March 6, 2024

VIA CERTIFIED MAIL

Office of Quality and Patient Safety
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, Illinois 60181

Re: Saint Vincent Hospital - 123 Summer Street, Worcester, MA 01608

This is the fourth official complaint we are filing with the Joint Commission regarding an ongoing and dire crisis in the safety of care for patients admitted to St. Vincent Hospital, with every patient and every nurse on every shift subject to abnormally dangerous conditions, with both patients and nurses at risk for imminent harm at the hands of an administration that fails to meet the most basic standards of patient care delivery. We have already reported to your agency and all other applicable agencies specific deficiencies in staffing, hospital policies, allocation of technology, and a deliberately punitive management culture that is resulting in dangerous delays in the administration of needed medications and treatments, preventable patient falls and other complications, including preventable sentinel events.

We issue this complaint as a measure of last resort as the nurses have exercised a good faith effort to alert our administration of the dangers these conditions pose for their patients and themselves. Our nurses have carefully documented these conditions and concerns and have made repeated requests to engage in a meaningful process to address these conditions, only to be met with rancor and recrimination. The last several weeks have seen the hospital's administration engage in a concerted effort to discipline several nurses who had taken the initiative to raise concerns about those abnormally dangerous conditions, which was in keeping with their legal rights and obligation to serve as advocates for their patients under Massachusetts Law. In our role as legally mandated advocates for our patients we once again appeal to the Joint Commission to immediately intervene, and take whatever steps are necessary to prevent the further erosion of patient care conditions, and to protect our patients and our community from continued harm and unnecessary suffering.

The patients of Saint Vincent Hospital in Worcester, MA continue to be at risk for harm despite multiple recent onsite inspections by The Joint Commission inspectors and notice of ongoing deficits to The Joint Commission, CMS, and the Division of Health Care Facility Licensure and Certification in Massachusetts in December of 2023 and January of 2024. The Joint Commission and the Massachusetts Department of Public Health were both onsite in late January- early February because of the ongoing concerns. During your recent onsite review, the organization was found to be non-compliant with applicable Centers for Medicaid and Medicare Services (CMS) Conditions. In the weeks since your findings were reported, conditions at St. Vincent Hospital have not improved.

The hospital continues to admit patients despite inadequate staff to appropriately meet the patients' needs, in violation of TJC standard PC.01.01.01 "The hospital accepts the patient for care, treatment and services based on its ability to meet the patient's needs." Nurses continue to witness the violation of *Patient Rights and Responsibilities*, but their concerns have gone unanswered. The hospital repeatedly violates 105 CMR 130.311: Registered Nurse Coverage- There shall be a sufficient number of registered nurses on duty at all times to plan, supervise and evaluate nursing care, as well as to give patients the nursing care that requires the judgment and specialized skills of a registered nurse and 105 CMR 130.312: Registered Nurses, Licensed Practical Nurses, and Ancillary Staff Coverage: The number of registered nurses, licensed practical nurses and unlicensed nursing personnel assigned to each nursing unit shall be consistent with the types of nursing care needed by the patients and the capabilities of the staff.

The nurses working on the inpatient units do not receive handoff communication from the Emergency Department when a patient is being admitted to their unit. Nurses report they have not received an SBAR report since the facility institute the use of the Cerna electronic documentation system 10 months ago. There is reportedly a means to access the ED report in Cerna, but the staff have still not received education and training on it despite requests. Because of the lack of communication, the admitting nurse is unaware of medications given and sometimes has to investigate medications given by calling the pharmacy. Once patients are assigned to rooms, they are transported to the floor quickly, eliminating any time for the accepting floor nurses to assign the patient, prepare the room with necessary equipment (such as a telemetry box if needed). The accepting nurse has no time to ask questions or clarify information from the originating staff or to assess if the assignment is appropriate for that room.

We ask for your continued investigation and intervention at the hospital to protect the patients of Worcester County.

