

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 7, 2014

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

Dear Mr. Woodin:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 10, 2014**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

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: 09/19/2014
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 09/10/2014
NAME OF PROVIDER OR SUPPLIER GIFFORD MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 44 SOUTH MAIN STREET RANDOLPH, VT 05060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
C 000	INITIAL COMMENTS An unannounced recertification survey was conducted on 9/8/14 - 9/10/14 by the Division of Licensing and Protection to determine compliance with Conditions of Participation for Critical Access Hospitals at 42 CFR, Part 485, Subpart F. At the time of survey Complaint # 00012096 was also investigated.	C 000	Nursing leadership will provide a PowerPoint in-service entitled "meeting the emotional needs of patients". This will be shared with nursing staff. 75% of hospital nursing staff to complete by 10/31/2014. 100% of regularly scheduled nursing staff to complete by 11/28. Per Diem staff not scheduled during this time period will be expected to complete training on their next scheduled shift. This will be managed by nurse managers with presentation summary and attendance records submitted to QM.		
C 152	485.608(b) COMPLIANCE W ST & LOC LAWS & REGULATIONS All patient care services are furnished in accordance with applicable State and local laws and regulations. This STANDARD is not met as evidenced by: Based on staff interview and record review, during the provision of care and services staff failed to maintain patient rights in accordance with State statute, Title 18, Chapter 42; Bill of Rights for Hospital Patients; § 1852. "The patient has the right to considerate and respectful care at all times and under all circumstances with recognition of his or her personal dignity" for 1 applicable patient. (Patient #18). The CAH also failed to report an allegation of abuse in accordance with State statute, Title 33, Chapter 69: Reports of Abuse, Neglect, and Exploitation of Vulnerable Adults; § 6903 for 1 applicable patient. (Patient #18) Findings include:	C 152	A patient complaint "nursing algorithm" has been created to guide nursing staff in proper complaint management. This includes immediate reassignment of nursing staff when indicated, reporting requirements for allegations of abuse/neglect, responsibility of nursing staff to directly attempt complaint resolution, and the role of management and patient relations. Policy PR-301 "Resolution of Patient/ Visitor Complaint or Grievance" has been revised to clarify reporting requirements for allegations of abuse/ neglect, responsibility of nursing staff to directly attempt complaint resolution, the role of Nursing and Patient Relations, and the mechanism for an appeals process if the patient remains dissatisfied. Communication of new processes/revised policies will occur through staff meetings, email, and electronic sign off/ competency through Policy Manager for all hospital nursing staff. Completion of competency will be monitored through QM and followed up with nursing leadership as needed.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X8) DATE	

POC accepted
F. MacIntosh / *J. Kelly RN MSN* / *10/16/14*

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 152	Continued From page 1 1. Per record review, Patient # 18 was admitted to the CAH on 7/9/14 for alcohol withdrawal, atypical chest pain and pancreatitis. The patient has a past history of long term substance abuse, Traumatic Brain Injury (TBI), chronic head and neck pain and generalized anxiety disorder. Upon admission Patient #18 was placed on a CIWA protocol (Clinical Institute Withdrawal Assessment for alcohol. A 10 item scale used in assessment and management of Alcohol withdrawal). Patient #18 also reported during his/her initial treatment on 7/9/14 in the Emergency Department s/he was also experiencing narcotic withdrawal. Upon admission a nursing assessment rated Patient #18 to be a fall risk and a "High Risk" protocol was initiated to include: chair and bed alarm, 1 hour safety rounds by nursing and the use of a gait belt/ one person assisting Patient #18 with ambulation. On 7/10/14 Patient #18's CIWA score was rated as "Moderate to Severe" and required repeat doses of Lorazepam (benzodiazepine/antianxiety) to help reduce the patient's symptoms of withdrawal which included tremors of extremities, anxiety and agitation. The patient also began receiving Dilaudid (narcotic/pain medication) for ongoing pain complaints related to Pancreatitis and chronic issues associated with neck and shoulder injury. Per interview on 9/9/14 at 4:30 PM, Nurse #1, assigned to Patient #18 on the evening of 7/10/14 stated s/he heard the bed alarm go off at approximately 5:30 PM and entered the patient's room and observed Patient #18 attempting to enter the bathroom without assistance. Nurse #1 stated the intravenous pole had fallen to the floor and the patient's intravenous (IV) access was in	C 152			

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C 152	<p>Continued From page 2</p> <p>jeopardy of being pulled out as the patient advanced toward the bathroom. Nurse #1 stated s/he requested the patient to stop and prevented Patient #18 from entering the bathroom. Per the nursing progress note for 7/10/14, Nurse #1 states "I immediately prevented the patient from continuing forward by placing one hand on the door and one hand on the patient's left upper arm (above the IV site)..." Nurse #1 requested the patient to return to bed so the patient's IV access could be checked. The progress note further states Patient #18 then told Nurse #1 " Don't touch my arm". This statement was again repeated by the patient. Eventually Patient #18 cooperated, returned to bed, IV was checked, a gait belt was applied and Patient #18 with assistance by Nurse #1, the patient was brought to the bathroom.</p> <p>Within approximately 30 minutes, the evening charge nurse on 7/10/14 was notified by Registration that Patient #18 had called saying that s/he was "assaulted" by a nurse. The nurse manager notified the Patient Relations Specialist of the allegation. The Patient Relations Specialist choose to come to the CAH to speak with Patient #18, whom s/he has known during Patient #18's repeated hospitalizations. After discussions with Patient #18, and despite the fragility of Patient's #18's emotional and physical compromise and allegation of assault by staff, the Patient Relations Specialist requested Nurse #1 meet with Patient #18 so the patient could apologies. However, per Interview on 9/9/14 at 4:40 PM Nurse #1 stated " I thought I don ' t know what s/he feels s/he needs to apologize for ..it was odd ... I said to (Patient #18) I ' m also sorry if there ' s anything I did to offend you ...s/he (Patient 18) started crying and s/he said I just don ' t want you</p>	C 152			

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C 152	<p>Continued From page 3</p> <p>to get angryI didn ' t hear anything more about holding her/his arm ...if there was any harm to her/him that I had caused I wish someone had come to tell me but nobody did..." Nurse #1 further stated the Patient Relations Specialist never informed her/him of the allegations made by Patient #18. Per interview on 9/9/14 at 3:58 PM, the Patient Relations Specialist confirmed Patient #18 was "...very emotional..." about the event. Per interview on 9/10/14 at 10:00 AM, Nurse #2 (evening charge nurse on 7/10/14) confirmed s/he had not interviewed the patient or assessed the patient for injuries but felt "...it was better to have the Public Relations Specialists address the issue".</p> <p>Consideration of the circumstances alleged by Patient #18 were not appropriately addressed by staff and a failure to assure an emotionally safe environment was maintained. Although an incident had occurred and a allegation of assault was made by Patient #18 who expressed concern for not wanting staff to "...get angry", the patient was subjected to a face to face encounter with Nurse #1 (the alleged perpetrator) for the purpose of "apologizing". Within 2 hours of the alleged incident, Nurse #2 overheard Patient #18 weeping while informing his/her family member by phone that Nurse #1 "...had brutally assaulted ..." her/him. In addition, there was no additional consideration by staff to assign a different nurse to provide care to Patient #18 on the evening of 7/10/14. It was not until the patient's family contacted Nurse #2 at approximately 10:00 PM voicing concern about Patient #18's safety and requesting Nurse #1 no longer provide care to the patient, a change in the nursing assignment was made, removing Nurse #1 from having contact with Patient #18.</p>	C 152			

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C 152	Continued From page 4 2. CAH staff, identified as mandated reporters, failed to report to Adult Protective Services (APS) an allegation of abuse made by Patient #18 on 7/10/14 within the required time frame of 48 hours. As above mentioned, Patient #18 alleged that on 7/10/14, Nurse #1 had physically assaulted her/him while preventing the patient from using the bathroom. Although several staff became involved in the incident, to include the Public Relations Specialist, Nurse #2 (charge nurse), both Nurse Manager and Assistant Nurse Manager for Howell Pavilion (Patient Care Unit) and the Director of Quality/Risk, all failed to take on the responsibility of reporting, as required, to APS within 48 hours of the incident. It was not until 7/21/14, 9 days later, when the VP of Hospital Services did file a report of the alleged "assault" to APS. Per interview on 9/10/14 at 10:00 AM, when asked why s/he had not filed the report to APS, Nurse #2 (charge nurse on the evening of 7/10/14) stated "I didn't think anything at the time ...thought if anything needed to be done the Public Relations Specialist would take care of it ...".	C 152	Policy ADM-125 "Reporting Allegations of Abuse" has been created to educate and instruct staff on this requirement. Competencies will be assigned through Policy Manager to all nursing staff. 75% of hospital nursing staff to complete by 10/31/2014. 100% of regularly scheduled nursing staff to complete by 11/28. Per Diem staff not scheduled during this time period will be expected to complete training on their next scheduled shift. Completion of competency will be monitored through QM and followed up with nursing leadership as needed. ADM- 125 will be presented at Senior Management meeting 10/7/2014 to ensure that everyone understands the requirement to report allegations of abuse/ neglect to APS within 48 hours. This will be documented in meeting minutes. A patient complaint "nursing algorithm" has been created to guide nursing staff in proper complaint management. This includes immediate reassignment of nursing staff when indicated, reporting requirements for allegations of abuse/ neglect, responsibility of nursing staff to directly attempt complaint resolution, and the role of management and patient relations. Policy PR-301 "Resolution of Patient/ Visitor Complaint or Grievance" has been revised to clarify reporting requirements for allegations of abuse/ neglect, responsibility of nursing staff to directly attempt complaint resolution, the role of Nursing and Patient Relations, and the mechanism for an appeals process if the patient remains dissatisfied. Communication of new processes/revised policies will occur through staff meetings, email, and electronic sign off/ competency through Policy Manager for all hospital nursing staff. 75% of hospital nursing staff to complete by 10/31/2014. 100% of regularly scheduled nursing staff to complete by 11/28. Per Diem staff not scheduled during this time period will be expected to complete training on their next scheduled shift. Completion of competency will be monitored through QM and followed up with nursing leadership as needed.		
C 211	485.620(a) NUMBER OF BEDS Except as permitted for CAHs having distinct part units under §485.647, the CAH maintains no more than 25 inpatient beds. Inpatient beds may be used for either inpatient or swing-bed services. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain no more than 25 inpatient beds. Findings include: During tour of the facility, with the Nurse Manager	C 211			

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C 211	Continued From page 5 of the Medical Surgical Unit, on the afternoon of 9/9/14, the surveyor noted a total of 26 beds in or adjacent to locations where the beds could be used for Inpatient care. This was confirmed by the Nurse Manager of the Medical Surgical Unit at the time of tour.	C 211	Bed removed on 9/11/14 for a total count of 25.	
C 270	485.635 PROVISION OF SERVICES Provision of Services This CONDITION is not met as evidenced by: Based on observations, interviews and record review the Condition of Participation: Provision of Services was not met as evidenced by: C - 271: The CAH staff failed to follow policies and procedures related to the process, management and resolution of a patient complaint. C- 276: The CAH Pharmacy Department failed to assure the safe and secure storage and ongoing monitoring of all drug storage areas within the hospital for content, usage and outdated drugs as per professional standards of practice. C - 277: The CAH Pharmacy Department failed to assure a physician was notified in a timely manner when a medication prescribed by the physician was unavailable for administration. C - 278: The CAH Infection Control program failed to assure staff consistently maintained infection control standards of practice and failed to conduct ongoing surveillance and monitoring of the CAH environment to assure a sanitary and safe environment was being maintained.	C 270		

