



AGENCY OF HUMAN SERVICES  
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection  
103 South Main Street, Ladd Hall  
Waterbury VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

January 8, 2013

Melvyn Patashnick, Administrator  
Copley Hospital  
528 Washington Highway  
Morrisville, VT 05661

Provider #: 471305

Dear Mr. Patashnick:

The Division of Licensing and Protection completed a survey at your facility on **November 28, 2012**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **January 7, 2013**.

Sincerely,

*Frances L. Keeler*

Frances L. Keeler, RN, MSN, DBA  
Assistant Division Director  
Director State Survey Agency

FK:ne

Enclosure



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

PRINTED: 12/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  471305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 11/28/2012
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NAME OF PROVIDER OR SUPPLIER  COPLEY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 528 WASHINGTON HIGHWAY MORRISVILLE, VT 05661
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C 000	INITIAL COMMENTS  An unannounced on-site complaint investigation was completed by staff from the Vermont Division of Licensing and Protection on 11/28/12. The following regulatory violations were found.	C 000		
C 294	485.635(d) NURSING SERVICES  Nursing services must meet the needs of patients.  This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview, nursing staff failed to assure that all needs were identified for 1 of 10 patients in the sample, by failing to conduct ongoing assessments of the patient's health condition and status. (Patient #1). Findings include:  Per record review there was no evidence that nursing conducted consistent and ongoing assessments of Patient #1's condition, during his/her hospitalization between 1/4/12 and 1/6/12. The patient presented to the ED (Emergency Department), at 7:50 AM on the morning of 1/4/12, with multiple injuries, including lacerations, abrasions and bruising and complaints of lower back pain, following a motor vehicle accident. Patient #1 underwent surgical repair of a wrist injury on the evening of 1/4/12 with the intent to discharge home following the procedure. A PACU (Post Anesthesia Care Unit) nursing assessment, at 9:48 PM, identified that both of the patient's feet were edematous (accumulation of fluid). A subsequent nurse's note, two and a half hours later, at 12:15 AM on 1/5/12, stated; "not able to bear wt on feet, c/o intense pain of top of feet." The physician was notified and an order obtained for the patient to	C 294	Review policies regarding: A) Nursing Assessment and Reassessments and B) Patient Falls, for necessary updating and initiation to be in alignment with industry standards in: <ul style="list-style-type: none"><li>o Emergency Department</li><li>o Peri-Operative Services</li><li>o Med Surg / SCU</li></ul> Educate nursing staff to Nursing Assessment/Reassessments, and to Patient Falls policies at staff meetings with ongoing feedback of performance at departmental and individual levels. Conduct random chart reviews on 5% of patient charts per month for compliance with Nursing Assessment/ Reassessment policy, and to Patient Falls policy in each area by nursing with reporting oversight to the Hospital Quality Committee, which includes representatives of senior leadership and department directors, for 3 months.	03/15/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE CEO	(X8) DATE
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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.

