



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

October 18, 2016

Arthur Mathisen, Administrator  
Copley Hospital  
528 Washington Highway  
Morrisville, VT 05661

Dear Mr. Mathisen:

The Division of Licensing and Protection completed a survey at your facility on **August 4, 2016**. 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 **October 17, 2016**.

Sincerely,

A handwritten signature in cursive script that reads "Suzanne E. Leavitt RN, MS".

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

Enclosure

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

PRINTED: 08/18/2016  
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  08/04/2016
NAME OF PROVIDER OR SUPPLIER  COPLEY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 528 WASHINGTON HIGHWAY MORRISVILLE, VT 05661		
(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	
C 000	INITIAL COMMENTS  An unannounced recertification survey was conducted on 8/1/16-8/4/16 by the Division of Licensing and Protection to determine compliance with Conditions of Participation for Critical Access Hospitals at 42 CFR, Part 485, Subpart F.  Based on information gathered, the hospital was determined not to be in compliance with the Federal Condition of Participation for Critical Access Hospitals to include: COP: Surgical Services at 485.639 and COP: Provision of Services at 485.635. The following regulatory deficiencies are the result of the recertification survey. Findings include:	C 000			
C 270	485.635 PROVISION OF SERVICES  Provision of Services This CONDITION is not met as evidenced by: Based on observations, staff interviews and record reviews throughout the survey, the Critical Access Hospital (CAH) Condition of Participation for Provision of Services was not met related to non-compliance with the following standards.	C 270	C-271 Concerns identified: No facility policy defining physician-ordered intervention/service of 1:1 observation of patient.		
C 271	485.635(a)(1) PATIENT CARE POLICIES  The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on review of CAH policies, and confirmed through staff interview, physician orders for 3 applicable patients included interventions/services for which there was no facility policy to define and direct those services. (Patients #26, #28 & #10). Findings include:	C 271	a) A Patient Sitter policy and procedure will be developed to include definitions, and role description. <b>Draft policy completed 8/19/16</b> Draft policy to be reviewed/approved at September Professional Practice Committee (PPC) meeting. <b>PPC approved draft policy 9/8/16</b> . Policy to be presented for approval at October Medical Staff Executive Committee. b) 50% of current Environmental Services staff and LNAs/Techs will be educated on new policy and procedure by 10/31/16. Education of all sitter staff will be complete by 12/31/16. Attendance will be documented and tracked by Directors. Copies of attendance rosters will be submitted to Quality Department. <i>Doc and 10.17.16 SD/SR</i>		

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

*Lisa A. Jones, VP, Operations*

9/21/16

(X8) 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 15 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 271	Continued From page 1 1. Per record review Patients #26 & #28, both of whom had exhibited aggressive and potentially unsafe behaviors, each had ED (Emergency Department) physician orders, dated 5/24/16 and 6/27/16 respectively, that directed staff to provide patient observation levels/status of 1:1. Despite these orders there was no policy that defined the scope of service or provided staff with training in how to conduct the observations including: parameters for, what constitutes 1:1 observation, (does it include constant eyes on the patient, inclusive of bathroom use); what distance from the patient should the observer be located; who should conduct the observations, (licensed or non-licensed staff), and what information should be relayed to nursing regarding concerns/issues; will the observer provide any direct care in the form of hands and what documentation is expected related to the observations.  2. Per record review for Patient #10, on 6/7/16 at 0:811 a physician's order read, "Constant observation for safety". Per interview on 8/4/16 at 9:28 AM with the Nurse Manager (NM) of Medical Surgical Services and Special Care Unit, s/he stated that a one to one (constant observation) was instituted for Patient #10 on 6/7/16, due to increased agitation. Per the NM, the staff who performed the one to one observation were the housekeepers and/or security personnel; and that these personnel were to sit with the patient and were not to perform any hands on care. Per the NM, the security guard and/or housekeeper were to alert the nurse caring for the patient when, "something does not look right". S/he confirmed that there was no training for the personnel who performed the constant observation (one to one) and no hospital policy.	C 271	C 271 continued c) Using our PDSA methodology, Sitter policy and procedure will be piloted during the next quarter.  <b>Monitoring:</b> Department Directors will audit a minimum of 75% of sitter patient records for compliance with Sitter policy and procedure. Audit results and any recommendations will be reported to Utilization Review and Hospital Quality Committee.	

