

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

PRINTED: 03/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/08/2012
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NAME OF PROVIDER OR SUPPLIER CENTRAL VERMONT MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE BOX 547 BARRE, VT 05641
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A 000	INITIAL COMMENTS An unannounced complaint survey was conducted from 8/7/12 - 8/8/12 by staff from the VT Division of Licensing & Protection, as authorized by the Centers for Medicare and Medicaid Services. The following regulatory violations were found.	A 000		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on staff interview and record review, the Condition of Participation : Quality Improvement and Performance Improvement Program was not met based on the hospital's failure to meet the requirement's for quality improvement and related nursing care and discharge planning prior to discharge of one applicable patient in the sample. Patient #1 was placed at risk upon discharge by the hospital's failure to assure that all components required for safe discharge from the hospital had been met prior to discharge. A	A 263		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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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A 263	Continued From page 1 patient who required specialized equipment subsequent to placement of a tracheostomy was discharged home without assuring that the suction machine was in the home and training provided to the patient and spouse, prior to discharge from the hospital. The hospital completed a root cause analysis subsequent to a patient adverse event report on 5/3/12; however the hospital failed to identify all deficient practice and failed to initiate an appropriate action plan, including documentation of the plan, a system for monitoring progress of the plan and ongoing evaluation and analysis of the plan's progress by the Quality Department.	A 263			
A 287	Refer to TAGS A 287, A 288, and A 302 482.21(c)(2) QAPI IMPROVEMENT ACTIVITIES [Performance improvement activities must track medical errors and adverse patient events,] and analyze their causes, and ... This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital's QAPI committee failed to develop and document data for a corrective action plan in response to an adverse patient event reviewed during a Root Cause Analysis (RCA) for 1 applicable patient in the total sample of 11 patient records reviewed. (Patient #1). Findings include: Per review of the medical record for Patient #1 and interview with hospital staff from Discharge Planning, Nursing Services, Respiratory Therapy and Quality Improvement on 8/7/12 and 8/8/12, the hospital's QAPI response to an adverse patient event failed to completely identify causes which contributed to the event during the RCA (Root Cause Analysis) process. The QAPI	A 287			

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A 287	<p>Continued From page 2</p> <p>response failed to show evidence of follow up with corrective action plans and failed to include written data of the audits being completed by responsible department staff (Nursing and Respiratory Therapy). The QAPI response failed to address the lack of patient teaching and care planning regarding self care for a newly placed tracheostomy.</p> <p>A regulatory complaint regarding incomplete discharge planning was investigated after Patient #1 died within hours of discharge from the hospital's medical surgical unit on 4/26/12. The patient had received emergent placement of a tracheostomy after experiencing respiratory failure. The patient was hospitalized at CVMC during the period from 3/21/12 - 4/26/12, excluding a 5 day hospitalization at another hospital from 4/18/12 - 4/23/12. The hospital course included inpatient status in the ICU for almost 1 month. In addition to respiratory failure, diagnoses included multiple co-morbidities contributing to the patient's acute medical condition. The patient was discharged home from the hospital with no evidence of adequate training to assure competency for self care of the new tracheostomy post discharge. CMs (case managers), RTs (respiratory therapists) and RNs (registered nurses) failed to assure that necessary medical supplies, including a suction machine, were available in the home prior to the patient's arrival home. The patient was discharged at 12:35 PM on 4/26/12 and the suction machine arrived at the home at 5:28 PM, later the same day, per interview with the Director of Cardiopulmonary Services on 8/7/12 at 3 PM. He confirmed that the respiratory therapist working with the patient on 4/26/12 spoke with the</p>	A 287			

