduction of restraint use, Patient #2 continued to be physically restrained until 08:13 on 3/14/12. Per interview on the afternoon of 5/14/13, the ED nurse manager confirmed there was a lack of evidence to consistently warrant the need for restraints and there was no attempt by staff to utilize the least restrictive interventions. Refer to Tag A-271	C 152		
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in	C 271		

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C 271	Continued From page 3 accordance with appropriate written policies that are consistent with applicable State law.	C 271		
	This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interviews the CAH (Critical Access Hospital) failed to provide care and services in accordance with established policies for 2 of 10 applicable patients. (Patients #1 and #2) Findings include: Per record review staff failed to provide care in accordance with the CAH's policy for restraint use for Patients #1 and #2 both of whom were physically restrained during the course of their respective individual treatment in the ED (Emergency Department). Each of the patients had an extended length of stay in the ED, exceeding 24 hours, while awaiting available bed placement for involuntary admission to an inpatient psychiatric unit. Per record review the policy, titled Restraint and Seclusion Policy last approved on 1/10/2013 states "....that all patients have the right to the least restrictive alternative for restraint and seclusion and support the fundamental patient right to be free from physical restraint, chemical restraint, and seclusion. Restraint alternatives will be considered prior to restraint and/or seclusion.....It is our responsibility to facilitate the discontinuation of restraint or seclusion as soon as possible.....are committed to preserve the patient's safety and dignity when restraint or seclusion is used." And under Assessment for early release of the violent and self-destructive patient: " A. With each monitoring , the patient is reassessed to determine that continuation of the			

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C 271	Continued From page 4 restraint is necessary. B. Reduction or removal of restraint will be considered when the patient demonstrates a change in the behavior that was the reason for the initial application of the restraint." 1. Per record review Patient #1 was brought to the ED on 10/23/12, in custody of the Sheriff's department with behavioral changes, suicidal thoughts, delusional, paranoid and aggressive, homicidal thoughts. The patient was in need of a medical clearance to facilitate a involuntary inpatient psychiatric unit admission. Patient #1 remained in the ED for 11 days, during which time restraints were utilized on multiple occasions, with limited documentation to ensure least restrictive alternatives were attempted or that restraints were removed as soon as possible. In addition, Sheriff's department and hospital staff also remained present outside the patient's room throughout patient's ED admission. Staff failed to consider termination of restraint use, as per policy, as evidenced by ED Nursing notes: 10/24/12 at 23:26 "Pt released from restraints to use commode - pt very cooperative.....Pt placed back in wrist restraints...". On 10/26/12 at 09:01 (Pt calm in room.) Released from leg restraints and allowed to stand and ambulate in room...Pt released for 20 minutes, cooperative the entire time. Got back into bed and given the option of which two restraints s/he wanted applied, pt decided on leg restraints and leg restraints reapplied". 10/26/12 at 14:44 "pt. released from restraints for 15 minutes. ...pt. again cooperative....ankles placed back in restraints". 10/26/12 at 18:46 "Pt released from restraints...medications given...placed back	C 271		

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C 271	Continued From page 5 in ankle restraints. is going to try to settle down for the night". Nursing notes further state Patient #1 slept for most of the night and was cooperative when awake. During this time period Patient #1 was not posing an imminent risk of patient harming self or others nor did staff identify why the patient was continuously being placed back in restraints after being released. Per CAH policy, removal of restraint should have been considered when Patient #1 demonstrated a change in his/her behavior that was the reason for the initial application of the restraint. The hospital restraint policy also notes medical staff will order physical restraints for acute behavioral management to be limited to 4 hours for adults, followed by a reassessment by a member of the medical staff before issuing a new order. However, on 10/30/12 at 2030 an order was obtained to apply restraints on Patient #1 with the duration noted to be "until behavior resolves-maximum time before reassessment by physician is 12 hours with orders for continuation every 24 hours". This same incorrect order was renewed on 11/1/12 at 11:00. Per interview on the afternoon of 5/14/13, the ED Nurse manager confirmed ED staff failed to follow hospital policy related to the use of restraints and that medical staff orders written and accepted where not in accordance to CAH policy. 2. Per record review, Patient #2 was brought to the ED on 3/13/13 at 16:49 with a chief complaint of being anxious and depressed with a diagnosis of Schizophrenia. The patient was accompanied by police and required a medical screening for involuntary inpatient psychiatric unit admission.	C 271		