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C 271	Continued From page 2	C 271			
C 276	<p>During interview, on the afternoon of 8/3/16, the Director of Quality acknowledged that there was no facility policy related to services for 1:1 observation status.</p> <p>485.635(a)(3)(iv) PATIENT CARE POLICIES</p> <p>[The policies include the following:]</p> <p>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:</p> <p>Based on observation, record review and interview, the pharmacy service failed to ensure that policies and procedures for the safe storage, handling, labeling, dispensation and monitoring of drugs throughout the hospital were followed in accordance with accepted professional principles. Findings include:</p> <p>1. Per observation in the Multidisciplinary clinic on 8/3/16 beginning at approximately 9:30 AM, the following drug storage issues were identified: In Exam room #7, a bottle of Betadine (a broad spectrum topical antiseptic) and a bottle of isopropyl alcohol 70% were not dated when opened. In the storage closet in Exam room #1, a bottle of Betadine was not dated when opened. In Exam room #6, a bottle of Lidocaine hydrochloride 2% (a local anesthetic) oral/topical solution was not dated when opened and put in use. A staff nurse confirmed the above</p>	C 276	<p>C 276 1. Concerns identified: In Specialty Clinic, bottles of multi-use Betadine, isopropyl alcohol, and Lidocaine hydrochloride were not dated when put in use.</p> <p>a) Just-in-time education provided by Practice Manager to staff and providers regarding need to date multi-use drugs and biologics when opened on 8/3/16. Staff not working on 8/3/16 are expected to read and sign minutes on next scheduled shift.</p> <p>b) Sharpies were placed in every exam room on 8/3/16.</p> <p>c) Practice Manager will add review of procedure for dating multi-use drugs and biologics to new hire orientation checklist by 8/31/16.</p> <p>d) Pharmacy Director will provide education to all clinical areas on current "Stability and Sterility of Pharmaceuticals" policy, including the process for dating topicals, liquids, and compounding components when opened and the process for discarding, by October 31, 2016.</p> <p><b>Monitoring</b> Daily checks of each exam room will be conducted by Practice Manager or designee each morning and documented. Infection Preventionist will add checks for opened/undated medications and biologics to Environment of Care rounding. <b>Added to EOC rounds 8/26/16.</b></p>		

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C 276	Continued From page 3 observations at the time of the tour and stated that the above solutions are used for multiple patients and should have been dated when opened. Additionally, the medication storage closet in the nurses office contained drugs provided by manufacturer representatives to be given to patients as samples. On the shelf above the sample medications, was a container of germicidal wipes (opened) and cloths; on a shelf below the medications, was an open bottle of urine test strips, pipettes, a test tube rack, nonsterile gauze pads and paper replacement rolls. The sample medication log book was positioned on top of the container holding the lab supplies. A staff nurse confirmed the above observations at the time of the observation. S/he also confirmed that the urine test strip bottle was currently in use and posed a potential infection control issue related to its storage in the same cabinet with the sample medications. Per review, the facility policy: III-09.2 Unit Inspections states that "All drug storage areas within Copley Hospital will be inspected at least monthly by pharmacy technicians and/or pharmacists to ensure proper storage of medications" ... "inspections shall address at least the following: ... Test agents, germicidals, disinfectants and other household substances shall be stored separately from drugs." Per interview with the Pharmacy Director (PD) on 8/4/16 beginning at 9:32 AM, s/he confirmed that the pharmacy department is responsible for safe drug storage in all areas of the hospital. S/he stated that s/he was not aware of the storage issues in the multidisciplinary clinic until identified during the survey though the clinic had been inspected monthly by pharmacy technicians. Per review, the last inspection of the sample closet	C 276	C 276 1. continued Concerns identified: cleaning and lab supplies stored with medications in Sample Medication cabinet in Specialty Clinics. a) Lab and cleaning supplies removed and relocated on 8/3/16. b) Practice Manager provided just-in-time education to all current staff regarding correct storage of medication on 8/3/16. Staff not present on 8/3/16 are expected to read and sign minutes. c) Practice Manager will add to orientation checklist by 8/31/16.  8/25/16 <i>Sample medications were moved to Pharmacy for management and dispensing until Pharmacy and Therapeutics Committee meets on September 15, 2016 to make its recommendation to either discontinue or develop a new policy to manage sample medications.</i>  <i>account 10-17-16 SD/SL</i>		

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C 276	Continued From page 4 and procedure rooms occurred on 7/13/16 and no concerns were identified. The PD confirmed that drugs should be stored separately from cleaning and lab supplies. Additionally, the PD stated that the current procedure for sample drugs includes that the PD review the completed Pharmaceutical Sample Log Forms monthly; however, s/he confirmed that s/he has not reviewed the forms from the multispecialty clinic for quite a while and could not remember the last time they were forwarded for review. S/he reported that she had just heard that the clinic's office manager (OM) had revised the log form but had not reported that there had been discrepancies related to a lack of consistent documentation on the forms. Per review of the current log form, the PD agreed that it would be difficult to track and account for medications due to the current entry and disposition procedure on the form and s/he identified a need for further revision. 2. Per observation on 8/1/16 at 3:15 PM of Operating Room #2, a bottle of Betadine (Povidone-iodine, a broad spectrum antiseptic for topical application, used as a skin preparation for surgery) was noted in the supply cabinet; the bottle had previously been opened and was without a date as to when it was opened. The Nurse Manager of Surgical Services confirmed that the bottle had been opened and was without an open date on the bottle. S/he stated that there was no way to know how long the bottle of Betadine had been in the cabinet. Per manufacturer's guideline's, Betadine was good for one year from the date opened. This was further confirmed by the CAH Pharmacy Director, who stated on 8/2/16 at 2:20 P.M, that bottles of Betadine would be safe for use for 1 year after being opened, with the expectation staff would	C 276	C 276.1 Concern identified: Pharmacy failed to secure storage of drugs within the hospital - no inventory of Specialty Clinic sample medications.  8/25/16 Sample medications were moved to Pharmacy for management and dispensing until Pharmacy and Therapeutics Committee meets on September 15, 2016 to make its recommendation to either discontinue or develop a new policy to manage sample medications.  C 276 2. Concern identified: Bottle of Betadine found in OR #2 opened and undated. a) Director of Periop provided just-in-time education to current periop staff on 8/3/16. b) Periop will transition to all single-use Betadine bottles by 9/15/2016.  Monitoring: Director of Periop or designee will check for compliance during daily rounds.  <i>Be Ann ID 17-16 SD 181</i>	9/1/16