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A 287	<p>Continued From page 3</p> <p>CM and it was then discovered that no arrangements had yet been made to order a suction machine for delivery to the home that day. Per review of the Discharge Instructions Sheet signed by the Registered Nurse (RN) discharging the patient home on 4/26/12, the form was incomplete and had nothing written in the section for home medical supplies. Page 2 of the form revealed the section of the form for patient education was blank, as well as the area for other instructions. During interview on 8/8/12 at 3:17 PM, the CM responsible for the discharge plan confirmed that no one was aware the patient needed suctioning equipment at home until the day of discharge. A discharge note by the CM dated 4/26/12 at 1402 stated "respiratory therapy is working on obtaining the suction equipment she will need at home". This note was written 1 and 1/2 hours after the patient's discharge from the hospital.</p> <p>Per review of a CM late entry progress note for 4/26/12 at 1615 (written at 1335 on 4/27/12), "CM spoke with spouse who expressed concerns regarding -----(patient's) inability to cough up mucus and that the suction equipment had not yet arrived. ----- (patient) responded in the back ground that "I can't cough anything up and I can't breath". The CM gave instructions to the spouse and said if the patient could not breath to return to the Emergency Department via ambulance. Although the spouse called back a short time later and said that -----(patient) felt better, this was a potentially dangerous situation for the patient.</p> <p>During the hospital's RCA, staff failed to identify all of the issues that contributed to this event. During interview on 8/8/12 at 4:19 PM, the</p>	A 287		

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A 287	Continued From page 4 Medical Director for Quality Improvement stated that s/he felt that they met the priority of the RCA by determining who is responsible for respiratory equipment at discharge. A checklist was designed to assure all necessary referrals/equipment was in place for future discharges home. Although the Director of Cardiopulmonary Services (DCPS) developed an audit form to review all discharges for evidence of appropriate discharge services, and provided education to his staff, he failed to assure written data was completed to show evidence of compliance, adherence to the PI plan and evaluation of needed changes to the interventions in the plan. The DCPS also confirmed that respiratory therapists are responsible for patient teaching on trach self care, a responsibility shared with nursing staff, and that his staff failed to document adequate evidence of teaching/patient/spouse competency for trach self care prior to discharge home from the hospital. At approximately 9 PM on 4/26/12, in the presence of the Home Health RN, the patient collapsed on the bedroom floor and EMS was called to transport to the Emergency Department, where the patient expired. The hospital QA response was not sufficient to assure that a similar situation with potentially life threatening consequences for a patient would not occur again. There was no nursing action plan as a result of the RCA, per interview with the RN Director of Critical Care Services on 8/8/12 at 8:20 AM. S/he stated that s/he was not aware of any QA plans for nurses re: discharge process, patient education and patient care planning. The Director of Quality Assurance, interviewed on 8/8/12 at 3:30 PM also confirmed that she was not aware of any quality response plan for	A 287		

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A 287	Continued From page 5 corrective action regarding this patient's care and discharge process from the nursing department. She stated that the usual process for a RCA has been to utilize a tracking tool to monitor what the corrective plan is, where staff are in the process, communication with work groups to assure that process is on-going and evaluation of actions to maintain compliance. The Director stated that she was on a leave of absence during the RCA for this patient. The hospital failed to assure that trained staff were available to carry on QA activities during the Director's absence. In addition, the Director stated that the RCA was not brought to the hospital wide Quality Council meetings for review May and July, 2012. During interview on 8/8/12 at 4:20 PM, the staff member conducting the RCA stated that a committee was devised to determine who was responsible when a patient with a tracheostomy was being discharged home, including what each discipline was responsible for. A checklist document was devised which has not yet been implemented. There have been no follow up meetings or evidence of follow up contact with committee members since the RCA meeting by the responsible Quality staff. The Director of QA, who was also present for the interview, confirmed that the hospital's quality assurance staff had not followed the department's procedural processes for this case.	A 287			
A 288	482.21(c)(2) QAPI FEEDBACK AND LEARNING [Performance improvement activities must track medical errors and adverse patient events, analyze their causes and] implement preventive actions and mechanisms that include feedback and learning throughout the hospital.	A 288			

