

December 24, 2013

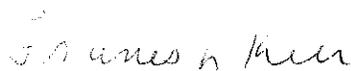
Timothy Ford, Administrator  
Springfield Hospital  
Po Box 2003  
Springfield, VT 05156

Dear . Ford:

The Division of Licensing and Protection completed a survey at your facility on **November 14, 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 **December 23, 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

RECEIVED  
Division of  
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Licensing and  
Protection  
PRINTED: 11/27/2013  
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 _____	DEC 13 13 Licensing and Protection	(X3) DATE SURVEY COMPLETED  C 11/14/2013
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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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C 000	INITIAL COMMENTS	C 000		
C 152	<p>485.608(b) COMPLIANCE W ST &amp; LOC LAWS &amp; 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 interviews and record review the facility failed to assure timely reporting to the appropriate State Agency (SA), as stated in VSA Title 33, Chapter 69, of an allegation of patient mistreatment by staff. (Patient #1). Findings include:</p> <p>Per VSA Title 33, Chapter 69, § 6903. Reporting suspected abuse, neglect, and exploitation of vulnerable adults (a) Any of the following, other than a crisis worker acting pursuant to 12 V.S.A. § 1614, who knows or has received information of abuse, neglect, or exploitation of a vulnerable adult or who has reason to suspect that any vulnerable adult has been abused, neglected, or exploited shall report or cause a report to be made in accordance with the provisions of section 6904 of this title within 48 hours: Per record review, conducted on 11/12/13, Patient #1 had a Patient Progress Note, written by MHW #1 and dated 8/4/13, that stated the</p>	C 152	<p>Please see attached plan of correction.</p> <p>POC accepted B. Howell F. Keenan MSN DBA 12/23/13</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Justin R. Wood* TITLE: CEO (X6) DATE: 12 December 2013

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

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C 152	Continued From page 1 patient had "asked to speak with this writer at the start of shift. [S/he] expressed some paranoid thoughts about a male RN on the night shift..." During interview, at 2:31 PM on 11/12/13, MHW #1 stated that Patient #1 had requested to talk with the MHW on 8/4/13. The MHW stated that the patient's conversation had been "a bit disjointed", which the MHW stated was usual for the patient. The patient reportedly told MHW #1 that s/he was remembering a night nurse being on top of him/her, and the patient gave a fairly specific description of who the night nurse was. The MHW also stated that the information from the patient was fragmented and s/he felt the patient's thoughts were based in paranoia and delusion. MHW #1 then reported what Patient #1 had said to RN #1. The MHW further stated that s/he had not made any report to the SA and had not been aware that s/he was obligated to either report or cause a report to be made to the SA regarding allegations of mistreatment Per interview, on 11/12/13 at 12:33 PM and 1:26 PM, respectively, both RN #1 and the RN Clinical Leader confirmed that MHW #1 had reported to them, on 8/4/13, that Patient #1 had expressed some paranoid thoughts about inappropriate interactions with a night nurse. Both staff members confirmed a report had not been made to the SA at that time. The Nurse Manager stated during interview at 10:19 AM on 11/12/13, that s/he had not been made aware of the incident in which Patient #1 had alleged inappropriate treatment by a staff member until 8/9/13, at which time it was reported to the state agency.	C 152		
C 271	485.635(a)(1) PATIENT CARE POLICIES  The CAH's health care services are furnished in	C 271	Please see attached plan of correction.	

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C 271	Continued From page 2 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 facility failed to assure that care and services were provided in accordance with established Policies and Procedures regarding; reporting of Abuse, Neglect and Exploitation and completion of event reports. (Patients #1 and #3). Findings include:  Per review, the facility policy, titled SB - Prevention of Abuse and Neglect of Patients by Staff of Springfield Medical Care Systems, dated 6/13/13, stated: E. Identification and Reporting of Abuse, Neglect, or Misappropriation of Property; 1. Identification by a Staff Member - "Any employee of Springfield Hospital has the right and the duty to report suspected incidents of abuse, neglect, mistreatment of patient or misappropriation of property of hospital patients. If any staff member knows of, or has received information of abuse neglect, mistreatment of a patient or misappropriation of their property, or has reason to suspect that a patient is being or has been, either physically or verbally abused by anyone (including family members, other patients, or visitors) or witnesses theft, the incident should be reported immediately. 2. How to Report - All incidents at Springfield Hospital should be reported to the Administrator and in the Event Reporting System. Reports need to be made to one of the Co-Directors at the Windham Center...4. Reporting to the State - A report must be made to Adult Protective Services within 48 hours of the incident."	C 271			

