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PRINTED: 06/10/2013
FORM APPROVED
OMB NO. 0938-0391

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

JUN 24 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED C 05/23/2013
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 INITIAL COMMENTS

C 000

See attached Plan of Correction.

An unannounced onsite complaint investigation was conducted on 5/21/13 through 5/23/13 by the Division of Licensing and Protection. Based on information gathered, the CAH was determined not to be in compliance with Conditions of Participation for Federal, State and Local laws, Emergency Services and the Provision of Services.

C 150 485.608 COMPLIANCE WITH FEDERAL, STATE, & LOCAL LAWS

C 150

The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations.

This CONDITION is not met as evidenced by:
The following requirements under the Condition of Participation: Compliance with Federal, State, and Local laws relative to Title 18, Chapter 42, Bill of Rights for Hospital Patients, were determined not to be met.

1. Failure to provide each patient with the right to considerate and respectful care at all times and under all circumstances with recognition of his or her personal dignity." Refer to C-0152

2. The patient has the right to refuse treatment to the extent permitted by law. In the event the patient refuses treatment, the patient shall be informed of the medical consequences of that action and the hospital shall be relieved of any further responsibility for that refusal." Refer to C-0152

C 152 485.608(b) COMPLIANCE WITH STATE & LOCAL LAWS

C 152

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

TITLE

(X8) DATE

ACTING LRO

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	<p>Continued From page 1</p> <p>All patient care services are furnished in accordance with applicable State and local laws and regulations.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, the hospital failed to be in compliance with State of Vermont Statute Title 18, Chapter 42: Bill of Rights for Hospital Patients for 2 applicable patients. (Patient # 19, 20). Findings include:</p> <p>1. Per State Statute 1852. Patients' Bill of Rights for Hospital Patients: "(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."</p> <p>Per record review Patient #19, who presented to the ED (Emergency Department) on 5/8/13, and remained there on involuntary status, awaiting bed placement in an inpatient psychiatric unit, was treated in a disrespectful and undignified manner on two separate occasions, both involving the administration of scheduled oral medications. A nurse's note, dated 5/13/13 at 8:50 PM, indicated that Patient #19 had asked for scheduled medications and then refused to take the meds when Nurse #1 attempted to administer them. The note stated Nurse #1 "told [patient] I was going to get [his/her] meds in IM [intramuscular] form and [s/he] could have them that way, at which point [s/he] decided that [s/he] could take them orally."</p> <p>During interview, on the afternoon of 5/23/13, the Director of Patient Care Services agreed that Nurse #1's response to the patient's initial refusal</p>	C 152		

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C 152	<p>Continued From page 2</p> <p>to take PO [oral] meds was disrespectful and could be perceived as intimidating.</p> <p>A nurse's note, dated 5/19/13 at 11:20 AM, indicated that at 10:20 AM, that morning, the 'pt had escalated when RN had attempted to administer all meds. Pt was keeping meds in [his/her] mouth and became combative when the RN had to pinch nose to get pt to swallow meds. Pt was upset when RN had "outsmarted" [him/her]...s/he stated after "I was just playing, it was a game " Pt then was swinging (punching) at RN then grabbing at my waist.... attempted to hit my back as I was exiting the room.... was following me out of the room swinging." The sheriffs that were outside the door then intervened, holding [patient] as [s/he] began to curse and swing at all people around....then threw [himself/herself] onto the floor, and was banging [his/her] head onto the floor.' The note further indicated the patient began kicking and biting at staff, and subsequently had a spit hood as well 4 point restraints applied. In addition, the patient also received intranasal and intramuscular involuntary medications.</p> <p>During interview, at 8:20 AM on the morning of 5/23/13, Nurse #2, who had been responsible for the care of Patient #19 at the time of the incident, stated s/he had been told during report on the morning of 5/19/13 that Patient #19 was court ordered to be there, that 2 sheriffs were there, that the patient could be combative and that the patient had the mentality of a young child and should be treated like a pediatric patient. The nurse stated s/he had given the patient her scheduled PO (by mouth) medications in the morning and the patient had taken them without</p>	C 152	

