

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

August 19, 2014

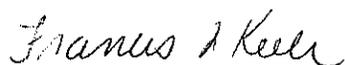
Mr. Timothy Ford,
Springfield Hospital
Po Box 2003
Springfield, VT 05156-2003

Dear Mr. Ford:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 8, 2014**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



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

FK:jl



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

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Division of
AUG 11 14

PRINTED: 07/28/2014
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 _____	Licensing and Protection (X3) DATE SURVEY COMPLETED C 07/08/2014
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 2003 SPRINGFIELD, VT 05156
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS	C 000		
C 152	<p>485.608(b) COMPLIANCE W ST & LOC LAWS & REGULATIONS</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 staff interview and record review, during the provision of care and services 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, and § 1852. 5) The patient has the right to refuse treatment to the extent permitted by law, for 1 of 3 applicable patients (Patient #1). Findings include: 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. Per record review the policy, titled Restraint and Seclusion Policy last approved on 4/7/14 states "...Restraint and seclusion will not be used as a means of coercion, discipline, convenience or retaliation by staff ... It is our responsibility to facilitate the discontinuation of restraint or seclusion as soon as possible...we are committed</p>	C 152	<p>Right to Respect and Dignity; Right to Refuse Treatment to the extent permitted by law All Staff and Physicians will review and sign off on the Restraint and Seclusion Policy and the Vermont Department of Mental Health restraint requirements. A written physician order to continue restraint will be provided each 4 hours during duration of restraint use. Patient will be immediately removed from restraint once physician provides order for restraint removal. Coercion will not be utilized to facilitate restraint removal.</p> <p>Education: Staff will be educated to methods of potential coercion with attention to use of medications, smoking, and toileting as potential methods of coercion. Therapeutic alternatives based upon patient assessment will be considered prior to implementation of any restrictive restraint. These include comfort measures, activity diversion measures and psychosocial measures.</p> <p>Monitoring: Behavior flow sheets will be reviewed to assess documentation of appropriate assessments, implementation of appropriate interventions and treatment outcomes. Any deviation from policy will be reported through the electronic adverse event reporting system.</p> <p>Goal: All patients are treated with dignity and respect.</p> <p>Follow up: Failure to comply with the policy will result in case review and re-education of staff and identification of further improvement actions.</p>	<p>08 22 14</p> <p>09 05 14</p>

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

James R. Ford CEO *Picaccini T. Coffey* *File RN 8/14/14* *6 August 2014*

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

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C 152	<p>Continued From page 1</p> <p>to preserving the patient's safety and dignity when restraint or seclusion is used." Procedures listed in the policy include " maintain dignity and respect during restraint and seclusion use through ...attention to the patient 's needs ...patient comfort related to toileting will be assessed. " Procedures regarding restraint orders include " The order for physical restraint for acute behavioral management is limited to: Four (4) hours for adults " .</p> <p>Patient # 1, whose diagnoses include mania and delusional thoughts and behavior, was admitted to the Windham Center/ PPS Excluded Distinct Part Psychiatric Unit of Springfield Hospital on 5/27/14.</p> <p>Per record review, Physician Progress Notes for 5/27/14 at 5:15 P.M. record the patient is " angry, agitated, grossly delusional ...threatening to assault staff. ...refuses to discuss voluntary medication use with MD ... patient was offered oral medications which s/he refused. ... patient escorted from courtyard where s/he has been shouting for several hours down to h/her room ...patient placed in restraint bag " .</p> <p>At 10:08 P.M. the physician documents " patient seen ... patient placed in restraint bag around dinner time ... patient has not been out of restraints to use bathroom since 1800 [6:00 P.M.] ... "</p> <p>Nursing Notes for 10:05 P.M. record " Dr. Miller told patient that if s/he took medication we would allow h/her out of the restraint to go to the bathroom " . The patient was then offered an anti-psychotic medication. At 10:15 P.M. Nursing Notes report Patient #1 " spit out 15 mg tablet. 5 mg tablet was not found. Dr. Miller informed and s/he told this RN to continue with restraint " .</p> <p>At 1:15 A.M. on 5/28/14 Nursing Notes state the patient " complained of need to urinate;</p>	C 152	<p>Restraint Seclusion Policy:</p> <p>Restraint Seclusion policy and order set will be revised to remove use of safety coat/ restraint bag. Policy and procedure will be developed for use of restraint chair at the Windham Center. Education will be provided on use of restraint chair along with a competency sign off for Windham Center staff.</p>	09 12 14

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C 152 Continued From page 2
encouraged to do so in restraint suit " . 4 ½ hours later Nursing Notes record " [Patient #1] has been on constant 1 on 1 observation for this shift. S/he has been restrained in the restraint bag as well. ...has made several requests to go to the bathroom. Patient was offered PRN [as needed] meds in order to enable h/her to get up to use the bathroom, as Dr. Miller specified. " AT 5:47 A.M. Patient #1 " reported s/he urinated in restraint bag. Reassured s/he ' d get cleaned up once out of restraints. " Per record review at 6:15 A.M. on 5/28/14 a Physician Order is written " to release patient from body restraint bag " . Nursing Notes from 6:20 A.M. document " MD called re: patient assessment after having been in restraints since yesterday evening. Orders given to release patient from restraints but to remain behind locked double doors in the hallway. Patient agreed to take PRN medications first and then s/he could shower. " A Nursing Note written 34 minutes after the order to release Patient #1 from the body restraint bag records the patient was " requesting a cigarette and to use phone at 6:30 A.M. checks ...s/he could have a cig and use the phone if s/he took medication first. Patient agreed. This RN, along with 2 MHWs [Mental Health Workers] and another RN entered patient ' s room ...patient was raised to an upright position and supported while s/he took 20mg liquid Haldol [an antipsychotic] ... mouth was checked and clear. Patient then removed from the restraint and allowed to use the toilet ...and assisted to the shower. Clean clothes were provided " . Per record review of Social Services notes from 6/4/14 " [Patient #1] spoke about how traumatizing it had been to be in the restraint bag and believes a line had been crossed. States that

