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

October 31, 2013

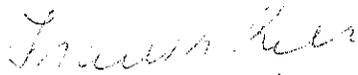
Glenn Cordner, Administrator
Springfield Hospital
Po Box 2003
Springfield, VT 05156

Dear Mr. Cordner:

The Division of Licensing and Protection completed a unannounced onsite visit at your facility on **September 4, 2013** as a follow-up to surveys conducted on May 14, May 22 and May 23, 2013. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **October 31, 2013**.

Sincerely,



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

FK:jl

Enclosure

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

PRINTED: 09/18/2013
RECEIVED: FORM APPROVED
Division: 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 OCT 28 13	(X3) DATE SURVEY COMPLETED R-C 09/04/2013
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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
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{C 000}	INITIAL COMMENTS	{C 000}		
{C 271}	<p>485.635(a)(1) PATIENT CARE POLICIES</p> <p>The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the Critical Access Hospital (CAH) failed to provide care and services in accordance with established policies for 1 of 8 applicable patients. (Patient #1) Findings include: Per record review, Emergency Department (ED) staff failed on 8/10/13 to conduct a complete triage assessment for Patient #1, failed to appropriately reassess and initiate safety interventions when the patient demonstrated a change in condition and failed to complete and submit an adverse event report associated with the provision of care provided to Patient #1 as required per hospital policy. On 8/10/13 Patient #1, who was 7 weeks pregnant, was referred by a local clinic to the ED for treatment of Hyperemesis Gravidarum (abnormal condition in pregnancy characterized by protracted vomiting) requiring intravenous hydration. Patient #1 was triaged at 12:25 with an Acuity level of 3 (Emergency Severity Index rating 1-5, determining extent of emergency presentation and resources required). Per CAH policy Emergency Department Plan of Care, last</p>	{C 271}	See attached Plan of Correction	10/4/13

*POC accepted F. McIn Tash /
Francis & Keeler 10/31/13*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>ACCUM CRO</i>	(X8) DATE <i>09/26/2013</i>
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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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{C 271}	<p>Continued From page 1</p> <p>approved 06/13/2013, states "...the urgency of patient ' s presenting problem/complaint is determined on arrival by a qualified Registered Nurse ". However, at the time of Triage, the nurse failed to complete the Social History component of the triage assessment, specifically the " self harm assessment " which questions patients regarding thoughts of self harm, whether the patient experienced feelings of depression or hopelessness.</p> <p>Patient #1 was checked into an ED room and briefly seen by a Physician Assistant (PA) who prescribed intravenous fluids and medication for Patient #1. At 13:30 a nursing note states Patient #1 was " ...very upset ... " regarding the breakup of a relationship and future plans regarding the pregnancy. ED nursing note states at 14:10 " Pt. continues to cry. Told PA ' life wasn ' t worth living ' ". The PA note further states Patient #1 crying during treatment and when questioned Patient #1 stated " ...felt so badly that she wanted to die " .</p> <p>Per Initial Nursing Assessment and Reassessment: Emergency Department last approved 05/09/2013 " Assessment of nursing care needs will include appropriate considerations of biophysical, psychosocial, environmentalfactors " and " in order to identify and prioritize patient care needs, problems or nursing diagnosis, information related to the assessment will be obtained as appropriate through input from the patient " .</p> <p>Despite the patient demonstrating and acknowledging feelings of hopelessness and noting their life was not worth living and with the determination Patient #1 should be screened for possible psychiatric hospitalization, neither the PA or the RN assigned to Patient #1 reassessed the need for further safety precautions to be initiated for Patient #1. Patient #1 was left alone in an ED</p>	{C 271}		

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{C 271}	<p>Continued From page 2</p> <p>room where hospital equipment and supplies had not been removed. At approximately 14:30 the Crisis Screener arrived to evaluate Patient #1. Upon entering the patient ' s room for interview, the Screener found Patient #1 with oxygen tubing wrapped tightly multiple times around their neck and was pulling on the tubing. Per the Screener ' s note, red marks were noted still present around the patient ' s neck 2 hours after removal of the oxygen tubing. It was not until this event occurred, Patient #1 was placed on Suicide precautions which included the stripping of the patient ' s room of any supplies and equipment that could be used for further self-harm and 1:1 supervision was begun.</p> <p>Per interview on 9/3/13 at 4:30 PM both the ED Nurse Manager and the Director of Patient Care Services confirmed staff failed to follow hospital policy when conducting the Triage assessment, acknowledging specific social history questions may have provided the opportunity to identify Patient #1 ' s potential risk for self harm. In addition, it was confirmed staff failed to reassess the patient ' s environment and potential safety concerns until after the suicide attempt had occurred.</p> <p>In addition, despite the significant event, nursing staff and PA involved with Patient #1 ' s care on 8/10/13 failed to complete an Event Report of the suicide attempt. Per Event Reporting Procedure dated 02/02/2005 states " The person who discovers, witnesses, or to whom the event is reported should complete an electronic event report using the Safety Risk Management ". The scope of reporting includes all employees and medical staff. Per interview on 9/4/13 at 12:10 Nurse #1 involved in Patient #1 ' s ED care confirmed there was a " ..Presumption another nurse involved was going to complete a report " .</p>	{C 271}		