*pme*

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C 294	<p>Continued From page 1 be admitted overnight for observation. Despite the patient's inability to bear weight and complaints of pain in both feet, there was no evidence of any further assessment of the feet describing their physical condition. A nurse's note at 5:03 AM on 1/5/12 stated the physician had seen the patient and the patient had expressed no pain "except with palpation to feet by MD." A subsequent nurse's note, at 5:30 AM, indicated both feet were swollen and bruised. Although a nurse's note, at 5:45 AM that same morning, indicated the patient had been found on the floor of the room, necessitating mechanical transfer back to bed, there was no evidence of any assessment of his/her condition to identify if any injuries had been sustained in the fall. In addition, although a nurse's note at 8:30 AM stated; "went to X-ray and found potential fractures. Neurological assessment inconsistent", there was no description of the neurological assessment to indicate if the inconsistency referred to ability to feel sensation, level of consciousness; cognitive function or other. There was no further assessment of the patient's neurological status until 11:15 AM, at which time the notes indicated the patient was alert and oriented to time, place, person and purpose. The patient returned to surgery on the evening of 1/5/12 for treatment of fractures of both feet. Nurses notes following surgery indicate the patient was having difficulty following simple commands and had voiced concerns about feeling disoriented and unclear mentally. The patient's mental status and health condition continued to deteriorate and s/he was transferred to a tertiary care center for further evaluation and treatment on the evening of 1/6/12. RN #2, who had provided care for the patient in</p>	C 294	<p>Following implementation of revised/new policies</p> <ul style="list-style-type: none"> <li>o Develop audit tool for chart reviews on Nursing Assessment and Reassessments and Patient Falls. Based upon audit results strategies will be developed to achieve desired outcomes.</li> </ul> <p>Incorporate random reviews into annual quality plan for nursing upon completion of the 3 month audit.</p> <p>Project Team Members: Team composition includes multi-disciplinary management staff and unit specific representatives. VP Patient Care Services will ensure fulfillment of above actions.</p> <p><i>C294 POC accepted 1/7/13 BHOWERN   PNC</i></p>	
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C 294	Continued From page 2 the PACU following surgery on the evening of 1/4/12, confirmed the lack of assessment of Patient #1's feet on the morning of 1/5/12 when the patient was unable to bear weight and complained of pain. The RN stated, at the time of interview on the afternoon of 11/27/12, that the patient's feet "just did not look right."  The ED Nurse Manager confirmed, during interview at 12:44 PM on 11/28/12, the lack of full assessment and description regarding the 1/5/12, 8:30 AM documentation of a neurological assessment identified as 'inconsistent', and the lack of further neurological assessment for a period of greater than 2 hours.  The lack of assessment, following the patient's fall from bed was confirmed by both the CNO and Director of Quality during interview at 2:15 PM on 11/28/12.	C 294		
C 304	485.638(a)(4)(i) RECORDS SYSTEMS  For each patient receiving health care services, the CAH maintains a record that includes, as applicable--  identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;  This STANDARD is not met as evidenced by: Based on staff interview and record review, the CAH failed to maintain medical records with	C 304	Part A Review policy regarding Triage Assessment Policy/Procedure for necessary updating to be in alignment with industry standards. Educate ED nursing staff to Triage Assessment Policy/Procedure policy at staff meetings with ongoing feedback of performance at departmental and individual levels.	03/15/13

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C 304	<p>Continued From page 3</p> <p>complete documentation regarding properly executed consents, pertinent medical history and evidence of assessment of the health status and patient care needs for 2 of 10 patients in the total sample. Findings include:</p> <ol style="list-style-type: none"> <li>1. Per record review on 11/27/12 and 11/28/12, the anesthesia consent form for Patient #10, dated 5/13/12 at 10 AM, was not completely documented. The form included the signed, dated and timed signatures of the patient, the RN witness and the anesthesiologist, with the entire top section of the consent left blank. There was no description of the type of anesthesia to be used and no documentation that the risks were explained and stated to the patient prior to obtaining the patient's signature.</li> <li>2. Per review of the Emergency Department Physician and Nursing Records for Patient #10, both were incompletely documented. The Physician Emergency Record for the patient failed to include the patient's history of Asthma. The Nursing Emergency Record documented only 1 set of the patient's vital signs (VS) for the greater than 3 hour stay in the Emergency Department (ED), (from 2203 hours on 5/12/12 - 0115 on 5/13/12). There was no documentation of assessment of the patient's pain levels and the effectiveness of the pain medication administered. The documentation did not meet the criteria described in the hospital's Triage Assessment Policy/Procedure. The policy stated that a patient triaged as 'Level 3' should have VS taken at least every 2 hours while in the ED. Pain assessments should be documented, including effectiveness of the medication administered.</li> </ol>	C 304	<p>Conduct random chart reviews on 5% of patient charts per month for compliance with Triage Assessment Policy/Procedure in the ED by nursing with reporting oversight to the Hospital Quality Committee, which includes representatives of senior leadership and department director, for 3 months following implementation of revised/new policies.</p> <ul style="list-style-type: none"> <li>o Develop audit tool for chart reviews on Triage Assessment Policy/Procedure. Based upon audit results strategies will be developed to achieve desired outcomes.</li> </ul> <p>Incorporate random reviews into annual quality plan for nursing upon completion of the 3 month audit.</p> <p><b>Part B</b></p> <p>Conduct review and update the Consent policy and Transfer policy with associated forms.</p> <p>Educate physician and nursing staff to changes in Consent policy and Transfer policy with associated forms at respective staff meetings.</p> <p>Monitor completion of consents via Department of Surgery monthly case reviews.</p>	