C 152

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C 152	Continued From page 3 s/he does not believe it was necessary to be in the bag as long as s/he was...tearful throughout exchange in which s/he talked about being in restraints ..." Per interview with the Nursing Director of the Windham Center Inpatient Psychiatric Unit on 7/8/14 at 1:14 P.M. the Director confirmed Patient #1 was not treated with respect and dignity regarding multiple requests to go to the bathroom and being forced to void then remain in the soiled restraint bag. The Director also confirmed coercion was used regarding releasing Patient #1 from the restraint bag only if s/he took a voluntary medication, and confirmed that the physician's order for restraint was not written for 4 hours and was not renewed per policy, and that Patient #1 remained in the restraint bag for greater than 12 hours, and was not released from the restraint immediately after the order for the restraint to be discontinued was written.	C 152		
C 270	485.635 PROVISION OF SERVICES Provision of Services This CONDITION is not met as evidenced by: Based on patient/patient representative and staff interviews as well as record review the Condition of Participation for Provision of Services was not met as evidenced by: Per record review, the Windham Center/ PPS Excluded Distinct Part Psychiatric Unit of Springfield Hospital staff failed to maintain dignity and respect during restraint use, used coercion in order for the patient to accept medications, and failed to follow procedures regarding orders for physical restraints per hospital policy. Refer to tag: 271	C 270		

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C 271	<p>Continued From page 5</p> <p>Part Psychiatric Unit of Springfield Hospital on 5/27/14.</p> <p>Per record review, Physician Progress Notes for 5/27/14 at 5:15 P.M. record the patient is "angry, agitated, grossly delusional ...threatening to assault staff. ...refuses to discuss voluntary medication use with MD ... patient was offered oral medications which s/he refused. ... patient escorted from courtyard where s/he has been shouting for several hours down to h/her room ...patient placed in restraint bag".</p> <p>At 10:08 P.M. the physician documents "patient seen ... patient placed in restraint bag around dinner time ... patient has not been out of restraints to use bathroom since 1800 [6:00 P.M.] ..."</p> <p>Nursing Notes for 10:05 P.M. record "Dr. Miller told patient that if s/he took medication we would allow h/her out of the restraint to go to the bathroom". The patient was then offered an anti-psychotic medication. At 10:15 P.M. Nursing Notes report Patient #1 "spit out 15 mg tablet, 5 mg tablet was not found. Dr. Miller informed and s/he told this RN to continue with restraint".</p> <p>At 1:15 A.M. on 5/28/14 Nursing Notes state the patient "complained of need to urinate; encouraged to do so in restraint suit". 4 1/2 hours later Nursing Notes record "[Patient #1] has been on constant 1 on 1 observation for this shift. S/he has been restrained in the restraint bag as well. ...has made several requests to go to the bathroom. Patient was offered PRN [as needed] meds in order to enable h/her to get up to use the bathroom, as Dr. Miller specified."</p> <p>AT 5:47 A.M. Patient #1 "reported s/he urinated in restraint bag. Reassured s/he 'd get cleaned up once out of restraints."</p> <p>Per record review at 6:15 A.M. on 5/28/14 a Physician Order is written "to release patient</p>	C 271		

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C 271 Continued From page 6
from body restraint bag " .
Nursing Notes from 6:20 A.M. document " MD called re: patient assessment after having been in restraints since yesterday evening. Orders given to release patient from restraints but to remain behind locked double doors in the hallway. Patient agreed to take PRN medications first and then s/he could shower. "
A Nursing Note written 34 minutes after the order to release Patient #1 from the body restraint bag records the patient was " requesting a cigarette and to use phone at 6:30 A.M. checks ...s/he could have a cig and use the phone if s/he took medication first. Patient agreed. This RN, along with 2 MHWs [Mental Health Workers] and another RN entered patient ' s room ...patient was raised to an upright position and supported while s/he took 20mg liquid Haldol [an antipsychotic] ... mouth was checked and clear. Patient then removed from the restraint and allowed to use the toilet ...and assisted to the shower. Clean clothes were provided " .
Per record review of Social Services notes from 6/4/14 " [Patient #1] spoke about how traumatizing it had been to be in the restraint bag and believes a line had been crossed. States that s/he does not believe it was necessary to be in the bag as long as s/he was...tearful throughout exchange in which s/he talked about being in restraints ... "
Per interview with the Nursing Director of the Windham Center Inpatient Psychiatric Unit on 7/8/14 at 1:14 P.M. the Director confirmed Patient #1 was not treated with respect and dignity regarding multiple requests to go to the bathroom and being forced to void then remain in the soiled restraint bag. The Director also confirmed coercion was used regarding releasing Patient #1 from the restraint bag only if s/he took a voluntary

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C 271	Continued From page 7 medication, and confirmed that the physician ' s order for restraint was not written for 4 hours and was not renewed per policy, and that Patient #1 remained in the restraint bag for greater than 12 hours, and was not released from the restraint immediately after the order for the restraint to be discontinued was written.	C 271		