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C 270	Continued From page 6 C - 283: The CAH Radiology Department failed to maintain a sanitary environment.	C 270		
C 271	C - 294: Nursing staff failed to meet the emotional needs of a patient who expressed concern and anxiety regarding an encounter with a nurse during the provision of services. 485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on interview and record review, the CAH staff failed to follow policies and procedures related to the process, management and resolution of a patient complaint for 1 applicable patient. (Patient # 18) Findings include: 1. Per record review, the CAH policy Resolution of Patient and Visitor Complaint or Grievance effective 1/10/2014 states: "Swift and effective resolution of a concern is an opportunity to be a more successful health care facility and can prevent an issue from escalating to more complex patient concerns." The procedure for handling a complaint and/or grievance states "Hospital or Medical Staff members who receive a complaint from a patient or visitor have the responsibility to resolve or attempt to resolve the issue in a timely manner by: listening to the complaint, offering a sincere apology....doing what they can (within their authority) to promptly fix the problem". However, when informed by hospital staff on 7/10/14 that Patient #18 was alleging s/he was "assaulted" by a nurse on the Howell Pavilion/Patient care unit, the evening charge nurse failed to speak directly with Patient	C 271		

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C 271	<p>Continued From page 7</p> <p>#18 regarding the patient's allegations. Instead, the nurse manager choose to contact the Patient Relations Specialist, who was familiar with Patient #18's previous medical and psychosocial history, who subsequently came to the CAH and met with Patient #18.</p> <p>The process for a "...swift and effective resolution..." of Patient #18's concerns did not follow process. The policy further states: "All patient or visitor complaints or grievances are to be dealt with in a timely, satisfactory and uniform manner by making the special effort necessary to satisfy an aggrieved patient or visitor when there was an actual or potential breakdown in services" On 9/10/14 at 4:00 PM the Patient Relations Specialist confirmed s/he brought Nurse #1 into the patient's room and informed the nurse Patient #18 was going to tell her/him why the Patient Relations Specialist had been contacted to visit with Patient #18. The "resolution" of this complaint was a confrontation between the "alleged victim" and the "alleged perpetrator" resulting in the patient informing Nurse #1 s/he had hurt the patient earlier in the evening when attempting to assist the patient back to bed. Upon leaving the CAH after making the onsite visit to Patient #18 the Patient Relations Specialist assumed his/her actions were sufficient and appropriate to manage the complaint voiced by Patient #18 stating at the time of interview: "in this particular instance I did not want to be stirring the pot...".</p> <p>Resolution had not resulted. Patient #18 continued to complain and approximately 2 hours after the visit with the Patient Relations Specialist on 7/10/14 a family member contacted the evening charge nurse voicing concern about the</p>	C 271	<p>A patient complaint "nursing algorithm" has been created to guide nursing staff in proper complaint management. This includes immediate reassignment of nursing staff when indicated, reporting requirements for allegations of abuse/ neglect, responsibility of nursing staff to directly attempt complaint resolution, and the role of management and patient relations.</p> <p>Policy PR-301 "Resolution of Patient/ Visitor Complaint or Grievance" has been revised to clarify reporting requirements for allegations of abuse/ neglect, responsibility of nursing staff to directly attempt complaint resolution, the role of Nursing and Patient Relations, and the mechanism for an appeals process if the patient remains dissatisfied.</p> <p>Patient Relations Specialist will write an article for the November employee newsletter (the Pulse) that discusses our process for patient complaints.</p> <p>Communication of new processes/revised policies will occur through staff meetings, email, and electronic sign off/ competency through Policy Manager for all hospital nursing staff.</p> <p>75% of hospital nursing staff to complete by 10/31/2014. 100% of regularly scheduled nursing staff to complete by 11/28. Per Diem staff not scheduled during this time period will be expected to complete training on their next scheduled shift.</p> <p>Completion of competency will be monitored through QM and followed up with nursing leadership as needed.</p>		

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C 271	Continued From page 8 continued nursing care being provided by Nurse #1 despite the concerns raised by Patient #18. Nursing failed to eliminate further potential complaints and allegations by failing to remove Nurse #1 from the responsibility for the provision of care of Patient #18. Patient #18's family member was informed in a phone call by the Patient Relations Specialist at approximately 10:00 PM on 7/10/14 that s/he had been in contact with all parties involved, no "assault" had occurred and Patient #18 and Nurse #1 had "made up". However, concerns continued to be made by Patient #18's family, further alleging on 7/15/14 the patient experienced brushing of the right arm which was directly attributed to the event of 7/10/14. As per policy Resolution of Patient and Visitor Complaint or Grievance when a complainant remains dissatisfied "A formal grievance procedure has been established to provide for a discussion and a decision regarding a complainant's unresolved concerns regarding quality of care.....". There was a failure to recognize the complaint as a grievance or to formally resolve issues identified. This eliminated the opportunity for Quality/Risk Management and Nursing Department to assure all circumstances regarding the event of 7/10/14 were effectively reviewed to determine if resolutions and actions by both Nursing and the Patient Relations Specialist were appropriate, effective and maintained patient rights.	C 271			
C 276	485.635(a)(3)(iv) PATIENT CARE POLICIES [The policies include the following:] Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage	C 276			

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C 276	<p>Continued From page 9</p> <p>area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the CAH Pharmacy Department failed to assure the safe and secure storage and ongoing monitoring of all drug storage areas within the hospital for content, usage and outdated drugs as per professional standards of practice. This had the potential to affect patients receiving medications in the radiology and medical surgical department. Findings include:</p> <p>Per the American Society of Hospital Pharmacy (ASHP) Drug Distribution and Control revised 1981 states regarding Drug Storage and Inventory Control: "Storage is an important aspect of the total drug control system. Proper environmental control (i.e., proper temperature, light, humidity, conditions of sanitation, ventilation and segregation must be maintained wherever drugs and supplies are stored in the institution. Storage areas must be secure; fixtures and equipment used to store drugs should be constructed so that drugs are accessible only to designated and authorized personnel."</p> <p>1. Per observation, on the morning of 9/9/14, an unlocked cabinet containing (18) 100 ml vials of Isovue-370 (Iopamidol) 76% injectable contrast solution and a 250 ml bag of Intravenous saline 0.9% solution was unsecured, and unmonitored in the CT room of the radiology department. The door to the room was unlocked and accessible by a common hallway used by housekeeping.</p>	C 276	<p>Pharmacy schedule for monthly clinic rounding and checklist for surveillance created 10/02/2014. Rounding to begin 10/15/2014.</p> <p>Monitoring: Findings of medication surveillance program will be reported to the medication utilization and safety team monthly.</p> <p>1. All contrast and saline in the department is stored in a locked cabinet. Completed 09/22/2014 Replacement lock for contrast warmer has been ordered. 09/22/2014</p> <p>Contrast/ saline will not be left in contrast warmer until new lock has been installed.</p> <p>Multi-use saline replaced with single use saline effective 09/22/2014</p> <p>Monitoring: Daily checks will be performed and documented ensuring that any pharmaceuticals are in a locked cabinet. This will be added to the checklist for the room preparedness and compliance and will be monitored as part of the department inspections.</p> <p>Radiology manager or designee will inspect rooms for cleanliness, proper storage of biologicals, and appropriate packaging of tubing used in suction and O2 twice per week for a minimum of three months to ensure compliance with daily room cleaning process. Reassess frequency of inspections at three months, in coordination with environmental rounds performed by Safety Committee and Infection Prevention.</p> <p>Records of room inspections will be submitted to QM weekly.</p>		

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C 276	Continued From page 10 patients and other unauthorized staff. The lack of secure storage and oversight of the contrast solution cabinet and intravenous solution was confirmed by the department supervisor at the time of the observation at 10:28 AM. 2. Per observation on the medical surgical unit during the afternoon of 9/9/14, 10 unsecured bins of patient medications were observed in the medication room. The bins were labeled with patient names and included the following medications: fenofibrate 145 mg (a cholesterol lowering medication), Humalog mix 75/22 pen and needles (an injectable insulin), 3 syringes prefilled with Lantus (an injectable insulin), Levetiracetam 100 mg/ml oral solution (a treatment used for seizures), Nystatin powder (an antifungal powder), Aubagio tablets (used in the treatment of Multiple Sclerosis), Fish oil capsules, Vytorin 10-20 mg (cholesterol lowering medication), a Spiriva inhaler (used for respiratory conditions), Brilinta (an antiplatelet medication), Elmiron (used to treat cystitis), Hydrocerin cream, Res-Q omega 3 supplement, Januvia 25 mg (used to treat diabetes) and Lantanoprost eye drops (used to treat glaucoma). Per interview at 2:54 PM at the time of the initial observation, Staff Nurse #1 reported that she has observed unescorted housekeeping staff in the medication room cleaning the floor and taking out trash. At 3:10 PM the Nurse Unit Manager, confirmed that housekeeping staff have the access code to enter the medication storage room unescorted for cleaning purposes and that the medications in the bins were not stored in a secure manner to prevent access from unauthorized staff. Per review, the facility policy Medication	C 276	2. In order to further secure the medications in the HIP med room, the med bins have been moved to the bottom area of the Pyxis tower. This is where you will now find: Pt's own meds, Insulin syringes that pharmacy draws up, Topicals, Spiriva inhalers, IV meds that pharmacy makes per patient, Etc. All patients will have an entry on their MAR and Pyxis profile that will allow access to the bottom door in the Pyxis tower where nursing staff will be able to access the med bins that once sat on the counter. Sign has been placed on Pyxis machine in med room advising staff of new process. Email to nursing staff was sent also. Process and communication completed 09/23/2014.	

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C 276	<p>Continued From page 11</p> <p>Inspections and Refrigerator Checks, states that "A. Each department and provider practice in the hospital system that stores medications will be inspected intermittently by a pharmacist or his/her designee. The following will be inspected on each visit: 1. Medication cabinets 2. Refrigerators 3. Emergency meds 4. Stock supplies 5. Sample medication storage and procedure 6. Narcotics 7. Any area that could store medication." ... "G. All medication are to be stored in locked cabinets, drawers and refrigerators, At no time are any medications (including cleaning agents such as hydrogen peroxide and isopropyl alcohol as well as over-the-counter medications) to be available to the general public or non-clinical staff." The policy Contrast Material Stored in Radiology states that "All contrast material and drugs stored in the Radiology Department must be kept in the locked radiology storage room, a locked radiology exam room, the locked contrast warmer in the CT room, or a locked cabinet in an exam room within the radiology department."</p> <p>On 9/9/14 during an interview at 2:09 PM, the Pharmacy manager stated that the Pharmacy department is responsible for all medications in the hospital. S/he reported that s/he and a pharmacy tech perform periodic clinic and department inspections looking for safe and secure storage, expired medications and correct labeling on multi-dose vials (dated when opened) and other parameters; however, s/he reported that the department did not have adequate staff to do monthly inspections and that those had stopped in December 2013. Per review of a list of inspections provided by the pharmacy manager, the radiology nuclear medicine department was last inspected on 6/2/14 (the previous inspection was documented as occurring on December 11,</p>	C 276			

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C 276	<p>Continued From page 12</p> <p>2014); the acute care unit was last inspected on 6/3/14 (the previous inspection occurred on December 11, 2013). S/he confirmed that pharmacy had not inspected the OR (Operating Room) malignant hypothermia cart, refrigerators or cabinets in the past year; the OR Crash cart was listed as Inspected on 6/11/14. The manager stated that the individual departments had assumed inspection of the facilities crash carts; in the past pharmacy had checked monthly.</p> <p>Per the American Society of Hospital Pharmacy (ASHP) Drug Distribution and Control revised 1981 states regarding Emergency Medication Supplies: " Emergency drug supplies should be inspected by pharmacy personnel on a routine basis to determine contents have become outdated and are maintained at adequate levels."</p> <p>3. During a tour of the Ambulatory Care Unit and special procedure rooms on 7/9/14 at 2:20 PM with the Surgical Services nurse manager unsecured medications were found in the Endoscopy room. The door of a metal wall cabinet was open and a key remained inserted into the lock. Within the cabinet were 2 plastic boxes containing the following drugs: in the "Conscious Sedation Kit 1": 4 vials of Fentanyl 100 mcg/2ml per vial (Opioid analgesic/controlled substance/scheduled II) and 16 vials of midazolam 2 mg./2 ML vials (Anxiolytic used for sedation/controlled substance/schedule IV). Within the Conscious Sedation Reversal Kit 1: Flumazenil 0.5mg/5 ML (used to reverse sedation), Nitrolingual tablets (used to treat chest pain), 2 vials Ondansetron 4 mg/2ml (used to treat nausea), 2 vials Naloxone 0.4 mg/ml (to reverse effects of narcotic), 2 vials of Atropine 1 mg/1 ml (used to treat cardiac antarrhythmics), 1</p>	C 276	<p>3. Lock-box has been removed from Endo Suite, 09/18/2014 New process requires nursing to store sedation medication kits in the Pyxis Anesthesia Machine when not in use.</p> <p>Surgical Services Nurse Manager communicated new process individually with all Nurse circulators, who are responsible for IVCS (09/22-09/23).</p> <p>Email to all staff 9/23/2014.</p>		

