

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

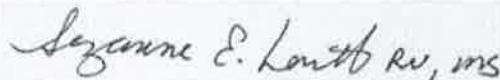
February 24, 2016

Mr. Jayesh Shukla,  
University Of Vt Medical Center Dialysis Berlin  
Po Box 547  
Barre, VT 05641

Dear Mr. Shukla:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on  
February 3, 2016.

Sincerely,



Suzanne Leavitt, RN, MS  
Assistant Division Director  
Director State Survey Agency

THE  
University of Vermont  
MEDICAL CENTER

JHP

February 19, 2016

Susan Leavitt  
Assistant Division Director  
Division of Licensing and Protection  
HC 2 South- 280 State Drive  
Waterbury, VT 05671-2060

VIA email: Tammy Wehmeyer.  
and VSPS

**Re: CMS Certification Number: 473500  
Survey 2/3/2016**

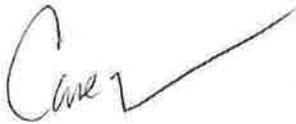
Dear Ms. Leavitt,

I am very pleased to submit Form CMS -2567 and the attached Plan of Correction in response to the Statement of Deficiencies and findings from the survey completed by the Division on February 3, 2016.

The University of Vermont Medical Center is committed to continuously improving the quality of services we provide to our patients. As part of our ongoing performance improvement program we would like to take this opportunity to respond to the regulatory deficiencies that were cited.

If you have any questions about the attached Plan of Correction or require further clarification, please do not hesitate to contact me.

Sincerely,



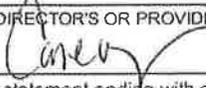
Carol Muzzy, Director  
Accreditations and Regulatory Affairs  
The University of Vermont Medical Center  
111 Colchester Avenue  
Burlington, Vermont 05401  
Phone: 802-847-5007  
Fax: 802-847-6274

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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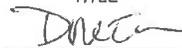
PRINTED: 02/12/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  473500	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/03/2016
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY OF VT MEDICAL CENTER DIALYSIS BERLIN			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 547 BARRE, VT 05641		
(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	
V 000	INITIAL COMMENTS	V 000			
V 113	<p>494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE</p> <p>Wear disposable gloves when caring for the patient or touching the patient's equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.</p> <p>This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to assure that all staff consistently utilized appropriate hand hygiene during the provision of care for 1 of # patients. (Patient #14). Findings include:</p> <p>Per observation on 2/2/16 at 11:55 AM the Hemodialysis Technician (HT) failed to follow facility policy and appropriate infection control practice during the provision of care for Patient #14. During the initiation of Patient #14's dialysis with a AV (arteriovenous) fistula, the HT failed to sanitize and/or wash hands when removing gloves and donning clean gloves on 2 separate occasions during the process of touching the patient's equipment at the dialysis station and caring for the patient. Per facility policy Infection Prevention Policy: Hemodialysis Out-patient and In-patient Care Sites published 7/2013 states: " I.</p>	V 113	See Attached Plan of Correction	2/19/16	

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



TITLE



(X6) DATE

2/19/16

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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V 113	Continued From page 1 Infection Prevention Precautions for all Patients A. 5.: Hand hygiene will be performed after gloves are removed and between patient contacts, as well as after touching blood, body fluids, secretions, excretions and contaminated items. If hands are not visibly soiled, use of an alcohol based sanitizer.....may be substituted for handwashing....". Per interview on 2/2/16 at 3:15 PM, the the Dialysis Nurse manager confirmed it is the expectation staff will sanitize hands after removing gloves and prior to donning clean gloves.	V 113	See Attached Plan of Correction Poc approved V113 Bonnie Howe RN 2/23/16	2/19/16	
V 116	494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT  Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient. -- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient -- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patient's station should be used only for that patient and should not be returned to a common clean area or used on other patients.  This STANDARD is not met as evidenced by. Based on observation, staff interviews and record review the facility failed to assure that staff maintained consistent appropriate infection control practices when transporting nondisposable and reusable items out of patient	V 116	See Attached Plan of Correction	2/19/16	