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C 152	<p>Continued From page 3</p> <p>incident. However the nurse had to administer two other medications and when s/he did so the patient took the meds and "puffed" her cheeks out, making the nurse question whether or not the medications had been swallowed. S/he stated the patient giggled and shook his/her head when questioned if s/he had swallowed the medications and the nurse decided to "pinch" the patient's nose to induce a swallow reflex. Nurse #2 also stated that s/he did not fully understand what involuntary hospitalization status meant and thought it included that the patient had to take all his/her meds. The nurse stated that s/he had enlisted the help of a sheriff, who was present in the room, and told him/her to make sure the patient didn't swing at the nurse during the action of pinching his/her nose. Nurse #2 further stated that s/he felt the act of pinching the patient's nose was directly related to the patient's subsequent angry outburst and subsequent need for physical and chemical restraints. The ED Nurse Manager and the Director of Patient Care Services both confirmed, during interview on the afternoon of 5/23/13, that the nurse's action had been inappropriate.</p> <p>2. ED staff failed to maintain the rights of a psychiatric patient who was actively psychotic by failing to provide "...considerate and respectful care at all times and under all circumstances with recognition of his or her personal dignity." as per State Statute 1852. Patients' Bill of Rights for Hospital Patients. Per record review, 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 complaints were Depression, hallucinations, delusions, and bizarre behavior and had a past</p>	C 152	

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C 152 Continued From page 4
history of Paranoid Schizophrenia and Bipolar Disorder.

Patient #15 was brought via EMS after threatening a case worker from HCRS (Health Care and Rehabilitation Services). 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.....". 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 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". At the time of the Medical Screening Exam conducted by the ED Medical Director, the physician's "Clinical Impression" of Patient # 15 written on 3/4/13 states "Exacerbation of bipolar disorder (manic state) after a warrant for an immediate exam was ordered and it was later determined (the patient) was in need of inpatient psychiatric hospitalization".

However, because the coffee destroyed 2 computers, the decision was made by the ED Medical Director and staff to press charges. As a result, despite the Crisis screening evaluation, and patient's active psychosis, the ED Medical

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C 152	<p>Continued From page 5</p> <p>Director agreed to have the patient charged with destruction of hospital property and the patient was discharged from the ED and brought to jail.. Further interview on 5/23/13 at 10:10 AM, the ED Medical Director in defense of discharging Patient #15 to police, commented on the incident involving Patient # 15 stating s/he "... know right from wrong".</p> <p>3. Per State Statute 1852. Patients' Bill of Rights for Hospital Patients: " (5) The patient has the right to refuse treatment to the extent permitted by law. In the event the patient refuses treatment, the patient shall be informed of the medical consequences of that action and the hospital shall be relieved of any further responsibility for that refusal."</p> <p>Per record review, Patient #20 was brought to the ED on 5/1/13 with a chief complaint of being in need of a medical clearance for a potential involuntary inpatient psychiatric admission. The patient's past history includes Bipolar Disorder. Per the "Application for Warrant for Immediate Exam" for 5/1/13, Patient #20 was "...paranoid, angry, delusional and manic". Per "Emergency Department Physician/PA Clinical Report", The PA states " PT refused to get out of street clothes. S/he is yelling in the doorway and refusing labs and all work up...s/he was placed in restraints." The Order Sheet for Violent or Self-Destructive Patient Restraint signed by the PA for 4 point restraints states at 1855 on 5/1/13 "...won't allow labs and other required test." Although the patient has a right to refuse treatment, specifically having labs drawn, CAH ED staff provided no options or discussed medical consequences of Patient #20's actions</p>	C 152			

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C 152	Continued From page 6 when refusing to have blood drawn for testing.	C 152		
C 200	485.618 EMERGENCY SERVICES	C 200		

The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.

