



*Jeffords Institute for Quality and
Operational Effectiveness*
111 Colchester Avenue
MCHV Campus, Patrick 228
Burlington, Vermont 05401

11/12/2013

Kathy Mackin, Health Insurance Specialist
Certification & Enforcement Branch
Centers for Medicare & Medicaid Services -Via Fax and US Mail-
JFK Federal Building, Government Center
Room 2325
Boston, Massachusetts, 02203

**Re: CMS Certification Number (CCN): 470003
Survey IDofev11, 09/16/2013**

Dear Ms. Mackin,

I am very pleased to submit Form CMS Certification Number (CCN): 470003 and the attached Plan of Correction in response to the Statement of Deficiencies and findings from the survey completed by the Division on 09/16/2013.

Fletcher Allen Health Care is committed to continuously improving the quality of services we provide to our patients. As part of our ongoing performance improvement program we would like to take this opportunity to respond to the regulatory deficiencies that were cited.

If you have any questions about the attached Plan of Correction or require further clarification, please do not hesitate to contact me.

Sincerely,

Carol Muzzy
Director of Accreditation and Regulatory Affairs
James M. Jeffords Institute for Quality
And Operational Effectiveness
Fletcher Allen Health Care
111 Colchester Avenue, Patrick 228
Burlington, Vermont 05401
Phone: 802-847-5007 Fax: 802-847-5294

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

PRINTED: 09/20/2013
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 09/16/2013
NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401		
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A 000	INITIAL COMMENTS	A 000			
A 120	<p>482.13(a)(2) PATIENT RIGHTS: TIMELY REFERRAL OF GRIEVANCES</p> <p>[The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.] The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:</p> <p>This STANDARD is not met as evidenced by: Based on patient and staff interview and record review the staff failed to follow their established process for resolution of patient grievances and timely referral of the patients' concerns regarding quality of care to the Quality Department for 1</p>	A 120	SEE ATTACHED PLAN OF CORRECTION	10/2/13	

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

Carol May

TITLE

Director

(X6) DATE

11/14/13

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 120	Continued From page 1 patient. (Patient #1). Findings include: Per record review the facility failed to implement the process for grievance resolution in accordance with established policies, for Patient #1, who contacted the Patient-Family Advocacy Program to voice concerns regarding an incident of mistaken identity. The Customer Feedback Policy stated, as its purpose, 'To provide a consistent, coordinated process for responding to customer feedback....., and to encourage and use customer feedback to drive improvement in the provision of patient care.' The policy stated....'FAHC is committed to ensuring that concerns are addressed in a timely, consistent and effective manner. At FAHC the Office of Patient and Family Advocacy has been designated to coordinate the review of complaints.' The policy further stated; 'Feedback and Suggestions, 6. Office of Patient and Family Advocacy staff shall:....Facilitate the resolution of complaints as appropriate; Refer complaints to appropriate department managers/health care service leaders;....Provide reports to the Quality Council for use in the planning, design and implementation of performance improvement strategies as requested.' Per interview, at 8:40 AM on 9/3/13, Patient #1 stated that during a March or April 2013 visit to his/her Primary Care Provider (PCP), who, as part of the FAHC system, had access to all FAHC records, the PCP questioned the patient about a visit to the ED on 2/5/13. Patient #1 told the PCP that s/he had not made a visit to the ED on that date. Subsequently, Patient #1 received a bill for diagnostic testing done in the ED on 2/5/13. When the patient received a copy of the EMR from his/her PCP, which contained inaccurate	A 120	SEE ATTACHED PLAN OF CORRECTION	10/2/13	

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A 120	<p>Continued From page 2</p> <p>information, including a CT scan and lab results, referencing the ED visit on 2/5/13, s/he recognized that Patient #2, who had a similar name and who had been escorted by law enforcement to the ED, had mistakenly been identified as Patient #1. The patient contacted the Patient-Family Advocacy Program at the hospital at the end of April 2013 and explained his/her concern about the mistaken identity and the receipt of a bill for diagnostic testing. The patient expressed feeling disrespected by the Patient Advocate with whom s/he had spoken, feeling the Advocate did not believe him/her. Although the Advocate recommended Patient #1 contact the police to request help in confirming the mistaken identity issue, there was no further assistance provided by the Advocacy program, to help resolve the issue. The wrong identity was confirmed when Patient #1 presented to the police station and a law enforcement official confirmed Patient #1 was not the patient escorted by that officer to the ED on 2/5/13. The patient stated there had been no further contact with the hospital and described feeling anxious and great emotional distress related to feeling his/her integrity was in question when the hospital did not offer assistance to help resolve the issue, but rather, the patient felt, left it up to him/her to resolve it on their own. The patient also expressed distress that the inaccurate information might be accessible to other FAHC employees.</p> <p>Patient-Family Advocate #1 confirmed, during interview at 11:03 AM on 9/4/13, that Patient #1 had contacted him/her to express concerns around mistaken identity and billing. S/he stated that since the patient name, address and medical record number were correct on Patient #1's EMR,</p>	A 120	<p>SEE ATTACHED PLAN OF CORRECTION</p>	10/2/13	

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A 120	Continued From page 3 s/he had assumed the photo identity had been used at the time of registration, on 2/5/13, to confirm the patient's identity. The advocate stated the only plan s/he could think of to assist Patient #1 was to recommend the patient talk with the police to help confirm Patient #1 was not the person escorted to the ED on 2/5/13. The Advocate stated that s/he told the patient to contact Patient-Family Advocacy with any further concerns and felt Patient #1 had agreed with the plan. The advocate further confirmed that there had been no further contact with Patient #1 and s/he confirmed s/he did not refer the complaint to ED or Registration management or leadership staff, and no further follow up had been done by the Patient-Family Advocacy Program.	A 120		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on patient and staff interviews and record review the facility failed to assure care was provided in a safe manner for two patients, when identity was not verified prior to treatment, and for one vulnerable patient who was able to elope from the facility unsupervised. (Patients #1, #2 and #5). Findings include: 1. Per record review the facility failed to assure safe care was provided for Patient #2 when s/he presented to the Emergency Department (ED), on 2/5/13, in a condition that prevented him/her from providing accurate information. Staff failed to follow facility policy to confirm the patient's identity through review of 3 data elements,	A 144	SEE ATTACHED PLAN OF CORRECTION	11/30/13

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A144	<p>Continued From page 4</p> <p>including name, date of birth, address and or social security number, and failed to use the patient's previously scanned photo ID to confirm the patient's identity. The only form of identification used appeared to be patient name, and, as a result, the inaccurate information from the EMR for Patient #1 (a patient with a similar name) was used to assess and treat Patient #2.</p> <p>Per interview, at 8:40 AM on 9/3/13, Patient #1 stated that during a March or April 2013 visit to his/her Primary Care Provider (PCP), who, as part of the FAHC system, had access to all FAHC records, the PCP questioned the patient about a visit to the ED on 2/5/13. Patient #1 told the PCP that s/he had not made a visit to the ED on that date. Subsequently, Patient #1 received a bill for diagnostic testing done in the ED on 2/5/13. When the patient received a copy of the EMR from his/her PCP, which contained inaccurate information, including a CT scan and lab results, referencing the ED visit on 2/5/13, s/he recognized that Patient #2, who had been escorted by law enforcement to the ED, had mistakenly been identified as Patient #1. The patient contacted the Patient-Family Advocacy Program at the hospital at the end of April 2013 and explained his/her concern about the mistaken identity and the receipt of a bill for diagnostic testing. The patient expressed feeling disrespected by the Patient Advocate with whom s/he had spoken, feeling the Advocate did not believe him/her. Although the Advocate recommended Patient #1 contact the police to request help in confirming the mistaken identity issue, there was no further assistance provided to help resolve the issue. The wrong identity was confirmed when Patient #1 presented to the police station and a law enforcement official</p>	A144	<p>SEE ATTACHED PLAN OF CORRECTION</p>	12/15/13	