Emergency Department and Emergency Department Behavioral Health

The hospital repeatedly has violated TJC standards LD.03.01.01, "*Leaders create and maintain a culture of safety and quality throughout the hospital"*; TJC standard LD 04.01.11 "*The hospital makes space and equipment available as needed for the provision of care, treatment, and services";* and TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

St. Vincent Hospital has been designated as a Primary Stroke Service by the Massachusetts Department of Public Health which requires a readiness to provide timely acute stroke evaluation and treatment (Commonwealth of Massachusetts, 2023). However, St. Vincent Hospital has been consistently without adequate staff to assess and treat patients in a timely manner which directly contradicts the commitment made in obtaining that designation.

January 6, 2024- When 14 RNs are required to provide care in the ED, only 5 nurses were on shift. One nurse reported a 10-patient assignment, including a designated ICU admission, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

February 28, 2024- One assignment included 6 patients, all of whom required close monitoring. That nurse juggled an ICU boarder, a patient with a GI bleed, a Code Stroke patient and a confused patient who needed monitoring for safety. It is impossible to provide care to multiple critical patients simultaneously. The hospital violated TJC Standard LD 04.01.11 "*The hospital makes space and equipment available as needed for the provision of care, treatment, and services" and* TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

Intensive Care Unit

The hospital consistently understaffs the ICU, directly violating MGL 111 Section 231, Limitation on patient assignments per nurse in Intensive Care Units; development and certification of acuity tool. This violates TJC standard LD.04.01.01 *"The hospital complies with law and regulation,"* and TJC Standard PC02.01.03 "*The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation*." The law states "Notwithstanding any general or special law to the contrary, in all intensive care units the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient as assessed by the acuity tool and by the staff nurses in the unit, including the nurse manager or the nurse manager's designee when needed to resolve a disagreement." However, the nurses are routinely assigned more than one patient regardless of the RNs assessment of the acuity of the patient, the experience of the nurse and other relevant factors identified by the Health Policy Commission in Massachusetts. Nurses have been assigned up to 3 patients at times, a blatant violation of the regulation. The resource RN is almost always responsible for a full patient assignment, and therefore, unable to respond to emergencies within other units in the hospitals when patients are critically ill and require the expertise of a critical care nurse, violating hospital policy.

January 7, 2024- Staffing was inadequate and patients suffered. Because nurses were juggling multiple critical patients, and a nurse could not closely monitor some patients, one patient pulled out his pacing wire – requiring activation of the cardiac cath lab; simultaneously a patient self extubated. The hospital violated TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

January 14, 2024- Multiple patients were assessed by the responsible RN as requiring 1:1 care but were part of a multi-patient assignment, violating TJC standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."* Patients who were on CVVH and required the individual attention of a registered nurse were doubled; patients who were intubated, chemically paralyzed and sedated and patients who were hemodynamically unstable on multiple vasopressor infusions were doubled and not given the 1:1 care required for safety.

January 17-18, 2024- a hemodynamically unstable patient assessed by the RN as requiring 2 nurses to care for them was not given the adequate resources. The patient was transcutaneously paced to maintain cardiac output. Multiple nurses were required in the room.

January 19, 24, February 2, 4, 2024- Patients assessed as requiring 1:1 nursing care were doubled with another patient in violation of MGL 111 Section 231, Limitation on patient assignments per nurse in Intensive Care Units; the patients were hemodynamically unstable on multiple vasopressors and required close monitoring.

February 10, 2024- The charge nurse was responsible for 2 patients in violation of MGL 111 Section 231, Limitation on patient assignments per nurse in Intensive Care Units. When a night shift nurse went home after a 17 hour shift, the charge nurse was responsible for a third patient, further violating the ICU staffing law and placing all three patients at risk. On the night shift of that same day, the charge nurse was responsible for the unit plus a patient who was deemed unstable and required 1:1 nursing care.

February 16, 2024- Charge nurse was responsible for an unstable hemodynamically unstable patient who survived a cardiac arrest and was unable to response to 4 Rapid Responses on the floors, violating hospital policy. Another nurse was assigned two patients who were located on opposite sides of the unit and not visible to each other, violating MGL 111 Section 231, Limitation on patient assignments with consideration of the environmental factors of the ICU.