This CONDITION is not met as evidenced by: Based on observations, interviews and record review the Condition of Participation for Emergency Services was not met as evidenced by:

The CAH Emergency Services failed to provide care and services in accordance with hospital policies and procedures and compliance with State and Local laws for 2 of 13 applicable patients. (Patients # 15 and 20) Findings include:

1. Per State Statute 1852. Patients' Bill of Rights for Hospital Patients: " (5) The patient has the right to refuse treatment to the extent permitted by law. In the event the patient refuses treatment, the patient shall be informed of the medical consequences of that action and the hospital shall be relieved of any further responsibility for that refusal." and CAH Patient Rights and Responsibilities approved 10/13/11 F). " Participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment."

Per record review, Patient #20 was brought to the ED on 5/1/13 with a chief complaint of being in need of a medical clearance for a potential involuntary inpatient psychiatric admission. The

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C 200	<p>Continued From page 7</p> <p>patient's past history includes Bipolar Disorder. Per the "Application for Warrant for Immediate Exam" for 5/1/13, Patient #20 was "...paranoid, angry, delusional and manic". Per "Emergency Department Physician/PA Clinical Report", The PA states "PT refused to get out of street clothes. S/he is yelling in the doorway and refusing labs and all work up...s/he was placed in restraints." The "Order Sheet for Violent or Self-Destructive Patient Restraint" signed by the PA for 4 point restraints states at 1855 on 5/1/13 "...won't allow labs and other required test." Although the patient has a right to refuse treatment, specifically having labs drawn, CAH ED staff provided no options or discussed medical consequences of Patient #20's actions when refusing to have blood drawn for testing. In addition, per CAH's Restraint and Seclusion Policy approved 1/10/2013 states "The Registered Nurse and PA-Cs in the Emergency Department are responsible forProtecting and preserving the patient's rights, dignity and well-being".</p> <p>2. ED staff failed to maintain the rights of a psychiatric patient who was actively psychotic by failing to provide "...considerate and respectful care at all times and under all circumstances with recognition of his or her personal dignity." as per State Statute 1852. Patients' Bill of Rights for Hospital Patients. Per record review, 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</p>	C 200		

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C 200	Continued From page 8 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 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". 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. Seven hours after being removed from the ED,	C 200		
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C 200	<p>Continued From page 9</p> <p>the patient is returned to the ED at 18:48 on 3/5/13 after a court appearance. 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 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 90/47 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</p>	C 200			

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C 200 Continued From page 10
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, despite the Medical Director's "Clinical Impression" written on 3/4/13 stating Patient #15 was experiencing a "Exacerbation of bipolar disorder (manic state) after a warrant for 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".

C 200

C 221 Refer also to C-0271
485.623(a) CONSTRUCTION

C 221

The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of direct services.

This STANDARD is not met as evidenced by:
Based on observation and staff interview, the CAH failed to ensure the Emergency Department was constructed, arranged and maintained to ensure access to and safety of patients and provides adequate space for the provision of direct services. Findings include:

During the course of observations in the ED from 5/21/13 through 5/23/13, equipment was observed cluttering hallways, adequate private space for the provision of direct care services for

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C 221	Continued From page 11 patients receiving treatment was limited with observation of patients sitting on stretchers without the benefit of a privacy curtain and within direct observation of other patients. Cabinets and carts with obsolete equipment/supplies stored in locations where the provision of care was being provided or public access. Adult and pediatric code carts soiled with dust and the required daily monitoring of code cart equipment by ED staff not being performed. The ED Nurse Manager confirmed on the morning of 5/21/13 that checks had not been completed, on a daily basis, in accordance with the policy and acknowledged multiple areas within the ED were compressed and cluttered with equipment with limited space for the provision of patient care.	C 221		
C 225	485.623(b)(4) MAINTENANCE [The CAH has housekeeping and preventive maintenance programs to ensure that- the premises are clean and orderly; This STANDARD is not met as evidenced by: Based on observation and interview, the CAH failed to assure the equipment and premises within the Emergency Department were kept clean and orderly. Findings include: During a tour of the ED on 5/21/13 at 10:05 AM the following observations were made and confirmed by the ED Nurse Manager: 1. The Adult Code Cart located in a patient treatment area was found to have dust on top of the cart along with equipment located on top of	C 225		