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C 276	Continued From page 13 vial Glycopyrrolate (anticholinergic used preoperatively) and 1 vial Labetalol 5 mg/ml (antihypertensive). The nurse manager confirmed the medications should not have been left in the cabinet after the completion of endoscopic procedures and the kits would be returned to the pharmacy. The cabinet should never be left unlocked and open to unauthorized individuals.	C 276			
	4. During a tour of the Peri-operative area on the afternoon of 9/8/14 the Surgical Services nurse manager identified a small refrigerator as the location where multiple medications used during surgical eye procedures were stored. Review of the temperature monitoring sheet noted the refrigerator temperatures were consistently documented once every 24 hours, however the acceptable temperature range for medication storage (approximately 36 - 46 F) was not noted on the monitoring sheet and there was no evidence of monitoring the temperatures during weekends. The thermometer presently used by staff did not provide or record continuous monitoring to assure the medications were consistently maintained within acceptable parameters. This was confirmed by the Surgical Services nurse manager.		4. Replacement of current thermometer system with one with alarm and recording capabilities. New alarm/ thermometer installed 09/30/2014. Modification of current recording sheet to include appropriate temperature ranges and entry for weekend temperature control. New log sheet started 10/01/2014. Monitoring will be incorporated into Pharmacy rounds.		
C 277	485.635(a)(3)(v) PATIENT CARE POLICIES [The policies include the following:] Procedures for reporting adverse drug reactions and errors in the administration of drugs. This STANDARD is not met as evidenced by: Based on interview and record review, the CAH Pharmacy Department failed to assure the availability of a medication to prevent the occurrence of drug error by omission for 1 of 23	C 277			

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C 277	<p>Continued From page 14 patients in the survey sample (Patient # 10). Findings include:</p> <p>Per medical record review, Patient #1 was admitted to the facility on 9/5/14 for the treatment of a traumatic laceration and tendon injury of his/her foot. Unrelated to the foot injury, the admission orders included an order for Elmiron 100 mg capsules three times per day, a medication that Patient #10 was taking prior to his/her hospitalization (Elmiron is a medication used to treat interstitial cystitis, a chronic bladder condition that is often associated with pain and bladder pressure).</p> <p>Per 9/9/14 at 2:09 PM interview, the Pharmacy Manager reported that Elmiron was non-formulary and unavailable. The pharmacist reported that when medications are not available in the hospital pharmacy attempts are made to obtain the medication from home, use therapeutic substitutions, utilize other hospitals, or fill prescriptions from retail stores so a patient will not miss doses. The pharmacist reported visiting Patient #10 to see if s/he could bring the medication from home as it was not available in the hospital pharmacy.</p> <p>Per review of the MAR (Medication Administration Record), on 9/5/14, 1 dose of Elmiron was not administered to Patient #10; on 9/6/14, 2 doses of Elmiron were not administered; notations were made in the MAR on 9/5/14 that Elmiron was "omitted: pt own med, not in pyxis;" on 9/6/14 that "med not available." A note was added to the Elmiron order, "Pt Own Med.." On 9/9/14 at 11:45 AM, a facility pharmacist documented, "I spoke with patient about [his/her] Elmiron. [S/he] is OK skipping one dose because [s/he] will not be able</p>	C 277			

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C 277	<p>Continued From page 15</p> <p>to supply it until 9/10/14 in the morning;" however, on the MAR, the 9/9/14 14:36 entry states that "Patient Refused" Elmiron. On 9/9/14 during an interview at 2:09 PM with the Pharmacy Manager, the staff pharmacist reported that Patient #10's wife could not bring more Elmiron to the hospital until 9/10/14 and that there was only 1 Elmiron capsule left following his/her morning dose, so Patient #10 opted to miss the 9/9/14 afternoon dose but will take the PM dose. When asked if the provider was contacted about the change in the medication order, the staff pharmacist called a staff hospitalist for approval during the interview.</p> <p>Per review, the policy Nonformulary Medications and Patient's Own Medications (effective 2013-11-18) states that "The pharmacy department is responsible for ensuring medications are available to meet patient needs while they are receiving care at Gifford Medical Center." Under the heading Non-formulary medications, Section B. states "The pharmacy will make all attempts to get the medication in house within 24 hrs. If the medication is not going to be available within 24 hours, documentation will be placed in the patient's chart in the progress notes by the pharmacist regarding the status of the needed medication. C. If the medication is expected on the following day, the patient's chart and MAR must reflect that start date. Also, the staff pharmacist who receives the order will leave a detailed report for the pharmacist coming on the following day that a medication is expected and what further steps need to be taken. The pharmacist will then be responsible for ensuring that the medication is made available to the patient. D. If the pharmacy is closed, the charge nurse and on call provider will assess if the</p>	C 277	<p>Policy PH- 132 "NonFormulary Medications and Patient's Own Medications" and associated processes have been revised with the following changes:</p> <ol style="list-style-type: none"> 1. Earlier attempt to procure medication from local pharmacy when not quickly brought in by family. Accounts have been established at both local pharmacies to facilitate this. 2. When meds are not available and it is determined by provider that med is not needed for a given period of time, MAR/ Order must be updated to reflect the change in order. <p>Competency quiz has been created through Policy Manager for all HP nursing, providers, and pharmacy to demonstrate understanding of each role in the process.</p> <p>75% of applicable staff to complete by 10/31/2014. 100% of regularly scheduled staff to complete by 11/28. Per Diem staff not scheduled during this time period will be expected to complete training on their next scheduled shift.</p> <p>Completion of competency will be monitored through QM and followed up with HP/ pharmacy leadership as needed. Monitor tracking log starting 10/1/2014 in order to monitor pharmacy, provider, and nursing compliance with non-formulary policy.</p> <p>Pharmacy will monitor non-formulary meds using our tracking form and report to medication utilization and safety team monthly. Once compliance with the policy has been achieved, (100% x three months) random audits will be conducted regularly.</p>	

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C 277	<p>Continued From page 16</p> <p>patient will need the medication prior to 7 AM and what steps should be taken prior to the pharmacy reopening. If the medication is a patient 's own medication and deemed critical, a dose can be given only if it is identified using the Imprint code and Clinical Pharmacology Online... E. If nursing sees that a medication is still unavailable after 24 hours, they are to call the pharmacy so that the steps outlined below can be taken."</p> <p>On 9/10/14 at 9:43 AM, the Pharmacy Manager reported that a 24 hour time frame was determined as an appropriate in-house time frame to assure that ordered medications are available for patients. When asked for clarification for the process for contacting the ordering provider about a change in orders when medications are not available (as it was not specified in the above policy), the Pharmacy Manager confirmed that provider contact was not included in the policy and confirmed that s/he could not provide documentation that the provider was contacted for a change in orders for Patient #10 when the Elmiron was not available on the first 2 days of admission. S/he reported that since Patient #10 received Elmiron within 24 hours as per the above policy, there was no need for further pharmacy documentation. S/he confirmed that there is no list of critical medications that can safely be omitted for 24 hours and added that the pharmacists use professional judgment to determine whether a medication should not be missed for 24 hours.</p> <p>Per 9/10/14 interview with the Medical Director of the Hospital Division, s/he confirmed that discussions about non-formulary medications occur but changes in medication orders are not documented; s/he confirmed that an order to omit</p>	C 277			

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C 277	Continued From page 17 non-formulary/unavailable medications should be obtained and confirmed that the process for non-formulary medication availability and responsibilities for nursing, pharmacy and physicians needs to be "...tightened" to make medication orders clearer when there are medication omissions.	C 277		
C 278	485.635(a)(3)(vi) PATIENT CARE POLICIES [The policies include the following:] A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation and interview, the CAH Infection Control program failed to assure staff consistently maintained infection control standards of practice and failed to conduct ongoing surveillance and monitoring of the CAH environment to assure a sanitary and safe environment was being maintained. Findings include: 1. During tour of the ED (Emergency Department) at 10:20 AM on 9/8/14, with the ED Nurse Manager the following observations were made: a. 3 of the 6 patient stretchers had wheels and or frames heavily soiled with dirt and/or dust b. there was used tubing and a nebulizer mouthpiece attached to the oxygen wall equipment in a clean patient exam room that had been made ready for patient use. c. there were 2 patient commodes, 2 wheel chairs and a rapid infuser IV pump stored in the hallway leading to the ambulance doors, all without evidence of whether or not the equipment	C 278	1. Clean area identified for clean equipment storage. Sign will be posted by 10/1 to indicate "clean equipment only" Completed "Clean" tags ordered 09/30. Expected delivery 10/8. Process: Equipment is cleaned in the room by nursing before leaving room. Equipment will be "tagged" when placed in clean holding area. Equipment not labelled as "clean" will be assumed to be dirty. Equipment which is "out of service" will be tagged as "out of service" and removed from unit to biomed or facilities as appropriate. Process to be fully implemented by 10/13. Policy NUR-682 (Infection Prevention- Emergency Department) will be revised to reflect nursing cleaning between patients and disposal of single use items, and weekly "deep clean" by environmental services (in addition to usual daily cleaning by ES), and process for cleaning/ storing equipment. Completed 10/02/2014	

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C 278	Continued From page 18 had been cleaned after last use. During interview at the time of tour, the ED Nurse Manager confirmed the soiled wheels and/or frames of the patient stretchers. S/he also confirmed the failure of staff to remove the used oxygen tubing and nebulizer mouth piece when cleaning the room for subsequent patient use, and stated that although equipment is typically stored in the hallway after being cleaned, there is currently no process to assure the stored equipment has been cleaned. 2. During a tour of the Endoscope cleaning and processing area on the afternoon of 9/8/14, flexible gastrointestinal Endoscopes, (a semicritical instrument requiring a high level of disinfectant) which had been processed and deemed clean and ready for patient use were observed hanging in a vertical position on a rack suspended on a wall which was not enclosed exposing the endoscopes to not only movement from staff within the area, it was not free from dust or other contaminants. Also noted was a soiled and stained towel laying on the floor approximately 6 inches below the scopes. Per the Society of Gastroenterology Nurses and Associations, Inc. Standards of Infection Control in Reprocessing of Flexible Gastrointestinal Endoscopy " last revised 2012, page 21 states: "A storage area should be clean well ventilated and dust free thus discouraging any microbial contamination" and per the Healthcare Infection Control Practices Advisory Committee (HIPAC) Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008 states: "Store the endoscope in a way that prevents recontamination and promotes drying". The Surgical Services nurse manager confirmed the unprotected storage of the Endoscopes. 3. During a tour of the Peri-operative areas on	C 278	2. Cabinet designed for this purpose to be purchased for scope storage in Endoscopy suite. Ordered 10/01/2014. Expected delivery/ installation 11/15/2014.		