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V 116	Continued From page 2 treatment stations. Findings include:  Per observation on 2/3/16 at 11:20 AM, a HT (Hemodialysis Technician) was observed not adhering to appropriate infection control practice when s/he failed to disinfect a plastic container before returning the reusable container to a designated "clean" common area. After the initiation of dialysis for Patient#16, the HT was observed removing an empty white plastic container (previously filled with patient supplies for initiation of dialysis) from the overbed table at Station #6. The HT failed to disinfect the plastic container, prior to returning the container to the metal cart identified as a designated common clean area. The white plastic containers are filled each day of dialysis operation by staff, with supplies dedicated for each patient's specific prescribed treatment and access. Per interview on 2/3/16 at 11:40 AM, the Dialysis Nurse Manager confirmed due to potential contamination after use during initiation of dialysis, staff are required to "wipe down" using a bleach cloth, each white plastic container prior to returning them to the designated common clean area.  In addition, it was also noted staff were not consistent when disinfecting the portable ear thermometers which was repeatedly used on multiple patients daily. Throughout the 3 days of survey staff were observed bringing the thermometer into patient dialysis stations to obtain a patient's temperature prior to initiation of dialysis treatment. After obtaining a temperature reading, the thermometer was returned to a charging device. Some staff were observed disinfecting the device prior to returning it to a designated common clean area however, other	V 116	See Attached Plan of Correction  POC approved for V116 2/23/16 Bonnie Howe RN	2/19/16

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V 116	Continued From page 3 staff failed to disinfect the device.	V 116	<i>See Attached Plan of Correction</i>	2/19/16	
V 132	494.30(a)(1)(i) IC-TRAINING & EDUCATION  Infection Control Training and Education  Infection control practices for hemodialysis units intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices.  This STANDARD is not met as evidenced by: Based on observation, staff interview and record review a staff member failed to use appropriate infection control technique when cleaning the access site in preparation for initiation of treatment for 1 of 2 applicable patients. (Patient #14). Findings include:  Per observation on 2/2/16 at 11:55 AM a HT (Hemodialysis Technician) was observed using improper disinfectant technique when prepping the skin over the cannulation site of Patient#14's AV fistula. The HT utilized 1 Chlorhexidine Gluconate/Isopropyl Alcohol swab, disinfecting the skin at both sites in one circular motion, treating the area as one site. Per facility policy Vascular Access: Needle Placement and Removal Published 11/13/13 states: Step 5. "Chlorhexidine is the first choice disinfectant scrub sites gently for 30 seconds each site, and then allow to dry completely". Per interview on 2/2/16 at 3:15 PM, the HT acknowledged how Patient # 14's skin was prepped at the AV fistula site, stating it was how s/he had been instructed. However, further discussion with the Dialysis Nurse Manager confirmed the vascular access	2/19/16			

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V 132	Continued From page 4 must be scrubbed separately for 30 seconds at each site (arterial & venous), using more than one disinfectant swab and HTs should not be dragging the disinfectant up and down over both sites which is contraindicated per policy and standards of infection control practice. The Manager further stated s/he will be reviewing the training process with the dialysis educator to confirm correct technique for disinfecting the skin is being taught.		V 132 See attached Plan of Correction Poc approved for V132 2/23/16 Bonnie Howe RW	2/19/16	
V 147	494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE  Recommendations for Placement of Intravascular Catheters in Adults and Children  I. Health care worker education and training A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections. B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.  II. Surveillance A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.  Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.  VI. Catheter and catheter-site care		V 147 See attached Plan of Correction	2/19/16	