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C 278	<p>Continued From page 6</p> <p>cart. At 3:15 PM in OR #2 also noted 2 blades were also stored without a protective covering. It could not be verified by the Peri-Operative manager if the blades had been reprocessed, had been recently used and/or were safe for patient use. Per interview on the afternoon of 8/1/16 the Manager for Central Sterile confirmed all used laryngoscope blades after reprocessing always leave the Central Sterile department in a covered pack. Per CDC (Centers for Disease Control and Prevention) Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 states: Semicritical items contact mucous membranes or nonintact skin. This category includes respiratory therapy and anesthesia equipment.....laryngoscope blades. These medical devices should be free from all microorganisms.....Semicritical items minimally require high-level disinfection using chemical disinfectants..."</p> <p>b. At 3:05 PM in OR #3 and at 3:15 PM in OR #2 a powder-like dust was observed on the ventilation faceplates covering each out take airvent located on the lower walls of each of the operating rooms. Per CAH policy Cleaning Surgical Suite last approved 03/18/15 states " 6. Scheduled Cleaning: Every 6 months damp wipe all wall vents, mop ceiling and damp mop ceiling vents ". It could not be confirmed when the last cleaning of the airvents was conducted.</p> <p>2. Per tour of the Multispecialty clinic with the practice manager and a staff nurse on 8/3/16 beginning at 9:30 AM, the following observations were made and confirmed at the time of the observation:</p> <p>a. In the medication closet, an open container of germicidal wipes and lab supplies that included</p>	C 278	<p>C 278 1.b. Concern identified: Powder-like dust observed on ventilation plates covering out take vents in OR #2 and #3. Vents in all OR rooms cleaned 8/1/16. Nightly cleaning of vent covers added to OR night cleaner's list duties 8/1/16. <b>Monitoring</b> Director of Periop or designee will check air vents for cleanliness during daily rounds.</p> <p><i>pc averts 10-17-16 SD/SL</i></p>	8/1/16

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C 278 Continued From page 7

an open bottle of urine test strips, pipettes, a test tube rack, nonsterile gauze pads and paper replacement rolls were stored in the same cupboard as sample medications. The sample medication log book was positioned on top of the container holding lab supplies. A staff nurse confirmed that the urine test strip bottle was being used by the clinic. S/he agreed that the storing used lab supplies in the same cupboard as medication samples posed a potential infection control issue. Per review, the facility's pharmacy policy: III-09.2 Unit Inspections states "...Test agents, germicides, disinfectants and other household substances shall be stored separately from drugs."

b. In Exam room #7, oxygen tubing was unpackaged and loosely coiled on the oxygen wall outlet. An office nurse stated that the plastic bag had come off the tubing and agreed that it looked used and should have been discarded and replaced.

c. Also in Exam room #7, two open bottles of single use gauze packing tape were in a storage cupboard and had not been discarded after use. Per interview with the Infection Control Practitioner (IP) on the morning of 8/3/16, s/he confirmed that the above observations/practices in the multispecialty clinic did not follow infection control standards.

3. During a tour of the Outpatient Rehab Unit and therapy pool with the rehab supervisor on 8/1/16 beginning at 2:37 PM, the following infection control issues were identified and confirmed.

a. Open cell and soft foam positioning/exercise blocks and cylinders were ready for patient use in the clinic. The rehab supervisor confirmed that the equipment was used with multiple patients and that the foam surfaces could not be

C 278 C 278 2.a.

Concerns identified: cleaning and lab supplies stored with medications in Sample Medication cabinet in Specialty Clinics.

a) Lab and cleaning supplies removed and relocated on 8/3/16.

b) Just-in-time education provided by Practice Manager to staff and providers regarding proper storage of medication on 8/3/16. Staff not working on 8/3/16 are expected to read and sign minutes on next scheduled shift.