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C 271	<p>Continued From page 3</p> <p>The Event Reporting and Management Policy, dated 6/24/09 stated; ".....Event reporting is a means to assess and improve organizational process and provide a safe environment for patient care." The policy also stated; "...All medically relevant events should be documented in the patient's record including a description of the event, the time of the event, all actions taken (ex. Evaluation in the ED, notification of the attending physician, diagnostic procedures and treatment performed), and the results of interventions." Under Responsibilities: "...Reports are to be completed promptly on the day of the event occurrence. Late reporting is allowed though timely reporting is expected." The Event Reporting Procedure, dated 4/29/09, states; "Responsibility: The person who discovers, witnesses, or to whom the event is reported should complete an electronic event report...."</p> <p>1. Per record review, conducted on 11/12/13, Patient #1 had a Patient Progress Note, written by MHW #1 and dated 8/4/13, that stated the patient had "asked to speak with this writer at the start of shift. [S/he] expressed some paranoid thoughts about a male RN on the night shift..." During interview, at 2:31 PM on 11/12/13, MHW #1 stated that Patient #1 had requested to talk with the MHW on 8/4/13 and the patient's conversation had been "a bit disjointed", which the MHW stated was usual for the patient. The patient reportedly told MHW #1 that s/he was remembering a night nurse being on top of him/her, and the patient gave a fairly specific description of who the night nurse was. The MHW also stated that the information from the patient was fragmented and s/he felt the patient's thoughts were based in paranoia. The MHW</p>	C 271			

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C 271	Continued From page 4 stated s/he informed the patient that s/he was going to report the patient's concerns to the doctor and the patient expressed anger and said s/he didn't want the MHW telling his/her secrets. MHW #1 then reported the information to RN #1. MHW #1 further stated that s/he had not made any report to the SA and had not been aware that s/he was obligated to either report or cause a report to be made to the SA regarding allegations of mistreatment Per interview, on 11/12/13 at 12:33 PM and 1:26 PM, respectively, both the RN Clinical Leader and RN #1 confirmed that MHW #1 had reported to them, on 8/4/13, that Patient #1 had expressed some paranoid thoughts about interactions with a night nurse, and the issue had then been discussed by the Treatment Team. Both staff members confirmed a report had not been made to the SA at that time. The Nurse Manager stated during interview at 2:59 PM on 11/12/13, that s/he had not been made aware of the incident in which Patient #1 had alleged inappropriate treatment by a staff member until 8/9/13, at which time an event report was completed and the event was reported to the SA. The Nurse Manager further confirmed that staff did not, but should have, reported the incident within 48 hours of becoming aware of it, in accordance with the facility's established policies and procedures, and should have completed an event report. 2. Per review, on 11/12/13, a Physician had ordered " Benadryl 100 mg. orally now" on 11/8/13 at 7:50 AM for Patient #3. The rationale for the order states "anaphylactic reaction mushrooms". A repeat order for "Benadryl 100 mg orally x1 now" was ordered at 11/8/13 at 10:10 AM. However, per review of Patient # 3's Progress Notes for 11/8/13, nursing staff failed to	C 271			

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C 271	Continued From page 5 document the events associated with Patient # 3's reaction to mushrooms to include evidence of vital signs, physical presentation during the reaction, response to the Benadryl administered.  During interview, on the afternoon of 11/13/13, the Nurse Manager confirmed that documentation regarding Patient #3's allergic reaction had not been completed and also confirmed that no event report had been completed in accordance with established policies and procedures.	C 271		
C 296	485.635(d)(2) NURSING SERVICES  A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.  This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interviews nursing staff failed to evaluate the ongoing care needs for 1 patient for whom a change in condition had occurred. (Patient #1). Findings include:  Per record review, conducted on 11/12/13, Patient #1 had a Daily Nursing Note, dated 8/5/13 at 7:03 PM, that stated "Complains of pain in [his/her] abdomen behind [his/her] belly button. [His/her] abdomen is noted to be distended and [his/her] belly button pushed out. S/he states s/he normally has a belly button that indents into [his/her] abdomen. States s/he feels as though there is something hard behind [his/her] belly button that is pushing it out. Will continue to monitor." Despite this assessment there was no evidence of any further evaluation of the condition	C 296	Please see attached plan of correction.	

