

Division of Licensing and Protection

103 South Main Street, Ladd Hall

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Voice/TTY (802) 871-3317

To Report Adult Abuse: (800) 564-1612

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October 31, 2012

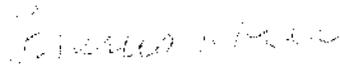
Joseph Woodin, Administrator  
Gifford Medical Center  
44 South Main Street  
Randolph, VT 05060

Dear Mr. Woodin:

The Division of Licensing and Protection completed a complaint investigation at your facility on **September 12, 2012**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **October 30, 2012**.

Sincerely,



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

Enclosure



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

PRINTED: 09/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  471301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/12/2012
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NAME OF PROVIDER OR SUPPLIER  GIFFORD MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 44 SOUTH MAIN STREET RANDOLPH, VT 05060
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(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
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C 000	INITIAL COMMENTS	C 000		
C 302	<p>485.638(a)(2) RECORDS SYSTEMS</p> <p>The records are legible, complete, accurately documented, readily accessible, and systematically organized.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the CAH (Critical Access Hospital) failed to ensure complete and accurate documentation of the Emergency Department (ED) medical record for 2 of 20 records in the total sample. (Patients #10,13 )Findings include:</p> <p>1. Per record review on 9/10/12, Patient #13 (age 7) was brought to the ED on 9/3/12 after sustaining a finger amputation while using a leg splitter. Due to the nature of the injury and the psychosocial component which developed during the care of the patient, a request was made to have a staff social worker assist with managing the case and the logistic of transferring the patient to a tertiary hospital. Difficulties arose regarding parental consent, mode of transfer, identifying who would accompany Patient #13 when transferred via helicopter, however the nursing notes did not reflect a social service consultation or the ongoing issues surrounding care and services while the patient received treatment in the ED. Per CAH policy Emergency Department Nursing Standards of Care effective date 6/16/11 states: Psychosocial support is provided as well as consultations to appropriate</p>	C 302	<p>C - (302)</p> <p>Concerns Identified: Complete and accurate documentation of ED medical record for 2 of 20</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> <li>1) Educate and train ED nursing staff on basics of documentation</li> <li>2) ED nurses will review own charts using chart review form (enclosed) (5 charts per shift (or all if less than 5 patients in shift) x 10 shifts)</li> <li>3) Staff development review of charts and will work with nurses whose documentation is not meeting expectation</li> </ol> <p>Monitoring: Staff development nurse will collect and monitor chart reviews.</p> <p>Completion Date: Begin October 1, 2012 and continue until documentation is meeting expectations</p> <p><i>Re-assessed 10/30/12 Bellefleur-Ross, Franca-Ross CAH, U.S. 10/13/12</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE VP of Hospital Division	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 302	Continued From page 1 resources such as social services, Chaplin or psychiatric services. These consultations should be documented in the nursing documentation." The incomplete documentation was confirmed on the afternoon of 9/11/12 by the Vice President of the Hospital Division.  2. Per record review on 9/10/12, the Triage Nursing Assessment for Patient #10, dated 6/7/12 at 2015 hours, included no documentation regarding an initial pain assessment related to a reported finger injury and no initial blood pressure reading. The patient, who was 11 years old, was later diagnosed with a fracture of the proximal phalanx of the right 5th finger. The 'Discharge Care and Disposition' section of the triage assessment included no documentation in the vital signs area and a pain level documented as 5 out of 10, which is above minimal pain. Per review of the hospital's policy/procedure entitled "Emergency Department Nursing Standards of Care" under B. Subjective/Objective Assessment, 5. "Assessment of physical pain will be included in the initial assessment of all patients, using the 0 - 10 numeric pain distress Scale for Adults, the FLACC (non-verbal) for ages >3 and the Faces Rating Scale for children 3-7 years old". Additionally, under B.1.f. "Complete vital signs are taken for all patients" (includes all patients >5 years of age). The nurse's failure to completely document all areas of the triage assessment was confirmed during interview with the Vice President of Hospital Services and the Director of Quality Assurance (QA) on 9/11/12 at 4:30 PM.	C 302			
C 304	485.638(a)(4)(i) RECORDS SYSTEMS  For each patient receiving health care services,	C 304			