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V 147	Continued From page 5 B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].  This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to assure that staff consistently adhered to appropriate guidelines and practices during provision of care of central venous catheters for 2 of 2 applicable patients. (Patients #6 and #15). Findings include:  1. Per observation on 2/2/16 at 12:25 PM during the provision of Central Venous Catheter (CVC) site care for Patient #15, the RN failed to follow facility policy and manufacturers' recommendations regarding skin preparation. Using Chlorhexidine Gluconate/Isopropyl Alcohol swabsticks, the RN cleansed the CVC exit site as per facility policy, however failed to allow the skin prep solution to air dry as per manufacturers' directions which state: "Allow the prepped area to air dry for one and one half minutes (1.5 minutes). Do not blot or wipe dry". Instead, immediately after cleansing the exit site the RN placed a 4 x 4 gauze pad over the prepped skin and pat the gauze pad with his/her gloved fingers. Per interview on 2/2/16 at 3:00 PM the Dialysis Nurse Manager, confirmed the RN failed to follow Infection Prevention policy by not allowing the prepped skin to air dry ensuring the effectiveness of the skin prep solution.  2. Per observation of initiation of dialysis with a CVC on 2/1/16 at 12:47 PM for Patient #6 and 2/2/16 at 12:15 PM for Patient #15 the RN failed	V 147	See attached Plan of Correction POC approved for V 147 2/23/16 Bonnie Home RN	2/19/16

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V 147	Continued From page 6 to follow facility policy regarding accessing of the catheter hub. Per Care and Maintenance of Central Venous Access Devices; Adult and Pediatric last published 11/25/13 states: " II. Infection Prevention D. Aseptic technique should be used for all access of CVADs (Central Venous Access Devices); the needless connector or hub should be vigorously disinfected with 70 % isopropyl alcohol for 15 seconds prior to EACH access and allowed to air dry for a minimum of 15 seconds." However, during the process of preparing the patients for connecting to the dialysis machine, the RN failed to consistently disinfect each hub for 15 seconds nor did s/he allow the isopropyl alcohol to air dry for 15 seconds during observations of the procedure for both Patient #6 and Patient # 15. Per interview at 2/2/16 at 3:00 PM, the Dialysis Nurse Manager confirmed it is the expectation staff would follow stated policy for CVC care	V 147	See attached Plan of Correction	2/19/16
V 401	494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT  The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.  This STANDARD is not met as evidenced by: Based on observation, staff interview, and document review, the facility failed to assure that a portable oxygen tank was safely and securely stored in a manner to maintain a safe treatment environment for patients, staff and the public.  Per observation on 2/1/16 at 11:25 AM, an unsecured portable oxygen (O2) tank was	V 401	See attached Plan of Correction	2/19/16

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V 401 Continued From page 7  
observed on the floor at the the foot of Patient #3's bed. The unsecured portable O2 tank was directly in the path of foot traffic. Per staff interview on 2/1/16 at 11:27 AM, the Registered Nurse Dialysis Site Supervisor confirmed the portable O2 tank was not secured in a manner to maintain a safe treatment environment for patients, staff and the public.  
Per review of the University of Vermont Medical Center Policy #SEH31 titled "Compressed Gas Cylinders: Safe Storage, Handling and Use", the purpose is to minimize or eliminate hazards posed to staff, patients, and visitors, associated with compressed gas cylinders. Per section 1.2, cylinders should not be stored near elevators, in stairwells, or in other areas where they can be knocked down or damaged. Per section 1.4, cylinders should be stored with the valve end up and chained or otherwise securely held/anchored in an upright position.

V 401 See attached Plan of Correction  
POC approved for V401 2/23/16  
Bonnie Howe RD  
2/19/16

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**V 000 INITIAL COMMENTS**

*An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection on 2/1/16 - 2/3/16 to determine compliance with 42 Code of Federal Regulations Part 405, Subpart U, Conditions for Coverage for End Stage Renal Disease Services. The following regulatory violations were identified.*

**PLAN OF CORRECTION**

**V 113 494.30(a)(1) IC-WEAR GLOVES/HAND HYGIENE**

*Wear disposable gloves when caring for the patient or touching the patients equipment at the dialysis station. Staff must remove gloves and wash hands between each patient or station.*