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C 296	Continued From page 6 for a period of two days. Subsequent nursing notes, dated 8/7/13 stated, at 5:47 PM, "...Also, continues to report that [his/her] abdomen is very tender and has been tender for a few days. It is noted to be distended. S/he reports that [his/her] umbilicus does not normally extrude but it is noted to be extruded currently due to abdominal distension." At 7:28 PM the nursing note stated: "Pt reports umbilical pain 6/10 that has been going on for 2 days.....states s/he has reported this to other nurses but nothing has been done." The patient underwent a medical evaluation at 11:08 AM on the morning of 8/8/13 and was diagnosed with an umbilical hernia.	C 296			
C 298	During interview at 5:38 PM on 11/13/13, the Nurse Manager confirmed there was no evidence of ongoing nursing assessment for a period of 2 days following a change in the patient's condition. 485.635(d)(4) NURSING SERVICES  A nursing care plan must be developed and kept current for each inpatient.  This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interviews the care plan for one patient had not been revised to reflect current status. (Patient #1). Findings include:  Per record review, conducted on 11/12/13, Patient #1 had a Daily Nursing Note, dated 8/5/13 at 7:03 PM, that stated "Complains of pain in [his/her] abdomen behind [his/her] belly button. [His/her] abdomen is noted to be distended and [his/her] belly button pushed out. S/he states s/he normally has a belly button that indents into [his/her] abdomen. States s/he feels as though	C 298	Please see attached plan of correction.		

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C 298	Continued From page 7 there is something hard behind [his/her] belly button that is pushing it out. Will continue to monitor." Despite this assessment there was no evidence of any further assessment or evaluation for a period of two days. Subsequent nursing notes, dated 8/7/13 stated, at 5:47 PM, "....Also, continues to report that [his/her] abdomen is very tender and has been tender for a few days. It is noted to be distended. S/he reports that [his/her] umbilicus does not normally extrude but it is noted to be extruded currently due to abdominal distension." At 7:28 PM the nursing note stated: "Pt reports umbilical pain 6/10 that has been going on for 2 days.....states s/he has reported this to other nurses but nothing has been done." The patient underwent a medical evaluation at 11:08 AM on the morning of 8/8/13, was diagnosed with an umbilical hernia and the follow up plan included a recommendation that an abdominal CT scan be done at a future date. Per review the patient's care plan had not been revised to reflect the change in condition and current status.  During interview at 5:38 PM on 11/13/13, the Nurse Manager confirmed that Patient #1's care plan had not been revised to reflect his/her current status.	C 298		
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 interview and record review the nursing staff failed to complete documentation of an event involving a patient who experienced a	C 302	Please see plan of correction.	

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C 302	Continued From page 8 food reaction. Patient #3 (Findings include)  Per review on 11/12/13 a Physician had ordered "Benadryl 100 mg. orally now" on 11/8/13 at 7:50 AM for Patient #3. The rationale for the order states "anaphylactic reaction mushrooms". A repeat order for "Benadryl 100 mg orally x1 now" was ordered at 11/8/13 at 10:10 AM. However, per review of Patient # 3's Progress Notes for 11/8/13, nursing staff failed to document the events associated with Patient # 3's reaction to mushrooms to include evidence of vital signs, physical presentation during the reaction, response to the Benadryl administered. Per interview on 11/12/13 at 4:35 PM, the Dietary Manager confirmed that although it was noted on Patient #3's dietary profile s/he had an allergy to mushrooms, another staff cook had served the patient on 11/8/13 an omelette with mushrooms. The clinical record also did not include circumstances associated with the food source.  During interview, on the afternoon of 11/13/13, the Nurse Manager confirmed the lack of documentation regarding Patient #3's allergic reaction and confirmed that no event report had been completed to date.	C 302		
C 306	485.638(a)(4)(iii) RECORDS SYSTEMS.  [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-]  all orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such	C 306	Please see attached plan of correction.	

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C 306	<p>Continued From page 9</p> <p>as temperature graphics and progress notes describing the patient's response to treatments; [and]</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, nursing notes did not reflect an event regarding a food reaction experienced by 1 applicable patient nor did it describe the patient's response to treatment for the allergic reaction. (Patient #3) Findings include:</p> <p>Per review on 11/12/13 a Physician had ordered " Benadryl 100 mg. orally now" on 11/8/13 at 7:50 AM for Patient #3. The rationale for the order states "anaphylactic reaction mushrooms". A repeat order for "Benadryl 100 mg orally x1 now" was ordered at 11/8/13 at 10:10 AM. However, per review of Patient # 3's Progress Notes for 11/8/13, nursing staff failed to document the events associated with Patient # 3's reaction to mushrooms to include evidence of vital signs, physical presentation during the reaction, response to the Benadryl administered. Per interview on 11/12/13 at 4:35 PM, the Dietary Manager confirmed that although it was noted on Patient #3's dietary profile s/he had an allergy to mushrooms, another staff cook had served the patient on 11/8/13 an omelette with mushrooms. The circumstances associated with the food source was also not documented.</p> <p>During interview, on the afternoon of 11/13/13, the Nurse Manager confirmed the lack of documentation regarding Patient #3's allergic reaction and confirmed that no event report had been completed to date.</p>	C 306		