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A 144	<p>Continued From page 5</p> <p>confirmed Patient #1 was not the patient escorted by that officer to the ED on 2/5/13. The patient stated there had been no further contact with the hospital and described feeling anxious and great emotional distress related to feeling his/her integrity was in question when the hospital did not offer assistance to help resolve the issue, but rather, the patient felt, left it up to him/her to resolve it on their own. The patient also expressed distress that the inaccurate information might be accessible to other staff members.</p> <p>Patient-Family Advocate #1 confirmed, during interview at 11:03 AM on 9/4/13, that Patient #1 had contacted him/her to express concerns around mistaken identity and billing. S/he stated that since the patient name, address and medical record number were correct on Patient #1's EMR, s/he had assumed the photo identity had been used at the time of registration to confirm the patient's identity. The advocate stated the only plan s/he could think of to assist Patient #1 was to recommend the patient talk with the police to help confirm Patient #1 was not the person escorted to the ED on 2/5/13. The Advocate stated that s/he told the patient to contact Patient-Family Advocacy if any further concerns and felt Patient #1 had agreed with the plan. S/he stated the patient did not contact the department again and confirmed no further follow up had been done by the Patient-Family Advocacy Program.</p> <p>During interview, at 11:49 AM on 9/3/13, the Operations Manager for Health Information Management (HIM) confirmed that a data integrity incident had occurred when Patient #2 visited the ED on 2/5/13, was not able to provide clear</p>	A 144	<p>SEE ATTACHED PLAN OF CORRECTION</p> <p>SEE ATTACHED PLAN OF CORRECTION</p>	11/30/13	11/30/13

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A 144	<p>Continued From page 6</p> <p>information and the visit was registered under Patient #1's name, which was similar to Patient #2. S/he stated s/he was not notified of the incident until late April 2013, at which point the information from Patient #1's record was transferred to Patient #2's record and a note which identified the data integrity incident was placed in Patient #1's EMR. This information was verified during review of Patient #1's record, on 9/3/13, which noted; 'Data Integrity Alert: This record was recently involved in a data integrity incident. Please review problem list, meds and allergies carefully with patient at next visit.'</p> <p>The ED Medical Director and Physician Assistant (PA) #2, who provided direct care to Patient #2, both agreed, during interview at 1:08 PM on 9/4/13, that there was potential for errors to occur if inaccurate health information is used as part of an assessment and treatment of a patient. PA #2, stated that the Registration Department is responsible for confirming the identity of patients in the ED and, as s/he reviewed Patient #2's record, there was nothing that would have alerted him/her, at the time of treatment, to false patient identity. S/he further stated there was nothing s/he would have done differently in the treatment of Patient #2, if the accurate medical record had been used. The Medical Director confirmed that, although Patient #1's record had been mistakenly used to provide care to Patient #2, (indicating that the ED provider's assessment had been based, in part on the inaccurate information from Patient #1's record), Patient #2 received appropriate care and there had been no negative outcome for Patient #2 as a result of the incident. Both the Medical Director and PA #2 stated they had not been aware of the incident until brought to the facility's attention by the surveyor on 9/3/13.</p>	A 144	<p>SEE ATTACHED PLAN OF CORRECTION</p>	9/3/13

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A 144	Continued From page 7 The Patient Identification policy, dated 7/1/11, included the Policy Statement: 'Guidelines have been established to maximize patient safety through a universal standard of unique patient identification', and stated, as it's purpose: 'To properly and accurately identify patients so that they may receive appropriate care.' The policy procedure included; '1. General identification - A. Patient Identification....is defined as a positive match to a minimum of 3 distinct data elements. Patients' Legal Name as provided by the patient, DOB and Gender.....social security number and/or mailing address will be considered additional data elements utilized to make a positive match....B. In an emergency, and three data elements are unavailable, an "Unidentified ED" patient number will be issued until data is provided.' The Registration Supervisor stated during interview, at 4:14 PM on 9/3/13, that patient identification is confirmed by registrars during the registration process for all ED patients. S/he stated the policy includes asking the patient's name, DOB, address or social security number. S/he further stated the expectation is that staff should be looking at photo ID, if available in the record. Both the Supervisor and the Registrar #1, responsible for registration of Patient #2 on 2/5/13, who was also present during the interview, confirmed the policy had not been followed and the photo ID, although available in the EMRs of both Patient #1 and Patient #2, had not been accessed to confirm identity of Patient #2. Both also stated they had been unaware of this incident until notification was made by the surveyor.	A 144	SEE ATTACHED PLAN OF CORRECTION	11/30/13	

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A 144	<p>Continued From page 8</p> <p>The Director of Patient Registration and Customer Service, confirmed, during interview on the morning of 9/4/12, that Patient #2's ID had not been verified in accordance with the facility's policy, which led to the use of Patient #1's EMR in the treatment of Patient #2 on 2/5/13. S/he further stated s/he had not been made aware of the incident until notified through the surveyor.</p> <p>Although there was no identified negative outcome for Patient #2, the failure to accurately confirm his/her identify created an unsafe setting in which to receive care, and placed the patient at risk for potential medical errors to occur. Despite the fact that Patient #1 did not receive treatment on 2/5/13, the inaccurate identification of Patient #2, by registration staff, subsequently led to a series of events including; misinterpretation of Patient #1's medical information by his/her PCP, inaccurate billing of tests and the failure of the hospital Patient Advocacy staff to assist the patient in resolution of the issue. This ultimately resulted in what Patient #1 expressed as great emotional distress related to his/her perception that their personal integrity had been questioned. And, although there was no evidence that breach of confidentiality of Patient #1's medical information had occurred the patient expressed distress related to the potential for a breach. This has potentially created an emotionally unsafe healthcare setting for Patient #1, who receives the majority of his/her care through the FAHC system.</p> <p>2. Based on record review Patient #5, who was admitted on 1/24/13, and assessed by nursing, on 2/9/13 as an elopement risk, eloped, during an unsupervised leave from the inpatient unit on which s/he was housed, on 2/18/13. An initial RN</p>	A 144	<p>SEE ATTACHED PLAN OF CORRECTION</p> <p>SEE ATTACHED PLAN OF CORRECTION</p>	<p>11/30/13</p> <p>11/30/13</p>	

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A 144	Continued From page 9 Case Manager note, dated 1/28/13, indicated concerns regarding the patient's inability to manage self at home, appears impulsive with limited insight regarding care issues. An initial psychiatry evaluation was requested for the patient on 1/29/13 with the reason noted as "decision making capacity." The evaluation was deemed inconclusive due to psychiatry wanting to perform more cognitive testing. An attending MD note on 1/30/13 states that the patient is distrustful of staff and wants to go home. A social work note on 1/31/13 states that the case management team feels the patient would not be safe in his/her home environment and that the patient is confused and requiring a one to one for safety. Case management decided to then seek guardianship for the patient. Psychiatry re-evaluated the patient on 1/31/13 and concluded that the patient "does not have capacity." The patient's hospital stay was extended related to concerns regarding capacity to safely provide self care and the ongoing pursuit of legal guardianship. On 2/9/13 a Nursing Progress note indicated that the patient was irritable, irrational, and verbalized his/her desire to go home saying "I'm leaving here." Per nursing order on 2/9/13 the patient was subsequently placed on a one to one as an elopement precaution. The patient was transferred to the Baird 4 medical unit on 2/9/13, where, despite lack of evidence that a reassessment of elopement risk had been conducted, the patient was allowed unsupervised leaves from the unit to the cafeteria for specified periods of time. On 2/18/13 the patient signed out on the unit register that s/he was going to the cafeteria. S/he was discovered to have eloped from the unit when s/he did not return within the one hour time duration allowed off of the unit.	A 144	SEE ATTACHED PLAN OF CORRECTION 1/30/13	