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C 271	Continued From page 6 Prior to ED admission, patient had a violent outburst and attempted assault. Although the patient was cooperative upon arrival, a nursing note timed 17:47 states " The patient was taken to room #5 s/he was cooperative and undressed putting on pt gown and pants. I discussed his/her earlier behavior and stated I wanted to put him/her into 4 pt (point) restraints. We talked about starting with 3 pt both legs and his/her left wrist. he is doing well with this." Despite not demonstrating an immediate threat to himself/herself or others, ED staff applied restraints. At 23:20 on 3/13/13 Patient #2 was released from restraints, walked to the bathroom and then placed back in 3 point restraints. Without an assessment for the reduction of restraint use or a discussion to determine the patient's ability to contract for safe behavior, Patient #2 continued to be in restraints during the night, sleeping soundly until 04:43 when patient ambulated to bathroom and once again staff reapplied restraints. At 07:59 the same process was again repeated. At 8:13 on 3/14/12 a nursing note indicates restraints were removed. A physician ordered dated 3/13/13 at 17:42 for the use of 3 point restraints provides no duration for use, which is required per CAH policy and a second order for restraints dated 3/14/13 at 02:00 describing behaviors that were a danger to self and others, however per nursing notes Patient #2 was sleeping and when awake was cooperative throughout the night and morning of 3/14/13. Per interview on the afternoon of 5/14/13, the ED nurse manager confirmed the lack of an appropriate assessment by staff to warrant the initiation and continued use of restraints for Patient #2 and least restrictive interventions were	C 271		

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C 271	Continued From page 7 not attempted. In addition, the physician orders for restraints did not reflect the CAH policy regarding the use of restraint for behavioral management.	C 271		
C 302	485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on record review and interview, the CAH failed to assure documentation completed by staff in the ED was accurate and complete. Findings include: During the course of record review on 5/13 - 5/14/13, the "Emergency Department Clinical Report -Nurse" and "Constant Observation flow sheets" it was noted nursing staff failed to consistently include the date when entries were made in both the patient electronic medical records (EMR) and the hand written observation flow sheet. The omissions of dates in both the EMR/Observation Flow sheet prevents a accurate review and sequence of patient care provided by nursing staff. It was also identified the CAH medical staff utilized the incorrect restraint order sheet. The hospital restraint policy also notes medical staff will order physical restraints for acute behavioral management to be limited to 4 hours for adults, followed by a reassessment by a member of the medical staff before issuing a new order. However, on 10/30/12 at 2030 an order was obtained to apply restraints on Patient #1 with the duration for use noted to be "until behavior	C 302		

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C 302	Continued From page 8 resolves-maximum time before reassessment by physician is 12 hours with orders for continuation every 24 hours" . Continuing to use the incorrect order form designated for non-violent patients/medical restraints , restraints were renewed on 11/1/12 at 11:00. This inaccurate charting was also noted for Patient #2. A physician order dated 3/13/13 at 17:42 for the use of 3 point restraints provides no duration for use, and a second order for restraints dated 3/14/13 at 02:00 used the same incorrect form and purpose for restraint. The deficient practice was acknowledged by the ED nurse manager on the afternoon of 5/14/13.	C 302		
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 record review and confirmed through staff interviews the CAH failed to implement, in a timely manner, corrective actions developed as the result of a recognized deficient practice regarding the use of restraints. Findings include: Per interview on the afternoon of 5/14/13 the ED nurse manager, Chief of Quality and Chief Nursing Officer acknowledged that the deficient practice regarding the use of restraints had been identified through an investigation conducted as a result of a complaint filed with the facility on	C 336		

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C 336	Continued From page 9 2/12/2013. The plan to correct included a "Checklist for Mental Health Patient" which assist both nursing and medical staff to assure all multiple tasks are completed and are incorporated in each mental health patient record. "The Violent Patient with Potential for Harm in the Emergency Department" training was also reviewed to help staff in the ED who are responsible for the safety and management of patients who present or demonstrate violent behavior. Additional interventions by the ED nurse manager also included developing a paper chart for those patients brought to the ED for medical screening during the process of a involuntary inpatient psychiatric admission. Due to the increase in ED days spent by involuntary psychiatric patients as a result placement issues, nursing staff have increased their need for documentation for medication administration and restraint use. Despite the training and re-education of ED staff and security, the use of restraints remained a deficient practice as evidenced by the use of on going restraints on 3/13/13 when Patient #2 was brought to the ED for a medical screening for involuntary inpatient psychiatric unit admission. Although prior to this ED admission, Patient #2 had a violent outburst and attempted assault, the patient was cooperative upon arrival, however the patient was placed in 3 point restraints and even offered a choice of restraint placement. Patient #2 remained in restraints throughout the evening and night of 3/13/13 and was not released until after 8:00 AM on 3/14/13. Documentation did not substantiate Patient #2 was at imminent risk of harming self or others, however ED staff failed to follow CAH policy by not releasing Patient #2	C 336		

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C 336	Continued From page 10 from restraints at the earliest possible time. This incident was not identified as a Quality Assurance/Performance Improvement opportunity to assist the CAH at further corrective actions regarding the use of restraints when not warranted. Although chart audits are being conducted to monitor specific compliance issues, nursing staff continue to not incorporate dates when documenting within the "Emergency Department Clinical Report -Nurse" and "Constant Observation flow sheets". The omissions in the charts prevents accurate assessment of compliance from staff when evaluating the timely use of restraints, reduction and ongoing monitoring of behaviors. In addition, it was also identified medical staff continue to use the incorrect restraint order form resulting in noncompliance with CAH behavioral restraint policies. Refer to Tags A- 152, 302, 271	C 336		