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C 278	Continued From page 19 the afternoon of 9/8/14 with the Surgical Services nurse manager, multiple laryngoscope blades were stored unprotected in a plastic container on the top shelf of the anesthesia storage/supply room and multiple laryngoscopes blades were also stored unprotected in a anesthesia cart. The laryngoscope blades (used during the process of intubation and which come in direct contact with patient mucous membranes) are identified as a semi-critical device requiring high-level disinfection upon use. Per interview on 9/8/14 at 3:15 PM, the charge technician of Central Sterile Supply and reprocessing department confirmed although there is a process for cleaning the laryngoscope blades using a high-level disinfectant there is no process in place to assure the blades after processing are individually protected by an application of a covering to eliminate the risk of contamination while being stored. Per Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Centers for Disease Control (CDC) document entitled Guidelines for Preventing Healthcare-Associated Pneumonia, 2003 states on page 58 regarding the packaging of semi-critical items "...after disinfecting, proceed with appropriate rinsing, drying and packaging, taking care not to contaminate the disinfected item.....". 4. During a tour on 9/9/14 starting at approximately 9:00 AM with the Vice President of Surgical Services, the following observations were made and confirmed in the radiology department: a. In x-ray room #2, a heavy dust build up was observed on the top and sides of a linen cabinet (where patient gowns and drapes were stored); open cell foam positioning blocks and an apron/shield worn for protection during x-ray procedures were stored on the top of the cabinet	C 278	3. Implement use of Laryngoscope blade covers. Processing of blades will be conducted by Anesthesia support staff upon completion of training by Central Sterile Reprocessing staff (CSR). Blades will be decontaminated, cleaned, packaged individually and autoclaved. Blades will be stored in individual packages until used. Laryngo-sheath ordered 09/26/2014. Staff training 10/6-10/10 At time of implementation, Nurse manager will provide face-to face education for Anesthesia providers regarding usage of single wrapped blades and incorporation into time-out process. Implementation expected by 10/10/2014. Monitoring of process by CSR staff weekly, via daily log of sterilization cycles. Ongoing Monitoring each day by anesthesia tech staff for provider compliance. Anesthesia support staff will ensure that only packaged blades are available for use by the providers. ongoing		

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OMB NO. 0938-0391

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C 278	Continued From page 20 in contact with the dusty surface. Dust was observed on the x-ray tubing elbow which is positioned over the x-ray table during imaging. Tech #1 (radiology department technician) stated that department techs are responsible for cleaning the exam tables and all equipment; s/he reported that housekeeping was responsible for cleaning floors and bathrooms, emptying trash and restocking paper supplies. S/he confirmed that there is a risk that image quality of x-rays could be affected by the environmental dust. S/he stated that s/he was not aware of a specific policy regarding sanitizing foam positioners and that some staff covered the positioners in plastic wrap to aid in keeping them clean. S/he reported that newer positioners purchased by the department were vinyl clad to ease cleaning between patients. b. In the nuclear radiology room, the center of the floor was stained with black scuff marks and a large area of dark discoloration (approximately the size of the exam table). c. In x-ray room #1, scattered metal filings were observed on the tube tower head (which is part of the x-ray equipment and positioned over the x-ray examination table). Heavy dust build up was observed on the top of the storage cabinet; open cell foam positioners and a lead apron were stored in contact with the dusty surface. Tech #1 confirmed there was a risk that the environmental dust and metal filings could fall onto the exam table and affect imaging quality. S/he reported that s/he was not aware if there was a check list for cleaning examination rooms. d. In the cardiac rehab room, O2 (oxygen) and suction tubing was observed unpackaged and wound loosely over the wall connections. The top surface of the O2 regulator and suction canister were heavily soiled with dust. When asked how	C 278	B. Meet with Environmental Services manager to re-establish a room cleaning plan which addresses the deficiencies in cleanliness of the rooms. Completed 10/01/2014. Checklists for daily room cleaning, differentiating roles of environmental services and radiology personnel created/ completed. New process to begin 10/6/2014. ES and radiology personnel to be educated on new process/ expectations by respective managers by 10/6/2014 Non-compliant positioners have been removed from department and discarded 09/18/2014. New washable positioner cushions have been ordered with delivery expected 10/6/2014. Positioners will be disinfected after each use and have been added to room cleaning checklist. The entire floor in Nuclear Medicine has been stripped and cleaned. (10/1/2014) Once a week the floor will be mopped and cleaned including under the table. Tech will move table at end of day to facilitate the floor cleaning by housekeeping. Monitoring: Radiology manager or designee will inspect rooms for cleanliness, proper storage of biologicals, and appropriate packaging of tubing used in suction and O2 twice per week for a minimum of three months to ensure compliance with daily room cleaning process. Reassess frequency of inspections at three months, in coordination with environmental rounds performed by Safety Committee and Infection Prevention. Records of room inspections will be submitted to QM weekly.	

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C 278	Continued From page 21 staff assure that the tubing has not been used, the Respiratory Tech stated that staff depend that the tubing was replaced by the previous staff member after it was used. e. In the Echo lab, the top surface, vents and tube caps of the unit that is used to clean esophageal probes was heavily soiled with dust. f. In the CT room, O2 (oxygen) and suction tubing, was observed unpackaged and wound loosely over the wall connections. The top surface of the O2 regulator and suction canister were soiled with dust. A 250 cc bag of saline 0.9 % solution for intravenous injection hung from an IV pole. The bag was dated 9/9/14 at 8:00 AM. The radiology supervisor stated that staff withdraw saline to flush IV tubing for multiple patients for up to 24 hours after the initial use. g. In the EEG room, the vinyl cover on a patient positioning block was torn on four corners exposing open cell foam. Per review, the policy, Infection Prevention in Radiology (Effective date 2012-01-16) under Personnel Responsibilities, lists the responsibilities of the Department Head as: "a. Responsible for proper patient care and equipment safety. b. Maintain a clean and safe environment for the patient and employee. c. Assure that personnel comply with infection control guidelines within the department and throughout the hospital ..." Under the section "Equipment & Supplies" section 5. Any non-disposable patient equipment and trays must be washed in detergent-germicide solution before sending to Central Sterile ... 8. Clean gowns must be used for each patient ... 11. To avoid contamination sponges can be covered with pillowcase/towel when possible. The policy titled, Infection Prevention Program (which applies to Gifford Medical Center; Effective date	C 278	B. (continued) Remove all tubing that is not packaged and replace with single use packaged tubing. Inform staff of new expectations for use and storage of tubing. Completed 09/25/2014- reflected in minutes from staff meeting. Monitoring: Radiology manager or designee will inspect rooms for cleanliness, proper storage of biologicals, and appropriate packaging of tubing used in suction and O2 twice per week for a minimum of three months to ensure compliance with daily room cleaning process. Reassess frequency of inspections at three months, in coordination with environmental rounds performed by Safety Committee and Infection Prevention. Records of room inspections will be submitted to QM weekly.		

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C 278	Continued From page 22 2013-07-19) states that Gifford Health Center observes Standard Precautions for all patients. Additionally, Gifford Health Center will determine the need for and provide Transmission Based Expanded Precautions when indicated to prevent the spread of infection. Per 9/10/14 interview, beginning at approximately 2:20 PM, The Director of Quality and Risk Management and the Clinical Quality Specialist, RN who share infection prevention oversight at the facility confirmed that there had been no recent infection control rounds done in the radiology department. The Clinical Quality Specialist, RN confirmed that the observations listed above for the radiology department were infection control issues. 4. Per observations of medication administration to 2 patients in the medical surgical unit on 9/8/14 commencing at 1:25 PM, the following breaches in infection prevention practice for hand sanitization were observed: a. Registered Nurse (RN) #3 entered room 129 at 1:25 PM to administer via s.c. (subcutaneous) injection, 2 units Novolog Insulin, to Patient #5. The RN failed to sanitize hands upon entering the room and prior to donning gloves to administer the injection to the patient. When the RN was asked about the lack of hand cleansing prior to donning gloves, he/she replied that he/she sanitized after removing gloves. b. RN #3 entered Room 125 on 9/8/14 at 1:38 PM to administer 3 units s.c. of Novolog Insulin to Patient #6. The RN failed to cleanse/sanitize hands prior to donning gloves (after entering the room) and after removing the gloves. The nurse left the room and went to the nursing station where it was confirmed during surveyor interview that she/he had not sanitized hands either prior to and after direct contact with a patient.	C 278	4. The Staff Educator has developed a hand hygiene education program based on the World Health Organization's "Save Lives Clean Your Hands" campaign. Implementation of this program began on 9/29. Base line monitoring of hand hygiene compliance also began 9/29. Hand hygiene compliance monitors will be identified and trained by 11/15 for continued surveillance. The hand hygiene policy (IC-100) was revised on 9/17 to clearly indicate hand hygiene "moments" consistent with WHO hand hygiene campaign. Random hand hygiene compliance will be conducted monthly for a minimum of six months with a goal of demonstrated continuous improvement. Evaluate at six months for effectiveness and next steps. Hand hygiene monitoring data will be submitted to Infection Prevention. There will be an annual competency on hand hygiene for staff involved with patient care.		

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C 278	Continued From page 23 c. RN #3 entered room 129 at 2:30 PM to administer an oral dose of thyroid medication and set up and start the IV (Intravenous) administration of antibiotic therapy for treatment of a urinary tract infection for Patient #5. The RN failed to sanitize hands upon entering the room and administering the oral medication. The RN forgot some of the needed IV supplies and left the patient's room to get additional supplies and then returned to Patient #5's room; the RN again failed to sanitize/cleanse hands prior to setting up the IV tubing and attaching the medication for the IV administration of the antibiotic medication. These observations of failure to adhere to infection prevention practices (per hospital policy/procedure) during patient care were confirmed with the RN immediately after leaving the patient's room. Per review on 9/8/14, the hospital's policy/procedure, Nursing - Hand Hygiene, stated "decontaminate hands with either a hygienic hand rub or by washing with disinfectant soap prior to and after direct contact with the patients or objects immediately around the patient."	C 278			
C 283	485.635(b)(3) PATIENT SERVICES Radiology services. Radiology services furnished by the CAH are provided by personnel qualified under State law, and do not expose CAH patients or personnel to radiation hazards. This STANDARD is not met as evidenced by: Based on observation and staff interview, the Radiology Department failed to assure that environmental cleaning and infection control practices were followed to maintain a safe and sanitary environment. The deficient practices had the potential to effect patients undergoing imaging procedures in the radiology department.	C 283			

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C 283	Continued From page 24 Findings include: During a tour on 9/9/14 starting at approximately 9:00 AM with the Vice President of Surgical Services, the following observations were made and confirmed in the radiology department: a. In x-ray room #2, a heavy dust build up was observed on the top and sides of a linen cabinet (where patient gowns and drapes were stored); open cell foam positioning blocks and an apron/shield worn for protection during x-ray procedures were stored on the top of the cabinet in contact with the dusty surface. Dust was observed on the x-ray tubing elbow which is positioned over the x-ray table during imaging. Tech #1 (radiology department technician) stated that department techs are responsible for cleaning the exam tables and all equipment; s/he reported that housekeeping was responsible for cleaning floors and bathrooms, emptying trash and restocking paper supplies. S/he confirmed that there is a risk that image quality of x-rays could be affected by the environmental dust. S/he stated that s/he was not aware of a specific policy regarding sanitizing foam positioners and that some staff covered the positioners in plastic wrap to aid in keeping them clean. S/he reported that newer positioners purchased by the department were vinyl clad to ease cleaning between patients. b. In the nuclear radiology room, the center of the floor was stained with black scuff marks and a large area of dark discoloration (approximately the size of the exam table). c. In x-ray room #1, scattered metal filings were observed on the tube tower head (which is part of the x-ray equipment and positioned over the x-ray examination table). Heavy dust build up was observed on the top of the storage cabinet; open cell foam positioners and a lead apron were	C 283	Director of Ancillary services met with Environmental Services manager to re-establish a room cleaning plan which addresses the deficiencies in cleanliness of the rooms. Completed 10/01/2014. Checklists for daily room cleaning, differentiating roles of environmental services and radiology personnel created/ completed. New process to begin 10/6/2014. ES and radiology personnel to be educated on new process/ expectations by respective managers by 10/6/2014 Non-compliant positioners have been removed from department and discarded 09/18/2014. New washable positioner cushions have been ordered with delivery expected 10/6/2014. Positioners will be disinfected after each use and have been added to room cleaning checklist. The entire floor in Nuclear Medicine has been stripped and cleaned. (10/1/2014) Once a week the floor will be mopped and cleaned including under the table. Tech will move table at end of day to facilitate the floor cleaning by housekeeping. Monitoring: Radiology manager or designee will inspect rooms for cleanliness, proper storage of biologicals, and appropriate packaging of tubing used in suction and O2 twice per week for a minimum of three months to ensure compliance with daily room cleaning process; Reassess frequency of inspections at three months, in coordination with environmental rounds performed by Safety Committee and Infection Prevention. Records of room inspections will be submitted to QM weekly.		