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A 144	Continued From page 10 Per interview, on September 5, 2013 at 3:00 PM, the Baird 4 Nurse Manager confirmed that the patient had been assessed, on 2/9/13 while on Baird 3, as an elopement risk and that the patient's electronic medical record had been flagged to alert staff of the identified elopement risk. The elopement risk flag was on the EMR when the patient transferred that day to Baird 4. The Nurse Manager also confirmed that no reassessment of the elopement risk had been completed following Patient #5's transfer to Baird 4 on 2/9/13, the care plan had not been revised to discontinue the elopement risk and the patient was allowed unsupervised leaves from Baird 4 to the cafeteria, from where s/he eloped on 2/18/13. Patient #5 called the Baird 4 nursing unit to tell them s/he was "at home" and needed assistance with his/her care. The patient then returned to the hospital on the afternoon of 2/18/13.	A 144		
A 286	482.21 (a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.	A 286	SEE ATTACHED PLAN OF CORRECTION	12/15/13

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A 286	<p>Continued From page 11</p> <p>(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ...</p> <p>(3) That clear expectations for safety are established.</p> <p>This STANDARD is not met as evidenced by: Based on patient and staff interviews and record review staff failed to utilize the established event reporting system (SAFE) as a means to assess adverse patient events and identify opportunity for improvement and changes that would lead to improvement for an incident involving the mistaken identification of a patient. (Patient #1 and #2). Findings include:</p> <p>1. Per interview with multiple staff members, there was a failure by staff, on at least three separate occasions, to follow facility policy to complete S.A.F.E event reports related to an incident involving mistaken identity of Patient #2, who was brought to the Emergency Department (ED), on 2/5/13, in a condition that prevented him/her from providing accurate information. The only form of identification used appeared to be patient name, and, as a result, inaccurate information from the EMR for Patient #1 (a patient with a similar name) was used to assess and treat Patient #2.</p> <p>Per interview, at 8:40 AM on 9/3/13, Patient #1 stated that s/he had been made aware, sometime during a March or April 2013 visit to his/her</p>	A 286	<p>SEE</p> <p>Att 4CHD Plan of Correction</p>	12/15/13	

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A 286	Continued From page 12 Primary Care Provider (PCP), who, as part of the FAHC system, had access to all FAHC records, that his/her record indicated a visit to the ED on 2/5/13, which Patient #1 had not made. Subsequently, Patient #1 received a bill for diagnostic testing done in the ED on 2/5/13. When Patient #1 obtained a copy of their EMR, which contained inaccurate information, including a CT scan and lab results, referencing the ED visit on 2/5/13, s/he recognized that Patient #2, who had been escorted by law enforcement to the ED, had mistakenly been identified as Patient #1. The patient contacted the Patient-Family Advocacy Program at the hospital at the end of April 2013 and explained his/her concern about the mistaken identity and the receipt of a bill for diagnostic testing. The wrong identity was eventually confirmed when Patient #1 presented to the police station and a law enforcement official confirmed Patient #1 was not the patient escorted by that officer to the ED on 2/5/13. The facility policy, Adverse Event/Near Miss Reporting and Analysis, stated; 'Potential hazards or adverse events should be reported at the time of identification and/or occurrence. The Manager/Supervisor/Risk Manager or designee should be informed and appropriate action taken immediately to mitigate the event....Reported events and near misses will be tracked, trended and analyzed to improve quality and patient safety...' The ED Medical Director and Physician Assistant (PA) #2, who provided direct care to Patient #2, both agreed, during interview at 1:08 PM on 9/4/13, that there was potential for errors to occur if inaccurate health information is used as part of an assessment and treatment of a patient. PA #2, stated that the Registration Department is responsible for confirming the identity of patients	A 286	SEE ATTACHED PLAN OF CORRECTION	09/15/13

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A 286	<p>Continued From page 13</p> <p>in the ED and, as s/he reviewed Patient #2's record, there was nothing that would have alerted him/her, at the time of treatment, to false patient identity. Both the Medical Director and PA #2 stated they had not been aware of the incident until brought to the facility's attention by the surveyor on 9/3/13.</p> <p>Patient-Family Advocate #1 confirmed, during interview at 11:03 AM on 9/4/13, that Patient #1 had contacted him/her to express concerns around mistaken identity and billing. S/he stated s/he had assumed the photo identity had been used at the time of registration to confirm the patient's identity and the only plan s/he could think of to assist Patient #1 was to recommend the patient talk with the police to help confirm Patient #1 was not the person escorted to the ED on 2/5/13. The Advocate stated there had been no further follow up regarding the incident by the department of Patient Family Advocacy. S/he confirmed that s/he had not referred the complaint to ED or Patient Registration management or leadership staff.</p> <p>During interview, at 11:49 AM on 9/3/13, the Operations Manager for Health Information Management (HIM) confirmed that a data integrity incident had occurred. S/he stated s/he had not been notified of the incident until late April 2013, at which point the information from Patient #1's record was transferred to Patient #2's record, though no event report had been completed.</p> <p>The Registration Supervisor stated during interview, at 4:14 PM on 9/3/13, that patient identification is confirmed by registrars during the registration process for all ED patients. Both the Supervisor and Registrar #1, responsible for</p>	A 286	<p>SEE ATTACHED PLAN of CORRECTION</p>	12-15/13	

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A 286	<p>Continued From page 14</p> <p>registration of Patient #2 on 2/5/13, who was also present during the interview, confirmed the policy had not been followed and the photo ID, although available in Patient #2's EMR, had not been accessed to confirm identity of Patient #2. Both also stated they had been unaware of this incident until notification was made by the surveyor, and the Supervisor agreed that the lack of timely notification of the issue "seems like a missed opportunity to improve on process."</p> <p>The Director of Patient Registration and Customer Service, confirmed, during interview on the morning of 9/4/12, that Patient #2's ID had not been verified in accordance with the facility's policy. S/he further stated s/he had not been made aware of the incident until notified as a result of the current survey process. S/he stated that when data integrity incidents occur, the usual process is to notify the Registration department, which would trigger a need for an event report, and an investigation to identify and rectify the issue. S/he stated that a police officer reported the mistaken identity issue, providing positive identification of Patient #2 at the same time, to a Customer Service Representative (CSR) in the Billing Department, in late April. The Director stated the CSR failed to complete an event report, which should have occurred and would have provided notification to Patient Registration of the error. S/he agreed that a timely opportunity to improve patient care outcomes did not occur as a result of staff failure to complete the SAFE report.</p> <p>During interview, at 12:37 PM on 9/5/13 the VP of Quality stated that the event reporting system is a piece of the overall quality assessment program. The information obtained is reviewed, analyzed</p>	A 286			

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A 286	Continued From page 15	A 286		
A 395	<p>and used to identify opportunities for improvement. S/he stated there was no evidence that an event report had been completed by anyone regarding this issue and agreed reports should have been completed by the CSR involved, the data integrity team, as well as the Patient Family Advocacy Department.</p> <p>482.23(b)(3) RN SUPERVISION OF NURSING CARE</p> <p>A registered nurse must supervise and evaluate the nursing care for each patient.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to supervise and evaluate the nursing care for one patient at the time of discharge, and for one patient, # 5, who eloped from his care unit.</p> <p>Based on record review Patient #5, who was admitted on 1/24/13, and assessed by nursing, on 2/9/13 as an elopement risk, eloped, during an unsupervised leave from the inpatient unit on which s/he was housed, on 2/18/13. An initial RN Case Manager note, dated 1/28/13, indicated concerns regarding the patient's inability to manage self at home, appears impulsive with limited insight regarding care issues. An initial psychiatry evaluation was requested for the patient on 1/29/13 with the reason noted as "decision making capacity." The evaluation was deemed inconclusive due to psychiatry wanting to perform more cognitive testing. An attending MD note on 1/30/13 states that the patient is distrustful of staff and wants to go home. A social work note on 1/31/13 states that the case management team feels the patient would not be</p>	A 395	SEE ATTACHED Plan of Correction	11/30/13

