

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
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

April 10, 2014

Roger Allbee, Administrator
Grace Cottage Hospital
Po Box 216
Townshend, VT 05353

Dear Mr. Allbee:

The Division of Licensing and Protection completed a survey at your facility on **February 27, 2014**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **April 10, 2014**.

Sincerely,



Pamela Cota, RN.
Licensing Chief

PC:jl

Enclosure

[REDACTED]

[REDACTED]

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

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2014	
NAME OF PROVIDER OR SUPPLIER GRACE COTTAGE HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 216 TOWNSHEND, VT 05353		
(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 REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 151	<p>Continued From page 1</p> <p>have no need of the information. A physician progress note, dated 12/31/13 that indicated the patient had developed a pressure ulcer on his/her right heel. Despite the documentation, by Physician #2, that stated; ".....on [his/her] right heel [s/he] has a 1 cm (2) area that is tender to palpation with a Q-tip and is non-blanchable and necrotic. Photograph taken....", there was no photograph of the wound included as part of the patient's health information in the patient's medical record.</p> <p>During interview, at 3:28 PM on the afternoon of 2/27/14, Physician #2 confirmed that s/he had taken a photograph of Patient #2's pressure ulcer, had used his/her personal cell phone to capture the image and that the image was still stored on the phone. The CNO (Chief Nursing Officer), confirmed, during interview at 3:33 PM, that staff should not use personal cell phones to take pictures of patients. S/he further confirmed that the image of Patient #2's wound, taken on 12/31/13, had still not been included as part of the patient's health information or medical treatment in the patient's medical record, as of the date of survey.</p> <p>2. Per record review, Patient #1 experienced on 12/24/13 a nontraumatic cerebral hemorrhage (stroke) requiring neurosurgery. Post operative complications included seizures, impaired cognition, swallowing and mobility defects. On 1/21/14 Patient #1 was transferred to the CAH for rehabilitation. Shortly after admission to the CAH Patient #1 demonstrated erratic behaviors including paranoia, impulsivity, anger, belligerence toward staff and was assessed to be at high fall risk, subsequently experiencing multiple falls at the CAH.</p>	C 151	<p>see attachment 1 Plan of correction Issue #2 ()</p>	

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C 151	Continued From page 2 During the evening and into the early morning of 2/21/14 Patient #1's behaviors began to escalate. A Physician Progress note for 2/21/14 states " Around midnight however s/he became flamboyant paranoid and agitated, throwing furniture, breaking equipment, crawling into the bathroom and locking himself/herself repeatedly" (in the bathroom). At 04:20 on 2/21/14 Patient #1 got out of bed without assistance, fell and proceeded to crawl into the bathroom. At the time of the incident, staffing at the CAH included 2 RNs and 1 LPN, 2 out of the 3 staff members were male whom Patient #1 expressed dislike and demanded they not provide care. Without any other CAH staff available to provide assistance, the decision was made to call Rescue, Inc. (Emergency Medical Systems provider) based adjacent to the CAH. Although only authorized staff should be directly involved in treatment and care and services for Patient #1, Rescue, Inc. staff became involved with patient care in the patient's room while s/he laid on the bathroom floor. Patient #1 accepted assistance from Rescue, Inc staff who guided Patient #1 back to bed. Despite privacy concerns for Patient #1, Rescue, Inc staff, who are not employed by the CAH, proceeded to conduct a physical assessment of the patient to rule out any potential injury.	C 151			
C 250	485.631 STAFFING AND STAFF RESPONSIBILITIES Staffing and Staff Responsibilities This CONDITION is not met as evidenced by: Based on staff interview and record review, the	C 250	see attachment 2 Plan of Correction _____ 8		

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C 250 Continued From page 3
Condition of Participation: Staffing and Staff Responsibilities was not met as evidenced by the failure of the CAH to ensure sufficient staff coverage was available at all times to provide essential services and able to respond to emergent events or procedures and to be sufficient to meet the needs of all patients.

C 250

C 253 Refer to Tag: C-253
485.631(a)(3) STAFFING

C 253

The staff is sufficient to provide the services essential to the operation of the CAH.

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the CAH failed to ensure sufficient staff coverage was available at all times to respond to emergent events or procedures and to provide essential services to include Nursing and all therapy services. (Patients #1, #2, #3) Findings include:

1. Per record review, Patient #1 experienced on 12/24/13 a nontraumatic cerebral hemorrhage (stroke) requiring neurosurgery. Post operative complications included seizures, impaired cognition, swallowing and mobility deficits. On 1/21/14 Patient #1 was transferred to the CAH for rehabilitation. Shortly after admission to the CAH Patient #1 demonstrated erratic behaviors including paranoia, impulsivity, anger, belligerence toward staff and was assessed to be at high fall risk, subsequently experiencing multiple falls at the CAH. During Patient #1's course of rehabilitation, s/he remained more cooperative with rehabilitation staff and nursing staff on days and evening shift, but during late

*See attachment 2
Plan of correction
Issue # 1
(~~_____~~)*

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C 253	<p>Continued From page 4</p> <p>evening and night Patient #1's behaviors became more challenging. The census fluctuates between 11-17 CAH patients. During the 11 PM to 7:00 AM nursing staff also is required to provide nursing coverage for the 4 beds in the Emergency Department, this assignment is generally the responsibility of the assigned Charge Nurse. As a result, when only 3 nursing staff were regularly scheduled during the night shift, only 2 would be available to provide floor care duties at the CAH, limiting the ability of staff to consistently deliver patient care services and assure the safety for all patients was being met.</p> <p>During the evening and into the early morning of 2/21/14 Patient #1's behaviors began to escalate. A Physician Progress note for 2/21/14 states " Around midnight however s/he became flamboyant paranoid and agitated, throwing furniture, breaking equipment, crawling into the bathroom and locking himself/herself repeatedly" (in the bathroom). At 04:20 on 2/21/14 Patient #1 got out of bed without assistance, fell and proceeded to crawl into the bathroom. At the time of the incident, staffing at the CAH included 2 RNs and 1 LPN, 2 out of the 3 staff members were male whom Patient #1 expressed dislike and demanded they not provide care. Without any other CAH staff available to provide assistance, the decision was made to call Rescue, Inc. (Emergency Medical Systems provider) based adjacent to the CAH. Although not hospital employees, staff from Rescue, Inc. entered Patient #1's room, conversed with Patient #1 while s/he laid on the bathroom floor. Eventually, Patient #1 accepted assistance from Rescue, Inc staff who guided Patient #1 back to bed and conducted an assessment to rule out any potential injury.</p>	C 253		
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C 253	<p>Continued From page 5</p> <p>During the evening of 2/21/14 Patient #1's behaviors again escalated. Per Nursing progress note at 1940 "Pt. has pulled bed alarm wire and bed control out of bed and wall and wrapped the wires around his hand.....". During an attempt to remove the equipment from Patient #1 a LNA (Licensed Nursing Assistant) was repeatedly hit with bed control equipment by the patient. Shortly after the patient placed himself/herself in their wheelchair, exited his/her room, wheeling up and down hallways past other patient rooms and attempted to get into the elevator. The census on the evening of 2/21/14 was 15 and scheduled nursing staff was 1 RN (who was both charge nurse and assigned to the ED) and 2 LPNs. After contacting the Administrator on call to report concerns regarding Patient #1's ongoing behavioral incidents the RN charge nurse was authorized to contact the Windham County Sheriff's Department to request assistance. Per MD Progress note for 1/21/14 at 19:45 Physician #1 states "I was summoned by nurses saying that s/he was wildly agitated, violent and had struck a nurse. They wanted police intervention to help restrain him/her so that s/he could receive his/her Haldol. Sheriff has dispatched deputies". At 2000 Patient #1 is approached in his room by Physician #1 and 3 other staff members and is offered Haldol 10 mg. orally. Patient #1 accepts the Haldol, but when given, throws the pill, refusing to take the medication. Upon arrival of the Sheriff into the patient's room, Patient #1 is informed an injection of Haldol will be administered at which time Patient #1 again refused to receive the medication. As the patient sat in a wheelchair, the Sheriff restrained Patient #1's right arm, and other staff restraining other extremities, Physician #1 attempted to inject Haldol 10 mg. into Patient</p>	C 253		
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C 253	<p>Continued From page 6</p> <p>#1's left deltoid muscle, however the patient flexed their arm and the needle bent. A second attempt was made with a new needle and Physician #1 was successful at administering the medication. Per interview on 2/26/14 at 3:15 PM, Physician #1 confirmed after changing the gauge size of the needle for injection, the patient did receive the full dose of medication.</p> <p>A Nursing progress note reflecting Patient #1's history of falls and wandering via wheelchair for 2/20/14 at 16:44 states " Patient does not have one to one care so staff are not present in room with patient on a constant basis." Physician #1 documents on 2/21/14 at 17:16 "S/he needs huge amounts of reassurance and watching". When questioned regarding having sufficient staff the Chief Nursing Officer (CNO)/Interim Chief Operating Officer (COO) stated during interview on 2/26/14 at 3:50 PM "Our per diem pool has been decimated, we will mandate people to stay if we have to but we don't want to because it affects moral. No we do not have enough staff".</p> <p>In addition, although the CAH has a policy and procedure for calling a "Code Gray" when staff are requiring immediate assistance with a safety or behavioral situation/event, staff response would be sufficient during the day and for part of the evening, however after 9:00 PM and throughout the night ancillary services are not available and therefore only 3-4 nursing staff members are present without the assistance of other support staff and/or security.</p> <p>2. Per record review Patient #2, who was admitted on 12/20/13, for rehabilitation following an accident in which s/he sustained multiple traumatic injuries, did not consistently receive</p>	C 253	<p>see attachment 2 Plan of Correction Issue #2 (_____)</p>	