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{C 271}	Continued From page 3 Per interview on 9/4/13 at 12:38, the PA who provided the clinical evaluation/diagnosis for Patient #1 confirmed s/he has seldom completed an event report and in this specific case although aware of the reporting process s/he did not complete an event report. Per interview on the afternoon of 9/3/13, the Chief of Quality and Systems Improvement was not aware of the event that had occurred on 8/10/13, but confirmed the attempted strangulation by Patient #1 was a definite reportable event as per hospital policy.	{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 staff interview and record review, the CAH failed to assure staff consistently completed assessment documentation during the Triage process in the ED for 1 of 8 applicable patients. (Patient #1) Findings include: Per record review, Emergency Department (ED) staff failed on 8/10/13 to conduct a complete triage assessment for Patient #1. Patient #1, who was 7 weeks pregnant, was referred by a local clinic to the ED for treatment of Hyperemesis Gravidarum (abnormal condition in pregnancy characterized by protracted vomiting) requiring intravenous hydration. Patient #1 was triaged at 12:25 with an Acuity level of 3 (Emergency Severity Index rating 1-5, determining extent of emergency presentation and resources required). Per CAH policy Emergency Department Plan of Care last approved 06/13/2013 states "...the	{C 302}	See attached Plan of Correction	10/4/13

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{C 302}	Continued From page 4 urgency of patient ' s presenting problem/complaint is determined on arrival by a qualified Registered Nurse " . However, at the time of Triage, the nurse failed to complete the Social History component of the triage assessment, specifically the " self harm assessment " which questions patients regarding thoughts of self harm, whether the patient experienced feelings of depression or hopelessness. Patient #1 was checked into an ED room and briefly seen by a Physician Assistant (PA) who prescribed intravenous fluids and medication for Patient #1. At 13:30 a nursing note states Patient #1 was " ...very upset ... " regarding the breakup of a relationship and future plans regarding the pregnancy. Per ED nursing note states at 14:10 " Pt. continues to cry. Told PA ' life wasn ' t worth living " . The PA note further states Patient #1 crying during treatment and when questioned Patient #1 stated they " ...felt so badly that she wanted to die " . Patient #1 was left alone in an ED room where hospital equipment and supplies had not been removed. At approximately 14:30 the Crisis Screener arrived to evaluate Patient #1. Upon entering the patient ' s room for interview, the Screener found Patient #1 with oxygen tubing wrapped tightly multiple times around their neck and was pulling on the tubing. Per the Screener ' s note, red marks were noted still present around the patient ' s neck 2 hours after removal of the oxygen tubing. It was not until this event occurred, Patient #1 was placed on Suicide precautions which included the stripping of the patient ' s room of any supplies and equipment that could be used for further self-harm and 1:1 supervision was begun. Per interview on 9/3/13 at 4:30 PM both the ED Nurse Manager and the Director of Patient Care	{C 302}			

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{C 302}	Continued From page 5 Services confirmed staff failed to follow hospital policy when conducting the Triage assessment, acknowledging specific social history questions may have provided the opportunity to identify Patient #1 ' s potential risk for self harm. In addition, it was confirmed staff failed to reassess the patient ' s environment and potential safety concerns until after the suicide attempt had occurred.	{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 Quality Performance failed to consistently implement corrective actions developed as the result of a recognized deficient practice and staff failed to follow CAH policy by failing to complete a Adverse Event Report involving 1 of 8 applicable patients. (Patient #1) Findings include: On 8/10/13 Patient #1, who was 7 weeks pregnant, was referred by a local clinic to the ED for treatment of Hyperemesis Gravid arum (abnormal condition in pregnancy characterized by protracted vomiting) requiring intravenous hydration. Patient #1 was triaged at 12:25 with an Acuity level of 3 (Emergency Severity Index rating 1-5, determining extent of emergency presentation and resources required). Per CAH	{C 336}	See attached Plan of Correction	10/4/13	