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A 395	<p>Continued From page 16</p> <p>safe in his/her home environment and that the patient is confused and requiring a one to one for safety. Case management decided to then seek guardianship for the patient. Psychiatry re-evaluated the patient on 1/31/13 and concluded that the patient "does not have capacity." The patient's hospital stay was extended related to concerns regarding capacity to safely provide self care and the ongoing pursuit of legal guardianship. On 2/9/13 a Nursing Progress note indicated that the patient was irritable, irrational, and verbalized his/her desire to go home saying "I'm leaving here." Per nursing order on 2/9/13 the patient was subsequently placed on a one to one as an elopement precaution. The patient was transferred to the Baird 4 medical unit on 2/9/13, where, despite lack of evidence that a reassessment of elopement risk had been conducted, the patient was allowed unsupervised leaves from the unit to the cafeteria for specified periods of time. On 2/18/13 the patient signed out on the unit register that s/he was going to the cafeteria. S/he was discovered to have eloped from the unit when s/he did not return within the one hour time duration allowed off of the unit.</p> <p>Per interview, on September 5, 2013 at 3:00 PM, the Baird 4 Nurse Manager confirmed that the patient had been assessed, on 2/9/13 while on Baird 3, as an elopement risk and that the patient's electronic medical record had been flagged to alert staff of the identified elopement risk. The elopement risk flag was on the EMR when the patient transferred that day to Baird 4. The Nurse Manager also confirmed that no reassessment of the elopement risk had been completed following Patient #5's transfer to Baird 4 on 2/9/13, the care plan had not been revised to</p>	A 395	SEE ATTACHED Plan of Correction	11/30/13	

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A 395	Continued From page 17 discontinue theelopement risk and the patient was allowed unsupervised leaves from Baird 4 to the cafeteria, from where s/he eloped on 2/18/13. Patient #5 called the Baird 4 nursing unit to tell them s/he was "at home" and needed assistance with his/her care. The patient then returned to the hospital on the afternoon of 2/18/13.	A 395			
A 438	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 patient and staff interview and record review the facility failed to ensure the accuracy of the medical record for two patients: one whose record was erroneously used to document health information of another patient, and the second patient, for whom inaccurate information was used in the clinical assessment during an Emergency Department (ED) visit. Findings include: Per interview, at 8:40 AM on 9/3/13, Patient #1 stated that his/her medical record had contained inaccurate information that was accessed by the patient's Primary Care Provider (PCP), in March or April of 2013, and resulted in the PCP questioning the patient about activity that led to an Emergency Department (ED) visit on 2/5/13. The patient informed the PCP that s/he had not	A 438	SEE ATTACHED PLAN OF CORRECTION	11/30/13	

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A 438	<p>Continued From page 18</p> <p>been to the ED on 2/5/13. The patient subsequently received a bill for diagnostic testing that had been performed during the ED visit on 2/5/13. S/he then obtained a copy of his/her medical record, which contained inaccurate information including the fact that the patient had been escorted to the ED by police, as well as results of lab tests and CT scan. Patient #1 suspected his/her record had been used in the treatment of another patient (Patient #2) and contacted the Patient-Family Advocacy Department to inform them of the error. When no resolution was forthcoming from the facility Patient #1 presented to the police department and the police officer who had escorted Patient #2 to the ED on 2/5/13, confirmed that Patient #1 had not been the same person the officer had escorted to the ED. The police officer then notified the hospital of the mistaken identity of Patient #2.</p> <p>During interview, at 11:49 AM on 9/3/13, the Operations Manager for Health Information Management (HIM) confirmed that a data integrity incident had occurred when Patient #2 visited the ED on 2/5/13, was not able to provide clear information and the visit was registered under Patient #1's name, (which was similar to Patient #2). S/he stated s/he was not notified of the incident until late April 2013, at which point the information from Patient #1's record was transferred to Patient #2's record and a note which identified the data integrity incident was placed in Patient #1's EMR. This information was verified during review of Patient #1's record, on 9/3/13, which noted; 'Data Integrity Alert: This record was recently involved in a data integrity incident. Please review problem list, meds and allergies carefully with patient at next visit.'</p>	A 438	<p>SEE ATTACHED PLAN OF CORRECTION</p>	11/30/13	

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A 817	<p>482.43(c) DISCHARGE PLAN</p> <p>(1) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to assure implement an appropriate discharge plan for one patient. (Patient #4). Findings include:</p> <p>Per review of the medical record for patient #4, was admitted through the facility emergency department on 5/23/2013 approximately one month post total colectomy and ileostomy complicated by post-operative pelvic abscess. The initial general surgeon progress note on 5/29/13 states that the patient has a rectal tube in place for drainage and it is to be removed prior to the patient's discharge. A subsequent progress note dated 5/30/13 states that the plan is to discharge the patient that day (5/30/13) and to remove the rectal tube prior to discharge. Despite the physician documented intent for the rectal tube to be removed prior to discharge, there were no physician orders reflecting that plan. A Nursing Progress note, dated 5/30/13, indicated that RN #1, who was responsible for the patient's discharge, demonstrated irrigation of the rectal tube for a home health aide who would be providing care post discharge and the tube was not removed prior to the patient's discharge. Further review of the patient record, post discharge, revealed that the patient presented at his/her primary care physician office (PCP) to</p>	A 817	<p>SEE ATTACHED PLAN OF CORRECTION</p>	11/30/13	

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A 817	<p>Continued From page 20</p> <p>have the rectal tube removed on 6/7/13. Per PCP documentation on 6/7/13, s/he removed the rectal tube from the patient and stated also that the attending surgeon at the facility from where the patient was discharged was unaware that the patient had been discharged with the rectal tube still in place.</p> <p>During interview, on 9/5/2013 at 2:00 PM, RN #1 confirmed there were no physician orders to discontinue the rectal tube and no orders for use and care of the rectal tube post discharge. The RN Unit Manager, who was also present during the interview, confirmed that the expectation is there would be a physician order for both the continued use of, and care of, the drain. In addition, RN #1 further confirmed the lack of discharge instructions for use and care of the rectal tube.</p> <p>Despite the physician intent for the rectal tube to be removed, prior to discharge, there was a lack of communication regarding that discharge plan and the patient was discharged without a plan for continued use and care of the open drain.</p>	A 817	<p>SEE ATTACHED PLAN OF CORRECT</p>	11/30	

Plan of Correction

120 482.13(a)(2) PATIENT RIGHTS: TIMELY REFERRAL OF GRIEVANCES

[The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.] The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:

This STANDARD is not met as evidenced by: Based on patient and staff interview and record review the staff failed to follow their established process for resolution of patient grievances and timely referral of the patients' concerns regarding quality of care to the Quality Department for 1 patient. (Patient #1) Findings include:

Per record review the facility failed to implement the process for grievance resolution in accordance with established policies, for Patient #1, who contacted the Patient-Family Advocacy Program to voice concerns regarding an incident of mistaken identity. The Customer Feedback Policy stated, as it's purpose, To provide a consistent, coordinated process for responding to customer feedback, and to encourage and use customer feedback to drive improvement in the provision of patient care.' The policy stated 'FAHC is committed to ensuring that concerns are addressed in a timely, consistent and effective manner. At FAHC the Office of Patient and Family Advocacy has been designated to coordinate the review of complaints.' The policy further stated, 'Feedback and Suggestions, 6. Office of Patient and Family Advocacy staff shall Facilitate the resolution of complaints as appropriate; Refer complaints to appropriate department managers/health care service leaders: Provide reports to the Quality Council for use in the planning, design and implementation of performance improvement strategies as requested.'

