

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

PRINTED: 06/04/2012
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 05/23/2012
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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 Critical Access Hospital recertification survey was completed by the Division of Licensing and Protection on 5/23/12. The following regulatory violations were identified:	C 000		
C 151	485.608(a) COMPLIANCE WITH FEDERAL LAWS & REGULATIONS The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients This STANDARD is not met as evidenced by: Based on observations and staff interview, the CAH failed to complete and accurately post patient census and number of nursing staff providing direct patient care as required per Vermont Statute 18 Chapter 42, 1854. Findings include. Per observation on 5/21/12 at 11:20 AM, the "Direct Caregiver Full Time Equivalents" weekly sheets posted at the medical/surgical nurse's station were not completed for the dates 5/14/12 through 5/19/12. Vermont Statute Title 18, Chapter 42, 1854 requires the hospital to post the nursing full time equivalent (FTE) staffing per patient census per shift for the current date and the previous 7 days. There was no staffing posted on the special care unit and the birthing units. The failure to post the required nursing FTEs per patient per shift on each unit was confirmed with the unit clerk for the special care unit on 5/21/12 at 11:25 AM The Birthing Center Nurse Manager also confirmed, during interview at 2:05 PM on 5/23/12, that nursing FTE's was not currently	C 151	Unit clerk and assigned nurses will be responsible for completing the required paperwork for posting on a daily basis for day and night shifts. Clinical Administrative Supervisors (CAS) will monitor compliance of daily posting. Monitoring will be reported via the CAS shift report. Report will be revised to include 'Direct Care Giver' section. <i>acc accepted @ 6/15/12 M. ...</i>	06/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CEO	(X6) DATE 6/14/12
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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.

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C 151	Continued From page 1 posted on the unit, nor had it been posted for the 6 days prior to 5/23/12.	C 151		
C 276	485 635(a)(3)(iv) PATIENT CARE POLICIES [The policies include the following:] rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use. This STANDARD is not met as evidenced by: Based on observation and staff interview the CAH failed to assure all code carts where medications are stored were properly secured and/or monitored at all times. Findings include: Per observation, during tour with the ED (Emergency Department) Nurse Manager at 8.14 AM on 5/22/12, the Pediatric Code Cart located in an exam room of the ED (Emergency Department) was found unsecured and unmonitored, providing access to the emergency medications stored within the cart. An RN (Registered Nurse) working in the ED at the time of the observation discovered the plastic seal used to secure the cart on the floor approximately 4 feet away from the cart and stated that housekeeping may have accidentally hit the lock when cleaning near the cart, causing the seal to break and fall off. S/he further stated that the	C 276	Lock on Pediatric Crash Cart was relocated on cart and the cart was moved to a safe location in the room during the survey. Audits will be conducted by the ED Nursing Director, ED nurses, and other administration randomly for 30 random audits across 30 days to assess the integrity of the lock. The findings of the audit will be logged and reviewed to ensure actions have been successful.	07/13/12

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C 276 Continued From page 2
seal had been broken off on previous occasions and s/he felt it was related to the location of the cart, which was in close proximity to the stretcher, providing opportunity for anyone walking by to accidentally hit the plastic seal and break it. The RN stated that although the seal had previously been found broken the cart had not been relocated nor had any other action been taken, to date, to resolve the issue

C 276

C 278 485.635(a)(3)(vi) PATIENT CARE POLICIES

C 278

[The policies include the following:]

a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.

This STANDARD is not met as evidenced by:
Based on observation and staff interview, the facility failed to assure consistent and appropriate surgical attire was worn by perioperative staff in accordance with standards of practice as part of infection prevention and control. Findings include:

During a tour of the perioperative area on 5/21/12 at 1:45 PM a CRNA (Certified Registered Nurse Anesthetist) was observed wearing a hair covering that failed to completely cover their hair and jewelry. On 5/23/12 at 9:15 AM the anesthesiologist and other surgical staff observed in operating room #2 failed to cover their hair completely while a surgical procedure was being conducted. Per AORN (Association of periOperative Registered Nurses) Journal, January 2012 Vol 95 No 1 "Implementing AORN Recommended Practices for Surgical Attire " Perioperative nurses should not wear jewelry

All staff in OR area will be educated to proper surgical attire. Education will include posters, policy review, and one on one education as needed. Skull caps will not be deemed proper surgical attire. Routine monitoring of appropriate surgical attire will be performed by the team leaders in the OR and the Infection Control Practitioner while reinforcing compliance.