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A 288	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that it's performance improvement plans were implemented and failed to assure that mechanisms to include feedback and learning extended throughout the hospital regarding patient care for one applicable patient in the sample. (Patient #1). Findings include:</p> <p>Per interview on 8/8/12 at 4:30 PM, the QA staff member who was responsible for conducting a RCA (on 5/3/12) after an adverse patient event confirmed that s/he had not had follow up meetings with the subcommittee to evaluate and monitor the quality improvement process. Although nursing staff was involved in the discharge of the patient on 4/26/12, no performance improvement activities were put into place as a result of the findings of the RCA meeting. The Medical Director of Quality also confirmed that during the RCA they did not acknowledge the lack of of patient/significant other education prior to discharge to assure safe management of the patient's tracheostomy. The RN Director of Critical Care Services confirmed during interview on 8/8/12 at 3:45 PM that he was not aware of any corrective actions put into place for re-education of nursing staff regarding RN teaching of tracheostomy care in preparation for discharge home for the patient /significant other. He also confirmed that there was no care plan for patient/significant other education for tracheostomy care at home.</p> <p>Although the Respiratory Department did initiate some corrective action plans, they were not fully operationalized and there was no evidence of monitoring and assessment of the ongoing corrective action plan by the department director.</p>	A 288		

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A 288	Continued From page 7 This was confirmed during interview with the Director of Cardiopulmonary Services on 8/7/12 at 3 PM. The director also confirmed that he was not documenting the chart audits/results data that he was completing as part of the corrective action. During interview on 8/8/12 at 4 PM, the Director of Quality Assurance confirmed that the hospital's improvement plan after the RCA was lacking in follow through and analysis of the needed corrective actions necessary to assure safe patient care and planning related to discharges home with a newly placed tracheostomy requiring self care.	A 288		
A 302	482.21(d)(3) QAPI PROJECT DOCUMENTATION [The hospital must document what quality improvement projects are being conducted the reasons for conducting these projects, and] the measurable progress achieved on these projects. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that a quality improvement project initiated after an adverse patient event was properly documented and that measurable progress was achieved regarding the care of one applicable patient in the sample. (Patient #1). Findings include: Per interviews (8/7/12 and 8/8/12) with the QA staff assigned to conduct a RCA after an adverse patient event, there were no transcribed notes from the RCA; no documentation of a corrective action plan for nursing staff re:patient care planning and teaching in preparation for	A 302		

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A 302	Continued From page 8 discharge, no documentation of the respiratory department QA audit process and no evidence of written follow up and/or committee meetings to measure progress in the corrective action plan. The hospital completed a root cause analysis subsequent to a patient adverse event report on 5/3/12; however the hospital failed to identify all deficient practice and failed to initiate an appropriate action plan, including documentation of the plan, a system for monitoring progress of the plan and evaluation of the plan's progress by the Quality Department.	A 302		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that RNs evaluated, assessed and implemented a plan to provide appropriate tracheostomy self care training to Patient #1 and his/her significant other prior to discharge from the hospital to the home setting. Findings include: Per record reviews on 8/7/12 and 8/8/12, Patient #1 had a tracheostomy placed during a hospital stay and RNs failed to document adequate teaching of self care for the patient/spouse in preparation for discharge from the hospital to home on 4/26/12. Review of nursing notes from 4/23/12 - 4/26/12 reveals incomplete documentation regarding the skill level of the patient in completing their own trach care. There was no evidence of training in suctioning the tracheostomy if it should become blocked by thick	A 395		

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A 395	Continued From page 9 secretions. The patient expressed anxiety regarding responsibility for his/her own care during a meeting with a psychiatrist on 4/25/12. The progress note stated "She looks forward to going home but states she is afraid because if there is a medical complication, she will not have immediate help". There was no evidence that the patient was given any written educational materials regarding tracheostomy care upon discharge on 4/26/12. There was no evidence of any assessment of the patient's capabilities for self trach care. Per review of the Discharge Instructions Sheet, signed by the patient and the RN on 4/26/12 at 12:35 PM, the section regarding patient education was blank. This was confirmed during interview with the RN Director of Critical Care Services on 8/8/12 at 3:45 PM. Refer also to A 396	A 395			
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that RNs developed and kept current a nursing care plan for one patient/significant other regarding training of tracheostomy care in preparation for discharge home. (Patient #1). Findings include: Per record review on 8/7/12, there was no nursing care plan developed to address Patient #1's needs regarding education for him/her and the spouse for total care/self care at home for a newly placed tracheostomy during an extended hospital stay. Review of the 'teach back checklist'	A 396			