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C 225 Continued From page 12
the cart. The area where the Code Cart was stored was compressed and cluttered.
2. Hanging on the wall at the head of patient stretchers were plastic bags containing rubber nasal airways. The bags were soiled with dust and nasal airways protruding through holes in the plastic bags were also soiled with dust.
3. On the Pediatric Code Cart a used syringe was resting on top of the opening to the biohazard sharps container along with a used blood culture adapter.

C 225

C 270 485.635 PROVISION OF SERVICES

C 270

Provision of Services

This CONDITION is not met as evidenced by:
Based on staff interview and record review the Condition of Participation: Provision of Services was not met as evidenced by:

The CAH failed to assure that care was provided in accordance with established Policies and Procedures. Refer to Tag C-0271

The CAH pharmacy department failed to ensure all drugs were stored and secured in all CAH locations to include the Emergency Department (ED). Refer to Tag C-0276

The CAH failed to assure environmental surfaces and patient bedside equipment in the Emergency Department remains clean and staff consistently disposed of contaminated needles and syringes. Refer to Tag C-0278

The CAH nursing services failed to ensure education and training was sufficient and ongoing

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C 270	Continued From page 13 to meet the needs of psychiatric patients receiving care and services in the ED. Refer to Tag C-0294	C 270		
C 271	485.635(a)(1) PATIENT CARE POLICIES	C 271		

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 record review and confirmed through staff interviews the CAH failed to assure that care was provided in accordance with established Policies and Procedures for 4 of 13 patients. (Patients #13, 15, 19, 20). Findings include:

1. Per review, the CAH's Restraint and Seclusion Policy, with an approval date of 1/10/2013 and identified by staff as the currently used policy, stated under Methods of Restraint and Application of Restraint: Handcuffs: 1. Handcuffs are only applied by Police Officers/Correctional Officers for Patients in their custody. Under Restraint and Seclusion Procedure for Violent and Self - Destructive Patient (formerly known as Acute Behavioral Management): A. Restraint for the violent and self-destructive patient will ONLY be used in an emergency situation if needed to ensure the patient's physical safety AND only if less restrictive interventions have been found to be ineffective to protect the patient and others from harm; B. Restraint for the violent and self-destructive patients is an emergency measure to be taken ONLY when unanticipated, severely aggressive or destructive behavior takes place. Assessment for early release of the violent and self-destructive patient: B. Reduction or

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C 271	<p>Continued From page 14</p> <p>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. C. Assessment should include: 2. if the behavior has decreased so that the risk to the patient and others is no longer present, the restraint may be removed.</p> <p>Per record review Patient #19, who presented to the ED (Emergency Department) on 5/8/13, and remained there on involuntary status, awaiting bed placement in an inpatient psychiatric unit, was subjected to involuntary procedures, including application of handcuffs and leg cuffs, as a result of an action that occurred by nursing during administration of oral medications, and was not released from restraints at the earliest possible time in accordance with the facility's Policy and Procedures. A nurse's note, dated 5/19/13, indicated that at 10:20 AM that morning, Patient #19 had escalated when Nurse #2 had attempted to administer scheduled oral medications. The note stated, "Pt was keeping meds in [his/her] mouth and became combative when the RN had to pinch nose to get pt to swallow meds. Pt was upset when RN had "outsmarted" [him/her]"and had stated...."I was just playing, it was a game"...then was swinging (punching) at RN.....grabbing at my waist.....attempted to hit my back as I was exiting the room.....following me out of the room swinging....The sheriffs that were outside the door then intervened, holding [patient] as [s/he] began to curse and swing at all people around[him/her], [s/he] then threw [himself/herself] onto the floor, and was banging [his/her] head onto the floor." The note further stated the patient began kicking and biting at staff, and "(Pt was placed in</p>	C 271		