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Protection

Springfield Hospital
ID Number 471306
Date CMS Survey Completed 05/14/2013
Date Springfield Hospital Plan of Correction submitted 05/31/2013
Submitted by: Bob DeMarco, RN, MA, BSN, Chief of Quality

Provider Plan of Correction

SUMMARY STATE OF DEFICIENCIES (See CMS – 2567 Statement of Deficiencies for complete detail under each regulation heading.	Action Response	Measurement of compliance	Responsible	Date of Completion
C152 485.608(b) COMPLIANCE WITH STATE & LOCAL LAWS	All Emergency Department and ESNE, physician staff will be reeducated to the Patient Bill of Rights. All Emergency Department and ESNE, physician staff will be reeducated to the Springfield Medical Care System's policy entitled "Restraint and Seclusion Policy". Special focus of re-education will be towards: • Initiation of	All Emergency Department and ESNE, physician staff will be signed off for review of Patient Bill of Rights and Restraint Seclusion policies. All episodes of restraints will be reviewed daily for compliance with the Patient Bill of Rights and Restraint and	Cathy Howland, RN, BSN, Nurse Manager Rick Marasa, MD, ED Medical Director Janet Sherer, RN, BSN, MBA, Chief of Patient Care Services Bob DeMarco, RN, BSN, MA, Chief of Quality and Systems Improvement	June 14, 2013

	restraints • Reassessment for continued need of restraint • Assessing for alternatives to restraints • Assessing for least restrictive restraint • Assessing to terminate restraint • Documentation of restraint management including date and time when entries made. • Ordering of restraint to not exceed time limit expressed in Restraint and Seclusion policy • Documentation of restraint management per Restraint and Seclusion Policy All Emergency Department and ESNE, physician staff will be reeducated to the Springfield Medical Care System's order sheet entitled "Order Sheet for	Seclusion Policy utilizing the Restraint and Seclusion PI tool. Specific metrics to measure policy compliance will include: • Initiation of restraints • Reassessment for continued need of restraint • Assessing for alternatives to restraints • Assessing for least restrictive restraint • Assessing to terminate restraint • Documentation of restraint management including date and time when entries made. • Ordering of restraint to not exceed time limit expressed in		

	Non-Violent or Non-Self Destructive Patients Restraint". All Emergency Department and ESNE staff, physician will be reeducated to the Springfield Medical Care System's order sheet "Order Sheet for Violent or Self Destructive Patients Restraint". All Emergency Department staff will be reeducated to the Springfield Medical Care system's "Restraint PI Tool" The Emergency Department Manager or Section Chief will be notified of a patient in restraints/seclusion for more than 12 hours; of 2 or more separate episodes of restraints within 12 hours of any duration; and then every 24 hours afterwards for all episodes of restraints per "Restraint and	Restraint and Seclusion policy • Documentation of restraint management to include date and time per Restraint and Seclusion Policy.		

	Seclusion" Policy. All Episodes of restraints will be reviewed daily for compliance to the Restraint and Seclusion Policy utilizing the Restraint and Seclusion PI tool. Any failure to meet the standards of the Patient Rights and/or Restraint and Seclusion policy will be reported through the Event Reporting system.			
C 271 485.635(a)1) PATIENT CARE POLICIES	See response under C152			June 14, 2013
C302 RECORD SYSTEMS	See response under C152			June 14, 2013
C336 QUALITY ASSSURANCE	See response under C152 A plan has been initiated with the Windham Center psychiatric consultation to provide for a daily and as needed check in with the	Review of consultation orders and documentation.	Josh Dufresne, MBA, Chief of Practice Operations Rick Marasa, MD, ED	June 14, 2013 July 1, 2013

	Emergency Department to provide needed psychiatric consult as requested by the ED clinicians within 24 hours of admission to the Emergency Department.		Medical Director Rick Marasa, MD, ED Medical Director	
	Education will be provided to the Emergency Department Clinical Staff in regards to care of the psychiatric patient with schizophrenic and bipolar activity.	Review of attendance records and sign off.	Linda Hurly,RN, MSN, Director of Professional Development	July 1, 2013
	A meeting has occurred on May 28, 2013 with the VT Department of Mental Health and local law enforcement to discuss the management of psychiatric patients and violent psychiatric patient in the Emergency Department setting. Further focus of meeting was towards the appropriate utilization of law enforcement resources, interest and involvement of the Department of Mental		Janet Sherer, RN, MBA, BSN, Chief of Patient Care Services Cathy Howland, RN, BSN, ED Nurse Manger Rick Marasa, MD, ED Medical Director	May 28, 2013

	Health and the protection of patients and staff safety and rights.			