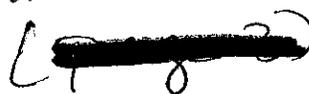
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C 253	Continued From page 7 physical therapy (PT) treatment as directed in the plan of care. Per review of a PT Daily Note, dated 1/3/14, the treatment plan included: Bed mobility training, Pain management, Patient education, Therapeutic activities, Therapeutic exercises, Transfer training, Wheelchair assessment and management and Safety education. The PT treatments were to occur daily for a period of 3 weeks. However, subsequent progress notes on two separate days, 1/4/14 at 5:27 PM and 1/5/14 at 5:31 PM, respectively, indicated "patient not seen for PT due to staffing constraints". 3. Per review Patient #3, who was admitted on 2/5/14 for rehabilitation following a stroke, had an initial Occupational Therapy (OT) evaluation, dated 2/6/14, that identified a plan of treatment for problems including: Balance deficits, basic ADL (Activities of Daily Living) deficits, and Strength/ROM (Range of Motion) deficits. The treatment plan indicated the patient would receive daily OT treatment for a period of 4 weeks. A progress note, dated 2/9/14 at 3:12 PM stated: "OT tx (treatment) withheld this date secondary to staffing limitations. " During interview, at 9:30 AM on 2/27/14, the Director of Rehabilitation services confirmed PT and OT treatments did not occur for Patients #2 and #3 on each of the respective dates related to a lack of staff to offer the services.	C 253		
C 270	485.635 PROVISION OF SERVICES Provision of Services This CONDITION is not met as evidenced by: Based on interview and record review the CAH failed to ensure the Condition of Participation:	C 270	see attachment 3 Plan of Correction 	



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C 270	<p>Continued From page 8</p> <p>Provision of Services requirement was met as evidenced by:</p> <p>The CAH failed to assure that care and services were provided in accordance with currently established written policies and procedures.</p> <p>The CAH failed to establish polices and procedures to reflect how the provision of services would be provided to include: the assessment and needs of patients who require transport to other facilities; staff use of pictures/images of patients; and how and when the Sheriffs Department and Rescue, Inc staff are to be utilized.</p> <p>The CAH Nursing Services failed to follow physician orders; failed to meet the needs of patients identified as at risk for falls and skin breakdown; failed to initiate care to patients with demonstrated needs requiring ongoing monitoring and interventions for fall prevention and at risk for impaired skin integrity and breakdown; failed to follow physician orders; and failed to develop and revise the Nursing Care Plan.</p> <p>The Electronic Medical Record (EMR) was not readily accessible and systematically organized to provide evidence to reflect provision of specific care and services and a failure within the EMR to accurately provide information for the ongoing monitoring for wounds.</p> <p>Refer to Tags : C-271, C-273, C-278, C-294, C-295, C- 298, C-302, C-306</p>	C 270		
C 271	<p>485.635(a)(1) PATIENT CARE POLICIES</p> <p>The CAH's health care services are furnished in</p>	C 271		

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C 271	Continued From page 9 accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview the CAH failed to assure that care and services were provided in accordance with currently established written policies and procedures, for 3 patients identified as at risk for falls and or skin breakdown. (Patients #1, #2 and #5) and for 1 patient who was restrained and was administered involuntary emergency medication (Patient #1). Findings include: 1. Per record review nursing staff failed to provide care in accordance with the facility's Skin Breakdown Prevention policy for Patient #2, admitted on 12/20/14 for rehabilitation following an accident in which s/he sustained multiple traumatic injuries which left him/her immobile in bed. The policy, dated 12/4/09, and last reviewed 8/28/13, stated, as it's purpose: "To effectively screen all inpatients for skin breakdown potential and implement appropriate precautions based on individual risk." Per the facility policy a Braden Scale Score of 15 - 18 indicates a mild risk for skin breakdown, for which the following interventions should be implemented: Frequent turning, Maximal remobilization, Protect heels, Manage moisture, nutrition, friction and shear, and Pressure reducing support surface if bed or chair bound. Although Patient #2 had a Braden Risk Assessment Scale completed on 12/20/13 which identified a score of 15, there was no indication that any of the identified interventions had been implemented. The patient, who was admitted with no evidence of any existing pressure ulcers, had a nursing progress note,	C 271	<i>see attachment 3 Plan of correction Issue # 1 (page)</i>		