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C 283	<p>Continued From page 25</p> <p>stored in contact with the dusty surface. Tech #1 confirmed there was a risk that the environmental dust and metal filings could fall onto the exam table and affect imaging quality. S/he reported that s/he was not aware if there was a check list for cleaning examination rooms.</p> <p>d. In the cardiac rehab room, O2 (oxygen) and suction tubing was observed unpackaged and wound loosely over the wall connections. The top surface of the O2 regulator and suction canister were heavily soiled with dust. When asked how staff assure that the tubing has not been used, the Respiratory Tech stated that staff depend that the tubing was replaced by the previous staff member after it was used.</p> <p>e. In the Echo lab, the top surface, vents and tube caps of the unit that is used to clean esophageal probes was heavily soiled with dust.</p> <p>f. In the CT room, O2 (oxygen) and suction tubing was observed unpackaged and wound loosely over the wall connections. The top surface of the O2 regulator and suction canister were soiled with dust. A 250 cc bag of saline 0.9 % solution for intravenous injection hung from an IV pole. The bag was dated 9/9/14 at 8:00 AM. The radiology supervisor stated that staff withdraw saline to flush IV tubing for multiple patients for up to 24 hours after the initial use.</p> <p>g. In the EEG room, the vinyl cover on a patient positioning block was torn on four corners exposing open cell foam.</p> <p>Per review, the policy, Infection Prevention in Radiology (Effective date 2012-01-16) under Personnel Responsibilities, lists the responsibilities of the Department Head as: "a. Responsible for proper patient care and equipment safety. b. Maintain a clean and safe environment for the patient and employee. c. Assure that personnel comply with infection</p>	C 283	<p>(continued) Remove all tubing that is not packaged and replace with single use packaged tubing. Inform staff of new expectations for use and storage of tubing.</p> <p>Completed 09/25/2014- reflected in minutes from staff meeting.</p> <p>Monitoring: Radiology manager or designee will inspect rooms for cleanliness, proper storage of biologicals, and appropriate packaging of tubing used in suction and O2 twice per week for a minimum of three months to ensure compliance with daily room cleaning process. Reassess frequency of inspections at three months, in coordination with environmental rounds performed by Safety Committee and Infection Prevention.</p> <p>Records of room inspections will be submitted to QM weekly.</p>	

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C 283	Continued From page 26 control guidelines within the department and throughout the hospital ... " Under the section "Equipment & Supplies" section 5. Any non-disposable patient equipment and trays must be washed in detergent-germicide solution before sending to Central Sterile ... 8. Clean gowns must be used for each patient ... 11. To avoid contamination sponges can be covered with pillowcase/towel when possible. The policy titled, Infection Prevention Program (which applies to Gifford Medical Center, Effective date 2013-07-19) states that Gifford Health Center observes Standard Precautions for all patients. Additionally, Gifford Health Center will determine the need for and provide Transmission Based Expanded Precautions when indicated to prevent the spread of infection. Per 9/10/14 interview, beginning at approximately 2:20 PM, The Director of Quality and Risk Management and the Clinical Quality Specialist, RN who share infection prevention oversight at the facility confirmed that there had been no recent infection control rounds done in the radiology department. The Clinical Quality Specialist, RN confirmed that the observations listed above for the radiology department were infection control issues.	C 283	Safety committee has created a schedule for environmental rounds throughout the organization, to include members of safety committee, infection prevention, QM and department leadership- facilitating a comprehensive evaluation. 10/01/2014 Rounds have been scheduled with individual departments 10/02/2014. In addition, Infection Prevention and QM will collaborate with safety committee and department managers to ensure that environmental rounding is conducted with a frequency and intensity necessary to ensure a clean and safe environment of care. Copies of environmental surveillance findings will be submitted to infection prevention on a weekly basis and summaries presented at safety committee. New schedule of rounds commencing week of 10/6/2014		
C 294	485.635(d), (d)(1) NURSING SERVICES §485.635(d) Standard: Nursing Services Nursing services must meet the needs of patients. (1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in	C 294			

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C 294	<p>Continued From page 27</p> <p>accordance with the patient's needs and the specialized qualifications and competence of the staff available.</p> <p>This STANDARD Is not met as evidenced by: Based on interview and record review, nursing staff failed to meet the emotional needs of 1 of 23 applicable patients who expressed concern and anxiety regarding an encounter with a nurse during the provision of services. (Patient #18) Findings include:</p> <p>1. Per record review, Patient # 18 was admitted to the CAH on 7/9/14 for alcohol withdrawal, atypical chest pain and pancreatitis. The patient has a past history of long term substance abuse, Traumatic Brain Injury (TBI), chronic head and neck pain and generalized anxiety disorder. Upon admission Patient #18 was placed on a CIWA protocol (Clinical Institute Withdrawal Assessment for alcohol. A 10 item scale used in assessment and management of Alcohol withdrawal). Patient #18 also reported during initial treatment in the Emergency Department s/he was also experiencing narcotic withdrawal. Upon admission a nursing assessment rated Patient #18 to be a fall risk and a "High Risk" protocol was initiated to include: chair and bed alarm, 1 hour safety rounds by nursing and the use of a gait belt/ one person assisting Patient #18 with ambulation. On 7/10/14 Patient #18's CIWA score was rated as "Moderate to Severe" and required repeat doses of Lorazepam (benzodiazepine/antianxiety) to help reduce the patient's symptoms of withdrawal which included tremors of extremities, anxiety and agitation. The patient also began receiving Dilaudid</p>	C 294	<p>Nursing leadership will provide a PowerPoint in-service entitled "meeting the emotional needs of patients". This will be shared with nursing staff. 75% of hospital nursing staff to complete by 10/31/2014. 100% of regularly scheduled nursing staff to complete by 11/28. Per Diem staff not scheduled during this time period will be expected to complete training on their next scheduled shift. This will be managed by nurse managers with presentation summary and attendance records submitted to QM.</p> <p>A patient complaint "nursing algorithm" has been created to guide nursing staff in proper complaint management. This includes immediate reassignment of nursing staff when indicated, reporting requirements for allegations of abuse/ neglect, responsibility of nursing staff to directly attempt complaint resolution, and the role of management and patient relations.</p> <p>Policy PR-301 "Resolution of Patient/ Visitor Complaint or Grievance" has been revised to clarify reporting requirements for allegations of abuse/ neglect, responsibility of nursing staff to directly attempt complaint resolution, the role of Nursing and Patient Relations, and the mechanism for an appeals process if the patient remains dissatisfied.</p> <p>Communication of new processes/revised policies will occur through staff meetings, email, and electronic sign off/ competency through Policy Manager for all hospital nursing staff.</p> <p>Completion of competency will be monitored through QM and followed up with nursing leadership as needed.</p>		

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C 294	<p>Continued From page 28</p> <p>(narcotic/pain medication) for ongoing pain complaints related to Pancreatitis and chronic issues associated with neck and shoulder injury.</p> <p>Per interview on 9/9/14 at 4:30 PM, Nurse #1, assigned to Patient #18 on the evening of 7/10/14 stated s/he heard the bed alarm go off at approximately 5:30 PM and entered the patients room and observed Patient #18 attempting to enter the bathroom without assistance. Nurse #1 stated the intravenous pole had fallen to the floor and the patient's intravenous (IV) access was in jeopardy of being pulled out as the patient advanced toward the bathroom. Nurse #1 stated s/he requested the patient to stop and prevented Patient #18 from entering the bathroom. Per the nursing progress note for 7/10/14, Nurse #1 states "I immediately prevented the patient from continuing forward by placing one hand on the door and one hand on the patient's left upper arm (above the IV site):..." Nurse #1 requested the patient to return to bed so the patient's IV access could be checked. The progress note further states Patient #18 then told Nurse #1 " Don't touch my arm". This statement was again repeated by the patient. Eventually Patient #18 cooperated, returned to bed, IV was checked, a gait belt was applied and Patient #18 with assistance by Nurse #1, the patient was brought to the bathroom.</p> <p>Within approximately 30 minutes, the evening charge nurse on 7/10/14 was notified by Registration that Patient #18 had called saying that s/he was "assaulted" by a nurse. The Patient Relations Specialist was notified of the allegation and proceeded to come to the CAH to speak with Patient #18. After discussions with Patient #18, and despite the fragility of Patient's #18's</p>	C 294			

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C 294	<p>Continued From page 29</p> <p>emotional and physical compromise and allegation of assault by staff the Patient Relations Specialist requested Nurse #1 meet with Patient #18 so the patient could apologize.</p> <p>The circumstances alleged by Patient #18 were not appropriately addressed by nursing staff and they failed to meet the patient's emotional needs and fears expressed. Although an incident had occurred and a allegation of assault was made by Patient #18, nursing staff failed to direct the handling of the alleged incident, transferring all responsibility to the Patient Relations Specialist. Patient #18 who expressed concern for not wanting staff to "...get angry", was subjected to a face to face encounter with Nurse #1 (the alleged perpetrator) for the purpose of "apologizing". Per interview on 9/9/14 at 3:58 PM, the Patient Relations Specialist confirmed Patient #18 was "...very emotional..." about the event. Per interview on 9/10/14 at 10:00 AM, Nurse #2 (evening charge nurse on 7/10/14) confirmed s/he had not interviewed the patient or assessed the patient for injuries but felt "...it was better to have the Public Relations Specialists address the issue".</p> <p>Within 2 hours of the alleged incident, Nurse #2 overheard Patient #18 weeping while informing his/her family member by phone that Nurse #1 "...had brutally assaulted ..." her/him. In addition, there was no additional consideration by nursing staff to assign a different nurse to provide care to Patient #18 on the evening of 7/10/14. It was not until the patient's family contacted Nurse #2 at approximately 10:00 PM voicing concern about Patient #18's safety and requesting Nurse #1 no longer provide care to the patient, a change in the nursing assignment was made, removing Nurse</p>	C 294			

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C 294	Continued From page 30	C 294		
C 297	#1 from having contact with Patient #18 during the rest of the 3:00 PM to 11:00 PM shift. 485.635(d)(3) NURSING SERVICES All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws. This STANDARD is not met as evidenced by: Based on interview and record review, nursing staff failed to administer a medication in accordance with physician orders and/or report that the medication was unavailable for 1 of 23 patients in the survey sample (Patient #10). Findings include: Per medical record review, Patient #1 was admitted to the facility on 9/5/14 for the treatment of a traumatic laceration and tendon injury of his/her foot. Unrelated to the foot injury, the admission orders included an order for Elmiron 100 mg capsules three times per day, a medication that Patient #10 was taking prior to his/her hospitalization (Elmiron is a medication used to treat interstitial cystitis, a chronic bladder condition that is often associated with pain and bladder pressure). Per 9/9/14 at 2:09 PM Interview, the Pharmacy Manager reported that Elmiron was non-formulary and unavailable. The pharmacist reported that when medications are not available in the hospital pharmacy attempts are made to obtain the medication from home, use therapeutic	C 297	Policy PH- 132 "NonFormulary Medications and Patient's Own Medications" and associated processes have been revised with the following changes: 1. Earlier attempt to procure medication from local pharmacy when not quickly brought in by family. Accounts have been established at both local pharmacies to facilitate this. 2. When meds are not available and it is determined by provider that med is not needed for a given period of time, MAR/ Order must be updated to reflect the change in order. Competency quiz has been created through Policy Manager for all HP nursing providers, and pharmacy to demonstrate understanding of each role in the process. 75% of applicable staff to complete by 10/31/2014. 100% of regularly scheduled staff to complete by 11/28. Per Diem staff not scheduled during this time period will be expected to complete training on their next scheduled shift. Completion of competency will be monitored through QM and followed up with HP/ pharmacy leadership as needed. Monitor tracking log starting 10/1/2014 in order to monitor pharmacy, provider, and nursing compliance with non-formulary policy. Pharmacy will monitor non-formulary meds using our tracking form and report to medication utilization and safety team monthly. Once compliance with the policy has been achieved, (100% x three months) random audits will be conducted regularly.	