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C 271	<p>Continued From page 15</p> <p>handcuffs and leg cuffs)". The record indicated the patient also had a spit hood applied, and received intranasal and intramuscular (IM) involuntary medications. There was no evidence in the record that Patient #19 was in police custody, warranting the need for use of handcuffs or leg cuffs in accordance with the stated policy, at the time of the incident. The order for use of 4 point restraints indicated they were applied at 10:30 AM and released at 12:36 PM. Despite the fact that there was no evidence that the patient continued to pose a threat of immediate danger to self or others and despite documentation, at 10:45 AM, that indicated the patient was "cooperative after medications" the patient remained in 4 point restraints for a period of approximately 2 hours.</p> <p>During interview, at 8:20 AM on the morning of 5/23/13, Nurse #2, who had been responsible for the care of Patient #19 at the time of the incident, stated s/he had been told during report on the morning of 5/19/13 that Patient #19 was court ordered to be there, that s/he had the mentality of a 4 year old and should be treated like a pediatric patient. Nurse #2 also stated that s/he did not fully understand what involuntary hospitalization status meant and thought it included that the patient had to take all his/her meds. The nurse confirmed that, s/he had used a technique to "pinch" the nose of Patient #19 to elicit a swallow reflex during administration of some PO (by mouth) medications because there was a question in mind about whether the patient had swallowed his/her meds. The nurse stated that s/he had enlisted the help of a sheriff, who was present in the room, and told him/her to make sure the patient didn't swing at the nurse during</p>	C 271		

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C 271	<p>Continued From page 16</p> <p>the act of pinching his/her nose. Nurse #2 further stated that after pinching the patient's nose, the patient became angry and assaultive towards staff and engaged in self - harming behavior, which led to the administration of chemical restraints and the application of physical restraints. The nurse confirmed that handcuffs and leg cuffs had been applied at some point and stated s/he did not know why they were used. S/he stated the patient had been cooperative with the removal of handcuffs and leg cuffs and replacement with soft restraints. Nurse #2 further stated that the patient's behavior calmed shortly after the administration of involuntary meds and that, although the patient at times cried and expressed remorse for his/her actions, s/he remained cooperative until all restraints were removed at 12:36 PM. The Director of Patient Care Services confirmed, during interview on the afternoon of 5/23/13, that handcuffs and leg cuffs should only be applied by law enforcement personnel for patients in their custody.</p> <p>2. 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 (MSE) by a qualified practitioner. A MSE 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....."</p> <p>However, on 3/13/13 at 13:12 Patient #13 was</p>	C 271		

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C 271	Continued From page 17 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 a 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 documents 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". 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 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 s/he 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.	C 271		

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C 271 Continued From page 18

The patient eventually went limp and the SPD arrived, got the patient up on a stretcher and 4 point restraints applied.

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 Medical Screening Exam (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.

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 be discharged and removed by the police. The PA stated s/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, as required per CAH policy and Federal regulation, the PA agreed a Medical Screening Exam was not