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C 271	<p>Continued From page 10</p> <p>dated 12/30/13 at 4:08 PM which indicated the patient's right heel was slightly boggy with some discoloration. A subsequent Interdisciplinary Team Meeting nursing note, dated 12/31/13 at 1:14 PM, identified ".....right heel pressure sore with dime size ulcer stage 2 , foot has been elevated with pillow and no pressure to heel site to promote healing.." Despite the identification of the pressure ulcer on Patient #2's right heel on 12/30/13 the care plan for Impaired Skin Integrity which included goals and interventions to facilitate wound healing, was not initiated until 1/10/14.</p> <p>During interview, on the afternoon of 2/27/14, the Nurse Manager and the CNO (Chief Nursing Officer), both confirmed that the Skin Breakdown Prevention Policy had not been followed, and interventions to prevent skin breakdown should have been implemented on admission when the patient had been identified as at risk for breakdown.</p> <p>2. Per record review, CAH nursing staff failed to provide care in accordance with the facility policy Fall Prevention and the use of the Morse Fall Scale last reviewed 11/3/13 for Patient #1, admitted to the CAH on 1/21/14 for rehabilitation after experiencing a stroke resulting in physical, neurological and behavioral deficits. At the time of admission and utilizing the Morse Fall Scale (MFS), nursing staff screened Patient # 1 at a score of 90 (45 or higher ranked a patient to be at High Risk risk for falls). The policy further directs staff to initiate "High Fall Risk Precautions" to include bed/charm alarm, rounding hourly, placing "Falling Star" placard on door jamb of patient's room along with placing bed in low position. Nursing progress note for</p>	C 271	<p>see attachment 3 Plan of Correction Issue # 2 (page 3)</p>	
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C 271	<p>Continued From page 11</p> <p>1/21/14 at 23:37 states "s/he is a fall risk; has made no attempts to get out of bed so as of now s/he is not on alarms". However, within hours of admission, at 7:00 AM on 1/22/14 Patient #1 was found on the floor in his/her room, face down naked sustaining a bruise to his/her left temple, shoulder and hand. Patient #1 also complained of pain across shoulders, neck and head. After the fall, Patient #1 was placed in a high low bed, mats were positioned beside the bed and alarms were put in place.</p> <p>Despite Patient #1's fall history and ongoing need to be maintained on "High Fall Risk Precautions", again a staff nurse failed to comply with CAH policy when on 2/15/14 at 19:30 the patient was left unattended on the toilet when a staff nurse left the bathroom to obtain clean linen and pajamas. Upon return, Patient #1 was found laying on the floor on his/her right side resulting in rib and elbow pain.</p> <p>Per interview on 2/27/14 at 8:45 AM, the Nurse Manager confirmed the staff nurse on 1/21/14 failed to follow CAH policy and procedures related to fall prevention protocols. In addition, the Nurse Manager acknowledged Patient #1 should not have been left alone on the toilet on 2/15/14, noting the staff nurse used poor judgement by not identifying the potential fall risk when leaving Patient #1 unattended.</p> <p>3. On 2/14/14 Patient #5, age 96, was admitted to the CAH for treatment of a non-healing leg ulcer/cellulitis of the left ankle. Per nursing progress note for 2/14/14 at 1740 describes Patient #5 as "...slow unsteady gate, malnutrition at 78 lbs, thin and frail...". A nursing progress note for 2/15/14 states " Approx. 1600 Pt was heard</p>	C 271	<p>see attachment 3 Plan of Correction Issue #3 (page 3)</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2014
NAME OF PROVIDER OR SUPPLIER GRACE COTTAGE HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 216 TOWNSHEND, VT 05353		
(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 271	<p>Continued From page 12</p> <p>crying out from the Hospice family room. Nursing found pt on the floor, shaken up. S/he had reached for a wooden chair and missed, landing on the floor stating pain under R arm/rib area. VS were elevated and s/he was shaky and not making much sense.....chair and bed alarms have been put into place". Per interview on the afternoon of 2/27/14, the Nurse Manager stated s/he was involved with Patient #5's admission and had directed other nursing staff to initiate fall risk interventions. However s/he acknowledged despite Patient #5's obvious physical compromise and risk for falls, staff failed to assure that care and services were provided in accordance with CAH Fall Prevention and use of the Morse Fall Scale policy. It was not until after Patient #5 sustained a fall, nursing staff implemented appropriate precautions.</p> <p>4. Per review, Physician #1 states in a progress note for 2/21/14 at 1945 "I was summoned by nurses saying that s/he (Patient #1) was wildly agitated, violent and had struck a nurse. They wanted police intervention to help restrain him/her so that s/he could receive Haldol. Sheriff has dispatched deputies". Shortly after arrival of the Deputy from Windham County Sheriff's Department, decision is made by Physician #1 to administer an injection of Haldol to Patient #1. While the patient sat in his/her wheelchair in Room #2, the Sheriff assisted CAH staff with hands on restraint of Patient #1 while Physician #1 administered the injection into Patient #1's left arm. The first attempt to inject resulted in a bent needle, a second attempt to administer the Haldol proved successful.</p> <p>Per policy Involuntary Procedures and Use of Restraints last reviewed on 8/28/13 states</p>	C 271	<p>see attachment 3 Plan of correction Issue #4 (pages)</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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C 271	Continued From page 13 "Restraint is the direct application of physical force to a patient, with or without the patient's permission, to restrict his/her freedom of movement... Holding a patient and restricting movement constitutes restraining him/her". Per interview on 2/26/14 at 8:35 AM, the Charge Nurse on the evening of 2/21/14 confirmed Patient #1 was physically restrained with "hands on" to the patient's extremities by the Deputy, the Charge Nurse and other nursing staff during the administration of an involuntary emergency medication. Although the policy further states "9. A Certificate of Need (CON) for emergency restraint shall be entered in the patient's record that documents emergency circumstances requiring the use of restraints..." and "..... when involuntary medications are administered (the CON) will be completed by the provider". There was no evidence in the medical record a CON was completed by Physician #1. Per interview on 2/27/14 at 9:45 AM, the Nurse Manager confirmed "..... the policy was not followed...." further acknowledging the Involuntary Procedures and Use of Restraints policy has not been utilized prior to 2/21/14 noting "...we have not had to use restraints...". Furthermore there was no debriefing with either the patient or staff involved with the restraint procedure including the physician, which is also required by CAH policy.	C 271			
C 273	485.635(a)(3)(i) PATIENT CARE POLICIES (i) A description of the services the CAH furnishes, including those furnished through agreement or arrangement. This STANDARD is not met as evidenced by: Based on interview and record review, the CAH failed to establish polices and procedures to	C 273	see attachment 4 Plan of Correction (Page 4)		

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1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice G. D. C. O'Connell" and "The Hon. Mr. Justice J. J. O'Connell".