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C 304	<p>Continued From page 4</p> <p>The above findings were confirmed during interview with the CNO (Chief Nursing Officer) and the Director of Quality Assurance (QA) on 11/28/12 at 5 PM.</p> <p>3. Per record review nursing staff failed to document assessments of pain for Patient #1, who presented to the ED (Emergency Department), at 7:50 AM on the morning of 1/4/12, with multiple injuries, including lacerations, abrasions and bruising and complaints of lower back pain, following a motor vehicle accident. Although the patient remained in the ED for a period of more than 9 hours and received pain medication, including; fentanyl, morphine, dilaudid or Toradol, on at least ten separate occasions, there was no assessment and/or reassessment, with the exception of 2 occasions, of the pain or effectiveness of the pain medication administered. In addition, although Patient #1 was transferred to a tertiary medial center on the evening of 1/6/12, there is no evidence of patient or patient representative signed consent for transfer and the physician signed Transfer Form lacked the date and time of transfer.</p> <p>The lack of documentation of ongoing assessments and reassessments of pain during the period of time the patient was in the ED was confirmed by both the ED Nurse Manager, during interview at 1:23 PM on 11/27/12, as well as RN (Registered Nurse) #1, who had provided care to the patient in the ED, during separate interview, at 11:40 AM on 11/28/12.</p> <p>The CNO confirmed, during interview at 2:15 PM on 11/28/12, the lack of date and time on the Transfer Form as well as the lack of signed</p>	C 304	<ul style="list-style-type: none"> <li>o Report data to Chief of Surgery to follow up with physicians as appropriate with reporting oversight to the Medical Staff Executive Committee</li> </ul> <p>Conduct chart reviews on transfers to another facility for compliance with Transfer policy in each nursing area with reporting oversight to the Hospital Quality Committee and the Medical Executive Committee, which includes representatives of senior leadership and department directors.</p> <ul style="list-style-type: none"> <li>o Develop audit tool for chart reviews on transfers. Based upon audit results strategies will be developed to achieve desired outcomes.</li> <li>o Audits conducted for 3 months following implementation of new policy.</li> <li>o Incorporate random reviews into annual quality plan for nursing upon completion of the 3 month audit</li> </ul> <p>Project Team Members: Team composition includes multi-disciplinary management staff, unit specific representatives, and medical staff representatives.</p>	

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C 304	Continued From page 5 consent for transfer.	C 304	VP Patient Care Services and Chief Medical Officer will ensure fulfillment of above actions.	
C 307	485.638(a)(4)(iv) RECORDS SYSTEMS  [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-]  dated signatures of the doctor of medicine or osteopathy or other health care professional.  This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interviews the facility failed to assure that all orders of physicians or other health care professionals had signatures that were dated and/or timed with the date of entry for 2 of 10 records reviewed. Findings include:  Per record review and despite the language contained on the Physician's Orders form that stated; 'No Orders Will Be Processed Unless Dated, Timed & Signed' there was evidence that the following physician orders had been implemented after acknowledgment by nursing staff, although they each lacked the date and time the respective order entries were made:  a. Patient #1, admitted on 1/5/12, had 2 separate sets of physician orders that were each lacking both the date and time the orders were written. The orders included: "please use 4 side rails on bed to remind pt to ask for help to get out of bed" and, "MRI brain - non contrast, MRA carotid arteries".  2. Patient #2, admitted on 11/26/12, had	C 307 C 304 POC accepted 1/7/13 BHOWENI PNE Conduct review of policies for physician orders and written orders form.  Develop policy for clinical staff to provide direction when orders not signed, dated, and/or timed. Conduct a review of 24 hour chart checks. Educate physician and clinical staff to changes in policy and associated forms at respective staff meetings. Track completion of orders through Medical Records.  o Report data to Chief Medical Officer and Chiefs of Services to follow up with physicians as appropriate with reporting oversight to the Medical Staff Executive Committee.  o Based upon data reports strategies will be developed to achieve desired outcomes.  Project Team Members: Team composition includes multi-disciplinary management staff, unit specific representatives, and medical staff representatives. VP Patient Care Services and Chief Medical Officer will ensure fulfillment of above actions.	03/15/13	

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C 307	Continued From page 6 physician orders stating; 1) Continue Niaspan 500 mg BID; atenolol 25 mg PO QD; Zetia 10 mg PO QD; 2) d/c all MVI and supplements which did not include the date and time the order was entered.  The CNO confirmed the lack of dates and times on each of the respective physician orders during interview at 2:15 PM on 11/28/12, and stated staff should have contacted the practitioner who made each of the order entries and confirmed the date and time of entry prior to implementing the orders.	C 307	C307 POC accepted 1/7/13 BHOWERN   PMC		