Per interview, at 8:40 AM on 9/3/13, Patient #1 stated that during a March or April 2013 visit to his/her Primary Care Provider (PCP), who, as part of the FAHC system, had access to all FAHC records, the PCP questioned the patient about a visit to the ED on 2/5/13. Patient #1 told the PCP that s/he had not made a visit to the ED on that date. Subsequently, Patient #1 received a bill for diagnostic testing done in the ED on 2/5/13. When the patient received a copy of the EMR from his/her PCP, which contained inaccurate information, including a CT scan and lab results, referencing the ED visit on 2/5/13, s/he recognized that Patient #2, who had a similar name and who had been escorted by law enforcement to the ED, had mistakenly been identified as Patient #1. The patient contacted the Patient-Family Advocacy Program at the hospital at the end of April 2013 and explained his/her concern about the mistaken identity and the receipt of a bill for diagnostic testing. The patient expressed feeling disrespected by the Patient Advocate with whom s/he had spoken, feeling the Advocate did not believe him/her. Although the Advocate recommended Patient #1 contact the police to request help in confirming the mistaken identity issue, there was no further assistance provided by the Advocacy program, to help resolve the issue. The wrong identity was confirmed when Patient #1 presented to the police station and a law enforcement official confirmed Patient #1 was not the patient escorted by that officer to the ED on 2/5/13. The patient stated there had been no further contact with the hospital and described feeling anxious and great emotional distress related to feeling his/her integrity was in question when the hospital did not offer assistance to help resolve the issue, but rather, the patient felt, left it up to him/her to resolve it on their own. The patient also expressed distress that the inaccurate information might be accessible to other FAHC employees. Patient-Family Advocate #1 confirmed, during interview at 11:03 AM on 9/4/13, that Patient #1 had contacted him/her to express concerns around mistaken identity and billing. S/he stated that since the patient name, address and medical record number were correct on Patient #1's EMR, s/he had assumed the photo identity had been used at the time of registration, on 2/5/13, to confirm the patient's identity. The advocate stated the only plan s/he

could think of to assist Patient #1 was to recommend the patient talk with the police to help confirm Patient #1 was not the person escorted to the ED on 2/5/13. The Advocate stated that s/he told the patient to contact Patient-Family Advocacy with any further concerns and felt Patient #1 had agreed with the plan. The advocate further confirmed that there had been no further contact with Patient #1 and s/he confirmed s/he did not refer the complaint to ED or Registration management or leadership staff, and no further follow up had been done by the Patient-Family Advocacy Program.

ACTION PLAN

- All staff members of the Patient and Family Advocacy team were educated by the Manager of Patient and Family Advocacy and the Director of Patient Safety and Advocacy using the referenced case as a learning opportunity. Topics reinforced were the importance of accurate medical documentation, opportunities to fully address patient concerns, along with the review of the Fletcher Allen Event Reporting Policy and the expectations for reporting safety concerns. All actions were complete as of 10/2/2013.
- Performance will be monitored through a weekly review of concerns brought forward, along with a monthly manager review of grievances to ensure appropriate and timely follow-up was completed

A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING

The patient has the right to receive care in a safe setting.

This STANDARD is not met as evidenced by: Based on patient and staff interviews and record review the facility failed to assure care was provided in a safe manner for two patients, when identity was not verified prior to treatment, and for one vulnerable patient who was able to elope from the facility unsupervised. (Patients #1, #2 and #5). Findings include:

1. Per record review the facility failed to assure safe care was provided for Patient #2 when s/he presented to the Emergency Department (ED), on 2/5/13, in a condition that prevented him/her from providing accurate information. Staff failed to follow facility policy to confirm the patient's identity through review of 3 data elements, including name, date of birth, address and or social security number, and failed to use the patient's previously scanned photo ID to confirm the patient's identity. The only form of identification used appeared to be patient name, and, as a result, the inaccurate information from the EMR for Patient #1 (a patient with a similar name) was used to assess and treat Patient #2.

Per interview, at 8:40 AM on 9/3/13, Patient #1 stated that during a March or April 2013 visit to his/her Primary Care Provider (PCP), who, as part of the FAHC system, had access to all FAHC records, the PCP questioned the patient about a visit to the ED on 2/5/13. Patient #1 told the PCP that s/he had not made a visit to the ED on that date. Subsequently, Patient #1 received a bill for diagnostic testing done in the ED on 2/5/13. When the patient received a copy of the EMR from his/her PCP, which contained inaccurate information, including a CT scan and lab results, referencing the ED visit on 2/5/13, s/he recognized that Patient #2, who had been escorted by law enforcement to the ED, had mistakenly been identified as Patient #1. The patient contacted the Patient-Family Advocacy Program at the hospital at the end of April 2013 and explained his/her concern about the mistaken identity

and the receipt of a bill for diagnostic testing. The patient expressed feeling disrespected by the Patient Advocate with whom s/he had spoken, feeling the Advocate did not believe him/her. Although the Advocate recommended Patient #1 contact the police to request help in confirming the mistaken identity issue, there was no further assistance provided to help resolve the issue. The wrong identity was confirmed when Patient #1 presented to the police station and a law enforcement official confirmed Patient #1 was not the patient escorted by that officer to the ED on 2/5/13. The patient stated there had been no further contact with the hospital and described feeling anxious and great emotional distress related to feeling his/her integrity was in question when the hospital did not offer assistance to help resolve the issue, but rather, the patient felt, left it up to him/her to resolve it on their own. The patient also expressed distress that the inaccurate information might be accessible to other staff members.

Patient-Family Advocate #1 confirmed, during interview at 11:03 AM on 9/4/13, that Patient #1 had contacted him/her to express concerns around mistaken identity and billing. S/he stated that since the patient name, address and medical record number were correct on Patient #1's EMR, s/he had assumed the photo identity had been used at the time of registration to confirm the patient's identity. The advocate stated the only plan s/he could think of to assist Patient #1 was to recommend the patient talk with the police to help confirm Patient #1 was not the person escorted to the ED on 2/5/13. The Advocate stated that s/he told the patient to contact Patient-Family Advocacy if any further concerns and felt Patient #1 had agreed with the plan. S/he stated the patient did not contact the department again and confirmed no further follow up had been done by the Patient-Family Advocacy Program.

During interview, at 11:49 AM on 9/3/13, the Operations Manager for Health Information Management (HIM) confirmed that a data integrity incident had occurred when Patient #2 visited the ED on 2/5/13, was not able to provide clear information and the visit was registered under Patient #1's name, which was similar to Patient #2. S/he stated s/he was not notified of the incident until late April 2013, at which point the information from Patient #1's record was transferred to Patient #2's record and a note which identified the data integrity incident was placed in Patient #1's EMR. This information was verified during review of Patient #1's record, on 9/3/13, which noted; 'Data Integrity Alert: This record was recently involved in a data integrity incident. Please review problem list, meds and allergies carefully with patient at next visit.'