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C 342	<p>485.641(b)(5)(ii) QUALITY ASSURANCE</p> <p>[The program requires that--] the CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.</p> <p>This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interviews the facility failed to recognize opportunity for improvement and failed to address previously identified deficient practice related to staff knowledge of reporting requirements and food safety. Findings include:</p> <ol style="list-style-type: none"> <li>1. Per record review, conducted on 11/12/13, Patient #1 had voiced concerns to MHW #1 on 8/4/13, regarding mistreatment by a staff nurse. Although the MHW notified the nurse in charge at the time, and although the RN Clinical Leader was made aware on that date, the information was not reported to the appropriate SA until 4 days later on 8/8/13. The Nurse Manager stated, during interview at 2:59 PM on 11/12/13, that she became aware of the allegations made by Patient #1 against a staff nurse on 8/9/13 and had identified, at that time, that staff had not reported to the SA in a timely manner. Although the Nurse Manager had identified this deficient practice, and had spoken with staff involved regarding the late reporting of this incident, no further action had been taken to assure all staff were aware of reporting requirements, in an effort to assure like incidents did not recur.</li> <li>2. Per record review on 11/12/13 a Physician had ordered "Benadryl 100 mg. orally now" on 11/8/13</li> </ol>	C 342	Please see attached plan of correction.	

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 11/14/2013
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 342	<p>Continued From page 11</p> <p>at 7:50 AM for Patient #3. The rationale for the order states "anaphylactic reaction mushrooms". A repeat order for "Benadryl 100 mg orally x1 now" was ordered at 11/8/13 at 10:10 AM. However, per review of Patient # 3's Progress Notes for 11/8/13, nursing staff failed to document the events associated with Patient #3's reaction to mushrooms to include evidence of vital signs, physical presentation during the reaction, response to the Benadryl administered</p> <p>During interview, at 4:37 PM on 11/12/13, the Dietary Manager stated that information regarding patient food allergies is documented on a dietary card and kept in the kitchen. S/he stated the process to assure patients do not have exposure to any known food allergen has been to not keep the food item in the kitchen. However, although Patient #3's allergy to mushrooms was documented, the patient ingested food, provided by dietary staff, containing mushrooms, resulting in an allergic reaction requiring medical intervention.</p> <p>Despite the knowledge of this incident no action had been taken to assure all patients remained free from exposure to allergy causing food items. The VP of Patient Care Services and the Nurse Manager both confirmed, during interview at 4:38 PM on 11/13/13, the lack of action taken to assure reporting requirements will be met by all staff and to assure patients will not ingest identified food allergens.</p>	C 342		

Springfield Hospital

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Date Springfield Hospital Plan of Correction submitted 12/12/13, Revised 12/23/13

Submitted by: Janet Sherer, RN, BSN, MBA Chief of Patient Care Services

Provider Plan of Correction

SUMMARY STATE OF DEFICIENCIES  (See CMS 256 Statement of Deficiencies for complete detail under each regulation heading)	Action Response	Measurement of compliance	Responsible	Date of Completion
C152, 485.608(b) COMPLIANCE W ST & LOC LAWS & REGULATIONS	<p>The following three policies will be reviewed and revised to provide hospital staff with clarity related to reporting responsibilities:</p> <ul style="list-style-type: none"> <li>-Abuse, Neglect, and Exploitation of Vulnerable Adults</li> <li>-SB-Prevention of Abuse and Neglect of Patients by Staff of Springfield Medical Care Systems</li> <li>-Child Abuse Neglect and Reporting</li> </ul> <p>Reporting of abuse, neglect, and exploitation is included in the Annual Safety</p>	<p>A self study that includes the revised policies and a post test will be distributed to hospital employees and physicians. The post test will be completed by hospital employees and physicians.</p> <p>We will continue to include this information in the</p>	<p>Janet Sherer, RN, BSN, MBA, Chief of Patient Care Services</p> <p>Linda Hurley, RN, Director of Professional Development</p> <p>Janet Sherer, RN, BSN, MBA, Chief of Patient Care Services</p>	<p>Review, revision, and distribution of self studies completed by 1-11-14.</p> <p>Completed.</p>