**Monitoring**  
Cabinet check added to daily room checks.

C 278 2.b.

Concerns identified: IC 278 Unpackaged O2 tubing hanging from wall in Specialty Clinics; unable to determine if clean or soiled. Single-use gauze packing tape not discarded after use.

Practice Manager provided just-in-time education to all staff present on 8/3/16 regarding need to leave patient items in packaging/covered until used and to discard single-use items immediately after use. Staff not working on 8/3/16 are expected to read and sign minutes on next scheduled shift.

**Monitoring**  
Added to daily room checks.

8/3/16

*DC (sup) 10. 12. 16 PSL*

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C 278	Continued From page 8 adequately sanitized between patients. b. Per review of the Therapy pool testing records and maintenance action logs from 1/1/16- 8/1/16, policies and procedures were not followed consistently to ensure that water quality fell within the prescribed ranges. [Bromine (3.0-5.0)]. Per review of the pool maintenance procedure, if the bromine level is above 8.0 suspend operations and/or add Chem Out per label to decrease concentration to acceptable levels, recheck in 2 hours. If Bromine is 0-2 ppm operate as normal, adjust bromine feeder up 10-15 points, recheck in 2 hours. Per review of the pool logs on days patients were scheduled to use the pool: on 1/29, 5/16, 5/24, 7/11 and 7/25/16 bromine levels tested out of range (high) and there is no documentation that the bromine level was retested in 2 hours after the addition of chemical treatments; on 6/6/16, there is no documentation that the pool water was tested at all; on 2/19 and 2/22/16, the Bromine levels were low ( 1 and 2.0) and not rechecked in 2 hours after treatment per policy. On multiple instances in this date range, "chem out" was added to the pool water to correct Bromine levels, but there was no evidence that the Bromine levels were retested in the 2 hour interval to assure that the level did not go below the accepted range and then need further adjustment (for example, on 7/18/16, the Bromine level tested high at 7:00 but was reportedly in range when retested at 7:02 after the addition of chem out).  On 8/2/16 at 12:00 noon, the Director of Rehab services (DR) confirmed that the policies and procedures for pool sanitization had not been followed consistently to ensure safe water quality. S/he further confirmed that the foam bolsters and cylinders in the outpatient rehab units could not	C 278	C 278 3.a. Concerns identified: Open cell and soft foam blocks and cylinders/bolsters not adequately sanitized between patients in OP Rehab.  All open cell and foam cell blocks/ cylinders on OP Rehab were discarded on 8/1/16. Alternative product that can be adequately sanitized between patients was identified and has been ordered.  C 278 3.b. Concerns identified: OP Rehab staff failed to consistently follow policies and procedures for pool sanitation to ensure safe water quality.  a) Pool water quality testing procedure and documentation logs will be revised to better capture data for ensuring safe water quality. Testing will be revised to include ANSI guidelines for safe patient water quality (operational water quality procedure). Operational quality testing will result in "pass" or "fail". Pool will not be opened for patient use if an operations test fails. Testing also to include Optimal Range procedure (Optimal ranges are set by manufacturer to maximize pool equipment longevity, and are narrower ranges than operational ranges for patient safety). Pool will be retested 100% of time following addition of chemicals. b) All Rehab staff involved in pool water testing will be educated on new procedure by October 31, 2016 and education will be documented.  <i>see unit 10.17.16 30/16</i>	8/1/16	

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C 278	Continued From page 9 bc adequately sanitized and would be removed from service and replaced.  4. During tour of the Emergency Department (ED), on the morning of 8/1/16, the tops to both suction canisters, attached to wall outlets located at the heads of each of the two beds in room #8, were heavily coated with dust. In addition there was a yankauer tip (the component of suction equipment that is placed in the patient's oral cavity during suctioning) attached to the end of the suction tubing on one of the canisters that was uncovered and exposed to potential environmental contamination. The beds were cleanly made and ready for patient access. The ED Nurse Manager confirmed the observations at the time of tour and also agreed that the yankauer tips should be kept covered to prevent contamination.	C.278	C 278 3.b. continued <b>Monitoring:</b> All daily pool water quality testing results will be reviewed by a second qualified tester and co-signed prior to pool opening until 100% compliance achieved and sustained for a minimum of 3 months.  C 278 4. Concerns identified: Tops of 2 suction canisters in ED room # 8 were heavily covered with dust. Yankauer suction tip uncovered and exposed to potential environmental contamination.  Environmental Services Director will review cleaning procedures with all EVS staff at August, 2016 EVS staff meeting; attendance will be documented. Those not in attendance are expected to read and sign Aug meeting minutes. On 8/1/16, ED Director provided just-in-time education to ED staff on need to keep patient items covered until used. <b>Monitoring:</b> Visual inspection during routine ED and EVS Director or designee rounds.	
C 279	485.635(a)(3)(vii) PATIENT CARE POLICIES  [The policies include the following:]  Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patient, and that the requirement of §483.25(i) of this chapter is met with respect to inpatients receiving posthospital, SNF care.  This STANDARD is not met as evidenced by: Based on observation and staff interview the Director of Food Services failed to assure that dietary staff adhered to recognized safe food handling practices for 1 of 3 observations of the kitchen areas. The Food Service Director also failed to assure that all staff were educated and	C 279		