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C 271	<p>Continued From page 19</p> <p>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.</p> <p>2. Per State Statute 1852. Patients' Bill of Rights for Hospital Patients: " (5) The patient has the right to refuse treatment to the extent permitted by law. In the event the patient refuses treatment, the patient shall be informed of the medical consequences of that action and the hospital shall be relieved of any further responsibility for that refusal." and CAH Patient Rights and Responsibilities approved 10/13/11 " F). Participate actively in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to refuse treatment."</p> <p>Per record review, Patient #20 was brought to the ED on 5/1/13 with a chief complaint of being in need of a medical clearance for a potential involuntary inpatient psychiatric admission. The patient's past history includes Bipolar Disorder. Per the "Application for Warrant for Immediate Exam" for 5/1/13, Patient #20 was "...paranoid, angry, delusional and manic". Per Emergency Department Physician/PA Clinical Report, the PA states " PT refused to get out of street clothes. S/he is yelling in the doorway and refusing labs and all work up...s/he was placed in restraints." The "Order Sheet for Violent or Self-Destructive</p>	C 271		

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C 271	<p>Continued From page 20</p> <p>Patient Restraint" signed by the PA for 4 point restraints states at 1855 on 5/1/13 "...won't allow labs and other required test." Although the patient has a right to refuse treatment, specifically having labs drawn, CAH ED staff provided no options or discussed medical consequences of Patient #20's actions when refusing to have blood drawn for testing. In addition, per CAH's Restraint and Seclusion Policy approved 1/10/2013 states "The Registered Nurse and PA-Cs in the Emergency Department are responsible forProtecting and preserving the patient's rights, dignity and well-being".</p> <p>3. CAH Patient Rights and Responsibilities approved 10/13/11 states ".... the patient's right to: Considerate and respectful care with consideration of his or her personal values and beliefs". However, Patient #15, treated in the ED on 3/4/13 at 21:26 on a involuntary warrant for possible inpatient psychiatric hospitalization, was not provided considerate and respectful care. 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 ". 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"</p>	C 271		

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C 271	Continued From page 21 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". 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. Per the Medical Directors "Clinical Impression" written on 3/4/13 Patient #15 was experiencing a "Exacerbation of bipolar disorder (manic state) after a warrant for 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". Subsequently the patient was returned to the ED 7 hours later by police still in need of psychiatric services and intervention.	C 271	
C 276	485.635(a)(3)(iv) PATIENT CARE POLICIES [The policies include the following:] rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.	C 276	

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C 276	<p>Continued From page 22</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the CAH pharmacy department failed to ensure all drugs were stored and secured in all CAH locations to include the Emergency Department (ED). Findings include:</p> <ol style="list-style-type: none"> 1. During a tour of the Emergency Department, on 5/21/13 at 10:35 AM, an open bottle of Nitrostat 0.4 mg (a cardiovascular medication) was found stored on an unsecured cart within a patient treatment area accessible to any unauthorized individual. The ED Nurse Manager, who was present at the time, confirmed the observation, and stated the drug should not have been stored in an unsecured location. 2. Per interview on 5/23/13 at 8:20 AM, Nurse #2 stated that on 5/19/13 s/he had taken scheduled medications for administration to Patient #19, from a zip lock bag stored, unsecured, inside the patient's medical chart which was located on a counter at the nurse's station in the ED (Emergency Department). The nurse stated the medications are supplied, on a daily basis in a zip lock bag, by pharmacy for the patient, who had arrived at the ED on 5/8/13 and remained there awaiting involuntary bed placement at an inpatient psychiatric unit. During interview, at 2:02 PM, the Director of Pharmacy services confirmed that medications for Patient #19, which included Lamotrigine (anti-seizure drug), Ondansetron (anti - nausea drug) and Sertraline (antidepressant) were supplied to the ED on a daily basis and stated 	C 276		

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C 278	<p>Continued From page 24</p> <p>[The policies include the following:]</p> <p>a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the CAH failed to assure environmental surfaces and patient bedside equipment in the Emergency Department remains clean and staff consistently disposed of contaminated needles and syringes. Findings include:</p> <p>During a tour of the ED on 5/21/13 at 10:05 AM the following observations were made and confirmed by the ED Nurse Manager:</p> <ol style="list-style-type: none"> 1. The Adult Code Cart located in a patient treatment area was found to have dust on top of the cart along with equipment located on top of the cart. 2. Hanging on the wall at the head of patient stretchers were plastic bags containing rubber nasal airways. The bags were soiled with dust and nasal airways protruding through holes in the plastic bags were also soiled with dust. 3. On the Pediatric Code Cart a used syringe was resting on top of the opening to the biohazard sharps container along with a used blood culture adapter. 	C 278		
C 294	<p>485.635(d) NURSING SERVICES</p> <p>Nursing services must meet the needs of patients.</p> <p>This STANDARD is not met as evidenced by:</p>	C 294		