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A 396	Continued From page 10 notes (4/18/12 - 4/26/12) on 8/8/12 revealed that the patient was instructed only briefly regarding instillation of NS (normal saline solution) into the trachea to loosen mucus. There was no evidence of training regarding how to suction the trachea for removal of excessive mucus if needed. Although a RN documented that a booklet with training materials was given to the patient while s/he was critically ill in the ICU, there was no evidence of follow through and return demonstration for all necessary trach care to be carried out by the patient/spouse after discharge home on 4/26/12. The discharge instructions sheet given to the patient by the RN at discharge documented no educational materials regarding trach care in the education section of the sheet. This was confirmed with the Director of Critical Care Services on 8/8/12 at 3:45 PM. Refer also to A395	A 396		
A 799	482.43 DISCHARGE PLANNING The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by: Based on staff interview and record review, the Condition of Participation: Discharge Planning was not met due to the hospital's failure to assure that a comprehensive and accurate discharge plan was devised and implemented prior to discharge of one applicable patient in the sample. Patient #1 was placed at risk of harm/adverse outcome upon discharge by the hospital's failure to assure that all components required for safe discharge from the hospital had been met prior to discharge. A patient who required specialized	A 799		

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A 799	Continued From page 11 equipment subsequent to placement of a tracheostomy was discharged home without assuring that the suction machine was in the home and training provided to the patient and spouse, prior to discharge from the hospital.	A 799		
A 808	Refer to TAGS A 808, A 810, A 820, and A 822. 482.43(b)(3) POST-HOSPITAL SERVICES The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that discharge planners identified all of the discharge services/equipment needs required post discharge for one applicable patient in the sample. (Patient #1) Findings include: Per record review and confirmed by staff interview on 8/7/12 and 8/8/12, hospital staff failed to assure that all necessary components of the discharge plan for Patient #1 were completed and/or arranged prior to discharge home on 4/26/12. Hospital staff providing care and services to the patient, including respiratory therapists, RNs and CM all failed to assure that the patient's needs regarding trach care, including necessary equipment and demonstration of competency to complete care was completed prior to discharging the patient home on 4/26/12. Per interview on 8/7/12 at 2:58 PM, the DCPC stated that the respiratory therapist for 4/26/12 had obtained the physician order for home suction equipment at approximate 2:45 PM, more	A 808		

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A 808	Continued From page 12 than 2 hours after the patient was discharged from the hospital. He stated that he spoke with the medical equipment driver who said that he arrived at the home with the suction machine at 5:28 PM. He confirmed that the when the CM called to patient's home at 3:30 PM, the CM was told that the patient was short of breath. He stated that the CM called the respiratory department who instructed her to have the patient call 911.	A 808			
A 810	Refer also to A 287, A 395, A 810 and A 822 482.43(b)(5) TIMELY DISCHARGE PLANNING EVALUATIONS The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge. This STANDARD is not met as evidenced by: Based on staff interview and record review, hospital personnel failed to complete a timely evaluation for all of the post hospital needs and services prior to discharge for one applicable patient in the sample. (Patient #1) Findings include: Per record reviews and information received from an anonymous complaint, hospital discharge planners failed to assure that all of the necessary post hospital needs for Patient #1, who had a newly placed tracheostomy, were made prior to discharge from the hospital. The failure to assure that a suction machine had been delivered to the home prior to the patient's arrival home from the hospital, placed the patient at risk of significant	A 810			

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A 810	Continued From page 13 harm from a failure to have necessary equipment available and evidence of competency to use the equipment properly. A failure to communicate all of the needs of the patient/spouse by hospital staff including respiratory therapists, staff RNs and CM (case manager) and obtain all necessary physician orders and equipment needed prior to discharge placed the patient at risk of significant harm. The hospital's policy "Discharge Planning", procedure, #8, states "Specific steps in discharge planning undertaken by each discipline must include: (a) an evaluation of need; (b) education and instruction of patient and family regarding the patient's needs, and (c) providing for continuing care following discharge to meet ongoing needs." During interview on 8/8/12 at 2:45 PM, the Director of Discharge Planning confirmed the lack of appropriate discharge planning for the patient and stated that s/he had instituted audits of discharge instruction sheets for accuracy and completeness of documentation in meeting patient needs.	A 810			
A 820	482.43(c)(3) IMPLEMENTATION OF A DISCHARGE PLAN The hospital must arrange for the initial implementation of the patient's discharge plan. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that initial implementation of the discharge plan regarding a physician ordered referral for one applicable patient in the sample was implemented upon discharge. (Patient #1) Findings include: Per review of the Discharge Instructions Sheet	A 820			