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C 297	<p>Continued From page 31</p> <p>substitutions, utilize other hospitals, or fill prescriptions from retail stores so a patient will not miss doses. The pharmacist reported visiting Patient #10 to see if s/he could bring the medication from home as it was not available in the hospital pharmacy.</p> <p>Per review of the MAR (Medication Administration Record), on 9/5/14, 1 dose of Elmiron was not administered to Patient #10; on 9/6/14, 2 doses of Elmiron were not administered; notations were made in the MAR on 9/5/14 that Elmiron was "omitted: pt own med, not in pyxis;" on 9/6/14 a notation states "med not available" for the 2 omitted doses. A note was added to the Elmiron order, "Pt Own Med." On 9/9/14 at 11:45 AM, a facility pharmacist documented, "I spoke with patient about [his/her] Elmiron. [S/he] is OK skipping one dose because [s/he] will not be able to supply it until 9/10/14 in the morning;" however, on the MAR, the 9/9/14 14:36 nursing entry states that "Patient Refused" Elmiron. On 9/9/14 during an interview at 2:09 PM with the Pharmacy Manager, the staff pharmacist reported that Patient #10's wife could not bring more Elmiron to the hospital until 9/10/14 and that there was only 1 Elmiron capsule left following his/her morning dose and Patient #10 opted to miss the 9/9/14 afternoon dose but planned to take the PM dose. When asked if the provider was contacted about the change in the medication order, the staff pharmacist called a staff hospitalist for approval during the interview.</p> <p>Per review, the policy "Nonformulary Medications and Patient's Own Medications" (effective 2013-11-18) states that "The pharmacy department is responsible for ensuring medications are available to meet patient needs</p>	C 297			

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C 297	<p>Continued From page 32</p> <p>while they are receiving care at Gifford Medical Center." Under the heading Non-formulary medications, Section B. states "The pharmacy will make all attempts to get the medication in house within 24 hrs. If the medication is not going to be available within 24 hours, documentation will be placed in the patient ' s chart in the progress notes by the pharmacist regarding the status of the needed medication. C. If the medication is expected on the following day, the patient ' s chart and MAR must reflect that start date. Also, the staff pharmacist who receives the order will leave a detailed report for the pharmacist coming on the following day that a medication is expected and what further steps need to be taken. The pharmacist will then be responsible for ensuring that the medication is made available to the patient. D. If the pharmacy is closed, the charge nurse and on call provider will assess if the patient will need the medication prior to 7 AM and what steps should be taken prior to the pharmacy reopening. If the medication is a patient ' s own medication and deemed critical, a dose can be given only if it is identified using the imprint code and Clinical Pharmacology Online... E. If nursing sees that a medication is still unavailable after 24 hours, they are to call the pharmacy so that the steps outlined below can be taken."</p> <p>On 9/10/14 at 9:43 AM, the Pharmacy Manager reported that a 24 hour time frame was determined as an appropriate in-house time frame to assure that ordered medications are available for patients. When asked for clarification for the process for contacting the ordering provider about a change in orders when medications are not available (as it was not specified in the above policy), the Pharmacy Manager confirmed that provider contact was not</p>	C 297			

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C 297	Continued From page 33 included in the policy and confirmed that s/he could not provide documentation that the provider was contacted for a change in orders for Patient #10 when the Elmiron was not available on the first 2 days of admission. S/he reported that since Patient #10 received Elmiron within 24 hours as per the above policy, there was no need for further pharmacy documentation. S/he confirmed that there is no list of critical medications that can safely be omitted for 24 hours and added that the pharmacists use professional judgment to determine whether a medication should not be missed for 24 hours. On 9/10/14 at 8:14 AM, the medical-surgical unit Nurse Manager (NM) stated that nonformulary medication unavailability is discussed at interdisciplinary grand rounds (attended by hospitalists, nursing, pharmacy, Quality, care management and rehab staff). S/he reported that pharmacy takes the lead to obtain nonformulary medications. The NM confirmed there was a documentation discrepancy in the MAR on 9/9/14 between a staff nurse documenting that Patient #10 "refused" Elmiron on 9/9/14 at 14:36 while the pharmacist documented that Patient #10 was "...OK skipping one dose" of Elmiron on 9/9/14 as s/he was not able to supply it until 9/10/14; the NM confirmed that documentation on the MAR should have read "med unavailable." The NM confirmed that there was no documentation in the record that nursing staff had contacted the physician to notify that Patient #10 was not administered Elmiron on 9/5 and 9/6/14 and there was no documentation of a request to change the order for the medication when it was not available. S/he further added that there is no specific "nursing policy" that addresses the use of nonformulary/home medications to provide direction to staff re notification to physicians when	C 297		

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C 297	Continued From page 34 the medication is unavailable or for the need to obtain a new order when medications are not available. On 9/10/14 during an interview beginning at approximately 11:00 AM, the current and former Vice Presidents of Patient Care Services confirmed that the issue of nursing responsibilities for patients taking nonformulary medications had not been addressed and that a nonformulary medication policy is under development. There was agreement that physician orders were not followed when a patient does not get medications as ordered and that nursing staff should notify the physician when a medication is unavailable and a new order should be obtained. Per 9/10/14 interview with the Medical Director of the Hospital Division, s/he confirmed that discussions about non-formulary medications occur but changes in medication orders are not documented; s/he confirmed that an order to omit non-formulary/unavailable medications should be obtained and confirmed that the process for non-formulary medication availability and responsibilities for nursing, pharmacy and physicians needs to be "...tightened" to make medication orders clearer when there are medication omissions.	C 297			
C 301	485.638(a)(1) RECORDS SYSTEMS The CAH maintains a clinical records system in accordance with written policies and procedures. This STANDARD is not met as evidenced by: Based on observation and interview, the CAH failed to assure all medical records were maintained and stored in accordance with established policies and procedures. Findings	C 301			

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C 301	Continued From page 35 Include: Per observation, during tour of the Health Center at Berlin, at 8:20 AM on 9/10/14, medical records were stored on open shelving in unlocked cabinets and accessible to cleaning staff. Per review, the facility's established Storage and Security of Medical Records policy, dated 3/30/2009, stated as it's purpose; "To provide maximum security to the confidentiality of the medical record.... All medical record areas are restricted except to authorized personnel. Medical record storage doors will remain locked unless a Health Information representative is present.....Health records should not be left unattended in areas accessible to unauthorized individuals." The Vice President of Surgery, responsible for the oversight of the clinic, confirmed, at the time of tour, that contracted cleaning staff, who have no need to access medical records, do have unmonitored access to the medical records during after hour cleaning of the room.	C 301	Quotes have been requested to install a locking door, restricting access to Medical Records. Door has been selected with contractor and order placed. Installation expected 10/20-10/31 Clinic staff will be responsible for ensuring that the door is locked at the end of each day, preventing access to medical records by unauthorized personnel, and for cleaning in the restricted access area. Expected completion: 10/20-10/31	
C 302	485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on interview and record review, nursing and pharmacy staff failed to accurately document the omission of a medication and failed to complete documentation in 1 of 23 applicable records for the notification to the prescribing physician of a medication omission and lack of medication availability as well as to request a change in order for the unavailable medication.	C 302		

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C 302	<p>Continued From page 36 (Patient # 10) Findings include:</p> <p>Per medical record review, Patient #1 was admitted to the facility on 9/5/14 for the treatment of a traumatic laceration and tendon injury of his/her foot. Unrelated to the foot injury, the admission orders included an order for Elmiron 100 mg capsules three times per day, a medication that Patient #10 was taking prior to his/her hospitalization (Elmiron is a medication used to treat Interstitial cystitis, a chronic bladder condition that is often associated with pain and bladder pressure).</p> <p>Per 9/9/14 at 2:09 PM interview, the Pharmacy Manager reported that Elmiron was non-formulary and unavailable. The pharmacist reported that when medications are not available in the hospital pharmacy attempts are made to obtain the medication from home, use therapeutic substitutions, utilize other hospitals, or fill prescriptions from retail stores so a patient will not miss doses. The pharmacist reported visiting Patient #10 to see if s/he could bring the medication from home as it was not available in the hospital pharmacy.</p> <p>Per review of the MAR (Medication Administration Record), on 9/5/14, 1 dose of Elmiron was not administered to Patient #10; on 9/6/14, 2 doses of Elmiron were not administered; notations were made in the MAR on 9/5/14 that Elmiron was "omitted: pt own med, not in pyxis;" on 9/6/14 a notation states "med not available" for the 2 omitted doses. A note was added to the Elmiron order, "Pt Own Med." On 9/9/14 at 11:45 AM, a facility pharmacist documented, "I spoke with patient about [his/her] Elmiron. [S/he] is OK skipping one dose because [s/he] will not be able</p>	C 302	<p>Policy PH- 132 "NonFormulary Medications and Patient's Own Medications" and associated processes have been revised with the following changes:</p> <ol style="list-style-type: none"> 1. Earlier attempt to procure medication from local pharmacy when not quickly brought in by family. Accounts have been established at both local pharmacies to facilitate this. 2. When meds are not available and it is determined by provider that med is not needed for a given period of time, MAR/ Order must be updated to reflect the change in order. <p>Competency quiz has been created through Policy Manager for all HP nursing, providers, and pharmacy to demonstrate understanding of each role in the process.</p> <p>75% of applicable staff to complete by 10/31/2014. 100% of regularly scheduled staff to complete by 11/28. Per Diem staff not scheduled during this time period will be expected to complete training on their next scheduled shift.</p> <p>Completion of competency will be monitored through QM and followed up with HP/ pharmacy leadership as needed.</p> <p>Monitor tracking log starting 10/1/2014 in order to monitor pharmacy, provider, and nursing compliance with non-formulary policy. Pharmacy will monitor non-formulary meds using our tracking form and report to medication utilization and safety team monthly. Once compliance with the policy has been achieved, (100% x three months) random audits will be conducted regularly.</p>		

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C 302	<p>Continued From page 37</p> <p>to supply it until 9/10/14 in the morning;" however, on the MAR, the 9/9/14 14:36 nursing entry states that "Patient Refused" Elmiron. On 9/9/14 during an interview at 2:09 PM with the Pharmacy Manager, the staff pharmacist reported that Patient #10's wife could not bring more Elmiron to the hospital until 9/10/14 and that there was only 1 Elmiron capsule left following his/her morning dose and Patient #10 opted to miss the 9/9/14 afternoon dose but planned to take the PM dose. When asked if the provider was contacted about the change in the medication order, the staff pharmacist called a staff hospitalist for approval during the interview.</p> <p>Per review, the policy "Nonformulary Medications and Patient's Own Medications " (effective 2013-11-18) states that "The pharmacy department is responsible for ensuring medications are available to meet patient needs while they are receiving care at Gifford Medical Center." Under the heading Non-formulary medications, Section B. states "The pharmacy will make all attempts to get the medication in house within 24 hrs. If the medication is not going to be available within 24 hours, documentation will be placed in the patient 's chart in the progress notes by the pharmacist regarding the status of the needed medication. C. If the medication is expected on the following day, the patient 's chart and MAR must reflect that start date. Also, the staff pharmacist who receives the order will leave a detailed report for the pharmacist coming on the following day that a medication is expected and what further steps need to be taken. The pharmacist will then be responsible for ensuring that the medication is made available to the patient. D. If the pharmacy is closed, the charge nurse and on call provider will assess if the</p>	C 302		

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C 302	<p>Continued From page 38</p> <p>patient will need the medication prior to 7 AM and what steps should be taken prior to the pharmacy reopening. If the medication is a patient's own medication and deemed critical, a dose can be given only if it is identified using the Imprint code and Clinical Pharmacology Online... E. If nursing sees that a medication is still unavailable after 24 hours, they are to call the pharmacy so that the steps outlined below can be taken."</p> <p>On 9/10/14 at 9:43 AM, the Pharmacy Manager reported that a 24 hour time frame was determined as an appropriate in-house time frame to assure that ordered medications are available for patients. When asked for clarification for the process for contacting the ordering provider about a change in orders when medications are not available (as it was not specified in the above policy), the Pharmacy Manager confirmed that provider contact was not included in the policy and confirmed that s/he could not provide documentation that the provider was contacted for a change in orders for Patient #10 when the Elmiron was not available on the first 2 days of admission. S/he reported that since Patient #10 received Elmiron within 24 hours as per the above policy, there was no need for further pharmacy documentation. S/he confirmed that there is no list of critical medications that can safely be omitted for 24 hours and added that the pharmacists use professional judgment to determine whether a medication should not be missed for 24 hours. On 9/10/14 at 8:14 AM, the medical-surgical unit Nurse Manager (NM) stated that nonformulary medication unavailability is discussed at interdisciplinary grand rounds (attended by hospitalists, nursing, pharmacy, Quality, care management and rehab staff). S/he reported that</p>	C 302			