*This STANDARD is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to assure that all staff consistently utilized appropriate hand hygiene during the provision of care for 1 off# patients. (Patient #14 ). Findings include:*

*Per observation on 2/2/16 at 11:55 AM the Hemodialysis Technician (HT) failed to follow facility policy and appropriate infection control practice during the provision of care for Patient #14. During the initiation of Patient#14's dialysis with a AV (arteriovenous) fistula, the HT failed to sanitize and/or wash hands when removing gloves and donning clean gloves on 2 separate occasions during the process of touching the patient's equipment at the dialysis station and caring for the patient. Per facility policy Infection Prevention Policy: Hemodialysis Out-patient and In-patient Care Sites published 7/2013 states: " I. Infection Prevention Precautions for all Patients A. 5.: Hand hygiene will be performed after gloves are removed and between patient contacts, as well as after touching blood, body fluids, secretions, excretions and contaminated items. If hands are not visibly soiled, use of an alcohol based sanitizer .....may be substituted for handwashing ....". Per interview on 2/2/16 at 3: 15 PM, the the Dialysis Nurse manager confirmed it is the expectation staff will sanitize hands after removing gloves and prior to donning clean gloves.*

**Action Plan**

- Under the direction of the Director of Dialysis and in collaboration with the Infection Prevention Manager and the Dialysis Manager, the Dialysis Site Supervisor reinforced with staff practice expectations outlined in the University of Vermont Medical Center (UVMCC) policy RENL95 Infection Prevention Policy: Hemodialysis Out-patient and In-patient Care Sites with topics reviewed in the policy for Education and Training: proper hand hygiene technique and Appendix A: Infection Prevention Practice at a Glance and included hand hygiene with doffing and donning of gloves, to available staff during the onsite visit completed February 3, 2016. Each staff member appropriate to their role was required to read, acknowledge and sign off on their understanding of the aforesaid policy. The Dialysis educator provided policy review, demonstration and observed return demonstration for appropriate use of PPE completed on all available staff by 2/19/2016. Re-education and acknowledgement as above will be completed by all UVMCC dialysis units by 03/28/2016.

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- Ongoing surveillance of UVMMC's infection prevention performance will be monitored through a combination of Dialysis Site Supervisor weekly observed audits and Regulatory Mock Surveys. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operation Committee.
- An organizational wide educational communication from the Director of Accreditation and Regulatory Affairs and the Manager of Infection Prevention will reinforce key infection prevention practices that everyone needs to know through an electronic communication in the Steps to Excellence during the month of March and April 2016.

**PLAN OF CORRECTION**

**V 116 494.30(a)(1)(i) IC-IF TO STATION=DISP/DEDICATE OR DISINFECT**

*Items taken into the dialysis station should either be disposed of, dedicated for use only on a single patient, or cleaned and disinfected before being taken to a common clean area or used on another patient.*

*-- Nondisposable items that cannot be cleaned and disinfected (e.g., adhesive tape, cloth covered blood pressure cuffs) should be dedicated for use only on a single patient*

*-- Unused medications (including multiple dose vials containing diluents) or supplies (syringes, alcohol swabs, etc.) taken to the patients station should be used only for that patient and should not be returned to a common clean area or used on other patients.*

*This STANDARD is not met as evidenced by:*

*Based on observation, staff interviews and record review the facility failed to assure that staff maintained consistent appropriate infection control practices when transporting nondisposable and reusable items out of patient treatment stations. Findings include:*

*Per observation on 2/3/16 at 11:20 AM, a HT (Hemodialysis Technician) was observed not adhering to appropriate infection control practice when s/he failed to disinfect a plastic container before returning the reusable container to a designated "clean" common area. After the initiation of dialysis for Patient#16, the HT was observed removing an empty white plastic container (previously filled with patient supplies for initiation of dialysis) from the overbed table at Station #6. The HT failed to disinfect the plastic container, prior to returning the container to the metal cart identified as a designated common clean area. The white plastic containers are filled each day of dialysis operation by stat, with supplies dedicated for each patients specific prescribed treatment and access. Per interview on 2/3/16 at 11:40 AM, the Dialysis Nurse Manager confirmed due to potential contamination after use during initiation of dialysis, staff*

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are required to "wipe down" using a bleach cloth, each white plastic container prior to returning them to the designated common clean area.