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A 820	Continued From page 14 dated 4/26/12 for Patient #1 on 8/7/12 and confirmed during interview with the Director of Discharge Planning on 8/8/12 at 3:10 PM, there was no evidence that a mental health referral documented on the section "referral for continuing health care or services at home" was ever implemented prior to discharge. During interview the Director of the department stated that there was no formal process to assure that this referral was picked up by anyone responsible for the discharge process. A consulting psychiatrist's progress note dated 4/25/12 stated "Make referral to WCMH" (a local mental health service) "as well as VNA" (Visiting Nurses Association). At 3:40 PM, the director also confirmed that if the Discharge Instruction Sheet stated WCMH referral was indicated, the CM would be responsible for calling WCMH. There was no way to determine during the review if this had been completed, based on the information obtained from staff and the record reviews. Refer also to A 810	A 820			
A 822	482.43(c)(5) PREPARATION FOR DISCHARGE As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This STANDARD is not met as evidenced by: Based on staff interviews and record reviews, the hospital failed to assure that the patient/spouse were counseled on all aspects of post discharge treatments/care to be done at home prior to discharge from the hospital for one applicable patient. (Patient#1) Findings include: Based on record review and confirmed by staff interviews on 8/7/12 and 8/8/12, CVMC staff	A 822			

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A 822	<p>Continued From page 15</p> <p>failed to assure that Patient #1 and her spouse received appropriate education and training in the care of a newly placed tracheostomy prior to discharge home on 4/26/12. Staff also failed to provide evidence of written instructions regarding safe care of the tracheostomy upon discharge home. The discharge instructions sheet dated 4/26/12, signed by the RN and the patient, was left blank for the section entitled 'patient education'. Per review, the hospital's policy titled "Patient & Family Education" states: "It is the policy of CVMC to assure that patients and/or their family, significant other, or caregiver are provided with appropriate... 2) training to learn skills and behaviors that promote recovery and improved function, and 3) referrals to assist with care as needed. Staff will work to ensure that patients and others involved in their care, have the necessary information including written instructions to assist in the recovery process...after discharge. All disciplines involved in the care of a patient are responsible for providing appropriate explanations and teaching based on the ongoing assessment of those needs."</p> <p>Based on review of the medical record and interviews on the afternoons of 8/7/12 and 8/8/12, the CM was not aware of the need for patient/spouse teaching regarding suctioning and overall care of the tracheostomy until the respiratory therapist asked her questions concerning what post discharge service would be providing a suction machine for the home, and had it ordered by the physician. A nursing progress note dated 4/25/12 at 2234 hours stated "Help...help, I am so anxious I can't breathe..." (patient words). PT instructed how to instill NS</p>	A 822		

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A 822	Continued From page 16 and cough via trach, declines suctioning trach. Assessment: Alt in resp function; trach with congested cough, chronic anxiety, cont. trach training.." Although the note stated to continue trach training, there was not documented evidence that the patient/spouse demonstrated competency with the trach care at any time during the hospitalization. A CM progress note written on 4/27/12 at 1335 as a late entry for 4/26/12 at 1615 stated "CM spoke with (spouse) who expressed concerns regarding ----'s inability to cough up mucus and that the suction equipment had not yet arrived. --- responded in the back ground "the nurse had shown me how to squirt saline into my trach and then cough it onto a napkin". She said several times, "I can't cough anything up and I can't breathe". The patient's spouse was instructed to call an ambulance and go the ED if unable to breathe. The CM spoke with the spouse a short time later to inform him that the suction equipment should be at the home within 60 minutes and the home health agency was called to have a RN visit ASAP. The spouse decided to wait for the HHA RN's visit when the patient felt better after a few minutes had passed. Refer also to A 287	A 822			