VIA UPS AND EMAIL

September 23, 2022

Roxanne Rocco
Manager, Northeast Acute & Continuing Care Branch
Northeast Survey & Enforcement Division, Survey & Operations Group
Centers for Medicare & Medicaid Services
801 Market Street, Suite 9400
Philadelphia, PA 19107-3134

Dear Ms. Rocco:

The Massachusetts Nurses Association is reaching out to you to address the continued dangerous conditions in the Good Samaritan Medical Center Emergency Room that have persisted for the past two years. We write this letter after reading the complaint documents that CMS, issued on February 9, 2022, and attached here, which included the Medical Center management's responses with actions they represented to CMS that they have taken to address the deficiencies found by CMS.

We are writing because in many or most cases, management has not effectuated the corrective actions prudently directed by CMS. In some of the cases, the plans management outlined for correction would not even in theory bring about a correction of the given issue.

The issues that the MNA raised previously are these:

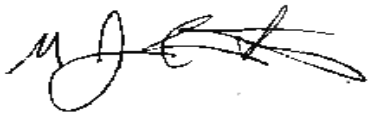
- Inappropriate care in the Emergency Department
- Inadequate patient care
- Emergency Room staffing plans habitually not followed
- Overcrowding of the Emergency Room
- The ability to call a "Code Help" denied

They have persisted because the Medical Center's response and stated plans of action were inadequate or remain unimplemented from the date they were presented to CMS on March 25, 2022.

We are asking that CMS continue its investigation of the continued dangerous conditions in the Emergency Room at Good Samaritan. These unresolved issues continue to pose a real threat of harm to patients. We ask that CMS revisit this complaint and reassess the hospital's plan to evaluate the effectiveness of the plan as implemented. We are available to assist in whatever way necessary and have attached a report of recent incidents on unsafe conditions filed by the nursing staff that verify the claims we are asserting about the dangerous conditions continuing unabated. The following pages provide details and examples of how the conditions cited by CMS continue.

Thank you for your attention and your help, past and present.

Sincerely,



Matthew Roth
Associate Director of Labor Action
Massachusetts Nurses Association

cc: Stephen Sullivan, Healthcare Facility Inspector II, Supervisor of Hospital Complaint Unit, Massachusetts Department of Public Health
Stephen Davis, Director, Division of Health Care Facility Licensure and Certification, Massachusetts Department of Public Health
Dana Simon, Director of Strategic Campaigns, Massachusetts Nurses Association
Julie Pinkham, Executive Director, Massachusetts Nurses Association
Joe-Ann Fergus, Division of Nursing Interim Director, Massachusetts Nurses Association

MR/rg

Recent examples of continuation of previously cited conditions:

NOTE: See the ED staffing grid on the last page to see how many RNs, by policy are supposed to be on shift.

Inappropriate Care in ED:

Example #1: 07/07/2022 RN was given an assignment with 6 high acuity patients with one ICU-level of care patient., requiring an insulin drip and Blood Glucose monitoring who required 1:1 attention due to repeatedly disconnecting IVs and monitoring equipment. Charge RN informed, but there was insufficient staff to provide assistance.

Inadequate patient care/ED Staffing plans habitually not followed/Overcrowding in the ED

(In descending order from the latest to earliest date):

Example #1: 8/07/22 RN took over the Triage assignment at 7AM with 10 patients in the waiting room with a greater than 9 hour wait time to go to the main department including angioedema who waited 9 hours without treatment. There were 17 admit holds. All techs were assigned to sit with patients one on one. No techs available for CPR on a 37-year-old Priority 1 code. Numerous patients left without being seen. Triage RN during the overnight, had 2 patient assignments which included ATA patients and triage. Second triage RN had been assigned after 11pm but was quickly pulled to assist throughout the department and eventually had to open an assignment at 3pm. There was a 7 hour wait to be brought into the department, a 1 hour wait to be triaged. There were 16 admit holds. Charge RN reported calling supervisor to approve double time for per diems but were declined by management.

Example #2: 08/05/22 Assignment with needed 1:1 care due to patient with V-tach, and trauma with bilateral pneumothorax and sternal fracture and multiple other injuries. Trauma was moved to admission RN and management gave no other alternative than for Charge RN being assigned and managing 5 additional patients in 15 minutes including hyperkalemia, chest pain, SOB on Bipap and new onset A-fib in hallway.