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NAME OF PROVIDER OR SUPPLIER  COPLEY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 628 WASHINGTON HIGHWAY MORRISVILLE, VT 05661	
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C 279	<p>Continued From page 10</p> <p>adhered to Manual and Automatic Dishwashing Policy/Procedures at all times.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Per observations in the hospital kitchen during the initial tour (11:04 AM, a package containing frozen pumpkin was observed defrosting on a tray at room temperatures. Additionally in another area of the kitchen, a tray on a baker's rack contained several bags of green beans removed from the freezer and defrosting at room temperature. Accepted safe food handling practice recommends that to minimize the growth of harmful bacteria, frozen foods should be defrosted in a manner that will assure that the food is not maintained in the temperature range between 41 degrees F. (Fahrenheit) and 135 degrees F. (This is known as the "temperature danger zone" and bacteria growth is limited when foods are held above or below the temperature danger zone*.)</li> <li>2. During the initial tour, near a prep area in the kitchen (11:20 AM), 3 cases identified as containing 'pudding' were observed sitting on the counter next to a reach-in refrigerator. When the staff person working there was asked how long the delivered items had been on the counter, they said that they were delivered earlier and they wanted to finish what they were doing before putting the pudding away. Per interview with the Sous Chef, the delivery arrived at approximately 10:15 AM that morning, and the driver left at about 10:25 AM.</li> </ol> <p>During interview, the Director of Food Services confirmed that staff should not be defrosting any frozen foods on trays at room temperature; s/he confirmed that this was not a safe way to defrost frozen foods. S/he also confirmed that deliveries</p>	C 279	<p>C 279 1:</p> <p>Concerns identified: Personnel failed to recognize safe food handling; observed to be defrosting pumpkin and green beans at room temperature.</p> <p>"Procedure for Thawing Potentially Hazardous and Non-Hazardous Foods" was revised on 8/8/16 to ensure temperature-sensitive foods are appropriately handled to maintain food safety. Staff will be educated at Aug, 2016 staff meeting; staff not in attendance will be expected to read and sign posted procedure by 9/15/16.</p> <p><i>Monitoring:</i> Daily visual inspection by Nutrition Services Director or designee during rounds until compliance achieved and sustained for a minimum of one month; then spot checks thereafter.</p> <p>C 279 2:</p> <p>Concerns identified: Kitchen personnel failed to recognize safe food handling. Frozen pudding that had been delivered was left on a shelf.</p> <p>"Procedure for Receiving Goods" was revised on 8/29/16. New language includes "foods requiring freezing or refrigeration are placed in freezer or refrigerator upon delivery whenever possible and always within 1 hour of delivery or food is discarded".</p> <p><i>Doc copy 10.17.16 SDP</i></p>
			8/31/16

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C 279	<p>Continued From page 11</p> <p>of perishable cold foods should be prioritized and put away upon delivery. (*Reference: ServSafe Manager, 6th edition book., Chapters 1 and 2.)</p> <p>3. Per observation of the Manual Dishwashing Procedure, staff had not followed the hospital's P/P "Nutrition Services, Pots and Pans Washing Procedure", revised 7/27/15. The staff used a damaged test strip to measure the level of sanitizing solution in the 3rd sink, used for the sanitizing of manually washed items. The only color chart available to compare the test strip to was damaged and inaccurate. A new container of test strips was obtained per surveyor suggestion and the proper process was reviewed with the staff present. Additionally, the sink had been filled to top, beyond the marked "fill line" on the outside of the sink. Overfilling the sink would dilute the sanitizing solution, that automatically dispenses from a wall mounted unit above the sink. These issues were confirmed with the staff present.</p> <p>4. Per observations of the automatic Dish Machine operation at 4 separate times on the first day of survey. The wash cycle failed to reach the recommended 160 degrees F.; per the Nutritional Services Policy "Proper Dish Machine Temperatures", revised 7/29/15. The temperatures for the washed cycles ranged from 149 degrees F. to 158 degrees F. Per interview with the staff present, s/he stated that the machine has not been reaching the required temperatures for washing on many recent days and s/he has to stop and restart the machine several times in order to get it to the proper temperatures. On the day of the observation, the Maintenance Director needed to adjust the temperatures prior to the booster motor and</p>	<p>C 279 2. continued Staff will be educated at Aug, 2016 staff meeting; staff not in attendance are required to read and sign posted procedure by 9/15/16.</p> <p><b>Monitoring:</b> Daily visual inspection by Nutrition Services Director or designee during rounds until compliance achieved and sustained for a minimum of one month; then spot checks thereafter.</p> <p>C 279 3. Concerns identified: Kitchen staff did not follow the hospital's Pots and Pans Washing Procedure. No color charts available to staff to determine if the water and sanitizer were at the proper range. kitchen staff used water- damaged test strips for measuring sanitizing solution level in sanitation sink.</p> <p>a) Holder for test strips and test strip reference chart was moved to higher location to avoid water splashes on 8/1/16.</p> <p>b) "Pots and Pans Washing Procedure" was revised to include the following language: "fill sink to fill line marked on the sink", "if test strips or test strip reference color chart are damaged by water, do not use and discard" on 8/26/16.</p> <p>c) All kitchen staff will be educated on revised procedure and expectations at Aug 2016 dept. meeting. Those not in attendance are expected to read and sign procedure by 9/15/16</p>	<p>8/31/16</p> <p>8/1/16</p> <p>8/26/16</p> <p>8/31/16</p>

