

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

PRINTED: 09/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471306</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/22/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SPRINGFIELD HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>PO BOX 2003</b> <b>SPRINGFIELD, VT 05156</b>
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C 000	INITIAL COMMENTS	C 000		
C2402	<p>The Division of Licensing and Protection was authorized by CMS to conduct a complaint survey on 5/21/13 through 5/22/13. The complaint, #9931 concerned an alleged violation of 42 C.F.R. 489.24, "Responsibilities of Medicare Participating Hospitals in Emergency Cases" and/or the related provisions at 42 C.F.R. 489.20. Regulatory violations were identified:</p> <p>489.20(q) POSTING OF SIGNS</p> <p>[The provider agrees,] in the case of a hospital as defined in §489.24(b), to post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital (e.g., critical access hospital) participates in the Medicaid program under a State plan approved under Title XIX.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview the Critical Access Hospital (CAH) failed to post signs in all areas specifying the rights of individuals, who present to the ED (Emergency Department)</p>	C2402		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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C2402	Continued From page 1 seeking health care services for emergency medical conditions or for women in labor. Findings include:  During tour of the Emergency Department on 5/21/13 at 10:15 AM the only EMTALA sign posting was observed in one of two patient waiting areas and in the Triage room. No other area of the department including the ambulance entrance, admitting area or treatment areas had signs posted specifying the rights of individuals with respect to examination and treatment for emergency medical conditions and women in labor. This was confirmed, at the time of tour, by the ED Nurse Manager.	C2402			
C2406	489.24(a) and 489.24(c) MEDICAL SCREENING EXAM  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  (b) If an emergency medical condition is	C2406			

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C2406	Continued From page 2 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) Nonapplicability of provisions of this section. Sanctions under this section for inappropriate transfer during a national emergency 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 located in an emergency area, as specified in section 1135(g)(1) of the Act. 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 for by 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	C2406			

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C2406	<p>Continued From page 3 have an emergency medical condition.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to assure a patient was provided a Medical Screening Exam (MSE) to determine if a emergency medical condition existed for Patient # 13. Findings include:</p> <p>1. On 3/13/13 at 13:12 Patient #13 was brought to the Emergency Department (ED) by the police and left in the patient waiting room. The patient's initial complaint was anxiety and depression with a diagnosis of Schizophrenia . Prior to arrival, the police had removed the patient from an office of HCRS (Health Care and Rehabilitation Services/the agency which provides psychiatric support and housing) after Patient #13 had tossed a chair at support staff at HCRS. Per the Emergency Department Clinical Report-Nurse notes the patient was unable to state what medications s/he was on. The nursing note states " Onset: prior to arrival. The patient has had anxiety and sleeping difficulties, describes feelings of depression and has been confused. Has been feeling agitated. Denies hallucinations". During the self harm assessment performed by the Triage nurse, Patient #13 answered "yes" to feeling "...down,depressed and hopeless".</p> <p>Per interview at 4:15 PM, the Physician Assistant (PA) confirmed s/he was working in the ED on 3/13/13 when Patient #13 was brought for treatment. S/he confirmed his/her interaction was brief with Patient #13 and became involved after hearing nurses screaming to call the Springfield</p>	C2406		

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C2406	<p>Continued From page 4</p> <p>Police Department (SPD). The PA stated s/he got up from a desk and walked around a corner and saw the patient standing in the doorway holding the collar of the security guard. The PA stated s/he attempted to calm Patient #13, asking him/her what was happening and placed a hand on the patient's chest meanwhile the patient continued to draw back his/her fist at the security guard. The PA further stated s/he grabbed the patients free arm and twisted behind the patient's back and placed the patient prone on the floor. The patient eventually went limp and the SPD arrived, got the patient up on a stretcher and 4 point restraints applied.</p> <p>The PA stated as soon as the patient was restrained, s/he choose to relieve himself/herself from further care of Patient #13, fearing his/her presence would escalate the patient's behaviors. When asked if another member of the ED medical staff conducted a MSE for Patient #13, the PA thought another member of the medical staff may have screened the patient but was unsure. The PA also confirmed s/he had not reviewed the patient's record (nursing and Triage notes) prior to his/her interaction with Patient #13. After a discussion with other ED staff including the Nurse Manager it was decided to press charges and allow the police to detain Patient #13 at a correctional facility..</p> <p>Although Patient #13 responded readily when restrained by the PA and security guard and shortly after by the SPD, the PA stated s/he was not sure why the patient did not remain in the ED, treated with emergency medications and provided a crisis screening. S/he stated in their opinion, the patient had committed a criminal act of assault and thus it was determined s/he should</p>	C2406		
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C2406	Continued From page 5 be discharged and removed by the police. The PA stated he had not been aware of the patient's diagnosis of Schizophrenia.  When asked if s/he felt a MSE was conducted to determine if Patient #13 was experiencing a emergency medical condition, the PA agreed a MSE was not conducted. Patient #13 was cited for a simple assault but was returned to the ED within 3 hours when a judge refused to allow Patient #13 to be incarcerated and ordered the patient to return to the hospital ED for evaluation. Upon Patient #13's second admission on 3/13/13 a MSE was conducted. The Emergency Evaluation for Involuntary Admission to a inpatient psychiatric unit states Patient #13 as lacking insight, danger to self and others, delusional and paranoid and required hospitalization.  In addition, per CAH policy titled Patients Seeking Care in the Emergency Department approved 4/16/12 states: "...all patients presenting to Springfield Hospital Emergency Department who request examination and/or treatment for a medical condition must be provided with a Medical Screening Exam by a qualified practitioner. A Medical Screening exam is defined by law to mean a medical history, physical exam and diagnostic evaluation sufficient to determine if an emergent medical condition exists. Triage of the patient does not met the criteria of a medical screening. This policy includes all patients.....".	C2406		
C2407	489.24(d)(1-3) STABILIZING TREATMENT  (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	C2407		

