

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

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2013
NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401		
(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	
A 000	INITIAL COMMENTS	A 000			
A 438	<p>482.24(b) FORM AND RETENTION OF RECORDS</p> <p>The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to assure a complete and accurate medical record was maintained for 1 of 10 applicable records reviewed. (Patient #1). Findings include:</p> <p>1. Per review of the medical record Patient #1 had a lab requisition, dated 4/16/12, that identified an area of the male genitalia as the source of a culture specimen obtained that day. However, the requisition further identified the Associated Diagnosis as "Wound infection following</p>	A 438	<p>SEE ATTACHED PLAN OF CORRECTION C. Muzzey 9/16/13 Completion DATE 10/29/13</p>	10/29/13	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carol Muzzey</i>			TITLE DIRECTOR		(X6) DATE 9/16/13

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 438	<p>Continued From page 1 cesarean section, postpartum".</p> <p>The director of the medical lab confirmed the documentation error during interview on the afternoon of 5/30/13. The inaccuracy of the medical record was also confirmed by the nurse who had been responsible for completing the lab requisition. The nurse stated, during interview at 12:30 PM on the afternoon of 5/1/13, that the requisition had been completed electronically and the diagnosis was chosen from a drop down box. S/he confirmed it appeared the wrong diagnosis had inadvertently been checked off.</p> <p>2. Per review of the record Patient #1 was admitted to the facility at 6:29 PM on the evening of 4/16/13 for treatment of a wound infection. Although a nurse's note, dated 4/16/13, stated the patient's "IV (intravenous) was D/C'd (discontinued) and patient left AMA (against medical advice)" at 8:45 PM, there was no evidence that an AMA form had been signed by the patient nor any indication that the patient had refused to sign the form. The facility's policy for Patients off the Unit (Includes AMA, Out on Pass, Elopement) , with a publish date of 10/12/2012 and identified by staff as the currently established policy, stated under Patients Who Wish to Leave the Unit without Permission: 2. "If a competent patient with decision-making capacity wishes to be discharged from the hospital against medical advice (AMA).....The patient may leave after signing AMA form.....If the patient refuses to sign the form, the patient's refusal to sign the form shall be documented in the record."</p> <p>During interview, at 1:30 PM on 5/1/13, the Nurse Director of the Medical Surgical Units, confirmed</p>	A 438	<p>See ATTACHED PLAN OF CORRECTION C. Murray</p>	01/29/13	

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A 438	Continued From page 2	A 438		
A9999	<p>CLOSING COMMENTS</p> <p>Based on staff interviews and record review the facility failed to be in compliance with The State of Vermont Statute Title 18, Chapter 21: Communicable Disease, for 1 applicable patient. (Patient #1). Findings include:</p> <p>Per review of Vermont State Statute: 18 V.S.A. . § 1141. Communicable Disease testing:</p> <p>(a) A health care provider may order a test for blood borne pathogens if a health care worker, public safety personnel, or emergency personnel has been exposed to the blood or bodily fluids of the source patient in a manner sufficient to transmit a blood borne pathogen-related illness to the affected worker while engaged in rendering health services to the source patient, and provided that:</p> <p>(h) Records pertaining to testing performed pursuant to this section shall not be recorded in the source patient's medical record unless authorized by the source patient and shall not be maintained in the location where the test was ordered or performed for more than 60 days.</p> <p>Per review, on 4/30/13, the medical record for Patient #1 contained the results of lab testing dated 4/11/12, conducted on the patient for the purpose of determining communicable disease status of the patient, following an accidental employee exposure. Although there was documentation that verbal consent to conduct the</p>	A9999	<p>SEE ATTACHED PLAN OF CORRECTION C. Muzz 9/15/13</p>	10/29/13

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A9999	Continued From page 3 testing had been obtained from the patient there was no evidence of authorization, by the patient, to record or maintain the information in the patients record. During interview, on the afternoon of 5/1/13, the VP of Quality confirmed the presence of the information in Patient #1's medical record and stated it should not be in in the record.	A9999	SEE ATTACHED PLAN OF CORRECTIONS C. Muzz 9/16/13	10/21/13	

PLAN OF CORRECTION

A 000 INITIAL COMMENTS

An unannounced on-site visit was conducted by the Division of Licensing and Protection on 4/30/13 and 5/1/13, to investigate complaint #9307. The Conditions of Participation authorized by the Centers for Medicare and Medicaid Services for review included; Patient Rights, 482.13; Medical Record Services, 482.24; Infection Control, 482.42 and Medical Staff, 482.22. The investigation was completed on 6/4/13. The following regulatory violations were identified related to Medical Record Services, as well as Vermont State Statute the patient has the right to receive care in a safe setting.

A438 Title 18.482.24(b) FORM AND RETENTION OF RECORDS

The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to assure a complete and accurate medical record was maintained for 1 of 10 applicable records reviewed. (Patient #1). Findings include: 1. Per review of the medical record Patient #1 had a lab requisition, dated 4/16/12, that identified an area of the male genitalia as the source of a culture specimen obtained that day. However, the requisition further identified the Associated Diagnosis as "Wound infection following cesarean section, postpartum".