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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 279	Continued From page 12 replace a part and the dish machine was fixed the next day. During interview, the Food Service Director confirmed s/he had not been aware of the problems with the dish machine and some staff's lack of knowledge of the proper manual dishwashing procedures and test processes.	C 279	C 279 3. continued d) "Pots and Pans Washing Procedure" will be added to orientation checklist for new kitchen staff. e) Procedure posted by the pot sink 8/29/16.  <b>Monitoring:</b> Daily visual inspection by Nutrition Services Director or designee during rounds until compliance achieved and sustained for a minimum of one month; then spot checks thereafter.	8/29/16	
C 291	485.635(c)(3) SERVICES PROVIDED THRU AGREEMENT/ARRANGEMENT  The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided. This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview the CAH failed to include all required components in the list of services provided under agreements or arrangements. Findings include:  Per review the list describing the nature and scope of services provided by the CAH through agreements or arrangements did not include whether or not the services being offered were offered on site or off; whether there is any limit on volume or frequency of services being offered or when the services are available.		C 279 4. Concerns identified: Kitchen Dishwasher failed to reach the required 160 degrees during 4 testing times. a) New dishwasher motor ordered and installed 8/12/16 b) New dishwasher temperature dual thermometer purchased. Thermometer will be placed in machine weekly to verify internal temperature reaches 160 degrees and to verify accuracy of machine temperature gauges. Thermometer implemented on 8/25/16. c) Kitchen staff will be educated on revised Dish Machine and Temperature Checks Procedure, including use of new thermometer, documentation requirements, and what to do if 160 degrees temperature not reached at Aug 2016 Department meeting. Education will be documented.	8/12/16  8/25/16	
C 320	485.638 SURGICAL SERVICES  If a CAH provides surgical services, surgical procedures must be performed in a safe manner			8/31/16	

8/12/16 SD/SL

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C 320	Continued From page 13 by qualified practitioners who have been granted clinical privileges by the governing body, or responsible individual, of the CAH in accordance with the designation requirements under paragraph (a) of this section.  This CONDITION is not met as evidenced by: Based on observation and interview the Condition of Participation for Surgical services was not met as evidenced by the failure of Perioperative Services to limit access to the operative and recovery areas to only authorized personnel; failure to assure staff providing housekeeping services were knowledgeable regarding the correct concentrations of disinfectant solutions used during the cleaning of operating rooms; and staff failed to adhere to maximum hair coverage when entering ORs and during surgical procedures. Findings include:  1. Throughout the days of survey, observations were made of the accessibility of unauthorized individuals to potentially enter the peri-operative area which included the operating rooms (ORs), Post Anesthesia Recovery Unit (PACU) and Central Sterile Supply. During a tour on 8/1/16 at 1:50 PM with the Director of Peri-Operative Services, the entrance into the Peri-Operative area was observed located on the second floor of the CAH. The sliding door entrance to this restricted location is accessed from a public hallway. The sliding doors can be opened by unauthorized individuals by pressing a push pad or waving a hand over an automatic eye sensor. Although a sign is posted stating only authorized individuals allowed beyond the door entrance and a red line is also noted on the floor in front of the sliding doors to the restricted area, unauthorized access can be easily accomplished. The Director	C 291	C 291 Concern identified: The CAH failed to include all required components in the list of services provided under agreements or arrangements. Quality Director generated list of services provided by contract/ agreement that contained all required elements on 8/4/16. New process developed on 8/4/16 so list will be updated as needed and is readily available in separate tab in "Contracts" electronic file. <b>Monitoring:</b> Quality Director will review list monthly to ensure current, accurate, and readily available.	8/4/16
		C 320	C 320 1. Concern identified: Failure of Perioperative Services to limit access to operative and recovery areas to only authorized personnel.  OR / PACU access will be converted to badge-access only to limit areas to authorized personnel only. Completion target date 10/1/16.  <i>Procurent ID: 1711 SDM</i>	