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C2407	<p>Continued From page 6</p> <p>that the individual has an emergency medical condition, the hospital must provide either-</p> <p>(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.</p> <p>(ii) For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section.</p> <p>(2) Exception: Application to inpatients.</p> <p>(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</p> <p>(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.</p> <p>(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.</p> <p>(3) Refusal to consent to treatment.</p> <p>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</p>	C2407		
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C2407	Continued From page 7 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 staff interview and record review, the CAH failed to stabilize an emergency medical condition prior to discharge for 1 of 20 patients. (Patient #15) Findings include:  Patient #15 arrived in the ED on 3/4/13 at 21:26 on an involuntary warrant for possible inpatient psychiatric hospitalization. The patient's chief complaint was depression, hallucinations, delusions and bizarre behavior and had a past history of Paranoid Schizophrenia and Bipolar Disorder. Patient #15 was brought via EMS after threatening a case worker from HCRS. The nursing assessment describes the patient as "...disoriented to place, time and situation...behavior is abnormal, including paranoid behavior and having apparent visual hallucinations. Appears animated...has abnormal breath sounds (expiratory wheezing throughout)". The patient has a past medical history of COPD; O2 SATs were 91% on room air. Although the first medical screening exam by the ED Medical Director stated the patient's lungs were "clear", the patient received Albuterol nebulizer treatment	C2407			

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C2407	<p>Continued From page 8</p> <p>and also Advair Discus inhaler. On 3/5/13 at approximately 10:30 AM upon return from the bathroom, Patient #15 accessed the Physician Assistant's office and threw coffee at computer equipment.. The patient then walked away and returned to his/her assigned room and was cooperative. The "Crisis Evaluation/Screening" report by HCRS staff on 3/4/13 states prior to ED first admission, Patient #15 "...engages in several delusions, and yells and sings. Patient attempting to get police to shoot him or cut off his head". Patient #15's mental status "flow of thought" was described as "psychotic" with "poor insight" and "poor judgement".</p> <p>However, because the coffee destroyed 2 computers, the decision was made by the ED Medical Director and staff to press charges. The police were contacted resulting in Patient #15 charged with Criminal Mischief and Disorderly Conduct and discharged from the ED, despite the fact the patient was experiencing a psychiatric emergency medical condition necessitating involuntary inpatient psychiatric hospitalization. The patient was not stable physically or mentally at the time of his/her first discharge from Springfield Hospital to jail on 3/5/13.</p> <p>Seven hours after being removed from the ED, the patient is returned to the ED at 18:48 on 3/5/13 after a court appearance and continuing to demonstrate a need for psychiatric intervention. Per the Triage Nurse's note: "Appears animated (patient bouncing back and forth between topics)". Also noted again were decreased breath sounds bilaterally, "...especially right mid and lower". The patient was placed on 1:1 with 2 sheriffs present. Patient was seen by Respiratory Therapist for a respiratory inhalation treatment at</p>	C2407		

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C2407	<p>Continued From page 9</p> <p>21:15 on 3/5/13 and with chest x-ray results Patient #15 was diagnosed with pneumonia and was placed on Levofloxacin (antibiotic).</p> <p>The PA notes on Patient # 15's second admission on 3/5/13 the patient has "a moderate cough productive of moderate amounts of green sputum...." Also noting the patient had bouts of hypoxemia (abnormal deficiency in concentration of oxygen in arterial blood). At 23:55 Nursing note states patient 's O2 SATs is 85% on room air and the patient was placed on nasal O2 @ 2L. On 3/6/13 at 02:30 the patient's B/P is 93/63 HR 70, O2 SATs again 88% on room air. Nsg. Note states: " Pt awake, stating " I feel strange, a little dizzy " At 3/6/13 06:30 B/P 0/47 HR 97 O2 SATs 83%, oxygen reapplied, O2 up to 92% on 2 liters.</p> <p>Per interview on 5/23/13 at 2:10 PM, the Medical Director for the ED confirmed s/he did the initial Medical Screening Exam on 3/4/13, Patient #15's first ED admission. The ED Medical Director stated s/he had auscultated the patient's lungs and in his/her note described the patient's lungs as "clear". S/he stated Patient #15 had previously been on an inhaler and that is why s/he prescribed the patient to continue with this treatment. S/he further stated ED staff reported to him/her on 3/5/13 after the coffee incident, that Patient #15 was not "homicidal and /or suicidal...s/he was considered stable". As a result, despite the Crisis screening evaluation, and patient's active psychosis, the ED Medical Director agreed to have the patient charged with destruction of hospital property and removed from the ED. And in addition, per the Medical Director's "Clinical Impression" written on 3/4/13 Patient #15 was experiencing a "Exacerbation of bipolar disorder (manic state) after a warrant for</p>	C2407		

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C2407	Continued From page 10 an immediate exam was ordered and it was later determined the patient was in need of inpatient psychiatric hospitalization". Further interview on 5/23/13 at 10:10 AM, the ED Medical Director commented on the incident involving Patient # 15 stating s/he "... know right from wrong".	C2407		
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