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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 09/10/2014
NAME OF PROVIDER OR SUPPLIER GIFFORD MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 44 SOUTH MAIN STREET RANDOLPH, VT 05060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
C 302	<p>Continued From page 39</p> <p>pharmacy takes the lead to obtain nonformulary medications. The NM confirmed there was a documentation discrepancy in the MAR on 9/9/14 between a staff nurse documenting that Patient #10 "refused" Elmiron on 9/9/14 at 14:36 while the pharmacist documented that Patient #10 was "...OK skipping one dose" of Elmiron on 9/9/14 as s/he was not able to supply it until 9/10/14; the NM confirmed that documentation on the MAR should have read "med unavailable." The NM confirmed that there was no documentation in the record that nursing staff had contacted the physician to notify that Patient #10 was not administered Elmiron on 9/5 and 9/6/14 and there was no documentation of a request to change the order for the medication when it was not available. S/he further added that there is no specific "nursing policy" that addresses the use of nonformulary/home medications to provide direction to staff re notification to physicians when the medication is unavailable or for the need to obtain a new order when medications are not available.</p> <p>On 9/10/14 during an interview beginning at approximately 11:00 AM, the current and former Vice Presidents of Patient Care Services confirmed that the issue of nursing responsibilities for patients taking nonformulary medications had not been addressed and that a nonformulary medication policy is under development. There was agreement that physician orders were not followed when a patient does not get medications as ordered and that nursing staff should notify the physician when a medication is unavailable and a new order should be obtained.</p> <p>Per 9/10/14 interview with the Medical Director of the Hospital Division, s/he confirmed that discussions about non-formulary medications</p>	C 302			

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

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C 302	Continued From page 40 occur but changes in medication orders are not documented; s/he confirmed that an order to omit non-formulary/unavailable medications should be obtained and confirmed that the process for non-formulary medication availability and responsibilities for nursing, pharmacy and physicians needs to be "...tightened" to make medication orders clearer when there are medication omissions.	C 302			
C 308	485.638(b)(1) PROTECTION OF RECORD INFORMATION The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use. This STANDARD is not met as evidenced by: Based on observation and interview, the CAH failed to assure the confidentiality of medical record information was maintained to prevent unauthorized access. Findings include: 1. During tour of the Health Center at Berlin, outpatient clinic, at 8:20 AM on 9/10/14, medical records were observed stored on the open shelves of unlocked cabinets in the reception area. The Vice President of Surgery, who is responsible for oversight of the clinic, confirmed, at the time of tour, that contracted cleaning staff, who have no need to access medical records, do have unmonitored access to the medical records during after hour cleaning of the room.	C 308	Quotes have been requested to install a locking door, restricting access to Medical Records. Door has been selected with contractor and order placed. Installation expected 10/20-10/31 Clinic staff will be responsible for ensuring that the door is locked at the end of each day, preventing access to medical records by unauthorized personnel, and for cleaning in the restricted access area. Expected completion: 10/20-10/31		
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	C 337			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 09/18/2014
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OMB NO. 0938-0391

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C 337	<p>Continued From page 41 furnished in the CAH and of the treatment outcomes. The program requires that-</p> <p>all patient care services and other services affecting patient health and safety are evaluated.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the CAH failed to assure all patient care services affecting patient health and safety were effectively monitored and failed to assure CAH staff consistently complied with the process for reporting and incident/adverse event and also filing reports as mandated by State statute. Findings include:</p> <p>1. The Quality Assurance/Performance Improvement (QA/PI) program had failed to identify opportunities for improvement within the CAH that were subsequently identified by surveyors at the time of survey. There was a failure within the QA/PI program to identify the provision of Pharmacy services was not consistently assuring the safe and secure storage and ongoing monitoring of all drug storage areas within the hospital for content, usage and outdated drugs as per professional standards of practice. The CAH Infection Control program failed to assure staff consistently maintained Infection control standards of practice and failed to conduct ongoing surveillance and monitoring of the CAH environment to assure a sanitary and safe environment was being maintained. Infection Control concerns were identified to include patient care locations to include Peri-operative, Emergency Department and the Radiology Department. Per Interview on 9/10/14</p>	C 337	<p>Safety committee has created a schedule for environmental rounds throughout the organization, to include members of safety committee, infection prevention, QM and department leadership- facilitating a comprehensive evaluation. 10/01/2014</p> <p>Rounds have been scheduled with individual departments 10/02/2014.</p> <p>In addition, Infection Prevention and QM will collaborate with safety committee and department managers to ensure that environmental rounding is conducted with a frequency and intensity necessary to ensure a clean and safe environment of care.</p> <p>Copies of environmental surveillance findings will be submitted to infection prevention on a weekly basis and summaries presented at safety committee.</p> <p>New schedule of rounds commencing week of 10/6/2014</p>	

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C 337	Continued From page 42 at 2:30 PM the Senior Director of Quality and Risk Management confirmed there has been a lack of consistent hospital-wide environmental safety rounds and/or Infection Control risk assessments Per CAH policy Incident/Adverse Event Reporting effective date 8/27/2014, staff "A. When a patient or visitor incident/event occurs and/or is recognized, it should be reported using the Safety Event Reporting link found on Gifnet within 24 hours of the event occurrence or when the event or error is identified." Once a report is filed a preliminary assessment of the event and situation is conducted. Following a review, a determination would be made to assure reporting to outside agencies as mandated by law was completed. However, on 7/10/14 Patient #18 and Nurse #1 were involved in an incident resulting in an allegation of "assault" made by both the patient and the patient's family. Although the Patient Relations Specialist, nursing staff, and various administrative staff, were aware of the event to include the Senior Director of Quality and Risk Management, no one completed a Incident/Adverse event report, as per CAH policy. As a result, there was a failure to identify opportunities for improvement and to evaluate present processes. In addition, there was no review by Quality and Risk Management of the event on 7/10/14 to determine if staff had completed the State mandated report to APS, within the required time frame. These omissions were also confirmed by the Senior Director of Quality and Risk Management on the afternoon of 9/10/14.	C 337	The QA/PI plan has enhanced the oversight and monitoring of the goals and objectives outlined in the program. Specifically, QM staff will have a weekly check-in with departments regarding items addressed in the corrective action plan to ensure progress is on track and completed timely. Routine Environment of Care rounds have been scheduled in all departments. Findings from EOC rounds will be documented and shared with the appropriate staff in each department. An article on Event Reporting will be published in the November issue of the employee newsletter, the Pulse. In addition, email communication on Event Reporting will be sent to all clinical departments by October 15. A new policy on Reporting Allegations of Abuse (ADM-125) has been created. It includes an algorithm to aide nursing with the management of patient complaints and the reporting of allegations of abuse. An e-signature for this policy has been assigned to nursing. Progress on the completion of this task will be monitored by QM via reporting in Policy Manager.		
C1000	485.635(f) PATIENT VISITATION RIGHTS	C1000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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C1000	<p>Continued From page 43</p> <p>A CAH must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation</p> <p>This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview the CAH's Patient Visitation policies did not identify the clinical rationale for restricting or limiting visitors in the SCU (Special Care Unit) and did not address how CAH staff would be trained to assure appropriate implementation of the policies and procedures. Findings include:</p> <p>Per review the CAH policy, titled CAH Patient Access and Visits, dated 2/20/2012, stated, as it's purpose; ".....recognizes the importance of visits by family and friends. At the same time, we want to ensure that our patients receive the rest and quiet they need to recover. Visiting hours and number of visitors are flexible but may be subject to restriction according to the individual needs of patients as determined by physicians or nursing staff." Although a section regarding visitation for the SCU stated; "Immediate family only. Two visitors at a time for no longer than five minutes at the discretion of the nurse in charge", it did not clarify the clinical rationale for restricting visitation to immediate family only, and the time limit of no longer than 5 minutes. In addition the policies did not address how CAH staff who play a role in facilitating or controlling visitor access to patients will be trained to assure appropriate, consistent implementation of the visitation policies to avoid</p>	C1000	<p>Policy CAH- 304 (CAH Patient Access and Visits) has been revised to eliminate unnecessary restrictions and provide guidance to staff regarding appropriate indications for restrictions.</p> <p>A quiz has been created through Policy Manager and assigned to all hospital nursing staff.</p> <p>75% of hospital nursing staff to complete by 10/31/2014. 100% of regularly scheduled nursing staff to complete by 11/28. Per Diem staff not scheduled during this time period will be expected to complete training on their next scheduled shift.</p>	

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C1000	Continued From page 44 unnecessary restrictions/limitations on patients visitors. The Vice President of Patient Care Services confirmed, during interview on the afternoon of 9/10/14, that the policies did not address staff training, and the SCU visitation policy did not include clinical rationale for the restriction of visitors to immediate family only, or the visitation time restriction in that unit.	C1000			



Nursing Patient Complaint Algorithm

Patient is unhappy or has a complaint

Notify charge nurse/supervisor Immediately

Is there an allegation of abuse/neglect?

YES

NO

Charge Nurse will immediately make assignment change to remove alleged employee from that patient's care and care of roommate if applicable. Staff will be directed to work in teams of 2 from this point on with this patient.

Charge Nurse / Supervisor will immediately go to the patient and interview and physically assess patient.

Directly after Charge Nurse / Supervisor interviews and assesses patient the unit manager (or designee), and provider are to be notified.

Management will file a report with Adult Protective Services

Notify Patient Relations Specialist

Documentation for complaint will be done in Quantros feedback report.

A nurse's note should be done by both the primary staff member that received complaint and the Charge Nurse / Supervisor interviewing / investigating a complaint

Charge Nurse / Supervisor will interview and discuss complaint with patient and attempt to resolve the complaint. - Asking patient if s/he wishes to file a formal complaint or if they feel you are able to resolve the issue at hand.

Documentation for complaint will be done in Quantros feedback report.

A nurses note should be done in the nurses notes in CPSI of the description of the complaint and resolution, if one was reached.

If patient wishes to continue further and file a formal complaint notify Patient Relations, page via text paging system, email her or call and leave her a voice mail at ext. 2377. Patient Relations will manage the complaint to resolution



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Title:	CAH Patient Access and Visits	Effective Date:	2014-09-23	Policy #:	CAH-304
Applies to:	<input checked="" type="checkbox"/> Gifford Health Care <input checked="" type="checkbox"/> Gifford Medical Center <input type="checkbox"/> Gifford Retirement Community				
Division:	<input checked="" type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Hospital <input checked="" type="checkbox"/> Surgical <input checked="" type="checkbox"/> Operations <input type="checkbox"/> Administrative Svcs.				
Contact:	VP Hospital Division				

Purpose/Policy Statement: Gifford Medical Center recognizes the importance of visits by family and friends. At the same time, we want to ensure that our patients receive the rest and quiet they need to recover. Visiting hours and number of visitors are flexible but may be subject to restriction according to the individual's clinical and emotional needs.

Visitors with colds, flu, or any other contagious illness are asked not to visit.

Visitors are asked to follow any infection prevention measures which are posted, or provided by staff.

- B. Visitors including clergy are expected to stop at the nursing station prior to going to a patient's room. The patient/resident has the right and Gifford shall provide immediate access to any patient / resident by the following:
 1. Any representative of the Secretary of the Department of Health and Human Services;
 2. Immediate family or other relatives of the patient with the patient's / resident's consent
 3. Other visitors of the patient / resident with the patient's / resident's consent.

C. Subject to reasonable restrictions Gifford shall provide access to the patient by any entity or individual that provides health, social, legal or other services as well as family and non-family visitors if the patient so desires.

D. As a general rule patient visits will be allowed per the following guidelines:

Howell Pavilion and

Transitional Care Unit

General visiting hours: 10:00 a.m. - 8:00 p.m.

Visitors may stay 24 hours a day if the patient is a child, terminally ill, or in critical condition. Other requests to remain at a patient's bed side will take into consideration the patient's emotional and clinical condition as well as roommate status.

Pediatrics

Parents of children in Pediatrics are welcome anytime. They are encouraged to stay with child as much as possible/overnight.