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

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C 273	<p>Continued From page 14</p> <p>reflect how the provision of services would be provided by Rescue, Inc. (Emergency Medical Services) and the Windham County Sheriffs Department; failed to establish a policy and procedure for the assessment and needs of patients who require transport to other facilities; and failed to establish a policy and procedure to reflect use of pictures/images of patients to be considered in the health information and medical treatment of patients and Findings include:</p> <p>1. Per record review, during the hospitalization of Patient #1 at the CAH nurses notes reflect and staff confirmed the use of members from Rescue, Inc., to augment staff during circumstances when additional staff support was deemed essential to meet the needs of patients. Although not employed by the CAH, staff from Rescue Inc, to include EMTs and/or Paramedics, have been requested to provide assistance with patient care. Per "Statement of Understanding" last renewed by CAH and Rescue, Inc. administrative staff on 10/18/13 states services provided would include: "Initiating care on a hospital patient who was never an EMS prehospital patient or transfer patient". The agreement specifies: "Often Rescue providers are asked to assist during an emergency for non-EMS patients in emergency rooms, radiology departments and occasionally on the patient floors..... The care provided is done in the usual domain/locale where EMS provider activities are performed..... The care provided is within approved, normal scope of care of that EMS provider."</p> <p>Provision of care by EMS was noted to have occurred when nursing staff summoned Rescue, Inc to assist with the management of Patient #1 at 04:20 on 2/21/14. The patient got out of bed</p>	C 273	<p>see attachment 4 Plan of correction Issue #1 page 4</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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C 273	<p>Continued From page 15</p> <p>without assistance, fell and proceeded to crawl into the bathroom. At the time of the incident, staffing at the CAH included 2 RNs and 1 LPN, 2 out of the 3 staff members were male whom Patient #1 expressed dislike and demanded they not provide care. Without any other CAH staff available to provide assistance, the decision was made to call Rescue, Inc. Upon arrival staff from Rescue, Inc. entered Patient #1's room, conversed with Patient #1 while s/he laid on the bathroom floor. Eventually, Patient #1 accepted assistance from Rescue, Inc staff who guided Patient #1 back to bed and conducted an assessment to rule out potential injury.</p> <p>Per interview on the afternoon of 2/27/14 the CNO confirmed the CAH had not developed a patient care policy and procedure to describe the services furnished through agreement with Rescue, Inc. The CNO further acknowledged, the CAH historically had a long standing arrangement with Rescue, Inc, however s/he had expressed concerns regarding the concept of utilizing Rescue, Inc staff to assist with in-patient care.</p> <p>2. Per record review, Patient #1 received the administration of a involuntary emergency medication during the evening of 2/21/14. Prior to the administration of the medication, the CNO gave approval to the RN charge nurse to contact the Windham County Sheriff's office requesting a sheriff be provided to assist staff as needed during a behavioral emergency involving Patient #1. Shortly after arrival of the Sheriff from Windham County, decision is made by Physician #1 to administer an injection of Haldol to Patient #1. While the patient sat in his/her wheelchair in Room #2, the Sheriff assisted CAH staff with</p>	C 273	<p>see attachment 4 Plan of correction Issue #2 (page 4)</p>	
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C 273	<p>Continued From page 16</p> <p>hands on restraint of Patient #1 while Physician #1 administered the injection into Patient #1's left arm.</p> <p>A contract exists between the Windham County Sheriff's Department and the CAH dated 2/1/15 - 1/31/15 for the use of law enforcement services. The CNO confirmed on the afternoon of 2/27/14 no written patient care policy existed defining for staff the circumstances during which the use of sheriff department personnel would be requested.</p> <p>3. On 2/27/14 Patient #1 required transportation to another hospital for diagnostic testing. The decision by CAH staff on 2/26/14 was to send Patient #1, who has both physical and mental deficits with behavioral issues and poor safety awareness, without CAH personnel and only accompanied by Patient #1's significant other. Upon discussion with surveyors on 2/26/14, CAH administrative staff recognized sending Patient #1 without a CAH staff escort was a safety risk. Staff was subsequently assigned to accompany Patient #1 during transport and testing. Upon further discussion on 2/27/14 at 3:50 PM, the CNO confirmed the CAH has not developed a patient care policy regarding transport of patients to another facility for testing, to include the level of supervision required, the degree of assistance needed and evaluation of safety precautions if necessary.</p> <p>4. Per record review, on 2/26/14, Patient #2 had a physician progress note, dated 12/31/13 that indicated the patient had developed a pressure ulcer on his/her right heel. Despite the documentation, by Physician #1, that stated; ".....on [his/her] right heel [s/he] has a 1 cm(2) area that is tender to palpation with a Q-tip and is</p>	C 273	<p><i>see attachment 4 Plan of correction Issue # 3 (Page #)</i></p> <p><i>see attachment 4 Plan of correction Issue # 4 (Page #)</i></p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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C 273	Continued From page 17 non-blanchable and necrotic. Photograph taken....", there was no photograph of the wound included as part of the patient's health information and medical treatment in his/her medical record. During interview, at 3:28 PM on the afternoon of 2/27/14, Physician #1 confirmed that s/he had taken a photograph of Patient #2's pressure ulcer, had used his/her personal cell phone to capture the image and that the image was still stored on the phone. The CNO (Chief Nursing Officer), confirmed, during interview at 3:33 PM, that staff should not use personal cell phones to take pictures of patients. S/he further stated that although pictures used as part of a patient's health information and medical treatment should be obtained using the facility's camera, there was currently no established policy and procedure to reflect the use of pictures/images for that purpose.	C 273		
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 interview and record review, CAH staff failed to follow a physician's order to obtain a wound culture for 1 applicable patient. (Patient # 5) Findings include: Per record review, Patient #5 was admitted to the CAH on 2/14/14 for the management and treatment of a non-healing cellulitis and abscess	C 278	see attachment 5 Plan of correction (page)	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2014
FORM APPROVED
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C 278	Continued From page 18 of wound of the left ankle. Admission orders included obtaining a wound culture. There was no evidence in the record a wound culture was obtained nor did the laboratory have evidence a culture was received. Per interview on the afternoon of 2/26/14, the Nurse Manager confirmed nursing staff failed to follow a physician order to obtain a wound culture.	C 278		
C 294	<p>485.635(d) NURSING SERVICES</p> <p>Nursing services must meet the needs of patients.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, Nursing Services failed to meet the needs of patients identified as at risk for falls and skin breakdown. (Patients #1, #2 and #5). Findings include:</p> <p>1. Per record review, nursing staff failed to prevent development of a pressure ulcer for Patient #2, who was admitted on 12/20/14 for rehabilitation following an accident in which s/he sustained multiple traumatic injuries which left him/her immobile in bed. The patient, who was admitted with no evidence of any existing pressure ulcers, was identified, through use of the Braden Scale Assessment on 12/20/13, as being at risk for skin breakdown. Despite the identified risk, there was no evidence that staff had implemented interventions to prevent skin breakdown, which were indicated in the CAH's Skin Breakdown Prevention policy and included; Frequent turning, Maximal remobilization, Protect heels, Manage moisture, nutrition, friction and shear, and Pressure reducing support surface if bed or chair bound. A nursing progress note, dated 12/30/13 at 4:08 PM, indicated the patient's</p>	C 294	<p>see attachment 6 Plan of correction Issue # 4a (page 6)</p>	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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C 294	Continued From page 19 right heel was slightly boggy with some discoloration. A subsequent Interdisciplinary Team Meeting nursing note, dated 12/31/13 at 1:14 PM, identified ".....right heel pressure sore with dime size ulcer stage 2 , foot has been elevated with pillow and no pressure to heel site to promote healing.." In addition, although staff identified a pressure ulcer on Patient #2's right heel on 12/30/13 the care plan for Impaired Skin Integrity, which included goals and interventions to facilitate wound healing, was not initiated until 1/10/14. During interview, on the afternoon of 2/27/14, the Nurse Manager and the CNO (Chief Nursing Officer), both acknowledged the lack of evidence that strategies to prevent skin breakdown had been implemented prior to identification of a pressure ulcer on 12/30/13. Both also confirmed the care plan had not been revised to reflect the patient's heel pressure ulcer until 1/10/14. 2. Per record review, nursing services failed to meet the needs of a patient identified at high risk for falls. Patient #1, admitted to the CAH on 1/21/14 for rehabilitation after experiencing a stroke resulting in physical, neurological and behavioral deficits. At the time of admission and utilizing the Morse Fall Scale (MFS), nursing staff screened Patient # 1 at a score of 90 (45 or higher ranked a patient to be at High Risk risk for falls). The policy further directs staff to initiate "High Fall Risk Precautions" to include bed/chair alarm, rounding hourly, placing "Falling Star" placard on door jamb of patient's room along with placing bed in low position. Nursing progress note for 1/21/14 at 23:37 states "...s/he is a fall risk; has made no attempts to get out of bed so as of now s/he is not on alarms". However, within hours	C 294	see attachment 6 Plan of correction Issue # 10 10 (page) see attachment 6 Plan of correction Issue # 2 (page)		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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C 294	<p>Continued From page 20</p> <p>of admission, at 7:00 AM on 1/22/14 Patient #1 was found on the floor in his/her room, face down naked sustaining a bruise to his/her left temple, shoulder and hand. Patient #1 also complained of pain across shoulders, neck and head. After the fall, Patient #1 was placed in a high low bed, mats were positioned beside the bed and alarms were put in place. Per interview on 2/27/14 at 8:45 AM, the Nurse Manager confirmed the staff nurse on 1/21/14 failed to meet the patient needs by not following CAH policy and procedures related to fall prevention protocols.</p> <p>3. Nursing services failed to meet the needs of a patient with identified fragility and at risk for falls. On 2/14/14 Patient #5, age 96, was admitted to the CAH for treatment of a non-healing ulcer/cellulitis of the left ankle. Per nursing progress note for 2/14/14 at 1740 describes Patient #5 as "...slow unsteady gate, malnutrition at 78 lbs, thin and frail...". A nursing progress note for 2/15/14 states " Approx. 1600 Pt was heard crying out from the Hospice family room. Nursing found pt on the floor, shaken up. S/he had reached for a wooden chair and missed, landing on the floor stating pain under R arm/rib area. VS were elevated and s/he was shaky and not making much sense.....chair and bed alarms have been put into place". Per interview on the afternoon of 2/27/14, the Nurse Manager stated s/he was involved with Patient #5's admission and had directed other nursing staff to imitate fall risk interventions. However s/he acknowledged despite Patient #5's obvious physical compromise and risk for falls, staff failed to assure that care and services were provided in accordance with CAH Fall Prevention and use of the Morse Fall Scale policy.</p>	C 294	<p>see attachment to Plan of correction Issue #3 (_____)</p>	
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C 295 Continued From page 21
C 295 485.635(d)(1) NURSING SERVICES

C 295
C 295

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 accordance with the patient's needs and the specialized qualifications and competence of the staff available.