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

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FORM APPROVED
OMB NO. 0938-0391

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 C 05/23/2013
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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
C 294	<p>Continued From page 25</p> <p>Based on observations, interview and record review, the CAH nursing services failed to ensure education and training was sufficient and ongoing to meet the needs of psychiatric patients receiving care and services in the ED. Findings include:</p> <p>During the course of interviews throughout the days of complaint investigation, Staff were unable to provide evidence of specific training related to the management and treatment of patients with psychiatric disorders. Training for ED staff in the management, techniques and skills for recognizing and assisting with addressing patients with aggressive behaviors has been limited. Last training noted was in November/2011. In addition, staff had limited understanding of the rights of patients who receive care and services under an involuntary status.</p> <p>Per interview on 5/23/13 at 8:20 AM, Nurse #2 stated s/he was under the assumption when a psychiatric patient is held in the ED under an involuntary status, scheduled medications could be forced. Nurse #2 also stated that s/he did not fully understand what involuntary hospitalization status meant and thought it included that the patient had to take all his/her scheduled medications. ED Nurse #3 also stated, during interview at 12:27 PM on 5/23/13, that s/he was "not sure" if patients with involuntary status had the right to refuse medication. A nurse's note, dated 5/13/13 at 8:50 PM, indicated that Patient #19 had asked for scheduled medications and then refused to take the meds when Nurse #1 attempted to administer them. The note stated Nurse #1 "told [patient] I was going to get [his/her]</p>	C 294		

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C 294	<p>Continued From page 26</p> <p>meds in IM [intramuscular] form and [s/he] could have them that way, at which point [s/he] decided that [s/he] could take them orally." During interview, on the afternoon of 5/23/13, the Director of Patient Care Services agreed that Nurse #1's response to the patient's initial refusal to take PO meds was disrespectful and could be perceived as intimidating.</p> <p>Also noted was the lack of compliance and understanding of CAH policies and procedures and State law regarding the rights of patients during the use of restraints. This included restraining patients after they have refused treatment and conducting testing that has been refused by the patient. In addition, restraints were utilized by nursing staff for extended periods of time beyond the necessity for use.</p> <p>Refer to Tags: C-0152, 0200, 0271</p>	C 294	

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 Date Springfield Hospital Plan of Correction submitted 06/17/2013
 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
C150.152 485.608 COMPLIANCE WITH STATE & LOCAL LAWS	All Emergency Department and ESNE, physician staff will be reeducated to the VT Statue 1852 Patient Bill of Rights. Special focus and re-education will be towards providing patients: <ul style="list-style-type: none"> • Considerate and respectful care at all times and under all circumstances with recognition of his or her personal dignity. • The right to refuse treatment to the extent 	All Emergency Department and ESNE, physician, PA staff will be signed off for review of Patient Bill of Rights and Restraint Seclusion policies.	Cathy Howland, RN, BSN, ED Nurse Manager Rick Marasa, MD, ED Medical Director Janet Sherer, RN, BSN, MBA, Chief of Patient Care Services	June 14, 2013