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C 304	<p>Continued From page 2</p> <p>the CAH maintains a record that includes, as applicable--</p> <p>identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the CAH failed to ensure properly executed informed consent for transfer from the CAH to another facility for 3 applicable patients. (Patients # 7, 13, 17 ) Findings include:</p> <p>1. Per record review on 9/10/12, Patient #13 required transfer to a tertiary facility due to a finger amputation. The CAH "Transfer Form" lacked required documentation to include: next of kin/legally responsible person with their phone number; transfer consent signatures were not obtained (Patient #13 was a minor); the name of the facility where the patient was transferred and who accompanied the patient during the transfer. The omissions were confirmed with the VP of the Hospital Division on the afternoon of 9/11/12.</p> <p>2. Per review on 9/10/12, the patient "Transfer Forms" for Patients #7 and #13 were incompletely documented in all required sections. The section for identification of the next of kin/legally responsible person(s) including contact</p>	C 304	<p><b>C - (304)</b></p> <p><b>Concerns Identified: Failed to ensure properly executed informed consent for transfer from CAH to another facility</b></p> <p><b>Corrective Action:</b></p> <ol style="list-style-type: none"> <li>1) Transfer form has been revised for clarity</li> <li>2) ED staff aware of new transfer form (notified via email 9/24 and ED meeting 9/26)</li> </ol> <p><b>Monitoring: 100% of transfers will be reviewed for completeness of transfer form. QM will generate a list of transfers from the ED. Patient Registration will conduct the review.</b></p> <p><b>Completion Date: Begin October 1, 2012 and continue for 3 months.</b></p>		

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C 304	Continued From page 3 information, was left blank for both of these patients. Patients #7 and #13 were each transferred from the hospital's Emergency Department (ED) to a tertiary care hospital for needed treatment. The failure to complete the Patient Transfer Forms was confirmed during interview with the VP of Hospital Division and the Director of QA on 9/11/12 at 4:30 PM.	C 304	C - (337)	
C 337	485.641(b)(1) QUALITY ASSURANCE  The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that all patient care services and other services affecting patient health and safety are evaluated.  This STANDARD is not met as evidenced by: Based on interview and record review, the CAH Emergency Department quality assurance program failed to identify the limitations of the present process of posting the "Call Schedule" for only a 24 hour period within the Emergency Department. As a result, ED providers lack the ability to appropriately refer a patient for timely consultations and/or follow-up treatment with a specialists. Findings include:  Per record review on 9/10/12, Patient #2, who sustained a thumb injury while playing soccer, was brought to the ED for treatment by his/her parent on 8/17/12. The patient was examined by the ED physician, and after x-rays was diagnosed	C 337	Concerns Identified: ED quality assurance failed to identify the limitations of the present process of posting the "call schedule" for only a 24 hour period within the ED.  NOTE: The full monthly on-call schedule that is posted on the hospital intranet is readily available (and has been for several years)  Corrective Action: 1) 24 hour call posting revised to add reminder to check monthly call schedule and if GMC Orthopedics is unavailable, refer to another Orthopedic provider 2) Posted a screen shot of hospital intranet (Gifnet) highlighting the link to the monthly call schedule 3) Provider/ED staff reminded to check readily available call schedules at ED meeting 9/26  Monitoring: 100% of orthopedic referrals to GMC Orthopedics reviewed to see if Provider was available per the call schedule. QM will generate a list of orthopedic cases and Patient Registration will conduct the review.  Completion Date: 1) 24 hour call schedule revised and posted as of 9/21 2) Posted screen shot of Gifnet in ED and at all nurses stations as of 9/21  Monitoring to begin October 1, 2012 and continue for 3 months.	

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C 337	Continued From page 4 with a fracture of the left thumb. The ED physician applied a thumb spica splint, wrap and casting material and provided a referral to the CAH orthopedic surgeon noting the patient should be seen within 3-4 days. The patient's injury was on Friday, the parents preceded to contact the orthopedic surgeons office on Monday 8/20/12 for follow up/consultation. After multiple phone calls, the parents were informed the orthopedic surgeon was not available for the entire week and another orthopedic surgeons office was also not providing appointments. Eventually, the patient was seen at a tertiary facility on the 5th day after his/her injury after obtaining a referral from Patient #2's pediatrician and required surgery the following day. Per interview on 9/11/12 at 11: 42 AM, the ED physician who treated Patient #2 on 8/17/12 stated the on-call list is only posted for each 24 hour period and s/he was unaware the orthopedic physician was not available to see and treat Patient #2 on the following Monday 8/20/12. If the full schedule for the month had been posted and available s/he would have not referred Patient #2 to the CAH orthopedic surgeon, and a referral to a tertiary hospital orthopedic service would have been made.	C 337			