February 23-24, 2024- Cerner documentation system was not connecting to the bed monitors and vital signs were not electronically entered into the EMR.

February 24, 2024- Charge nurse was responsible for 2 unstable patients (one on CVVH and one hemodynamically unstable cardiac surgery patient) and then required to take a transfer from the floor who was intubated on arrival to ICU. In addition to the responsibility of charge, the nurse was responsible for 3 unstable patients- all of whom were assessed as requiring 1:1 care, a blatant violation of MGL 111 Section 231, Limitation on patient assignments per nurse in Intensive Care Units.

February 25-26, 2024- A patient was admitted to Room 2521 on 2/23 following a Rapid Response on the floors. Two accounts were established for the patient in Cerner. The patient was moved to Room 2536 and documentation could not be completed on the patient as the flowsheet was incorrect. The patients' wrist band could not scan, eliminating the safety checks for medication administration. Documentation for the patient in Room 2536 had to be completed as if the patient was in Room 2521 in order to access the correct patient account. Hospital management was aware of two accounts for this patient since the 2/23 ICU admission but it was not resolved.

February 26, 2024- Resource nurse given a full 2 patient assignment and was unable to respond to Rapid Response calls within the facility, violating hospital policy. One of that nurse's patients cardiac arrested at the start of her shift, and she still had to accept responsibility for another patient when a patient became unstable and the assigned nurse was unable to attend to both of her patients, another blatant violation of MGL 111 Section 231.

February 27, 2024- The charge nurse was responsible for a full 2 patient assignment and unable to respond to rapid response calls within the facility in violation of both MGL 111, Section 231 in addition to the hospital's own policy for Rapid Response [to critical patients on the inpatient

units]. That nurse was unable to assist newer nurses who needed support and mentorship, unable to be a second check on blood and other colloid products on a bleeding patient. While assisting with a bedside Peg placement, the nurse was interrupted more than 10 times by the bed manager regarding moving patients in and out of the ICU. Because of the interruptions, her other patient's care was very delayed and medications and skin care were not completed as ordered.

February 29, 2024- Resource nurse began the shift with a full 2 patient assignment. Patients were not repositioned with skin assessments as ordered because of inadequate staff. The resource nurse was assisting physicians and nurses with transferring patients in and out of the unit but was unable to assist staff who required their expertise in the unit and was unable to appropriately care for their own patient assignment, in violation of MGL 111 Section 231.

Labor and Delivery

Documentation in the Labor and Delivery suite continues on 2 different systems despite TJC onsite survey a few months ago. When a patient initially arrives to the unit, most of the documentation is completed in Cerner, but a portion of the documentation (OB specific content) is completed in Centricity. After a vaginal delivery, the patient is monitored for 2 hours and documentation completed in Centricity and date, time, mode of birth with interventions for shoulder dystocia is documented in Cerner. A delivery summary is documented in Centricity, but most of the infants records are held in Cerner. When the patient is admitted to the post-partum unit, documentation is then completed in Cerner. For a patient who undergoes a c-section, some intake documentation is completed in Centricity (e.g. OB history, previous or current pregnancy complications, fetal monitoring strip documentation, prenatal lab work) then switched to Cerner during the intraoperative period. The initial 2-hour recovery documentation is completed in Centricity, with subsequent documentation being completed in Cerner. There is no continuous flow of the information from admission through the patient's hospital stay. This lack of information flow and access risks patient care. When the infant of a patient with gestational diabetes was admitted to the Level 2B nursery with respiratory depression, the infant's blood sugar was not checked because the receiving nurse did not have the information about the mom's diabetes diagnosis. When a post partum readmit returns to the L+D suite for magnesium therapy, the patient's frequent vital signs (every 5-minute blood pressure and neuro checks) flow into Centricity from the monitor but the hospital documentation is required in Cerner. This risk transcription error when RNs are manually placing VS into Cerner from Centricity. This convoluted documentation plan clearly violates TJC standard IM.02.02.03, "The hospital retrieves, disseminates, and transmits health information in useful formats"; TJC standard LC.03.01.01, "Leaders create and maintain a culture of safety and quality throughout the hospital" and TJC standard LD.03.08.01 "New or modified services or processes are well designed." While failing to meet the National Patient Safety Goal 2, "to improve the effectiveness of communication among caregivers."