The ED Medical Director and Physician Assistant (PA) #2, who provided direct care to Patient #2, both agreed, during interview at 1:08 PM on 9/4/13, that there was potential for errors to occur if inaccurate health information is used as part of an assessment and treatment of a patient. PA #2, stated that the Registration Department is responsible for confirming the identity of patients in the ED and, as s/he reviewed Patient #2's record, there was nothing that would have alerted him/her, at the time of treatment, to false patient identity. S/he further stated there was nothing s/he would have done differently in the treatment of Patient #2, if the accurate medical record had been used. The Medical Director confirmed that, although Patient #1's record had been mistakenly used to provide care to Patient #2, (indicating that the ED provider's assessment had been based, in part on the inaccurate information from Patient #1's record), Patient #2 received appropriate care and there had been no negative outcome for Patient #2 as a result of the incident. Both the Medical Director and PA #2 stated they had not been aware of the incident until brought to the facility's attention by the surveyor on 9/3/13.

The Patient Identification policy, dated 7/1/11, included the Policy Statement: 'Guidelines have been established to maximize patient safety through a universal standard of unique patient identification', and stated, as it's purpose: 'To properly and accurately identify patients so that they may receive appropriate care.' The policy procedure included; '1. General identification - A. Patient identification...is defined as a positive match to a minimum of 3 distinct data elements. Patients' Legal Name as provided by the patient, DOB and Gender social security number and/or mailing address will be considered additional data elements utilized to make a positive match B. In an emergency, and three data elements are unavailable, an "Unidentified ED" patient number will be issued until data is provided.'

The Registration Supervisor stated during interview, at 4:14 PM on 9/3/13, that patient identification is confirmed by registrars during the registration process for all ED patients. S/he stated the policy includes asking the patient's

name, DOB, address or social security number. S/he further stated the expectation is that staff should be looking at photo ID, if available in the record. Both the Supervisor and the Registrar #1, responsible for registration of Patient #2 on 2/5/13, who was also present during the interview, confirmed the policy had not been followed and the photo ID, although available in the EMRs of both Patient #1 and Patient #2, had not been accessed to confirm identity of Patient #2. Both also stated they had been unaware of this incident until notification was made by the surveyor.

The Director of Patient Registration and Customer Service, confirmed, during interview on the morning of 9/4/12, that Patient #2's ID had not been verified in accordance with the facility's policy, which led to the use of Patient #1's EMR in the treatment of Patient #2 on 2/5/13. S/he further stated s/he had not been made aware of the incident until notified through the surveyor.

Although there was no identified negative outcome for Patient #2, the failure to accurately confirm his/her identify created an unsafe setting in which to receive care, and placed the patient at risk for potential medical errors to occur. Despite the fact that Patient #1 did not receive treatment on 2/5/13, the inaccurate identification of Patient #2, by registration staff, subsequently led to a series of events including; misinterpretation of Patient #1's medical information by his/her PCP, inaccurate billing of tests and the failure of the hospital Patient Advocacy staff to assist the patient in resolution of the issue. This ultimately resulted in what Patient #1 expressed as great emotional distress related to his/her perception that their personal integrity had been questioned. And, although there was no evidence that breach of confidentiality of Patient #1's medical information had occurred the patient expressed distress related to the potential for a breach. This has potentially created an emotionally unsafe healthcare setting for Patient #1, who receives the majority of his/her care through the FAHC system.

2. Based on record review Patient #5, who was admitted on 1/24/13, and assessed by nursing, on 2/9/13 as an elopement risk, eloped, during an unsupervised leave from the inpatient unit on Case Manager note, dated 1/28/13, indicated concerns regarding the patient's inability to manage self at home, appears impulsive with limited insight regarding care issues. An initial psychiatry evaluation was requested for the patient on 1/29/13 with the reason noted as "decision making capacity." The evaluation was deemed inconclusive due to psychiatry wanting to perform more cognitive testing. An attending MD note on 1/30/13 states that the patient is distrustful of staff and wants to go home. A social work note on 1/31/13 states that the case management team feels the patient would not be safe in his/her home environment and that the patient is confused and requiring a one to one for safety. Case management decided to then seek guardianship for the patient. Psychiatry re-evaluated the patient on 1/31/13 and concluded that the patient "does not have capacity." The patient's hospital stay was extended related to concerns regarding capacity to safely provide self care and the ongoing pursuit of legal guardianship. On 2/9/13 a Nursing Progress note indicated that the patient was irritable, irrational, and verbalized his/her desire to go home saying "I'm leaving here." Per nursing order on 2/9/13 the patient was subsequently placed on a one to one as an elopement precaution. The patient was transferred to the Baird 4 medical unit on 2/9/13, where, despite lack of evidence that a reassessment of elopement risk had been conducted, the patient was allowed unsupervised leaves from the unit to the cafeteria for specified periods of time. On 2/18/13 the patient signed out on the unit register that s/he was going to the cafeteria. S/he was discovered to have eloped from the unit when s/he did not return within the one hour time duration allowed off of. Per interview, on September 5, 2013 at 3:00 PM, the Baird 4 Nurse Manager confirmed that the patient had been assessed, on 2/9/13 while on Baird 3, as an elopement risk and that the patient's electronic medical record had been flagged to alert staff of the identified elopement risk. The elopement risk flag was on the EMR when the patient transferred that day to Baird 4. The Nurse Manager also confirmed that no reassessment of the elopement risk had been completed following Patient #5's transfer to Baird 4 on 2/9/13, the care plan had not been revised to discontinue the elopement risk and the patient was allowed unsupervised leaves from Baird 4 to the cafeteria, from where s/he eloped on 2/18/13. Patient #5 called the Baird 4 nursing unit to tell them s/he was "at home" and needed assistance with his/her care. The patient then returned to the hospital on the afternoon of 2/18/13.

Action Plan

- A thorough review of Fletcher Allen Health Care's Patient Identification Policy was completed by a cross organizational team lead by the Director of Registration and Customer Service. As a result of this review, policy language was revised to include: Additional patient identifiers when appropriate, specific language added to articulate the requirement of adverse event reporting for misidentification, process modifications for misidentified patients, additional clarity regarding pre-arrival information from Emergency Medical Transport. The policy updates and changes were communicated organization wide by the referenced Director in November 2013
- The Fletcher Allen Policy Addendums, Amendments, Corrections and Deletions in the Medical Record were reviewed by a multidisciplinary team led by the Director of Health Information Management. The policy was updated to clearly articulate specific expectations regarding Adverse Event Reporting and the clinician notification of changes process within the data integrity process
- The Manager of Health Information Management and Data Integrity reported the case review with accompanying process updates to the Fletcher Allen Health Care Patient Safety Committee chaired by the Chief Quality Officer in October 2013.
- An organizational wide educational communication from Director of Patient Safety and Advocacy will reinforce the staff expectations of adverse events / near miss reporting as outlined in the Adverse Event/Near Miss Reporting and Analysis during the month of December 2013.
- The Manager of Registration reinforced individually with each staff member the expectations outlined in the Fletcher Allen Health Care Patient Identification Policy and the Adverse Event/ Near Miss Reporting and Analysis Policy. This was completed in October 2013.
- The Manager of Health Information Management and Data Integrity will educate members of the Data Integrity team on the Fletcher Allen Policies: Addendums, Amendments, Corrections and Deletions in the Medical Record, Adverse Event/Near Miss Reporting and Analysis. This education will be through a combination of electronic communication / and or staff meetings and will be completed by 11/30/2013.
- An organization wide educational communication from the Director of Accreditation and Regulatory Affairs entitled "Accuracy of documentation in the medical records" was communicated organization wide on 11/4/2013. The education focused on the accuracy and completeness of the medical record in relation to providing safe patient care. In addition, the education articulated the importance of filing an Adverse Event Report. Each area was requested to actively review the information with their teams.
- The Director of Registration and Customer Service in collaboration with the Manager of Health Information Integrity and Distribution and Director of Health Information Management defined metrics that have been identified as Key Performance Indicators that will be reviewed on a quarterly basis by the Patient Assess Leadership Team and The Standard of Operation Committee and Patient Safety Committee both chaired by the Chief Medical Officer

286 482.21(a), (c)(2), (e)(3) PATIENT SAFETY

(a) Standard: Program Scope

(1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will... identify and reduce medical errors.