In addition, it was also noted staff were not consistent when disinfecting the portable ear thermometers which was repeatedly used on multiple patients daily. Throughout the 3 days of survey staff were observed bringing the thermometer into patient dialysis stations to obtain a patients temperature prior to initiation of dialysis treatment. After obtaining a temperature reading, the thermometer was returned to a charging device. Some staff were observed disinfecting the device prior to returning it to a designated common clean area however, other staff failed to disinfect the device.

### Action Plan

- Under the direction of the Director of Dialysis and in collaboration with the Infection Prevention Manager and the Dialysis Manager, the Dialysis Site Supervisor reinforced with staff practice expectations outlined in the University of Vermont Medical Center (UVMCC) policy INFC00016 Infection Prevention Practices – Cleanliness of the Environment and Equipment's with topics reviewed in the policy for Appendix A: Guidelines for Low & Intermediate Level Cleaning and Disinfection and addressed the patient specific plastic containers and portable ear thermometers, to available staff during the onsite visit completed February 3, 2016. Each staff member appropriate to their role was required to read, acknowledge and sign off on their understanding of the aforesaid policy. The Dialysis educator provided policy review, demonstration and observed return demonstration for appropriate cleaning and disinfection for identified items above completed on all available staff by 2/19/2016. Re-education and acknowledgement as above will be completed by all UVMCC dialysis units by 03/28/2016.
- Ongoing surveillance of UVMCC's infection prevention performance will be monitored through a combination of Dialysis Site Supervisor weekly observed audits and Regulatory Mock Surveys. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operation Committee.
- An organizational wide educational communication from the Director of Accreditation and Regulatory Affairs and the Manager of Infection Prevention will reinforce key infection prevention practices that everyone needs to know through an electronic communication in the Steps to Excellence during the month of March and April 2016.

POC for Villo  
approved 2/23/16  
Bonnie Howe RN

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**PLAN OF CORRECTION**

**V 132 494.30(a)(1)(i) IC-TRAINING & EDUCATION**

*Infection Control Training and Education Infection control practices for hemodialysis units: intensive efforts must be made to educate new staff members and reeducate existing staff members regarding these practices.*

*This STANDARD is not met as evidenced by: Based on observation, staff interview and record review a staff member failed to use appropriate infection control technique when cleaning the access site in preparation for initiation of treatment for 1 of 2 applicable patients. (Patient #14 ). Findings include:*

*Per observation on 2/2/16 at 11:55 AM a HT (Hemodialysis Technician) was observed using improper disinfectant technique when prepping the skin over the cannulation site of Patient#14's AV fistula. The HT utilized 1 Chlorhexidine Gluconate/Isopropyl Alcohol swab, disinfecting the skin at both sites in one circular motion, treating the area as one site. Per facility policy Vascular Access: Needle Placement and Removal Published 11/13/13 states: Step 5. "Chlorhexidine is the first choice disinfectant scrub sites gently for 30 seconds each site, and then allow to dry completely'. Per interview on 2/2/16 at 3:15 PM, the HT acknowledged how Patient# 14's skin was prepped at the AV fistula site, stating it was how s'he had been instructed. However, further discussion with the Dialysis Nurse Manager confirmed the vascular access must be scrubbed separately for 30 seconds at each site (arterial & venous), using more than one disinfectant swab and HT's should not be dragging the disinfectant up and down over both sites which is contraindicated per policy and standards of infection control practice. The Manager further stated s'he will be reviewing the training process with the dialysis educator to confirm correct technique for disinfecting the skin is being taught.*