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{C 336}	Continued From page 6 policy Emergency Department Plan of Care last approved 06/13/2013 states "...the urgency of patient ' s presenting problem/complaint is determined on arrival by a qualified Registered Nurse ". However, at the time of Triage, the nurse failed to complete the Social History component of the triage assessment, specifically the " self harm assessment " which questions patients regarding thoughts of self harm, whether the patient experienced feelings of depression or hopelessness. Patient #1 was checked into an ED room and briefly seen by a Physician Assistant (PA) who prescribed intravenous fluids and medication for Patient #1. At 13:30 a nursing note states Patient #1 was "...very upset ..." regarding the breakup of a relationship and future plans regarding their pregnancy. Per ED nursing note states at 14:10 " Pt. continues to cry. Told PA ' life wasn ' t worth living' ". The PA note further states Patient #1 crying during treatment and when questioned Patient #1 stated they "...felt so badly that she wanted to die ". Despite the patient demonstrating and acknowledging feelings of hopelessness and noting their life was not worth living and with the determination Patient #1 should be screened for possible psychiatric hospitalization, neither the PA or the RN assigned to Patient #1 reassessed the need for further safety precautions to be initiated for Patient #1. Patient #1 was left alone in an ED room where hospital equipment and supplies had not been removed. At approximately 14:30 the Crisis Screener arrived to evaluate Patient #1. Upon entering the patient ' s room for interview, the Screener found Patient #1 with oxygen tubing wrapped tightly multiple times around their neck and was pulling on the tubing. Per the Screener ' s note, red marks were noted still present around	{C 336}			

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{C 336}	Continued From page 7 the patient ' s neck 2 hours after removal of the oxygen tubing. It was not until this event occurred, Patient #1 was placed on Suicide precautions which included the stripping of the patient ' s room of any supplies and equipment that could be used for further self-harm and 1:1 supervision was begun. Despite the significant event, nursing staff and PA involved with Patient #1 ' s care on 8/10/13 failed to complete an Adverse Event Report of the suicide attempt. Per Event Reporting Procedure dated 02/02/2005 states, " The person who discovers, witnesses, or to whom the event is reported should complete an electronic event report using the Safety Risk Management " . The scope of reporting includes all employees and medical staff. Per interview on 9/4/13 at 12:10 Nurse #1 involved in Patient #1 ' s ED care confirmed there was a " ..Presumption another nurse involved was going to complete a report " . Per interview on 9/4/13 at 12:38, the PA who provided the clinical evaluation/diagnosis for Patient #1 confirmed s/he has seldom completed an event report and in this specific case although aware of the reporting process s/he did not choose to complete an adverse event report. Per interview on the afternoon of 9/3/13, the Chief of Quality and the Director of Patient Care Services confirmed although recent corrective actions for previous deficient practice included a daily review of restraint use, although in this case Patient #1 was placed in restraints for a brief period, the Performance Improvement process failed to capture either the use of restraints which would have led to the adverse event involving Patient #1's attempted strangulation. As a result of not following corrective processes, and the failure of staff to file the Adverse Event Report, the Chief of Quality was not aware of the event	{C 336}			

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{C 336}	Continued From page 8 that had occurred on 8/10/13 until made aware by the surveyor, confirmed the attempted strangulation by Patient #1 was a definite reportable event as per hospital policy.	{C 336}		

Springfield Hospital
ID Number 471306
Date CMS Survey Completed 09/04/2013; Revised: 10/28/2013
Date Springfield Hospital Plan of Correction submitted 10/28/2013
Submitted by: Robert DeMarco, RN, MA, BSN, Chief of Quality

Provider Plan of Correction

SUMMARY STATE OF DEFICIENCIES (See CMS –Statement of Deficiencies for complete detail under each regulation heading.	Action Response	Measurement of compliance and action if recurrence occurs	Responsible	Date of Completion
C 271 485.635(a)(1) PATIENT CARE POLICIES Failed to conduct complete triage assessment <ul style="list-style-type: none"> Failed to complete social history component, self- harm assessment 	Policy Revision: Emergency Department Triage Policy will be revised to include and direct staff to complete a risk for abuse assessment and self-harm assessment for all patients utilizing Emergency Department Services.	Quality Assurance: 100% chart review will occur for: <ul style="list-style-type: none"> all patients with a psychiatric diagnosis all patients who have been restrained for any period of time. Chart Review will include monitoring for:	J. Sherer, RN, MBA, Chief of Patient Care Services C. Howland, RN, BSN, Emergency Department Nurse Manager R. Marasa, MD, Emergency Department Medical Director	October 4, 2013