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C 320	Continued From page 14 had indicated the doors are locked during the evening and night hours and can only be accessed by CAH personnel with ID badge authorization. S/he further stated during hours when surgical services are being provided there was always staff at the scheduling and charge nurse's desk located at the front entrance of the Peri-Operative suite. However, during frequent observations to include 8/3/16 at 10:10 AM, no staff were observed at the desk or hallway leading to the operating rooms or Central Sterile Supply. PACU nurses were observed often busy with patient care and unable to consistently monitor the entrance. The operating room scheduler assigned to the front desk, frequently sits with his/her back to the entrance and is often occupied on the phone with physician services. The Charge nurse is also frequently absent from the front desk, often participating in a supervisory role within the operating rooms or as an active participant in a surgical case.  2. Per interview on the afternoon of 8/1/16, housekeeping staff assigned to cleaning operating rooms in between surgical cases failed to demonstrate accurate knowledge for the correct concentration of disinfectant solution used when cleaning the operating room floors. Per CAH policy Cleaning Surgical Suite current version dated 03/18/15 states: "After Case Completed f. The floor should be mopped with a freshly laundered mop head and EPA-registered hospital-grade germicidal agent". The housekeeper identified Virex-II as the solution used for mopping the OR floors and stated s/he "...used 7-8 hand pumps..." (approximately 1 oz per pump) of the disinfectant cleaner into a mop bucket containing "...40 gallons of water". However, in accordance with the manufacturer	C 320	C 320 2. Concern identified: Environmental Services staff failed to demonstrate accurate knowledge for the correct concentration of disinfectant solution used when cleaning the operating room floors. a) New automatic delivery system was installed, and EVS staff educated on use; mixer placed into operation 8/2/16. b) OR floor cleaning solution will be tested prior to use using Virex test strips. Test strips ordered, awaiting delivery 8/25/16. All testing will be documented. c) Competency checklist on proper mixing of floor cleaning solutions will be developed; all EVS staff will be required to complete competency annually.  <b>Monitoring:</b> Director of EVS or designee review of test logs and observation of compliance during daily rounds.	8/2/16 9/1/16

*one unit 10.7.16 SD/16*

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C 320	Continued From page 15 Diversey recommendations, states Virex II "... used as directed at 1:256 dilution (1/2 oz per gallon of water)..." is indicated. The correct size of the mop bucket was confirmed by the Peri-operative Manager to be approximately only 5 gallons. The Manager further acknowledged there has been no recent competency and/or supervision to ensure housekeeping staff were aware of correct use and dilution of this very concentrated disinfectant. In addition, the Infection Preventionist acknowledged on the afternoon of 8/2/16 that although the CAH had an automatic feed system for Virex II in other housekeeping closets throughout the facility, the Peri-operative area had not been provided with this convenience and provision for accurate water/solution ratio. Prior to completion of this survey, an automatic delivery system was installed in the Peri-Operative housekeeping closet, thus providing staff with the correct dilution of Virex II when cleaning OR floors. Per AORN 2015 Edition Guidelines for Perioperative Practice states: "Environmental Cleaning: II.c.3. Cleaning chemicals must be prepared, handled, stored, and disposed of according to manufacturer's Instructions for use.....microbial contamination of disinfectants has been reported with improper dilution of the disinfectant."  3. Per observations on 8/2/16 at 7:45 AM during the course of a surgical procedure in OR #2, the circulating nurse was observed wearing Personal Protective Equipment (PPE) hair covering that failed to completely cover his/her hair which was protruding from under the protective hat at the nape of the nurse's neck while actively involved in the surgical procedure. Per AORN (Association of Perioperative Registered Nurses) Journal, January 2012 Vol 95 No 1 "Implementing AORN	C 320	C 320 3. Concern identified: OR staff failed to adhere to maximum hair coverage when entering ORs and during surgical procedures. On 2 occasions 2 staff members had hair coming out of their caps. a) OR staff will be re-educated regarding hospital's Surgical Attire policy at September 2016 Surgical Services meeting, including responsibility of all staff to speak up immediately if they identify an individual out of dress code compliance. Any OR staff not in attendance will be required to read and sign off meeting minutes. b) Periop Director or designee is currently exploring options for better structured hats. <b>Monitoring:</b> Daily visual observation of Periop staff headwear by Periop Director or designee to ensure compliance.	9/1/16

*Doc signed 10.17.16 SD/SP*

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C 320	Continued From page 16 Recommended Practices for Surgical Attire, 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 wearer's 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". In addition, per CAH policy Surgical Attire current version dated: 03/31/15 states: "Attire in Semi-restricted and Restricted Areas: All peri-operative personnel will cover head and facial hair, including sideburns and the nape of the neck."	C 320		
C 322	485.639(b) ANESTHETIC RISK & EVALUATION  (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed. (2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia. (3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.  This STANDARD is not met as evidenced by: Based on record review and staff interview, anesthesia services failed to conduct post anesthesia evaluations on both inpatient and	C 322	Concerns identified: Anesthesia Services failed to conduct post- anesthesia evaluations on both inpatient and outpatients who received the services of anesthesia for 3 post-surgery patients.  a) Policy for Post-Anesthesia Evaluation will be developed and approved. <b>Draft completed 8/25/16</b> . Draft Policy sent to Medical Staff Executive Committee for review/approval at September 12, 2016 meeting. b) Post-anesthesia evaluation tool based on ASA guidelines will be developed by 9/30/16. c) Education on new policy/procedure will be provided to all Anesthesia providers and PACU nursing staff by 10/31/16. Documentation of education will be sent to Director of Quality. <i>08/18/16 10:12:16 SD/ST</i>	9/12/16