**Action Plan**

- Under the direction of the Director of Dialysis and in collaboration with the Infection Prevention Manager and the Dialysis Manager, the Dialysis Site Supervisor reinforced with staff practice expectations outlined in the University of Vermont Medical Center (UVMMC) policy RENL000047 Vascular Access: Needle Placement and Removal policy and included Needle Insertion: Step 5 with topics reviewed in the policy for appropriate disinfection of skin at the arterial and venous sites to available staff during the onsite visit completed February 3, 2016. Each staff member appropriate to their role was required to read, acknowledge and sign off on their understanding of the aforesaid policy. The Dialysis educator provided policy review, demonstration and observed return demonstration for appropriate disinfection of skin at the arterial and venous sites, completed on all available staff by 2/19/2016. Re-education and acknowledgement as above will be completed by all UVMMC dialysis units by 03/28/2016.

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- Ongoing surveillance of UVMCC's infection prevention performance will be monitored through a combination of Dialysis Site Supervisor weekly observed audits and Regulatory Mock Surveys. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operation Committee.

**PLAN OF CORRECTION**

**V 147 494.30(a)(2) IC-STAFF EDUCATION-CATHETERS/CATHETER CARE**

*Recommendations for Placement of Intravascular Catheters in Adults and Children*

*I. Health care worker education and training*

*A. Educate health-care workers regarding the ... appropriate infection control measures to prevent intravascular catheter-related infections.*

*B. Assess knowledge of and adherence to guidelines periodically for all persons who manage intravascular catheters.*

*II. Surveillance*

*A. Monitor the catheter sites visually of individual patients. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or BSI [blood stream infection], the dressing should be removed to allow thorough examination of the site.*

*Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients.*

*VI. Catheter and catheter-site care*

*B. Antibiotic lock solutions: Do not routinely use antibiotic lock solutions to prevent CRBSI [catheter related blood stream infections].*

*This STANDARD is not met as evidenced by:*

*Based on observation, staff interviews and record review the facility failed to assure that staff consistently adhered to appropriate guidelines and practices during provision of care of central venous catheters for 2 of 2 applicable patients. (Patients #6 and #15). Findings include:*

- 1. Per observation on 2/2/16 at 12:25 PM during the provision of Central Venous Catheter (CVC) site care for Patient #15, the RN failed to follow facility policy and manufacturers' recommendations regarding skin preparation. Using Chlorhexidine Gluconate/Isopropyl Alcohol swabsticks, the RN cleansed the CVC exit site as per facility policy, however failed to allow the skin prep solution to air dry as per manufacturers' directions which state: "Allow the prepped area to air dry for one and one half minutes. (1.5 minutes). Do not blot or wipe dry". Instead, immediately after cleansing the exit site the RN placed a 4 x 4 gauze pad over the prepped skin and pat the gauze pad with his/her gloved fingers. Per interview on 2/2/16 at 3:00 PM the*

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*Dialysis Nurse Manager, confirmed the RN failed to follow Infection Prevention policy by not allowing the prepped skin to air dry ensuring the effectiveness of the skin prep solution.*

2. *Per observation of initiation of dialysis with a CVC on 2/1/16 at 12:47 PM for Patient#6 and 2/2/16 at 12:15 PM for Patient#15 the RN failed to follow facility policy regarding accessing of the catheter hub. Per Care and Maintenance of Central Venous Access Devices; Adult and Pediatric last published 11/25/13 states: " 11. Infection Prevention D. Aseptic technique should be used for all access of CVADs (Central Venous Access Devices); the needless connector or hub should be vigorously disinfected with 70 % isopropyl alcohol for 15 seconds prior to EACH access and allowed to air dry for a minimum of 15 seconds." However, during the process of preparing the patients for connecting to the dialysis machine, the RN failed to consistently disinfect each hub for 15 seconds nor did s/he allow the isopropyl alcohol to air dry for 15 seconds during observations of the procedure for both Patient #6 and Patient# 15. Per interview at 2/2/16 at 3:00 PM, the Dialysis Nurse Manager confirmed it is the expectation staff would follow stated policy for CVC care*