This STANDARD is not met as evidenced by:
Based on interview and record review, there was a failure of nursing services to initiate care for 2 applicable patients with demonstrated needs requiring ongoing monitoring and interventions for fall prevention, Patients # 1 and #5; failure to implement care for 1 applicable patient identified to be at risk for impaired skin integrity and breakdown (Patient #2); and failure of nursing services to follow physician orders for 1 applicable patient (Patient #5). Findings include:

1. On 2/21/14 nursing staff failed to initiate the Fall Prevention Protocol after Patient #1 was identified using the Morse Fall Scale to be at high risk for falls requiring specific interventions. Although upon admission Patient #1 scored a 90 (45 or higher ranked a patient to be at High Risk risk for falls) and was identified to have physical, neurological and behavioral deficits after experiencing a stroke resulting in neurosurgery, nursing staff failed to initiate safety protocols to prevent Patient #1 from experiencing a fall. High Fall Risk precautions include a chair and bed alarm, providing a low bed, placing a "Falling Star" placard on the door jamb of the patient's room and hourly rounding. On 2/22/14 at 0700 Patient #1 was found on the floor in his/her room

*see attachment 7
Plan of correction
Issue # 1a
(~~page 7~~)*

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
C 295	<p>Continued From page 22</p> <p>naked and complaining of pain in left shoulder and hand and sustained a bruise to the left temple.</p> <p>Patient #1 also experienced a second fall when nursing staff failed to meet Patient #1's safety needs when s/he was left unattended on a toilet by a nurse on 2/15/14 at 19:30, resulting in the patient being found on the bathroom floor resulting in the patient complaining of pain on his/her right side and elbow.</p> <p>Per interview on 2/27/14 at 8:45 AM, the Nurse Manager confirmed the staff nurse on 1/21/14 failed to meet the Patient #1's needs related to fall prevention. In addition, the Nurse Manager acknowledged Patient #1 should not have been left alone on the toilet on 2/15/14, noting the staff nurse used poor judgement by not identifying the potential fall risk when leaving Patient #1 unattended.</p> <p>2. Per record review nursing staff failed to prevent the development of a pressure ulcer for Patient #2, who was admitted on 12/20/14 for rehabilitation following an accident in which s/he sustained multiple traumatic injuries which left him/her immobile in bed. The patient, who was admitted with no evidence of any existing pressure ulcers, was identified, through use of the Braden Scale Assessment on 12/20/13, as being at risk for skin breakdown. Despite the identified risk, there was no evidence that staff had implemented interventions to prevent skin breakdown, which were indicated in the CAH's Skin Breakdown Prevention policy and included; Frequent turning, Maximal remobilization, Protect heels, Manage moisture, nutrition, friction and shear, and Pressure reducing support surface if</p>	C 295	<p>see attachment 7 Plan of correction Issue # 1 b (page 2)</p> <p>see attachment 7 Plan of correction Issue # 2 (page 2)</p>		

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C 295	<p>Continued From page 23</p> <p>bed or chair bound. A nursing progress note, dated 12/30/13 at 4:08 PM, indicated the patient's right heel was slightly boggy with some discoloration. A subsequent Interdisciplinary Team Meeting nursing note, dated 12/31/13 at 1:14 PM, identified ".....right heel pressure sore with dime size ulcer stage 2 , foot has been elevated with pillow and no pressure to heel site to promote healing.." In addition, although staff identified a pressure ulcer on Patient #2's right heel on 12/30/13 the care plan for Impaired Skin Integrity, which included goals and interventions to facilitate wound healing, was not initiated until 1/10/14.</p> <p>During interview, on the afternoon of 2/27/14, the Nurse Manager and the CNO (Chief Nursing Officer), both acknowledged the lack of evidence that strategies to prevent skin breakdown had been implemented prior to identification of a pressure ulcer on 12/30/13. Both also confirmed the care plan had not been revised to reflect the patient's heel pressure ulcer until 1/10/14.</p> <p>3. On 2/14/14 Patient #5, age 96, was admitted to the CAH for treatment of a non-healing leg ulcer/cellulitis of the left ankle. Per nursing progress note for 2/14/14 at 1740 describes Patient #5 as "...slow unsteady gate, malnutrition at 78 lbs, thin and frail...". A nursing progress note for 2/15/14 states " Approx. 1600 Pt was heard crying out from the Hospice family room. Nursing found pt on the floor, shaken up. S/he had reached for a wooden chair and missed, landing on the floor stating pain under R arm/rib area. VS were elevated and s/he was shaky and not making much sense.....chair and bed alarms have been put into place". Per interview on the afternoon of 2/27/14, the Nurse Manager stated</p>	C 295	<p><i>see attachment 7 Plan of correction Issue # 3 (page 7)</i></p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2014
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C 295	Continued From page 24 s/he was involved with Patient #5's admission and had directed other nursing staff to imitate fall risk interventions. However s/he acknowledged despite Patient #5's obvious physical compromise and risk for falls, nursing staff failed to provide care to this elderly patient in accordance with the identified needs to assure safety and freedom from injury.	C 295		
C 298	485.635(d)(4) NURSING SERVICES A nursing care plan must be developed and kept current for each inpatient. This STANDARD is not met as evidenced by: Based on interview and record review the Nursing Care Plan was not revised to address fall interventions in an effort to reduce falls and injury for 1 applicable patient. (Patient #1) and failure to develop a care plan upon admission to reflect identified potential risks for skin breakdown for 1 applicable patient. (Patient #2) Findings include: 1. Per record review nursing staff failed to develop and revise in a timely manner, the care plan for Patient #2, to reflect the patient's risk for skin breakdown and the actual development of a pressure ulcer. The patient was admitted on 12/20/13 for rehabilitation following an accident in which s/he sustained multiple traumatic injuries which left him/her immobile in bed. Although Patient #2, admitted with no evidence of any existing pressure ulcers, was identified as being at risk for skin breakdown, the care plan did not reflect the identified risk. A nursing progress note, dated 12/30/13 at 4:08 PM, indicated the patient's right heel was slightly boggy with some discoloration. A subsequent Interdisciplinary Team Meeting nursing note, dated 12/31/13 at	C 298	see attachment 8 Plan of correction Issue # 1 (page)	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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C 298	<p>Continued From page 25</p> <p>1:14 PM, identified ".....right heel pressure sore with dime size ulcer stage 2 , foot has been elevated with pillow and no pressure to heel site to promote healing.." Despite the identification of a pressure ulcer on Patient #2's right heel on 12/30/13 the care plan for Impaired Skin Integrity, which included goals and interventions to facilitate wound healing, was not initiated until 1/10/14.</p> <p>During interview, on the afternoon of 2/27/14, the Nurse Manager and the CNO (Chief Nursing Officer), both confirmed the care plan had not reflected the patient's risk for skin breakdown and had not been revised to reflect the patient's heel pressure ulcer until 1/10/14.</p> <p>2. Per record review, on 12/24/13 Patient #1 experienced a nontraumatic cerebral hemorrhage (stroke) requiring neurosurgery. Post operative complications included seizures, impaired cognition, swallowing and mobility deficits. On 1/21/14 Patient #1 was transferred to the CAH for rehabilitation. Shortly after admission to the CAH Patient #1 demonstrated erratic behaviors including paranoia, impulsivity, anger, belligerence toward staff and was assessed to be at high fall risk, subsequently experiencing multiple falls at the CAH. Review of Patient #1's Interdisciplinary Team Meeting notes, where multiple CAH's disciplines discuss Patient #1's progress, therapies, discharge plans and review/revise the care plan. Although "Risk for Falls Plan of Care" was initiated on 1/21/14, there was a lack of evidence to demonstrate additional precautions or interventions to be attempted in order to prevent further falls. Despite the "High Fall Risk Precautions", no other interventions were discussed or incorporated into Patient #1's</p>	C 298	<p><i>see attachment 8</i> <i>Plan of correction</i> <i>Issue #2</i> <i>(page 8)</i></p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

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C 298	Continued From page 26 care plan in an effort to prevent further falls with injury. Patient #1 had sustained 6 falls, some with injury during CAH hospitalization from 1/21/14 through 2/28/14.	C 298		
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 staff interview and record review, The Electronic Medical Record (EMR) was not readily accessible and systematically organized to provide evidence to reflect provision of specific care and services. CAH staff failed to accurately document the interventions and provision of care provided for 1 applicable patient with impaired skin integrity (Patient #2). The CAH staff failed to complete required documentation after the use of restraint and administration of an involuntary emergency medication for 1 applicable patient. (Patient #1) Findings include: Per record review nursing staff failed to consistently and accurately document the description of an identified pressure ulcer for Patient #2, admitted on 12/20/14 for rehabilitation following an accident in which s/he sustained multiple traumatic injuries which left him/her immobile in bed. The patient, who was admitted with no evidence of any existing pressure ulcers, had a nursing progress note, dated 12/30/13 at 4:08 PM which indicated the patient's right "heel was slightly boggy with dry skin splits that pt says [s/he] gets, with a couple of discolored areas black/blue." A note, at 7:00 PM on the same date, identified the area as "darkened, bruised area on	C 302		