February 13, 2024- a patient with a planned induction was "on hold" to allow a registered nurse be floated to another unit, leaving L+D unable to meet the needs of their patients, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

Center for Women and Infants (CWI)

January 12, 2024- The charge nurse was assigned 4 patients while precepting a new employee, violating TJC Standard HR.01.04.01, "*The hospital provides orientation to the staff"* and TJC Standard HR01.06.01, "S*taff are competent to perform their responsibilities"* and TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

February 14, 2024- The number of staff on CWI was inadequate to manage a neonatal arrest or manage a critically ill patient, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

GI Unit

January 12, 2024- An untrained nurse was assigned to a patient undergoing an ERCP procedure, violating TJC Standard HR.01.04.01, "*The hospital provides orientation to the staff"* and TJC Standard HR01.06.01, "S*taff are competent to perform their responsibilities"* and TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

Infusion

January 6, 7, and February 9, 2024- No resource nurse was present in the unit to assist with the flow of the unit and to double check chemotherapy infusions and perform safety checks of unit equipment per hospital policy, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

PCU

January 9, 2024- One of the only 2 nurses on the day shift had recently completed orientation. An obese patient could not be repositioned as necessary to assess and prevent soft tissue injury; medications and treatments administered with significant delay violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

January 12, 2024- A patient admitted to the unit from the Emergency Department arrived with hypotension requiring vasopressor infusion; one of 2 patients requiring interventional radiology required RN monitoring for the procedure, leaving only 2 RNs in the unit, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

22 South- Short Stay Telemetry

RNs have documented multiple days when inadequate staffing negatively impacted patient care. In addition, equipment issues raise concern for patient safety.

February 11, 2024- A patient admitted to the unit had fallen and was combative in the ED and pulled out his own IV catheter, but that information was not relayed to the admitting floor violating TJC standard LD.03.04.01, "The hospital communicates information related to safety and quality to those who need it…" All care, treatments and medication administration was delayed; patients were not repositioned as indicated by Braden score to protect the patient from soft tissue injury violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

February 15, 2024- All care was delayed including medication administration, incontinence care leaving patients in urine and feces for an extended time and wound care was delayed, placing patients at risk for infection and soft tissue injury violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

February 18, 19, 27, 2024- All medication administration late.

February 28, 2024- The 1:1 monitoring on an impulsive patient who was frequently found getting up alone was not renewed so that the patient would be accepted to a rehabilitation facility. The transfer of a hospice patient was delayed for hours because there was no secretary to make calls for a transport ambulance. Numerous phone calls were missed because nobody was at the desk to answer calls. All treatments and medication administration was delayed.

March 2, 2024- A pressure injury was discovered on a patient who had been admitted only 3 days prior, the result of a violation of he hospital's own handout, ***Patient Rights and Responsibilities***, ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity. A malfunction with the Omnicell medication administration system required newly ordered medications to be withdrawn using an override-bypassing the safety mechanisms in place.

23 South

RNs have documented multiple days when inadequate staffing negatively impacted patient care. In addition, equipment issues raise concern for patient safety.

January 12, 2024- Medications administration delayed; response to call lights delayed; RNs unable to provide education to patients and families. The hospital's own handout, ***Patient Rights and Responsibilities***, ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity.

January 27, 2024- All care and treatments were late, call bells and bed alarms were not responded to in a timely manner, placing patients at risk for injury violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

January 28, 2024- A confused and combative patient was left drenched in urine for an extended period of time, waiting for personal hygiene. Patients were not repositioned as required for skin care, medications were administered late including nebulizer treatments for patients with

respiratory disease, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs"* and the hospital's own commitment to patients, *Patient Rights and Responsibilities*, ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity

February 6, 2024- Two CMO (comfort measures only) patients were not repositioned and made comfortable every 2 hours as indicated; a patient frequently incontinent of stool was left on soiled linens for an extended period of time; telemetry box was missing for a patient ordered for cardiac telemetry monitoring; a patient requiring stat medications for agitation and ultimately restraints with security at the bedside required focused nursing care but the patient was part of a multi-patient assignment that required the nurse to attend to needs of multiple patients simultaneously, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs"* and the hospital's own commitment to patients, *Patient Rights and Responsibilities*, ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity

February 9, 2024- There was no secretary, therefore multiple calls went unanswered creating an issue with a lack of communication. All care, treatment and medication administration was delayed.