Springfield Hospital

ID Number 471306

Date CMS Survey Completed 09/04/2013; Revised: 10/28/2013

Date Springfield Hospital Plan of Correction submitted 10/28/2013

Submitted by: Robert DeMarco, RN, MA, BSN, Chief of Quality

SUMMARY STATE OF DEFICIENCIES (See CMS –Statement of Deficiencies for complete detail under each regulation heading.	Action Response	Measurement of compliance and action if recurrence occurs	Responsible	Date of Completion
<p>Failed to reassess to initiate safety precautions and interventions</p> <ul style="list-style-type: none"> • Patient left alone • Equipment and supplies not removed 	<p>Education:</p> <p>Emergency Department staff will review revised Emergency Department Triage policy and receive policy education through dedicated Skills Day education program and via e mail communication.</p> <p>Reassessment:</p> <p>Emergency Department Staff to including Physicians, Physicians Assistants, Nursing staff will be re-educated to the importance of frequent reassessment and</p>	<ul style="list-style-type: none"> • Complete triage assessment • Appropriate reassessment occurrence • Appropriate treatment and safety precautions provided based upon assessments and reassessment • Triage Policy compliance • Restraint Management Policy compliance • Event Reporting Policy 		

Springfield Hospital

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Submitted by: Robert DeMarco, RN, MA, BSN, Chief of Quality

SUMMARY STATE OF DEFICIENCIES (See CMS –Statement of Deficiencies for complete detail under each regulation heading.	Action Response	Measurement of compliance and action if recurrence occurs	Responsible	Date of Completion
Near miss of serious event	<p>evaluation of patient status as patient conditions warrant.</p> <p>Any change in condition that is assessed including risk for self-harm will be documented, communicated and responded to with appropriate treatment and safety measures. Any patient who is assessed or reassessed for risk for self-harm, will be immediately provided 1:1 continuous observation; items that could cause self-harm to the patient will be removed.</p>	<p>compliance</p> <ul style="list-style-type: none"> • Notification to Administration of patient with restraints <p>Education program attendance will be documented regarding:</p> <ul style="list-style-type: none"> • Triage Policy Revisions related to assessment at risk for abuse, self-harm and reassessment of potential for self-harm. • Appropriate Treatment and Safety Precautions provided for patients at risk 		

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unreported. Reporting of patient with restraints	Event Reporting: Staff will be re-educated to Event Reporting policy and importance of reporting potential. near miss and events that pose risk to patients and staff, that may deviate from policy and standard of care. Restraint patients will be reported daily to the Chief of Patient Care Services or Administrator on Call.	for abuse, self-harm. <ul style="list-style-type: none">• Reporting of Events that deviate from standard of care, policy, and that are near misses or serious event occurrence.• Reporting of Restraint use to Chief of Patient Care Services or Administrator on Call• Quality Assurance will occur by medical record and event occurrence		

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		review and concordance with electronic event reporting. <ul style="list-style-type: none"> Failure to report an event occurrence will result in follow and re-education with staff member. 		
C302 485.638(a)(2) RECORD SYSTEMS	See Action Response under C271			
C336 485.641(b) QUALITY ASSURANCE	See Action Response under C271 Emergency Department Medical Staff, Physician, PA Staff will receive	The Emergency Department Medical Director will maintain accountability among	R. Marasa, MD Medical Director of Emergency Services.	November 20, 2013

Springfield Hospital

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Submitted by: Robert DeMarco, RN, MA, BSN, Chief of Quality

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	<p>additional education & training regarding the importance of reporting adverse and near miss events and the process to report these events.</p> <ul style="list-style-type: none">• Primary responsibility of reporting an event belongs to staff member discovering an event.• Any adverse event, deviation from policy, or near miss event will be reported utilizing the	<p>the Emergency Department Medical Staff for appropriate reporting of adverse events, deviation from policy and near miss events.</p> <ul style="list-style-type: none">• Quality Assurance will occur by medical record and event occurrence review and concordance with electronic event reporting.• Failure to report an event occurrence will result in follow and re-		

Springfield Hospital

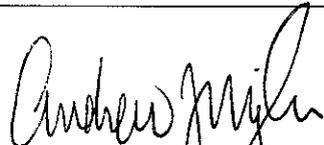
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Date Springfield Hospital Plan of Correction submitted 10/28/2013

Submitted by: Robert DeMarco, RN, MA, BSN, Chief of Quality

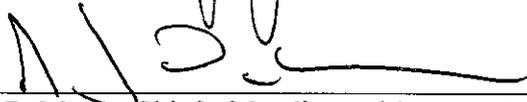
SUMMARY STATE OF DEFICIENCIES (See CMS –Statement of Deficiencies for complete detail under each regulation heading.	Action Response	Measurement of compliance and action if recurrence occurs	Responsible	Date of Completion
	electronic reporting system (SEM). • Training will be provided the Emergency Department Medical Staff in the use of the electronic reporting system (SEM)	education with staff member.		



Andrew Majka, Acting CEO, CFO

10/15/2013

Date



Robert DeMarco, Chief of Quality and Systems Improvement

Date