*see attachment 9
Plan of Correction
Issue # 1
(page 2)*

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

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C 302	<p>Continued From page 27</p> <p>heel, blanchable. Skin on heel dry and cracked but otherwise intact." On 12/31/13 at 6:00 AM, the note described the wound as a 2cm x 2cm Stage 3 (open ulcer -full thickness tissue loss), however, it identified the wound tissue as intact. An Interdisciplinary Team Meeting nursing note, also dated 12/31/13 at 1:14 PM, identified ".....right heal pressure sore with dime size ulcer stage 2...." (open, shallow ulcer or intact blister like area) The next note that described the right heel pressure wound was dated 1/4/14 and identified a Stage 1 wound. A subsequent right heel wound assessment, dated 1/10/14 indicated a Stage 2 wound with wound bed tissue type identified as necrotic tissue, eschar. On 1/15/14 the note stated the pressure wound was "tender to touch, spot of necrotic black tissue" and in a final note on 1/19/14 the wound is described as "dry, cracked bruising". In addition, although a physician progress note, dated 12/31/13 indicated that a photograph of the wound had been obtained on that date, there was no evidence of the photograph in the medical record.</p> <p>During interview, on the afternoon of 2/27/14, the Nurse Manager and the CNO (Chief Nursing Officer), both confirmed the description of the patient's pressure ulcer was inconsistently and inaccurately documented and both stated they were unable to determine in the medical record when the wound was healed. The CNO further confirmed that there was no photograph of the wound in the patient's medical record.</p> <p>2. Per policy Involuntary Procedures and Use of Restraints last reviewed on 8/28/13 states "Restraint is the direct application of physical force to a patient, with or without the patient's permission, to restrict his/her freedom of</p>	C 302	<p>see attachment 9 Plan of corrections Issue #2 ()</p>	
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C 302	Continued From page 28 movement...Holding a patient and restricting movement constitutes restraining him/her". Per interview on 2/26/14 at 8:35 AM, the Charge Nurse on the evening of 2/21/14 confirmed Patient #1 was physically restrained with "hands on" patient limbs by the Deputy, the Charge Nurse and other nursing staff during the administration of an involuntary emergency medication. Although the policy further states "9. A Certificate of Need (CON) for emergency restraint shall be entered in the patient's record that documents emergency circumstances requiring the use of restraints...." and ".....when involuntary medication s are administered will be completed by the provider..." there was no evidence in the medical record a CON was completed by Physician #1. Per interview on 2/27/14 at 9:45 AM, the Nurse Manager confirmed ".....the policy was not followed...." and there was no evidence in the Electronic Medical Record or paper record, a CON had been completed.	C 302			
C 306	485.638(a)(4)(iii) RECORDS SYSTEMS [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-] all orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics and progress notes describing the patient's response to treatments; [and]	C 306	see attachment 10 Plan of Correction (pages 1-12)		

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

PRINTED: 03/14/2014
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C 306	<p>Continued From page 29</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review there was a failure within the EMR to accurately provide information for the ongoing monitoring of an identified wound and the inability to determine when a wound was healed for 1 applicable patient (Patient #2) and the failure to acknowledge and promptly respond to a physician order to obtain a wound culture for 1 applicable patient. (Patient #5) Findings include:</p> <p>1. Per record review nursing staff failed to consistently and accurately document the description of an identified pressure ulcer for Patient #2, admitted on 12/20/14 for rehabilitation following an accident in which s/he sustained multiple traumatic injuries which left him/her immobile in bed. The patient, who was admitted with no evidence of any existing pressure ulcers, had a nursing progress note, dated 12/30/13 at 4:08 PM which indicated the patient's right "heel was slightly boggy with dry skin splits that pt says [s/he] gets, with a couple of discolored areas black/blue." A note, at 7:00 PM on the same date, identified the area as "darkened, bruised area on heel, blanchable. Skin on heel dry and cracked but otherwise intact." On 12/31/13 at 6:00 AM, the note described the wound as a 2cm x 2cm Stage 3, however, it identified the wound tissue as intact. An Interdisciplinary Team Meeting nursing note, also dated 12/31/13 at 1:14 PM, identified ".....right heel pressure sore with dime size ulcer stage 2...." The next note that described the right heel pressure wound was dated 1/4/14 and identified a Stage 1 wound. A subsequent right heel wound assessment, dated 1/10/14 indicated a Stage 2 wound with wound bed tissue type identified as necrotic tissue, eschar. On 1/15/14</p>	C 306	<p>See attachment 10 Plan of correction Issue # 1 (Page)</p>	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2014
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 OMB NO. 0938-0391

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C 306	Continued From page 30 the note stated the pressure wound was "tender to touch, spot of necrotic black tissue" and in a final note on 1/19/14 the wound is described as "dry, cracked bruising". During interview, on the afternoon of 2/27/14, the Nurse Manager and the CNO (Chief Nursing Officer), both confirmed the description of the patient's pressure ulcer was inconsistently and inaccurately documented and both stated they were unable to determine in the medical record when the wound was healed. 2. Per record review, Patient #5 was admitted to the CAH on 2/14/14 for the management and treatment of a non-healing cellulitis and abscess of wound of the left ankle. Admission orders included obtaining a wound culture. There was no evidence in the record a wound culture was obtained. Per interview on the afternoon of 2/26/14, the Nurse Manager confirmed the EMR lacked evidence whether staff had followed physician orders.	C 306		
C 330	485.641 PERIODIC EVALUATION & QA REVIEW Periodic Evaluation and Quality Assurance Review This CONDITION is not met as evidenced by: Based on staff interviews and record review the Condition of Participation: Periodic Evaluation and Quality Assurance Review was not met as evidenced by the failure of the CAH to ensure all patient care services and other services affecting patient health and safety had an effective and	C 330		

*See attachment 10
 Plan of correction
 Issue #2
 (page 10)*

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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C 330 Continued From page 31 responsive Quality Assurance Program.

There was a failure to identify opportunities for improvement to include: Administration of emergency medication without following policy and procedure; failure to effectively evaluate patient falls and implement further interventions to prevent falls; failure to evaluate the necessity to utilize non-hospital employees with the provision of patient care; failure to identify the development and prevention of pressure ulcers; and failure of consistent auditing and monitoring of the provision of services.

C 330

C 337 Refer to C-337 485.641(b)(1) QUALITY ASSURANCE

The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that-

all patient care services and other services affecting patient health and safety are evaluated.

C 337

*see attachments
91 page 1 & 2
(~~page 1 & 2~~)*

This STANDARD is not met as evidenced by:
Based on interview and record review, the CAH failed to monitor and evaluate patient care services for quality purposes, and failed to identify opportunities for improvement of those services including: the failure to identify that patient care services were not provided in accordance with established policies and procedures regarding Involuntary Procedures and Use of Restraints, Skin Breakdown Prevention and Fall Prevention;