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	<p>permitted by law. All Emergency Department and ESNE, physician staff will be reeducated to the Springfield Medical Care System's policy entitled "Restraint and Seclusion Policy".</p> <p>Special focus of re-education will be towards:</p> <ul style="list-style-type: none">• Initiation of restraints• Reassessment for continued need of restraint• Assessing for alternatives to restraints• Assessing for least restrictive restraint• Assessing to terminate restraint• Not restraining a patient who has refused a treatment or procedure to provide that treatment or procedure.• Understanding voluntary, involuntary, warranted, unwarranted.			
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	<p>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 Seclusion" Policy.</p> <p>All Episodes of restraints will be reviewed daily for compliance to the Restraint and Seclusion Policy utilizing the Restraint and Seclusion PI tool.</p> <p>Any failure to meet the standards of the Patient Rights and/or Restraint and Seclusion policy will be reported through the Event Reporting system.</p>	<p>All episodes of restraints will be reviewed daily for compliance with the Patient Bill of Rights and Restraint and Seclusion Policy utilizing the Restraint and Seclusion PI tool. Specific metrics to measure policy compliance will include:</p> <ul style="list-style-type: none">• Initiation of restraints• Reassessment for continued need of restraint• Assessing for alternatives to restraints• Assessing for least restrictive restraint• Assessing to terminate restraint		
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	<p>A Medical Screening will be performed for all patients being evaluated in the Emergency Department.</p> <p>No patient will be removed to a law enforcement facility unless charged with a crime, medical screening has occurred and a clinical determination is made that individual does not meet Emergency Evaluation (EE) criteria.</p>	<p>All ED medical records are reviewed for completion of a Medical Screening.</p> <p>All occurrences of patient removal to law enforcement facility are reviewed.</p>		
<p>C 220 485.618 EMERGENCY SERVICES</p>	<p>See response under C150</p>			
<p>C 221 485.623(a) CONSTRUCTION</p>	<p>2 stretchers, bed spaces 10,11 adjacent to ambulance entry door will be permanently removed.</p> <p>Code carts will occur per policy.</p>	<p>All beds will be provided with 100% availability for privacy curtains/screens.</p> <p>Adult and Pediatric Code Carts will be reviewed daily for check completion by the Nurse Manger or delegate.</p>	<p>Cathy Howland, RN, BSN, ED Nurse Manager</p>	<p>June 21, 2013</p>

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	Emergency Department will be free of dust and hallway clutter.	Area cleaning will be surveyed daily by the Nurse Manager or delegate and weekly by the Housekeeping Supervisor.	Cathy Howland, RN, BSN, ED Nurse Manager Julie Snide, Director of Housekeeping	June 14, 2013
C224 485.623(b)(4) MAINTENANCE	See response under C221 All sharps, blood culture adapters will be disposed of in a biohazard sharps container.	Daily survey by Nurse Manger or delegate	Cathy Howland, RN, BSN, ED Nurse Manager	June 14, 2013
C270 485.635 PROVISION OF SERVICES	See response under C221 All drugs will be maintained in secured locked areas. Education will be developed and provided to the Emergency Department Clinical Staff in regards to care of the psychiatric patient with schizophrenic and bipolar activity.	All drugs are secured at all times. Review of attendance records and sign off. Ongoing support and education for management of	Cathy Howland, RN, BSN, ED Nurse Manager Bob Baier, Director of Pharmacy Linda Hurley, RN, MSN, Director of Professional Development Todd Miller, MD Jim Walsh, NP	June 21, 2013 June 14, 2013 July 1, 2013 June 17, 2013

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		patients with psychiatric diagnosis will be provided for by Windham Center Clinical staff via on call consulting and daily check in. Educational materials related to management of patients with psychiatric patients in the ED setting have been developed and introduced to the ED staff.	C. Howland, RN, BSN, ED Nurse Mansger	June 17, 2013
C271 485.635(a)(1) PATIENT CARE POLICIES	See response under C150 & C270			
C276 485.635(a)(3)(iv) PATIENT CARE SERVICES	See responses under C221 & C270			
C278 PATIENT CARE POLICIES 485.635(a)(3)(vi)	See responses under C221 & C270			

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C294 485.635(d) NURSING SERVICES	See responses under C150, & C270			
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