NO. 774 #002

S.P.F.L.D HOSPITAL CEO - 8028857357

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	<p>Training self study.          Employees complete a post test that includes items related to the reporting of abuse, neglect, and exploitation.</p> <p>The Nurse Manager of the Windham Center created a notebook that includes information on abuse, neglect, and exploitation reporting. There is a post test for staff to complete.</p> <p>Accountability for reporting of events related to abuse, neglect and exploitation are the responsibilities of the Windham Center leadership.</p>	<p>Annual Safety          Training self study.</p> <p>The Windham Center staff will review the information in the notebook and complete the post test.</p> <p>The Windham Center will maintain accountability among Windham Center Staff for reporting of events related to abuse, neglect and exploitation to appropriate agencies and through the internal electronic event reporting system events.</p> <p>Quality Assurance</p>	<p>Linda Hurley, RN,          Director of Professional Development</p> <p>Colleen Fisk, RN</p> <p>Colleen Fisk, RN</p>	<p>12/31/13</p> <p>12/31/13</p>
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NO. 774 #003

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		<p>will occur by medical record and event occurrence review and concordance with electronic event reporting.</p> <p>Failure to report an event related abuse, neglect and exploitation occurrence will result in follow up and re-education with staff member.</p>		
	<p>Compliance with reporting events related to abuse, neglect and exploitation is a key component of our quality and safety program.</p>	<p>Oversight for reporting events and regulatory compliance related to abuse, neglect and exploitation and identifying further educational training needs are key components of SMCS quality and safety programs. Areas of concern are identified</p>	<p>Bob DeMarco, RN, BSN, MA, Chief of Quality and Systems Improvement</p>	<p>12/31/13</p>

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		<p>through the review of event reports; staff, patient and family concerns.</p> <p>Follow up recommendations for improvement are identified and communicated to Division Heads and Department Managers.</p>		
<p>C 271, 485.635(a)(1) PATIENT CARE POLICIES</p>	<p>The following policies will be reviewed with hospital staff and physicians to clarify responsibility for filing event reports in the electronic event reporting system:</p> <ul style="list-style-type: none"><li>-Event Reporting and Management</li><li>-Risk Prevention and Management Reporting Policy</li><li>-Adverse Event and Intentional Unsafe Act Reporting</li><li>-Event Reporting Procedure</li></ul>	<p>A self study that includes the policies and a post test will be distributed to hospital employees and physicians. The post test will be completed by hospital employees and physicians.</p>	<p>Janet Sherer, RN, BSN, MBA, Chief of Patient Care Services</p> <p>Linda Hurley, RN, Director of Professional Development</p> <p>Bob DeMarco, RN, BSN, MA, Chief of Quality and Systems Improvement</p>	<p>Review, revision, and distribution of policies completed by 1-11-14.</p>

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	<p>Reporting in the electronic event reporting system is also included in the Annual Safety Training self study. Employees complete a post test that includes items related to event reporting.</p>	<p>We will continue to include this information in the Annual Safety Training self study.</p>	<p>Janet Sherer, RN, BSN, MBA, Chief of Patient Care Services</p> <p>Linda Hurley, RN, Director of Professional Development</p>	<p>Completed.</p>
	<p>The Nurse Manager of the Windham Center will create a notebook with the event reporting policies and a form for staff to sign off on their review of the event reporting policies.</p>	<p>The staff of the Windham Center will review the information in the notebook and sign that they have reviewed the policies.</p>	<p>Colleen Fisk, RN</p>	<p>12-31-13</p>
	<p>The Nurse Manager of the Windham Center will review the event reporting policies at the next staff meeting on December 19<sup>th</sup>, 2013.</p>	<p>The policies will be reviewed at staff meeting with documentation of attendance and review in the minutes. Staff not attending will need to sign that they have reviewed the staff meeting minutes.</p>	<p>Colleen Fisk, RN</p>	<p>12-31-13</p>
	<p>Bob DeMarco, RN, BSN, MA will present an</p>	<p>Staff attending the inservice will be</p>	<p>Bob DeMarco, RN, BSN, MA</p>	<p>1-31-14</p>