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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C 337	<p>Continued From page 32</p> <p>failure to recognize the lack of policies and procedures to direct and guide staff regarding the roles and expectations of law enforcement and Rescue organization personnel to assist in the provision of care and treatment of patients; the use of pictures/images of patients to be considered in the health information and medical treatment of patients; and assessment and needs of patients who require transport to other facilities. Findings include:</p> <p>1. Per record review nursing staff failed to provide care in accordance with the facility's Skin Breakdown Prevention policy for Patient #2, admitted on 12/20/14 for rehabilitation following an accident in which s/he sustained multiple traumatic injuries which left him/her immobile in bed. Per the policy, dated 12/4/09, and last reviewed 8/28/13, a Braden Scale Score of 15 - 18 indicates a mild risk for skin breakdown, for which the following interventions should be implemented: Frequent turning, Maximal remobilization, Protect heels, Manage moisture, nutrition, friction and shear, and Pressure reducing support surface if bed or chair bound. Although Patient #2 had a Braden Risk Assessment Scale completed on 12/20/13 which identified a score of 15, there was no indication that any of the identified interventions had been implemented. The patient, who was admitted with no evidence of any existing pressure ulcers, developed a ".....right heel pressure sore with dime size ulcer stage 2 ...", and, despite the identification of the pressure ulcer on 12/30/13, the care plan for Impaired Skin Integrity which included goals and interventions to facilitate wound healing, was not initiated until 1/10/14.</p> <p>During interview, on the afternoon of 2/27/14, the</p>	C 337	<p><i>see attachment 11 page 1 of 2</i></p> <p><i>Plan of correction Issue #1 (Page 1)</i></p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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C 337	<p>Continued From page 33</p> <p>Nurse Manager and the CNO (Chief Nursing Officer), both confirmed that the Skin Breakdown Prevention Policy had not been followed, and interventions to prevent skin breakdown should have been implemented on admission when the patient had been identified as at risk for breakdown. The CNO further confirmed that although the patient had developed the pressure wound after admission to the CAH there had been no quality review of the medical record to determine whether or not the wound had been avoidable and therefore, no opportunity for improvement in skin breakdown prevention had been identified.</p> <p>2. Per record review, CAH nursing staff failed to provide care in accordance with the facility policy Fall Prevention and the use of the Morse Fall Scale last reviewed 11/3/13 for Patients #1 & #5. The policy directs staff to initiate "High Fall Risk Precautions" to include bed/charm alarm, rounding hourly, placing "Falling Star" placard on door jamb of patient's room along with placing bed in low position. Patient #1 was admitted to the CAH on 1/21/14 for rehabilitation after experiencing a stroke resulting in physical, neurological and behavioral deficits. At the time of admission and utilizing the Morse Fall Scale (MFS), nursing staff screened Patient #1 at a score of 90 (45 or higher ranked a patient to be at High Risk risk for falls). Despite the identification of high fall risk staff failed to follow the policy and did not implement use of bed/chair alarms and the patient sustained a fall within hours of admission resulting in injuries. In addition, staff again failed to follow the facility policy when, on 2/15/14, Patient #1 was left unattended in the bathroom and sustained another fall.</p>	C 337	<p>see attachment 11 page 1 Plan of Correction Issue #2 (_____)</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2014
NAME OF PROVIDER OR SUPPLIER GRACE COTTAGE HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 216 TOWNSHEND, VT 05353		
(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 337	<p>Continued From page 34</p> <p>Patient #5, admitted on 2/14/14 for treatment of a non-healing ulcer/cellulitis of the left ankle, was described in a nursing note as "...slow unsteady gate, malnutrition at 78 lbs, thin and frail..." Per interview, on the afternoon of 2/27/14, the Nurse Manager stated s/he was involved with Patient #5's admission and had directed other nursing staff to initiate fall risk interventions. Despite the nursing assessment, bed/chair alarms had not been initiated in accordance with the policy and Patient #5 sustained a fall on 2/15/14.</p> <p>Per interview on 2/27/14 at 8:45 AM, the Nurse Manager confirmed that nursing staff failed to follow CAH policy and procedures related to fall prevention protocols for Patients #1 and #5. In addition, the CNO and the Director of Quality both confirmed during interview, on</p> <p>3. Per record review, a CON (Certificate of Need) was not completed in accordance with the CAH's policy for Involuntary Procedures and Use of Restraints, regarding the physical restraint and administration of an involuntary medication to Patient #1. Per review the policy states: "9. A Certificate of Need (CON) for emergency restraint shall be entered in the patient's record that documents emergency circumstances requiring the use of restraints..." and ".....when involuntary medications are administered will be completed by the provider." Although the patient was restrained, on 2/21/14, for the purpose of administration of an involuntary medication by Physician #1, there was no evidence in the medical record a CON was completed by the physician.</p> <p>Per interview on 2/27/14 at 9:45 AM, the Nurse</p>	C 337	<p>See attachment 11 page 2 of 2</p> <p>Plan of Correction Issue #3 ()</p>	

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

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2014
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NAME OF PROVIDER OR SUPPLIER GRACE COTTAGE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 216 TOWNSHEND, VT 05353
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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C 337	<p>Continued From page 35</p> <p>Manager confirmed ".....the policy was not followed...." further acknowledging the Involuntary Procedures and Use of Restraints policy has not been utilized prior to 2/21/14 noting "...we have not had to use restraints...". Furthermore there was no debriefing with either the patient or staff involved including the physician after the procedures took place, which is also required by CAH policy. The CNO confirmed, during interview on the afternoon of 2/27/14, that there had been no quality review of Patient #1's medical record related to the use of restraints and involuntary medication administration and the failure to identify opportunity for improvement in the use of restraints and emergency involuntary procedures.</p> <p>4. Per record review the CAH failed to establish a policy and procedure to direct and guide staff in the utilization of non hospital personnel, including Rescue, Inc. and the Windham County Sheriff's Department to assist in providing direct care and/or medical treatment for Patient #1. Per record review nurses notes reflect, and staff confirmed, the use of members from Rescue, Inc., non hospital employees, to augment staff during circumstances when additional staff support was deemed essential to meet the needs of patients. Provision of care by EMS was noted to have occurred when nursing staff summoned Rescue, Inc to assist with the management of Patient #1 at 04:20 on 2/21/14. The patient got out of bed without assistance, fell and proceeded to crawl into the bathroom. At the time of the incident, staffing at the CAH included 2 RNs and 1 LPN, 2 out of the 3 staff members were male whom Patient #1 expressed dislike and demanded they not provide care. Without any other CAH staff available to provide assistance, the decision was made to call Rescue, Inc. Upon</p>	C 337	<p>see attachment 11 page 2 of 2</p> <p>Plan of Correction Issue # 4 (page 12)</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2014
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NAME OF PROVIDER OR SUPPLIER GRACE COTTAGE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 216 TOWNSHEND, VT 05353
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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C 337	<p>Continued From page 36</p> <p>arrival staff from Rescue, Inc. entered Patient #1's room, conversed with Patient #1 while s/he laid on the bathroom floor. Eventually, Patient #1 accepted assistance from Rescue, Inc staff who guided Patient #1 back to bed and conducted an assessment to rule out any potential injury.</p> <p>Per record the CNO gave approval to the RN charge nurse, on the evening of 2/21/14, to contact the Windham County Sheriff's office requesting a sheriff be provided to assist staff as needed during the behavioral emergency involving Patient #1. The record indicated that the Sheriff assisted staff in physically restraining Patient #1 while an involuntary medication was administered by Physician #1.</p> <p>Although a contract exists between the Windham County Sheriff's Department and the CAH for the use of law enforcement services, the CNO confirmed on the afternoon of 2/27/14, that no written patient care policy existed defining for staff the circumstances during which the use of sheriff department personnel would be requested. The CNO further confirmed the CAH had not developed a patient care policy and procedure to describe the services furnished through agreement with Rescue, Inc. S/he acknowledged, the CAH historically had a long standing arrangement with Rescue, Inc, however s/he had expressed concerns regarding the concept of utilizing Rescue, Inc staff to assist with in-patient care.</p> <p>5. On 2/27/14 Patient #1 required transportation to another hospital for diagnostic testing. The decision by CAH staff on 2/26/14 was to send Patient #1, who has both physical and mental deficits with behavioral issues and poor safety</p>	C 337	<p>see attachment 11 page 2 of 2 Plan of Correction Issue # 5 (page 2)</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2014
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2014
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NAME OF PROVIDER OR SUPPLIER GRACE COTTAGE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 216 TOWNSHEND, VT 05353
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C 337	<p>Continued From page 37</p> <p>awareness, without CAH personnel and only accompanied by Patient #1's significant other. Upon discussion with surveyors on 2/26/14, CAH administrative staff recognized sending Patient #1 without a CAH staff escort was a safety risk. Staff was subsequently assigned to accompany Patient #1 during transport and testing. Upon further discussion on 2/27/14 at 3:50 PM, the CNO confirmed the CAH has not developed a patient care policy regarding transport of patients to another facility for testing, to include the level of supervision required, the degree of assistance needed and evaluation of safety precautions if necessary.</p> <p>6. Per record review Physician #2's personal cell phone was used to obtain an image of Patient #2's pressure wound. The physician confirmed, during interview on the afternoon of 2/27/14, that the image was still stored on his/her phone and had not been included in the patient's medical record. During interview on the afternoon of 2/27/14 the CNO confirmed that although the CAH did possess a camera for the use of obtaining patient pictures/images for consideration in the patient's health history or medical treatment, there is no policy and procedure to direct and guide staff in the use of patient pictures/images.</p> <p>Per interview on 2/26/14 at 2:03 PM the Director of Quality/Compliance confirmed although there have been significant events involving the care and services provided to Patient #1 to include instances of at least 6 falls since admission on 1/24/14, s/he had not reviewed each individual event, stating it was the responsibility of the CNO and Nurse Manager. The Director also confirmed his/her awareness of nursing staff utilizing</p>	C 337	<p><i>See Attachment 11 page 2 of 2 Plan of correction Issue #6 (page 12)</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2014
NAME OF PROVIDER OR SUPPLIER GRACE COTTAGE HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 216 TOWNSHEND, VT 05353		
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C 337	Continued From page 38 Rescue, Inc during an incident with Patient #1 on 2/21/14, but failed to evaluate circumstances for the need to augment staff with EMS personnel. In addition, the Director failed to identify the opportunity for improvement after Patient #1 was physically restrained and administered emergency involuntary medication. As per Involuntary Procedures and Use of Restraints policy states "All instances of involuntary administration of medication, chemical and mechanical restraints, should be automatically, independently and regularly reviewed." At the time of interview, the Director confirmed an evaluation of the involuntary procedures, experienced by Patient #1 on the evening of 2/21/14, had not been conducted to include the appropriateness of the medication and its dosage, whether alternatives were available and offered or whether the required documentation was complete. The Director stated a Root Cause Analysis was pending in the near future.	C 337		