Example #3: 08/04/22 We were short staffed at the beginning of the shift at 7:00am. 11a-3p there were very heavy assignments with one having multiple unstable patients including repeatedly coding who required additional staff for an extended period of time. Every nurses assignment had to accept multiple ambulances, despite the acuity. At 7p, there were 13 RNs which decreased to 10 with a census of 74 patients in the department, 23 admit holds, 26 patients at triage with greater than 9 hours waiting. The RN was unable to revitalize patients per protocol due to excessive flow in triage, all to be handled by one RN (including disgruntled patients, lab calls, dealings with x ray and CT). Charge was unable to assign next available rooms to patients despite Priority 2 condition or complaints. Multiple ambulances to triage. Single lone RN at triage with a tech (when there should be two RNs staffed and a tech), a PA doing RME. Many left without being seen including patient who had subdural last month and here with HA but CT refused to

take him for scan because they were busy and it would require more than one trip to the waiting room due to lack of IV for his 'abd' CT. CEDOCS score of 171, level 5 severe overcrowding. By 10pm the supervisor was able to give beds to some admit holds.

Example #4: 08/03/22 Nurse had a 7 patient assignment while orienting a new grad RN to ED. The Charge RN was made aware. Multiple high acuity patients in the department including many traumas. Patient in that RN's assignment with fall with altered sensation in all limbs. Around 9am staffing going from 13 RNs to 9 RNs, so multiple assignments needed to be closed (a "closed assignment" means an RN is leaving for the day and the patients would need to be reassigned to other RNs) shortly, leaving numerous patients without any nurse and necessitating charge RN to have a patient assignment contrary to protocol.

Example #5: 07/31/22 At 11am there were 35 patients in the department and 9 RNs (See the grid, should have 16) on, high acuity throughout the day while RN numbers continued to drop. For reference, we are attaching management's ER staffing grid. There were 6 "Priority 2[1]" patients in waiting room for up to 8 hours. "Priority 2" patients should never remain in the waiting room. The Triage RN alone (Triage assignment should have 2 RNs and a tech) throughout the day leaving patients without reevaluation which should be done every 2 hours according to Steward Good Samaritan Medical Center policy. Patients were in in the waiting room medicated while waiting for rooms, most left without treatment due to excessive wait times. 17 Psych patients boarding requiring 3 RNs. Only 2 psych RNs were scheduled. From 11p-7am, one RN was left with no one to report off to. A tech was covering the triage assignment. It should be covered by an RN. No RN at triage due to critical staffing level of 5 RNs. At 11p the staffing grid is 12, at 12a drops by one to 11 RNs, at 1a drops to 10 RNs, and at 2am to 7a drops to 9 RNs. The nursing supervisor took report of the Triage assignment due to lack of RNs. We do not know if she worked the Triage assignment.

Example #6: 07/29/22 At 7am there were back-to-back critical patients including dissecting AAA, STEMI, resp distress requiring intubation on top of the other 4-5 patients in the assignment. We had 50 patients in the department at that time with 14 admit holds. Elderly demented patient walked out of department and made her way to the streets of Brockton, finally located by police. Only one triage RN throughout the day. There are supposed to be 2 RNs assigned to triage from 7am to 11pm as per the staffing grid. As the day progressed the waiting room swelled to 26 patients with 5 hour wait and eventually to 36 patients at 11pm with greater than 9 hour wait. Multiple "Priority 2" in waiting room. Multiple patients who were brought in by EMS were sent to waiting room with other patients. Charge RN unable to bring patients into assignments due to two issues 1) from 3pm-11pm we should have had 16 RNs, but we only had 12 RNs, and at 3pm-7pm we only had 11 RNs missing 5 RNs, and then at 11pm we should have had 12 RNs but we dropped down to 9 RNs and then finally at 3am we should have had to 9 RNs

[1] Priority 1: is Cardiac Arrest and imminent death and Priority 2: needs immediate intervention and needs life saving treatment. P3: Stable with multiple interventions needed P4: One two interventions needed and stable P5: Zero interventions required. This a general summary.

and 2) due to influx of EMS. Due to these factors at 9pm the charge had to close assignments.

Example #7: 07/26/22 Event occurred. RN had a 7-patient assignment as did all of the other RNs. RN had trauma patient that was struck by a car while motorcycle and unconscious at the scene[2]. Pt arrived at 15:48hrs, at the time of arrival there was only one RN but had assistance from GSMC paramedic tech to start IV's.

Example #8: 07/21/22 Triage RN was assigned alone. The Medical Center protocol from 11am-11pm is for the Triage assignment to be staffed with two RNs and a tech. 6 hour wait to come into the department from triage. Very high acuity with multiple traumas. EMS sent to waiting room with patients. Charge unable to assign rooms to patients.