(2) The hospital must measure, analyze, and track ...adverse patient events

(c) Program Activities

(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established.

This STANDARD is not met as evidenced by: Based on patient and staff interviews and record review staff failed to utilize the established event reporting system (SAFE) as a means to assess adverse patient events and identify opportunity for improvement and changes that would lead to improvement for an incident involving the mistaken identification of a patient. (Patient #1 and #2). Findings include:

1. Per interview with multiple staff members, there was a failure by staff, on at least three separate occasions, to follow facility policy to complete S.A.F.E event reports related to an incident involving mistaken identity of Patient #2, who was brought to the Emergency Department (ED), on 2/5/13, in a condition that prevented him/her from providing accurate information. The only form of identification used appeared to be patient name, and, as a result, inaccurate information from the EMR for Patient #1 (a patient with a similar name) was used to assess and treat Patient #2.

Per interview, at 8:40 AM on 9/3/13, Patient #1 stated that s/he had been made aware, sometime during a March or April 2013 visit to his/her Primary Care Provider (PCP), who, as part of the FAHC system, had access to all FAHC records, that his/her record indicated a visit to the ED on 2/5/13, which Patient #1 had not made. Subsequently, Patient #1 received a bill for diagnostic testing done in the ED on 2/5/13. When Patient #1 obtained a copy of their EMR, which contained inaccurate information, including a CT scan and lab results, referencing the ED visit on 2/5/13, s/he recognized that Patient #2, who had been escorted by law enforcement to the ED, had mistakenly been identified as Patient #1. The patient contacted the Patient-Family Advocacy Program at the hospital at the end of April 2013 and explained his/her concern about the mistaken identity and the receipt of a bill for diagnostic testing. The wrong identity was eventually confirmed when Patient #1 presented to the police station and a law enforcement official confirmed Patient #1 was not the patient escorted by that officer to the ED on 2/5/13. The facility policy, Adverse Event/Near Miss Reporting and Analysis, stated; 'Potential hazards or adverse events should be reported at the time of identification and/or occurrence. The Manager/Supervisor/Risk Manager or designee should be informed and appropriate action taken immediately to mitigate the event. Reported events and near misses will be tracked, trended and analyzed to improve quality and patient safety...'

The ED Medical Director and Physician Assistant (PA) #2, who provided direct care to Patient #2, both agreed, during interview at 1:08 PM on 9/4/13, that there was potential for errors to occur if inaccurate health information is used as part of an assessment and treatment of a patient. PA #2, stated that the Registration Department is responsible for confirming the identity of patients in the ED and, as s/he reviewed Patient #2's record, there was nothing that would have alerted him/her, at the time of treatment, to false patient identity. Both the Medical Director and PA #2 stated they had not been aware of the incident until brought to the facility's attention by the surveyor on 9/3/13.

Patient-Family Advocate #1 confirmed, during interview at 11:03 AM on 9/4/13, that Patient #1 had contacted him/her to express concerns around mistaken identity and billing. S/he stated s/he had assumed the photo identity had been used at the time of registration to confirm the patient's identity and the only plan s/he could think of to assist Patient #1 was to recommend the patient talk with the police to help confirm Patient #1 was not the person escorted to the ED on 2/5/13. The Advocate stated there had been no further follow up regarding the incident by the department of Patient Family Advocacy. S/he confirmed that s/he had not referred the complaint to ED or Patient Registration management or leadership staff.

During interview, at 11:49 AM on 9/3/13, the Operations Manager for Health Information Management (HIM) confirmed that a data integrity incident had occurred. S/he stated s/he had not been notified of the incident until late April 2013, at which point the information from Patient #1's record was transferred to Patient #2's record, though no event report had been completed.

The Registration Supervisor stated during interview, at 4:14 PM on 9/3/13, that patient identification is confirmed by registrars during the registration process for all ED patients. Both the Supervisor and Registrar #1, responsible for registration of Patient #2 on 2/5/13, who was also present during the interview, confirmed the policy had not been followed and the photo ID, although available in Patient #2's EMR, had not been accessed to confirm identity of Patient #2. Both also stated they had been unaware of this incident until notification was made by the surveyor, and the Supervisor agreed that the lack of timely notification of the issue "seems like a missed opportunity to improve on process."

The Director of Patient Registration and Customer Service, confirmed, during interview on the morning of 9/4/12, that Patient #2's ID had not been verified in accordance with the facility's policy. S/he further stated s/he had not been made aware of the incident until notified as a result of the current survey process. S/he stated that when data integrity incidents occur, the usual process is to notify the Registration department, which would trigger a need for an event report, and an investigation to identify and rectify the issue. S/he stated that a police officer reported the mistaken identity issue, providing positive identification of Patient #2 at the same time, to a Customer Service Representative (CSR) in the Billing Department, in late April. The Director stated the CSR failed to complete an event report, which should have occurred and would have provided notification to Patient Registration of the error. S/he agreed that a timely opportunity to improve patient care outcomes did not occur as a result of staff failure to complete the SAFE report.

During interview, at 12:37 PM on 9/5/13 the VP of Quality stated that the event reporting system is a piece of the overall quality assessment program. The information obtained is reviewed, analyzed and used to identify opportunities for improvement. S/he stated there was no evidence that an event report had been completed by anyone regarding this issue and agreed reports should have been completed by the CSR involved, the data integrity team, as well as the Patient Family Advocacy

Action Plan

- An organizational wide educational communication from Director of Patient Safety and Advocacy will reinforce the staff expectations of adverse events / near miss reporting as outlined in the Adverse Event/Near Miss Reporting and Analysis during the month of December 2013

*A395 Department. 482.23(b)(3) RN SUPERVISION OF NURSING CARE**A registered nurse must supervise and evaluate the nursing care for each patient.**This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to supervise and evaluate the nursing care for one patient at the time of discharge, and for one patient, # 5, who eloped from his care unit.**Based on record review Patient #5, who was admitted on 1/24/13, and assessed by nursing, on 2/9/13 as an elopement risk, eloped, during an unsupervised leave from the inpatient unit on which s/he was housed, on 2/18/13. An initial RN Case Manager note, dated 1/28/13, indicated concerns regarding the patient's inability to manage self at home, appears impulsive with limited insight regarding care issues. An initial psychiatry evaluation was requested for the patient on 1/29/13 with the reason noted as "decision making capacity." The evaluation was deemed inconclusive due to psychiatry wanting to perform more cognitive testing. An attending MD note on 1/30/13 states that the patient is distrustful of staff and wants to go home. A social work note on 1/31/13 states that the case management team feels the patient would not be safe in his/her home environment and that the patient is confused and requiring a one to one for safety. Case management decided to then seek guardianship for the patient. Psychiatry re-evaluated the patient on 1/31/13 and concluded that the patient "does not have capacity." The patient's hospital stay was extended related to concerns regarding capacity to safely provide self care and the ongoing pursuit of legal guardianship. On 2/9/13 a Nursing Progress note indicated that the patient was irritable, irrational, and verbalized his/her desire to go home saying "I'm leaving here." Per nursing order on 2/9/13 the patient was subsequently placed on a one to one as an elopement precaution. The patient was transferred to the Baird 4 medical unit on 2/9/13, where, despite lack of evidence that a reassessment of elopement risk had been conducted, the patient was allowed unsupervised leaves from the unit to the cafeteria for specified periods of time. On 2/18/13 the patient signed out on the unit register that s/he was going to the cafeteria. S/he was discovered to have eloped from the unit when s/he did not return within the one hour time duration allowed off of the unit.**Per interview, on September 5, 2013 at 3:00 PM, the Baird 4 Nurse Manager confirmed that the patient had been assessed, on 2/9/13 while on Baird 3, as an elopement risk and that the patient's electronic medical record had been flagged to alert staff of the identified elopement risk. The elopement risk flag was on the EMR when the patient transferred that day to Baird 4. The Nurse Manager also confirmed that no reassessment of the elopement risk had been completed following Patient #5's transfer to Baird 4 on 2/9/13, the care plan had not been revised to discontinue the elopement risk and the patient was allowed unsupervised leaves from Baird 4 to the cafeteria, from where s/he eloped on 2/18/13. Patient #5 called the Baird 4 nursing unit to tell them s/he was "at home" and needed assistance with his/her care. The patient then returned to the hospital on the afternoon of 2/18/13*