**Action Plan**

- Under the direction of the Director of Dialysis and in collaboration with the Infection Prevention Manager and the Dialysis Manager, the Dialysis Site Supervisor reinforced with staff practice expectations outlined in the University of Vermont Medical Center (UVMCC) policy NGP0009 Care and Maintenance of Central Venous Access Devices; Adult and Pediatric with topics reviewed in the policy for appropriate skin prep and hub cap dry time to available staff during the onsite visit completed February 3, 2016. Each staff member appropriate to their role was required to read, acknowledge and sign off on their understanding of the aforesaid policy. The Dialysis educator provided policy review, demonstration and observed return demonstration for appropriate use of PPE completed on all available staff by 2/19/2016. Re-education and acknowledgement as above will be completed by all UVMCC dialysis units by 03/28/2016.
- Ongoing surveillance of UVMCC's infection prevention performance will be monitored through a combination of Dialysis Site Supervisor weekly observed audits and Regulatory Mock Surveys. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operation Committee.
- An organizational wide educational communication from the Director of Accreditation and Regulatory Affairs and the Manager of Infection Prevention will reinforce key infection prevention practices that everyone needs to know through an electronic communication in the Steps to Excellence during the month of March and April 2016.

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**PLAN OF CORRECTION**

**V 401 494.60 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT**

*The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.*

*This STANDARD is not met as evidenced by: Based on observation, staff interview, and document review, the facility failed to assure that a portable oxygen tank was safely and securely stored in a manner to maintain a safe treatment environment for patients, staff and the public.*

*Per observation on 2/1/16 at 11:25 AM, an unsecured portable oxygen (O<sub>2</sub>) tank was observed on the floor at the the foot of Patient #3's bed. The unsecured portable O<sub>2</sub> tank was directly in the path of foot traffic. Per staff interview on 2/1/16 at 11:27 AM, the Registered Nurse Dialysis Site Supervisor confirmed the portable O<sub>2</sub> tank was not secured in a manner to maintain a safe treatment environment for patients, staff and the public.*

*Per review of the University of Vermont Medical Center Policy#SEH31 titled "Compressed Gas Cylinders: Safe Storage, Handling and Use", the purpose is to minimize or eliminate hazards posed to staff, patients, and visitors, associated with compressed gas cylinders. Per section 1.2, cylinders should not be stored near elevators, in stairwells, or in other areas where they can be knocked down or damaged. Per section 1.4, cylinders should be stored with the valve end up and chained or otherwise securely held/anchored in an upright position.*

**Action Plan**

- A patient's oxygen tank was identified as unsecured at bedside. Under the direction of the Director of Dialysis and the Dialysis Manager, the Dialysis Site Supervisor reinforced with staff practice expectations outlined in the University of Vermont Medical Center (UVMCC) policy SEH31 Compressed Gas Cylinders: Safe Storage, Handling and Use, to available staff during the onsite visit completed February 3, 2016 with topics reviewed for proper storage and placement of oxygen tanks. The Dialysis Site Supervisor secured an oxygen storage caddy to remain onsite as well as wheelchair with attached oxygen caddy retention for patient's presenting with said wheelchair until completion of dialysis to assure the safety and security for the oxygen tank while in use. Each staff member appropriate to their role was required to read, acknowledge and sign off on their understanding of the aforesaid policy. The Dialysis educator provided policy review, demonstration and observed return demonstration for appropriate use for the safety and security of oxygen tanks while in use, completed on all available staff by 2/19/2016. Re-education and acknowledgement as above will be completed by all UVMCC dialysis units by 03/28/2016.
- Ongoing surveillance of UVMCC's infection prevention performance will be monitored through a combination of Dialysis Site Supervisor weekly observed audits, Environment

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of Care Rounds and Regulatory Mock Surveys. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operation Committee.

POC for V401  
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