Example #9: 07/24/22 Triage RN was alone from 7am-11pm. The tech was pulled during the shift to assist in the ED. Greater than a 6 hour wait in the waiting room with 13 patients waiting to go into the ED. Multiple patients left without being seen including a patient with COVID, PNA, cancer, and critical low sodium. Charge RN was unable to bring in patients during the shift due to high acuity, low staffing, and admit holds, of which there were 15. Areas closing at 11pm due to lack of staff. RNs decrease to only 6 staff at 3am for oncoming shift. Charge RN with assignment on 7am-3pm shift. Male psychiatric patient eloped from the department and was able to get as far as Oak Street before being apprehended. No security in the department at the time.

Example #10: 07/23/22 At 7am the charge RN had to close assignments due to lack of staff and the decreasing staff throughout the day. At one point there were 21 admit holds in the department with 9 of the patients being psychiatric patients. Care delayed for patients requiring OR services because of cooling systems. HVAC broke.

Example #11: 07/14/22 78 patients in the department. 21 of which were admit holds. 24 are in the waiting room with 6+ hour wait to be brought into the ED, 12 psych patients. We have only 14 RNs on for the 11pm-3pm shift, which drops down to only 12 RNs at 3pm when we need a minimum of 16 RNs at that time of day. Triage and ATA will be left with only one RN after 3pm and hallway assignments must close. Multiple patients left the ER without treatment. Multiple patients had excessive wait times. Elderly patient with chest pains with cardiac history, abnormal labs, etc. left in waiting room while patients with lesser acuity being treated and discharged leaving sicker patients in the waiting room. Charge RN unable to bring patients into the main dept due to admit holds and lack of staffing.

Example #12: 07/06/22 An RN reports she came to triage at 7am and no nurse in the assignment since 3am due to hospital's inability to provide adequate staffing numbers. 9 patients left unattended in the waiting room and 8 untriaged. Hospital had planned

[2] GSMC is a Trauma accredited Hospital

downtime (computer system downtime) overnight as well adding to limited monitoring ability. Clinical Leader and Charge taking patient assignment in the department, so they were unable to monitor waiting room, leaving patients unattended and a 4 hour delay in care as no vital signs (VS) or nursing assessment had been done on these patients.

Example #13: 07/13/22 A lone Triage RN during the entire 16.5 hour shift, no tech from 3-11pm. Waiting room time 10 hours despite pediatric and elderly patients. 99 year old waiting 6 hours. 82 year old "Priority 2" patient, septic, waited 10 hours to go inside the department. Several patients had abnormal labs in the waiting room. No beds available to be assigned by the Charge RN throughout shift, staffing well below census. 24 admit holds, 78 patients in the department, 28 of those in the waiting room. Patients walking in and leaving after seeing the overcrowded ER, before they are even triaged. Clinical Leader and Charge RN requested but did not come or could not come to speak with disgruntled patients who have exhausted their patience during excessive wait times. Lesser acuity patients (Priority 4-5) taken into ATA or discharge completed by RME provider while leaving sicker, higher acuity and those patients at risk for worsening conditions in the waiting room without treatment.

Example #14: 07/12/22 This morning triage with only one RN and waiting room with 40 patients waiting greater than 10 hours to be seen by provider. Greater than one hour behind triaging patients. 7 ESI level "Priority 2" patients in the waiting room.

Example #15: 07/09/22 Night Shift with 8 nurses at 3am Charge RN had an assignment of up to 8 patients. Day shift scheduled with 8 RNs, missing to staff to core. Had to give report to RN in the morning to the oncoming day shift a 6 patient assignment. The 7th patient required hours of one-on-one care and eventually the patient expired.

Request for Code Helps denied:

Example #1: Current, September 2022 back to the filing of this complaint: Management has not made tracking CEDOC scores a regular assignment to any staff person or provided the CEDOC data to the staff. This would determine whether a Code Help would need to be called. This is despite the MNA's requests for a clarification of this process and implementation, at the parties bi-monthly ED meetings where management and ED staff RNs meet in an effort to continually address the repetitive and chronic issues.

A copy of the management's ED staffing grid, which is hospital policy, included for your reference.

	RN Grid
12:00 AM	11
1:00 AM	10
2:00 AM	9
3:00 AM	9
4:00 AM	9
5:00 AM	9
6:00 AM	9
7:00 AM	10
8:00 AM	11
9:00 AM	13
10:00 AM	13
11:00 AM	16
12:00 PM	16
1:00 PM	16
2:00 PM	16
3:00 PM	16
4:00 PM	16
5:00 PM	16
6:00 PM	16
7:00 PM	16
8:00 PM	16
9:00 PM	16
10:00 PM	16
11:00 PM	12

Express 1 RN 8am - 12pm
Triage 2 RN 7am - 11pm
ATA 2 RN 9/11am - 11pm