February 10. 2024- Because of lack of staff, nurses struggled to locate a second nurse to co-sign insulin doses per hospital policy; the nurse was responsible for a very sick patient who required frequent blood glucose checks and frequent insulin dosing to manage a blood sugar over 400, violating TJC Standard PC02.02.01*"The hospital coordinates the patient's care, treatment, and services based on the patient's needs.*

24 North

February 9, 2024- Medication administration and treatments with significant delay for patients including neurological checks ordered for every 2 hours on 2 patients, violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs"* the Cerner system was not functioning for an hour so that nurses had limited access to patient information for that time period; violating TJC standard LD 04.01.11 *The hospital makes space and equipment available as needed for the provision of care, treatment, and services."*

February 16, 2024- Patient transferred to floor from the ICU with multiple physician orders that were not discontinued but could not be carried out on the floor because of hospital policy. One nurse accompanied a patient to CT scan because the patient had fallen twice the day prior and the unwitnessed fall protocol was not followed violating TJC Standard PC02.02.01*"The hospital coordinates the patient's care, treatment, and services based on the patient's needs*

Behavioral Health

December 28, 2023- One RN was the only staff person assigned to the unit. There were no other licensed professional or ancillary staff members on the unit with no sitters for 4 hours of the shift, risking the safety of both staff and patients, and in disregard for TJC Standard

PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

33 South

There are numerous examples of the hospital's failure to meet the needs of the patient, violating both TJC Standards and the patients' rights to quality care. The hospital's own handout, *Patient Rights and Responsibilities,* ensures patients that they have the right to a prompt response to all reasonable requests, have the right to personal dignity, and have the right to have [your] pain managed.

February 6, 2024- Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; duoneb nebulizer treatments significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Hourly safety rounds were delayed; Personal hygiene and linen change delayed significantly for incontinent patients; Patients in active withdrawal requiring vistal signs and assessment using CIWA (The Clinical Institute Withdrawal Assessment for Alcohol) and RASS (Richmond Agitation & Sedation Scale) required close monitoring but were part of multi-patient assignment. Nurse unable to provide emotional support and education to patients and families violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

February 8, 2024- Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; duoneb nebulizer treatments significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Hourly safety rounds were delayed; Personal hygiene and linen change delayed significantly for incontinent patients; Nurse unable to provide emotional support and education to patients and families violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

February 12, 2024- Multiple call lights not answered for extended time; The hospital's own handout, *Patient Rights and Responsibilities*, ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity. Nurses were unable to monitor hemodynamics, assess pain adequately and in a timely manner; oral, intravenous medications (including insulin) significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered and unable to get to the restroom in a timely manner; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities,* which ensures patients that they have the right to a prompt response to all reasonable requests, have the right to personal dignity, and have the right to have [your] pain managed. Nurse were unable to provide emotional support and education to patients and families violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

February 19, 22, 2024- Multiple call lights not answered for extended time; The hospital's own handout, *Patient Rights and Responsibilities*, ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity. Nurses were unable to monitor hemodynamics, assess pain adequately and in a timely manner; oral, intravenous medications (including insulin) significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered and unable to get to the restroom in a timely manner; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities*, which ensures patients that they have the right to a prompt response to all reasonable requests, have the right to personal dignity, and have the right to have [your] pain managed. Nurse were unable to provide emotional support and education to patients and families violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

February 26, 2024- Staff were unable to maintain isolation and precautions per hospital policy because of inadequate staffing and high acuity of patients. Staff were not able to perform hourly safety checks violating hospital policy, 2 admissions were sent from the ED with no handoff communication, labs, vital signs and treatments were delayed; staff unable to attend to patient on heparin drip requiring frequent intervention; bedridden patients with high Braden Scores wer not repositioned with skin checks as required by hospital policy placing the patient at risk for soft tissue injury.