The director of the medical lab confirmed the documentation error during interview on the afternoon of 5/30/13. The inaccuracy of the medical record was also confirmed by the nurse who had been responsible for completing the lab requisition. The nurse stated, during interview at 12:30 PM on the afternoon of 5/1/13, that the requisition had been completed electronically and the diagnosis was chosen from a drop down box. S/he confirmed it appeared the wrong diagnosis had inadvertently been checked off.

2. Per review of the record Patient #1 was admitted to the facility at 6:29 PM on the evening of 4/16/13 for treatment of a wound infection. Although a nurse's note, dated 4/16/13, stated the patient's "IV (intravenous) was D/C'd (discontinued) and patient left AMA (against medical advice)" at 8:45 PM, there was no evidence that an AMA form had been signed by the patient nor any indication that the patient had refused to sign the form. The facility's policy for Patients off the Unit (Includes AMA, Out on Pass, Elopement), with a publish date of 10/12/2012 and identified by staff as the currently established policy, stated under Patients Who Wish to Leave the Unit without Permission: 2. "If a competent patient with decision-making capacity wishes to be discharged from the hospital against medical advice (AMA) The patient may leave after signing AMA form. If the patient refuses to sign the form, the patient's refusal to sign the form shall be documented in the record."

During interview, at 1:30 PM on 5/1/13, the Nurse Director of the Medical Surgical Units, confirmed that there should be evidence that the patient signed the AMA form or documentation of the refusal to sign

Plan of Action

- An educational communication regarding the accuracy and completeness of medical records has been developed by the Regulatory Coordinator in collaboration with the Director of Health Information Management. In addition to the highlights regarding medical record accuracy, the expectations outlined in The Fletcher Allen Health Care policy entitled "Patients off the Unit (Includes AMA, Out

on Pass, Elopement)” regarding documentation requirements if a patient refuses to sign the AMA form will be highlighted. This educational mailing will be used to reinforce the referenced topics with clinical staff during the month of October through a combination of electronic communications/ staff meetings conducted by the Director of Accreditation and Regulatory Affairs and local leadership. Education will be completed by 10/29/13.

- Effective in October 2013, The Health Information Quality Analysts will review patients who left AMA (against medical advice) for compliance with documentation requirements outlined in The Fletcher Allen Health Care Policy entitled “Patients off the Unit (Includes AMA, Out on Pass, Elopement).” Performance results will be provided to the Director of Health Information Services who will provide feedback as required to the appropriate Directors. This review will be performed monthly. Aggregate results will be reported to the Standard of Operation Committee, chaired by the Chief Medical Officer.
- The Health Information Quality Analysts will conduct a baseline review of a sample of medical records looking at the accuracy of the medical records according to defined criteria. Based upon the result of the baseline review, performance improvement efforts will be focused on those areas in need of improvement. This will be completed 9/30/13.

Based on staff interviews and record review the facility failed to be in compliance with The State of Vermont Statute Title 18, Chapter 21: Communicable Disease, for 1 applicable patient. (Patient #1). Findings include:

Per review of Vermont State Statute: 18 V.S.A. § 1141. Communicable Disease testing:

(a) A health care provider may order a test for blood borne pathogens if a health care worker, public safety personnel, or emergency personnel has been exposed to the blood or bodily fluids of the source patient in a manner sufficient to transmit a blood borne pathogen-related illness to the affected worker while engaged in rendering health services to the source patient, and provided that:

(h) Records pertaining to testing performed pursuant to this section shall not be recorded in the source patient's medical record unless authorized by the source patient and shall not be maintained in the location where the test was ordered or performed for more than 60 days. Per review, on 4/30/13, the medical record for Patient #1 contained the results of lab testing dated 4/11/12, conducted on the patient for the purpose of determining communicable disease status of the patient, following an accidental employee exposure.

Although there was documentation that verbal consent to conduct the testing had been obtained from the patient there was no evidence of authorization, by the patient, to record or maintain the information in the patient's record.

During interview, on the afternoon of 5/1/13, the VP of Quality confirmed the presence of the information in Patient #1's medical record and stated it should not be in the record.

Action Plan

- A consent for communicable disease testing standardized form was developed by the Supervisor of Employee Health and Injury Prevention in collaboration with the Directors of Risk Management and Regulatory Affairs and Medical Director, Infectious Disease. The consent form includes consent for testing as well as consent to record or maintain the information in the patient's record. The form will receive final review and approval on 9/30/13 by Health Information Management.
- The Supervisor of Employee Health and Injury Prevention educated the members of the Employee Health Team during team meetings the week of 9/16/13.
- A monthly audit for the presence consent documentation will be performed by Employee Health beginning in October. Performance feedback will be given to the area leaders. Audit frequency will be reviewed by the Supervisor of Employee Health based upon performance.