Action Plan

- As part of the November Nursing priorities the Nursing Directors will reinforce with the nursing staff the expectations outlined in the Fletcher Allen Policy: Patients off the unit. Specifically highlighted will be the importance of a current plan of care reflecting the patient current elopement risk. This will be completed by November 30, 2013 through a combination of electronic communications and meetings during the month of November by the Directors, Nursing Managers, Nursing Educators and or designee.
- An RN Clinical Analyst will monitor nursing compliance with required care plan documentation outlined in the Fletcher Allen Policy: Patients off the unit. Performance feedback will be provided to the Nursing Directors for any required action. Monitoring will be monthly and reevaluated based on performance.

A438 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 patient and staff interview and record review the facility failed to ensure the accuracy of the medical record for two patients: one whose record was erroneously used to document health information of another patient, and the second patient, for whom inaccurate information was used in the clinical assessment during an Emergency Department (ED) visit. Findings include:

Per interview, at 8:40 AM on 9/3/13, Patient #1 stated that his/her medical record had contained inaccurate information that was accessed by the patient's Primary Care Provider (PCP), in March or April of 2013, and resulted in the PCP questioning the patient about activity that led to an Emergency Department (ED) visit on 2/5/13. The patient informed the PCP that s/he had not been to the ED on 2/5/13. The patient subsequently received a bill for diagnostic testing that had been performed during the ED visit on 2/5/13. S/he then obtained a copy of his/her medical record, which contained inaccurate information including the fact that the patient had been escorted to the ED by police, as well as results of lab tests and CT scan. Patient #1 suspected his/her record had been used in the treatment of another patient (Patient #2) and contacted the Patient-Family Advocacy Department to inform them of the error. When no resolution was forthcoming from the facility Patient #1 presented to the police department and the police officer who had escorted Patient #2 to the ED on 2/5/13, confirmed that Patient #1 had not been the same person the officer had escorted to the ED. The police officer then notified the hospital of the mistaken identity of Patient #2.

During interview, at 11:49 AM on 9/3/13, the Operations Manager for Health Information Management (HIM) confirmed that a data integrity incident had occurred when Patient #2 visited the ED on 2/5/13, was not able to provide clear information and the visit was registered under Patient #1's name, (which was similar to Patient #2). S/he stated s/he was not notified of the incident until late April 2013, at which point the information from Patient #1's record was transferred to Patient #2's record and a note which identified the data integrity incident was placed in Patient #1's EMR. This information was verified during review of Patient #1's record, on 9/3/13, which noted; 'Data Integrity Alert: This record was recently involved in a data integrity incident. Please review problem list, meds and allergies carefully with patient at next visit.'

Action Plan

- The Fletcher Allen Policy Addendums, Amendments, Corrections and Deletions in the Medical Record were reviewed by a multidisciplinary team led by the Director of Health Information Management. The policy was updated to clearly articulate specific expectations regarding Adverse Event/ Near Miss Reporting and the clinician notification of changes process within the data integrity process
- The Director of Registration and Customer Service in collaboration with the Manager of Health Information Integrity and Distribution and Director of Health Information Management defined metrics that have been identified as Key Performance Indicators that will be reviewed on a quarterly basis by the Patient Assess Leadership Team and The Standard of Operation Committee and Patient Safety Committee both chaired by the Chief Medical Officer.

- The Manager of Health Information Management and Data Integrity reviewed the case referenced with accompanying process updates at Fletcher Allen Health Care Patient Safety Committee chaired by the Chief Quality Officer in October 2013.
- The Manager of Health Information Management and Data Integrity will educate members of the Data Integrity team on the Fletcher Allen Policies: Addendums, Amendments, Corrections and Deletions in the Medical Record, Adverse Event/Near Miss Reporting and Analysis. This education will be through a combination of electronic communication / and or staff meetings and will be completed by 11/30/2013.
- An organization wide educational communication from the Director of Accreditation and Regulatory Affairs entitled "Accuracy of documentation in the medical records" was communicated organization wide on 11/4/2013. The education focused on the accuracy and completeness of the medical record in relation to providing safe patient care. In addition, the education articulated the importance of filing an Adverse Event Report. Each area was requested to actively review the information with their teams

A 817 782.43(c) DISCHARGE PLAN

(1) A registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan if the discharge planning evaluation indicates a need for a discharge plan.

This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to assure implement an appropriate discharge plan for one patient. (Patient #4). Findings include:

Per review of the medical record for patient #4, was admitted through the facility emergency department on 5/23/2013 approximately one month post total colectomy and ileostomy complicated by post-operative pelvic abscess. The initial general surgeon progress note on 5/29/13 states that the patient has a rectal tube in place for drainage and it is to be removed prior to the patients discharge. A subsequent progress note dated 5/30/13 states that the plan is to discharge the patient that day (5/30/13) and to remove the rectal tube prior to discharge. Despite the physician documented intent for the rectal tube to be removed prior to discharge, there were no physician orders reflecting that plan. A Nursing Progress note, dated 5/30/13, indicated that RN #1, who was responsible for the patient's discharge, demonstrated irrigation of the rectal tube for a home health aide who would be providing care post discharge and the tube was not removed prior to the patient's discharge. Further review of the patient record, post discharge, revealed that the patient presented at his/her primary care physician office (PCP) to have the rectal tube removed on 6/7/13. Per PCP documentation on 6/7/13, s/he removed the rectal tube from the patient and stated also that the attending surgeon at the facility from where the patient was discharged was unaware that the patient had been discharged with the rectal tube still in place.

During interview, on 9/5/2013 at 2:00 PM, RN #1 confirmed there were no physician orders to discontinue the rectal tube and no orders for use and care of the rectal tube post discharge. The RN Unit Manager, who was also present during the interview, confirmed that the expectation is there would be a physician order for both the continued use of, and care of, the drain. In addition, RN #1 further confirmed the lack of discharge instructions for use and care of the rectal tube.

Despite the physician intent for the rectal tube to be removed, prior to discharge, there was a lack of communication regarding that discharge plan and the patient was discharged without a plan for continued use and care of the open drain.

Action Plan

- The referenced case was reviewed at the September Safety and Adjudication Meeting chaired by the Chief Quality Officer. As a result a multidisciplinary Quality Review was requested and performed. The review utilized as a teaching opportunity.
- As part of the November Nursing Initiative the Nursing Directors will use the referenced case as an education case study highlighting communication during the discharge planning process. This will be completed by November 30, 2013 through a combination of electronic communications and meetings during the month of November by the Directors, Nursing Managers, Nursing Educators and or designee.
- An RN Clinical Analyst will review documentation contained in discharge plans for patients with Lines and Drains noted for the admission to ensure the appropriateness of the discharge plan and accompanying documentation. Performance feedback will be provided to the Nursing Directors for any required action. Monitoring will be monthly and reevaluated based on performance.