34 North

February 17, 2024- Multiple call lights not answered for extended time; The hospital's own handout, *Patient Rights and Responsibilities*, ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity. Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications (including antibiotics for this post-op population) significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities*, which ensures patients that they have the right to a prompt response to all reasonable requests, have the right to personal dignity, and have the right to have [your] pain managed.

February 27, 2024- Inadequate staffing required nurses to take responsibility for too many patients to safely provide care. A newly diagnosed diabetic required frequent finger stick blood glucose tests with insulin coverage, education about his diagnosis and treatment plan received medications late and insufficient education.

March 2, 2024- All care and treatments were delayed, Omnicell medication administration system was not functioning and all medications were obtained using an override, therefore bypassing the safety system.

35 North

December 24, 2023- The hospital's own handout, *Patient Rights and Responsibilities*, ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity. Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications (including antibiotics for this post-op population) significantly delayed violating the hospitals own commitment, *Patient Rights and Responsibilities*, which ensures patients that they have the right to a prompt response to all reasonable requests, have the right to personal dignity, and have the right to have [your] pain managed.

36 North – Cardiac Step down

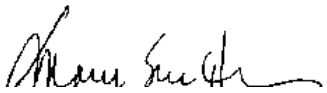
February 11-12, 2024- Multiple call lights not answered for extended time; The hospital's own handout, *Patient Rights and Responsibilities*, ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity. Nurses were unable to assess pain adequately and in a timely manner; oral, intravenous medications significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered; Patients were not ambulated as ordered; Incontinent patients waited extended periods of time for personal hygiene and clean linens violating the hospitals own commitment, *Patient Rights and Responsibilities*, which ensures patients that they have the right to a prompt response to all reasonable requests, have the right to personal dignity, and have the right to have [your] pain managed. Nurses were unable to provide emotional support and education to patients and families violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

February 26, 2024- Unstable patient was sent to the ICU diverting attention of the RNs from the other patients; staff did not recognize that one patient ordered for cardiac monitoring was not on telemetry; all care delayed including medication administration, violating the hospitals own commitment, *Patient Rights and Responsibilities*, which ensures patients that they have the right to a prompt response to all reasonable requests, have the right to personal dignity, and have the right to have [your] pain managed and TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."*

March 1, 2024- Multiple call lights not answered for extended time; The hospital's own handout, *Patient Rights and Responsibilities*, ensures patients that they have the right to be treated in a caring and respectful way and the right to personal dignity. Nurses were unable to monitor hemodynamics, significantly delayed; Patients at risk for pressure injury were not turned and repositioned every 2 hours as ordered violating the hospital's own commitment to patients *Patient Rights and Responsibilities*, which ensures patients that they have the right to a prompt response to all reasonable requests, have the right to personal dignity, and have the right to have [your] pain managed. Nurse were unable to provide emotional support and education to patients and families violating TJC Standard PC02.02.01, *"The hospital coordinates the patient's care, treatment, and services based on the patient's needs."* One the night shift, nearly all RNs (4 of 5) were travelers and not trained to care for this population and unfamiliar with policies and protocols for the procedures involved in the cardiac surgery patient population.

Again, this list is by no means exhaustive and be assured they represent a mere snapshot of what have become daily occurrences throughout the units at St. Vincent Hospital. These conditions are abhorrent by any medical or nursing standard and the nurses of St. Vincent Hospital are both outraged and overwhelmed by the suffering they have endured. As a result, dozens have left the facility unable to accept such lax and dangerous standards, as well as from the repeated abuse they have received from their administration. As an agency responsible for holding providers accountable for the care they provide, we reiterate our call for your immediate intervention, as without proper oversight, we fully expect many more patients to be harmed, and tragically, a number of our patients will die. Despite recent Joint Commission onsite inspections, hospital management continues to place patients at risk and has not resolved the issues that impact patient care and safety.

Sincerely,



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