06/30/12

In relation to nursing staff, performance evaluations will include their compliance with standards of attire. In relation to the anesthesia and surgical staffs, the chiefs of services will be responsible for addressing attire. Ongoing compliance will be monitored through the OR Committee.

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C 278 Continued From page 3
such as earrings, necklaces.... that cannot be contained within surgical attire because of the risk of contaminating the surgical attire" AORN further states "All personnel should cover their head and facial hair when in the semirestricted and restricted areas. Hair coverings should cover facial hair, sideburns, and the nape of the neck. Perioperative nurses can help minimize the risk of surgical site infections by covering head and facial hair..." AORN further states "Skull caps are not recommended because they do not completely cover the wearers hair and skin; they fail to cover the side hair above and in front of the ears and the hair on the nape of the neck".

C 278

Per interview at the time of the observation on 5/23/12, the assistant nurse manager of perioperative services confirmed staff failed to maintain appropriate infection control standards of practice. Per interview on the afternoon of 5/23/12, the Chief of Anesthesia acknowledged wearing a skull cap during surgery did not provide sufficient covering of all hair

C 295 485.635(d)(1) NURSING SERVICES

A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available.

This STANDARD is not met as evidenced by. Based on observation, interview and record review, nursing staff failed to conduct ongoing assessments of the needs of 1 patient to

C 295

Restraint Policy and associated documentation will be reviewed and evaluated by the Patient Safety subcommittee. All nursing will receive education as to the documentation of restraints focusing on assessments and re-assessments for the need of restraints, and all elements that will be reviewed in the restraint chart audit.

07/31/12

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C 295	<p>Continued From page 4</p> <p>determine effectiveness of and continued need for specific interventions/treatment that had been implemented in response to an identified concern. (Patient #18). Findings include:</p> <p>1. Per record review staff failed to provide assessments, in accordance with the facility's Restraint policy, to determine the ongoing need for use of soft wrist restraints for Patient #18 who was admitted on 4/6/12 for treatment of anaphylaxis (hypersensitive reaction to an allergen). The policy, last revised in March of 2012, stated, "1) Restraint orders are to be preceded by determination and documentation that other, less restrictive measures have been found to be ineffective to protect the patient or others from harm." and, the order for restraint must be, "8-d). Ended at the earliest possible time."</p> <p>A Patient Progress Note, dated 4/7/12 at 7:46 PM, stated the patient had become agitated, combative, attempting to get out of bed, pulling at the IVs (intravenous lines) and continued to struggle and strike out at others for a period of approximately 45 minutes, resulting in the need to apply soft wrist restraints to protect the patient and others. The restraints were applied in accordance with a physician order, dated 4/7/12 at 7:00 PM, and they remained on the patient throughout his/her hospitalization, with brief periods of release for repositioning and/or ROM (Range of Motion) exercises, until discharge on the afternoon of 4/8/12.</p> <p>Review of Patient Progress Notes indicated that during the 8 hour period between 11:00 PM on 4/7/12 and 7:00 AM on 4/8/12, the patient was</p>	C 295	<p>Electronic and paper versions of the Nursing Flowchart documentation will be revised to include assessment and re-assessment.</p> <p>Ongoing chart audits will be conducted for every chart when restraints have been ordered and reported on the monthly Dashboard of Indicators.</p>	

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C 295	<p>Continued From page 5</p> <p>asleep, "resting calmly" or "awake and appropriate . non-combative" with the exception of 1 period of restlessness, at 2:02 AM, that coincided with an episode of the patient's tongue swelling. In addition there was documentation that a 1:1 sitter remained with the patient until 11:30 PM at which time the Progress note stated; "nurse now providing constant monitoring from doorway " A Progress Note, at 6:17 AM identified that the patient was able to follow some commands and was non combative and stated "Restraints still in place at this time until patient is more alert and can assess demeanor " Although there was no evidence of reassessment to determine the need for continued use of the restraints during this time, nor any evidence of less restrictive measures employed, physician orders had been obtained, at 11:00 PM on 4/7/12 and again at 3.00 AM on 4/8/12, to continue the restraints for periods of up to 4 hours each.</p> <p>During interview, at 2:40 PM on 5/23/12, the CNO (Chief Nursing Officer) agreed that bilateral soft wrist restraints had been continuously used on the patient and there was no evidence of reassessment or less restrictive measures employed prior to continued use of the restraints from 11:00 PM on 4/7/12 through 7:00 AM on 4/8/12.</p>	C 295		