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	<p>inservice on event reporting to the Windham Center staff in January 2014.</p>	<p>documented. Staff not attending will need to sign off on any written information Bob provides for the inservice.</p>	<p>Colleen Fisk, RN</p>	
	<p>Accountability for reporting of adverse events are the responsibilities of the Windham Center leadership.</p>	<p>The Windham Center will maintain accountability among the Windham Center staff for appropriate reporting of adverse events, deviation from policy and near miss events.</p> <p>Quality Assurance will occur by medical record and event occurrence review and concordance with electronic event reporting.</p> <p>Failure to report an event occurrence will result in follow up and</p>	<p>Colleen Fisk, RN</p>	<p>12-31-14</p>

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	Compliance with reporting events related to abuse, neglect and exploitation is a key component of our quality and safety program.	re-education with staff member.  Oversight for event reporting and identifying further educational training needs are key components of SMCS quality and safety programs. Areas of concern are identified through the review of event reports; staff, patient and family concerns.  Follow up recommendations for improvement are identified and communicated to Division Heads and Department Managers.	Bob DeMarco, RN, BSN, MA, Chief of Quality and Systems Improvement	12/31/13
C 296, 485.635(d)(2) NURSING SERVICES	The Nurse Manager of the Windham Center will review and revise the Windham Center nursing	When nursing assessment policies have been reviewed and revised the Nurse	Colleen Fisk, RN	1-31-14

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	<p>assessment and re-assessment policies to include guidelines for the nursing assessment of medical issues in the psychiatric patient.</p> <p>The Nurse Manager of the Windham Center has discussed nursing assessment and re-assessment for medical issues at her staff meeting. She has also sent a memo to the nursing staff asking that they document the medical issue on the MedAct to remind nurses that a re-assessment of a medical issue is needed.</p>	<p>Manager of the Windham Center will ask staff to review them and sign off that they have.</p> <p>A chart review will be completed and documented for any patient having an active medical issue to assure the nursing assessment and re-assessment policy has been followed. Feedback will be provided to nursing staff if policies are not being adhered to.</p>		
<p>C298, 485.635(d)(4) NURSING SERVICES</p>	<p>The Nurse Manager of the Windham Center and the nursing staff are analyzing the nursing care planning system to determine what revisions may need to be made to improve the nurses' ability to document changes to the nursing care plan.</p>	<p>The Nurse Manager of the Windham Center has a staff meeting scheduled for December 19<sup>th</sup>, 2013 at which she and the nursing staff will discuss potential improvements to the system. The</p>	<p>Colleen Fisk, RN</p>	<p>Chart reviews will begin 12-30-13</p> <p>December 31, 2013</p>

NO. 774 #008

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		improvements discussed will be documented in the meeting minutes.		
	The Clinical Applications Specialist in the Technology Management Department at Springfield Hospital is working with the Nurse Manager of the Windham Center to make some additions to the nursing care plan. A trigger will be created in the electronic system to direct the nurses to the care plan for new problems that need to be assessed. The Nurse Manager and the Clinical Applications Specialist are creating an additional electronic page that will allow updates to the care plan to be made more effectively by nursing.	Staff will be instructed in the use of the changes to the nursing care plan system once they are complete. Chart reviews will be completed to review nursing care plan documentation.	Colleen Fisk, RN Kyle Peoples, Director of Technology Management Services	1-11-14 1-11-14
	The Nurse Manager has begun and will continue to have Nursing Care Planning	Discussion will be documented in staff meeting minutes and	Colleen Fisk, RN	December 19, 2013

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	as a regular agenda item for nursing staff meetings to educate nursing staff.	reviewed by those not attending.		
C302, 485.638(a)(2) RECORDS SYSTEMS	The Nurse Manager of the Windham Center will have nursing staff review the policy named, "Documentation Policy" and sign off that they have reviewed the policy.  Please see plan under tag C271.	Chart reviews will be completed to insure the documentation policy is being followed. Feedback will be given to individuals who need to make improvement in their nursing documentation.	Colleen Fisk, RN	12-31-13
C306, 485.638(a)(4)(iii) RECORDS SYSTEMS	Please see plan under tag C271.  Please see plan under tag C302.			
C342, 485.641(b)(5)(ii) QUALITY ASSURANCE	Please see plans under tags C152 and C271.  Patient food allergies are now posted next to the stove in the kitchen printed in red. The patient's picture is included for identification along with the allergies.	Dietary staff will review patient allergies at the beginning of their shift and prior to food preparation and	Colleen Fisk, RN	Completed

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