Special Care Unit

In general, visitors are limited to two visitors at a time to allow for optimized patient care. Exceptions may be granted on a case by case basis.

Birthing Center

Immediate family may visit anytime. Others are allowed anytime as desired by the patient and her family. Visitors are requested to respect the rest needs of the new mothers.

Post Anesthesia Care Unit

Special permission only and will be based on the patients' clinical needs.

Ambulatory Care Center

Due to space limitations, visitors will be restricted to one at a time. Exceptions may be granted on a case by case basis.

Provider Offices

Per patient request and exam room space.

E. Visitors who bring children to Gifford are responsible for their behavior, care, and safety. Minor children must remain in the presence of the responsible accompanying adult (not the patient).

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- F. Persons who have no medical reason to be in the facility or on its grounds may be asked to leave if his or her condition or actions in any way appears to affect the safety or well-being of patients, visitors or employees. If he or she refuses to leave, the police will be notified and he or she may be subject to arrest for unlawful trespass per Vermont State Statutes Annotated Title 13, Section 3705(A1).
- G. The clinical care team of a patient may determine that visitation rights may need to be restricted or limited for the health and welfare of the patient, or other patients. Visitation rights may be restricted for the following:
1. The patient is undergoing care interventions
 2. The visitor's risk of infection by the patient
 3. The patient's risk of infection by the visitor
 4. Extraordinary protections because of a pandemic or infectious disease outbreak
 5. Visitation may interfere with the care of other patients
 6. The existence of a court order limiting or restricting contact
 7. Behavior presenting a direct risk or threat to the patient, hospital staff or others in the immediate environment
 8. Behavior disruptive of the functioning of the patient care unit
 9. The patient's need for privacy or rest
 10. The need for privacy or rest by another individual in the patient's shared room
 11. Reasonable limitation on the number of visitors at one time
 12. The need for minimum age requirements for child visitors
 13. Inpatient substance abuse treatment program protocols requiring restricted visitation
- G. Pets* may be permitted to visit a patient if they have been authorized to do so and meet the following criteria:
1. Prior approval is obtained from the nurse in charge, before bringing a pet to the hospital.
 2. Pet owners who bring their pet to Gifford are responsible for their behavior, care and safety.
 3. Pets should be in good health, clean, free of parasites, fleas and ticks, ear mites, and skin diseases (have current rabies vaccine and licenses as appropriate)
 4. Pets must be restrained on a leash or manually held.
 5. Pets must be friendly and comfortable in a new environment and around strangers. No pet with a history of aggressive behavior will be permitted to visit.
 6. Visitors with pets will enter and leave facility in least conspicuous manner.
 7. Pet will only be allowed to enter the room of the patient to be visited (permission must be obtained from roommate by the charge nurse if applicable).
 8. Pets are not permitted in the patient treatment areas, dining areas, clean supply areas, medication preparation and other treatment/procedure areas. Pets are not permitted in the Emergency Department, Birthing Center, Surgical Services area, Minor Procedure Room or other public areas of the facility.

* Service animals (such as seeing eye dogs) are exempt.

DOCUMENTATION FOR PET VISIT

The patient or family will need to complete the form "Requirements for Pets" form. The completed form will be made part of the patient's medical record.

Key Words: Visiting hours, pet visits, documentation, children, service animals

All Staff (non-providers): A policy is intended to clarify expected practice and commit the organization/staff to a specific course of action. Any temporary requests or decisions to modify an expected course of action as outlined in a policy must be approved by Senior Management or the Administrator-on-Call.



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Providers: Not all patient situations will fit the policy as written. Patient care is individualized based on professional judgment and a patient's condition may require a change in the care provided. Deviation from the written, adopted policy should be clearly documented in the patient's medical record along with the rationale for such deviation.

Standard or Statute:	<input type="checkbox"/> N/A <input checked="" type="checkbox"/> CAH Standard <input type="checkbox"/> NH Standard <input type="checkbox"/> FQHC	<input type="checkbox"/> Labor Statute <input type="checkbox"/> VT State Statute <input type="checkbox"/> Compliance/HIPAA <input type="checkbox"/> Other	Standard or Statute Details:	§483.10(j) C-0370
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Title:	Nonformulary Medications and Patient's Own Medications	Effective Date:	2014-09-26	Policy #:	PH-132
Applies to:	<input checked="" type="checkbox"/> Gifford Health Care <input checked="" type="checkbox"/> Gifford Medical Center <input type="checkbox"/> Gifford Retirement Community				
Division:	<input checked="" type="checkbox"/> Primary Care <input checked="" type="checkbox"/> Hospital <input checked="" type="checkbox"/> Surgical <input type="checkbox"/> Operations <input type="checkbox"/> Administrative Svcs.				
Contact:	Pharmacy Manager				

Purpose/Policy Statement: To ensure patients are getting their medications in a timely manner when the medication is not on formulary. In addition, this policy will address how to handle patient's own medications and "take back" medications from the community.

The pharmacy department is responsible for ensuring medications are available to meet patient needs while they are receiving care at Gifford Medical Center.

Providers, working collaboratively with the patient, should assess patient's home medication list and evaluate the clinical necessity of all medications in an acute setting. If a non-formulary medication is considered part of their plan of care, the following procedure will address the procurement of that medication.

Non-formulary medications:

A. In the event that a non-formulary medication is ordered, the following steps will be taken:

1. The medication may be brought in from home. See process below.
2. A substitution may be made to a therapeutically equivalent formulary medication.
3. A sample of the medication may be obtained from a provider practice office, if available and quantity is sufficient.
4. A supply of the medication may be obtained from a nearby hospital.
5. The medication may be ordered from our wholesaler if time allows.
6. Neither pharmacy in town will sell medications to us directly. If a clinically necessary medication cannot be obtained using steps 1-5, the medication should be obtained from one of the two retail stores in town by filling a prescription for the medication and charging to the Gifford pharmacy account.

B. The pharmacy will make all attempts to get the medication in house as soon as possible (but not to exceed 24 hours).

C. If the medication is expected on a future day, the patient's record and MAR must reflect that start date, with provider approval. Also, the staff pharmacist who receives the order will leave a detailed report for the pharmacist coming on the following day that a medication is expected and what further steps need to be taken. That pharmacist will then be responsible for ensuring that the medication is made available to the patient.

D. If a non-formulary arrives when the pharmacy is closed, the charge nurse and on call provider will assess if the patient will need the medication prior to pharmacy reopening. A dose can be given only if it is identified using the imprint code and Clinical Pharmacology Online. After this dose, the medication must be placed in the pharmacy so that the steps outlined below can be taken.

E. If nursing sees that a medication is unavailable, they are to call pharmacy when the pharmacy is open to determine the availability of the medication. When the pharmacy is closed, nursing should see the provider regarding the unavailable drug. If the provider feels that the medication is clinically necessary, the pharmacy manager should be notified. If the provider feels that it is clinically appropriate to miss a dose, an order should be entered to indicate

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such, i.e. "okay to miss one/two/am/pm dose". Nursing may document as "omitted: hold order" if pharmacy has not retimed the medication.

F. Any missed doses of medication due to unavailability will be reported via the Quantros reporting system.

Procedure for using a patient's own medication:

A. When a patient is admitted to the hospital, medications that are written in the physician's order sheet are to be dispensed by the Gifford Medical Center pharmacy following the hospital guidelines. Patients can use their own medications or equipment in the following instances:

- 1) If pharmacy does not carry the medication,
- 2) If there is a delay in obtaining the medication from wholesaler,
- 3) If the medication is not covered by their insurance company, with the exception of control substances, in Observation, ER observation, or Level II Transitional Care patients.

B. When using a patient's own medication, the medication should be handled as follows:

- 1) The provider who is responsible for the care of the patient needs to write a medication order to include the name of the medication, strength, route of administration, and the frequency even if the medication container has been labeled with such.
- 2) The medication will be brought to the pharmacy for identification.
- 3) The pharmacist on duty will identify the medication using a reputable pharmacy reference such as Clinical Pharmacology Oncology and label the container according to physician's order with a bar code scannable label.
- 4) A label will be placed on the patient's chart indicating that the patient has a personal medication in house that needs to be returned upon discharge. Remaining medications will be returned to the patient upon discharge. If the medications are not returned and the patient has not claimed those medications within 15 days from discharge, they will be destroyed.
- 5) If a patient requests that medications be destroyed earlier than 15 days, the person who received that message should document in their note that the patient desired destruction of medications.
- 6) In the event that the patient expires while in the hospital, those medications will be destroyed immediately.

Patient's Own Medications (Community):

The hospital pharmacy is not staffed or outfitted to accept unwanted medications from community members. The clinic staff has been instructed not to accept these kinds of medications. The pharmacy will not destroy or store medications accepted by the clinics. It is understandable that patients will want to bring in medications for destruction. However, patients should be advised to secure these medications at home until the state or other approved entity sponsors a "take back program."

Key Words: Medications from home, patient's own meds, nonformulary meds.

All Staff (non-providers): A policy is intended to clarify expected practice and commit the organization/staff to a specific course of action. Any temporary requests or decisions to modify an expected course of action as outlined in a policy must be approved by Senior Management or the Administrator-on-Call.

Providers: Not all patient situations will fit the policy as written. Patient care is individualized based on professional judgment and a patient's condition may require a change in the care provided. Deviation from the written, adopted policy should be clearly documented in the patient's medical record along with the rationale for such deviation.



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Standard or Statute:	<input checked="" type="checkbox"/> N/A <input type="checkbox"/> CAH Standard <input type="checkbox"/> NH Standard <input type="checkbox"/> FQHC	<input type="checkbox"/> Labor Statute <input type="checkbox"/> VT State Statute <input type="checkbox"/> Compliance/HIPAA <input type="checkbox"/> Other	Standard or Statute Details:	
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VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 19, 2014

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

VIA FAX (802) 728-4245 AND FIRST CLASS MAIL

Provider ID #: 471301

Dear Mr. Woodin:

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

A survey was completed at your hospital on September 10, 2014. Based upon survey findings, Gifford Medical Center was found to be out of compliance with Conditions of Participation for Provision of Services (Fed-C-270), as well as several standard level requirements.

This letter serves to notify you of Gifford Medical Center failure to comply with the Conditions of Participation stated above. The projected date on which your agreement will terminate is December 9, 2014

Please submit a plan of correction for all deficiencies by September 29, 2014. A revisit will occur.

If you have any questions concerning this letter please contact me at (802) 871-3317.

Sincerely,

Frances L. Keeley, RN, MSN, DBA
Assistant Division Director
Director State Survey Agency





Gifford Medical Center

44 South Main Street, P.O. Box 2000 • Randolph, Vermont 05060
802-728-7000 • fax 802-728-4245

October 6, 2014

Department of Licensing and Protection
Attention: Frances L. Keeler, RN, MSN, DBA
103 South Main Street
Waterbury, Vt. 05671-2306

Re: Addendum to Plan of Correction Provider ID #47Z301

Dear Ms. Keeler:

Please accept the following addendum to Gifford's Plan of Correction for CAH survey submitted 10/3/2014.

Policy # PH- 132 "Non-Formulary Medications and Patient's Own Medications" has been revised in section E to state: "When the pharmacy is closed, nursing should contact the provider regarding the unavailable drug."

Policy # PR- 301 "Resolution of Patient/ Visitor Complaint or Grievance" and Policy # ADM-125 "Reporting Allegations of Abuse" have been assigned to all staff providing direct patient care, as well as Quality Management and Patient Relations staff. (Assigned through Policy Manager, which tracks competencies/attestations of reading and understanding policy, 10/06/2014)

Follow-up monitoring:

75% of all assigned staff will complete sign off by 10/31/2014. 100% of regularly scheduled staff to complete by 11/28/2014. Per Diem staff not scheduled during this time period will be expected to complete training on their next scheduled shift.

Completion of competency will be monitored by QM and communicated with managers and senior managers to ensure compliance.

In addition, there will be an article in the all staff newsletter for November 2014, explaining the expectation for all staff to understand the importance of our process for managing patient and visitor complaints.

Sincerely,

Thom Goodwin, Director Quality and Risk Management

www.giffordmed.org