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C 322	Continued From page 17 outpatients who received the services of anesthesia for 3 applicable patients. ( Patients #5, 17, 24) Findings include:  1. Patient #17 was admitted to the CAH on 5/21/16 and required emergent surgery for acute appendicitis. The patient received general anesthesia and remained hospitalized until 5/23/16. A post anesthesia evaluation was not conducted. This omission was confirmed on 8/4/16 at 12:00 PM by the CAH Clinical Director of Anesthesia Services. 2. Patient # 24 was admitted to the CAH on 8/1/16 for a total right knee replacement. The patient received intrathecal analgesia by anesthesia. The patient was discharged on 8/3/16. A post anesthesia evaluation was not conducted. 3. Patient #5 had an outpatient surgical procedure on 8/1/16 for a Right bunion. The patient also has a history of Atrial fibrillation and asthma. Prior to the patient being discharged home, there was no documentation regarding a post anesthesia evaluation.  Per interview on 8/3/16 at 9:05 AM the Clinical Director for Anesthesia Services acknowledged all patients receiving general anesthesia, regional anesthesia or monitored anesthesia care should be receiving a post anesthesia evaluation. The anesthesiologist stated: "We could be doing a better job" regarding the required follow-up to evaluate each patient's condition for proper anesthesia recovery.	C 322	C 322 continued <b>Monitoring:</b> Director of Periop will oversee Anesthesia compliance audit of post-anesthesia evaluations. Audit findings will be reported monthly at Hospital Quality Committee and to Medical Staff Executive Committee.
C1000	485.635(f) PATIENT VISITATION RIGHTS  A CAH must have written policies and procedures regarding the visitation rights of patients,	C1000	

*ROC Aug 10 12 16 JD 181*

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NAME OF PROVIDER OR SUPPLIER  COPLEY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 528 WASHINGTON HIGHWAY MORRISVILLE, VT 05661	
(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
C1000	Continued From page 18 including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation ....  This STANDARD is not met as evidenced by: Based on review of facility policies, and confirmed through staff interview, the CAH failed to include all components in their patient visitation policy that would assure it is consistently implemented by staff in an appropriate manner that would not limit or restrict the visitation rights of patients. Findings include:  Per review, the CAH's policy titled Visitation Rights of Patients, dated 1/22/16, did not address how staff who are involved in controlling visitor access to patients will be trained to assure ongoing consistent implementation of the policy, and avoid unnecessary limitations or restrictions on visitation for patients.  The Director of Quality acknowledged, during interview on the afternoon of 8/4/16, that the policy did not address staff training regarding the visitation policy.	C1000	C 1000 Concern Identified: Visitation Rights of Patients policy did not address how staff who are involved in controlling visitor access to patients will be trained to assure ongoing consistent implementation of the policy to avoid unnecessary limitations or restrictions on visitation for patients.  a) Compliance Officer will revise current visitation policy to include language on how staff are educated regarding visitation policy. b) All current staff will be educated on revised policy by 10/31/16. Education attendance will be documented and sent to Quality Department. c) Visitation Rights of Patients policy will be included in general orientation of new employees beginning September 2016. d) All employees will be required to complete annual review of Visitation Rights of Patients policy. <b>Monitoring:</b> Directors/Managers will track compliance with required education and follow-up with individual staff as needed.	9/19/16

*Acc count 10.17.16 SD/81*



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

August 18, 2016

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

Provider ID #: 471305

Dear Mr. Patashnick:

To participate in the Medicare & Medicaid programs, Critical Access Hospitals must meet the requirements in the Code of Federal Regulations (CFR) 485 established by Centers for Medicare & Medicaid Services (CMS). Failure to comply with all Conditions of Participation may result in a termination of your provider agreement.

A survey was completed at your hospital on August 4, 2016. Based upon survey findings, Copley Hospital was found to be out of compliance with Conditions of Participation for The Provision of Services and Surgical Services, as well as several standard level requirements.

This letter serves to notify you of Copley Hospital failure to comply with the Conditions of Participation stated above. The projected date on which your agreement will terminate is November 2, 2016.

Please submit a plan of correction for all deficiencies by August 28, 2016. A revisit will occur.

If you have any questions concerning this letter please contact me at (802) 241-0480

Sincerely,

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