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ATTACHMENT #1 – GRACE COTTAGE HOSPITAL – PROVIDER # 471300

Tag C151 – 485.608(a) Compliance with Federal Laws and Regulations

Tag C151, Issue #1 – Photograph of wound

Plan of Correction:

The photo in question was taken by a member of the Medical Staff who was spoken to during the time of the survey. He agrees to refrain from doing this again. Further, a Photographing, Video Recording, or Recording Device Policy has been completed. The Quality Director educated the Medical Staff at the 3/13/14 Medical Staff meeting regarding prohibition of cell phone and/or personal device use of picture taking of patients and patient's wounds. The Medical Staff was instructed to use the camera that is on the Med/Surg unit to document wound care or other pertinent pictures needed for treatment, care, and reporting. The camera, instructions for the camera operation and uploading the photos into patient's electronic medical record are stored in the triangle shaped room on the unit effective 3/19/14. This information was relayed to the Medical Staff at the March Medical Staff meeting. Nursing administration will educate the nursing staff on the implementation of the policy and procedures of photographing patients at the 3/26 & 28/14 staff meeting. The new policy "Photographing, Video Recording, or Recording Device Policy" will be distributed at the 4/10/14 Medical Staff meeting. Any/all photographs taken of patient's wounds will be uploaded and appended to the patient's EMR and then deleted from the camera effective immediately (see attachment #1A and #1B).

Addendum: 4/2/2014

Policy was reviewed with the staff by the CNO at the mandatory nursing meetings, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The policy is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the policy, and will adhere to the policy.

The medical staff will sign off that they will adhere to the policy and refrain from using personal devices for photography. This will be shown by the attendance sheet from the Medical Staff meeting on April 10, 2014. Any physician not in attendance will be spoken to directly by the Quality Director. Any known violation of the policy will be reported to the Quality Department for follow up.

Tag C151, Issue #2 – Use of Rescue, Inc. personnel

Plan of Correction:

Nursing staff have been notified via email, 3/19/14 (attachment #1C), not to use Rescue, Inc. personnel for anything other than a true emergency situation in the Emergency Department. A policy regarding the use of non-hospital personnel is in development. Expected date of completion is 4/23/14 for presentation to the hospital Quality Committee.

Rescue, Inc., Interim Chief, Drew Hazelton was informed on 3/20/14 that his employees are not to render care in the inpatient unit.



Attachment 1 continued

Addendum: 4/2/2014

The issue of not using Rescue Inc. personnel (see above) was reviewed with the staff by the CNO at the mandatory nursing meetings, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The hospital policy, once developed, will be posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the plan and will adhere to it.

Medical staff will be educated at the ER committee meeting on 4/2/14 by the CMO and on 4/10 at the Medical Staff Meeting, not to use EMS for anything other than a true emergency.

Any time Rescue Inc./EMS persannel are used for anything other than transition in care (during drop off or pick up) an occurrence report will be filed with the quality department for review and appropriate follow up as will be stated in the policy.

C151 POC accepted 4/10/14 Fmcintosh RN/PMC

A handwritten signature in black ink, appearing to be 'FMCINTOSH'.

SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 1 OF: 4
APPROVED BY:	EFFECTIVE:
AUTHORED BY: Elaine Swift, Quality Director	REVISED:

POLICY: Grace Cottage Hospital (GCH) must take reasonable steps to protect patients, visitors, and staff members from unauthorized photography, video or audio recordings, or other images. Due to the sensitive nature of patient information and to protect patient privacy, the facility must follow the guidelines and procedures outlined below before allowing, or prior to, photographing, video or audio recording, or otherwise imaging of patients, visitors or staff members.

PURPOSE:

1. To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and any and all other federal regulations and interpretive guidelines.
2. To establish guidelines for situations where patients and/or staff members may or may not be photographed, video or audio recorded or otherwise imaged within GCH.

DEFINITIONS:

- Audio Recordings: recording an individual's voice using a videorecording device (e.g., video cameras, cellular telephones), tape recorders, or other technologies capable of capturing audio.
- Authorization: A written form executed by the patient or the patient's legal representative.
- Consent: the patient's or patient's legal representative's written acknowledgement and/or agreement of the use and/or disclosure of protected health information for treatment, payment, or health operations purposes or other reasons permitted by the HIPAA Privacy Rule.
- Photography: recording an individual's likeness (e.g. image, picture) using photography (e.g. cameras, cellular telephones), video recording (e.g. video cameras, cellular telephones), digital imaging (e.g. digital cameras, web cameras), or other technologies capable of capturing an image (e.g. Skype™). This does not include medical imaging such as CTs, or images of specimens.

SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 2 OF: 4
APPROVED BY:	EFFECTIVE:
AUTHORED BY: Elaine Swift, Quality Director	REVISED:

- Staff Member: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for GCH, is under the direct control of GCH, whether or not they are paid by GCH.

PROCEDURE: As a general rule and to protect the privacy rights of staff and patients, video and other imaging of treatment and procedures are prohibited at GCH. Patient initiated videorecording of treatment and procedures has the potential to interfere with the provision of appropriate medical and nursing care. Additionally, such activity may intrude on the privacy interests of other patients, individuals and staff. It is therefore the policy of GCH to prohibit the use of video cameras during such treatment and procedures.

However, GCH does recognize that there may be instances where such imaging is necessary or desired. This section describes the limited circumstances in which photography and/or audio recordings may be used to capture or record the likeness or voice of a patient or staff member.

Imaging by patients, family members and/or visitors:

- Consent from the patient is not needed for photography or videorecording done by the patient's family members or friends provided the patient is alert and competent at the time (implied consent). Under no circumstances should a photo or video be taken during patient treatment or procedure.
- Permission of any staff captured on film is needed. Staff will note the imaging and their permission in the medical record.

Imaging by hospital or medical staff for documenting patient care:

- Any imaging done by or using equipment owned, leased or rented by GCH will become the property of GCH. Patients should provide consent for such imaging which will be filed as a portion of the patient's EMR. The staff member taking the image(s) is responsible for obtaining the consent.
- Photographs taken to document abuse and neglect, domestic violence, elder abuse, rape, and similar disclosures required by law do not require consent from the patient or authorized agent. Copies of such photographs may be submitted with the required report to the investigating agency (originals filed in the patient's

SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 3 OF: 4
APPROVED BY:	EFFECTIVE:
AUTHORED BY: Elaine Swift, Quality Director	REVISED:

EMR) but should not be used for other purposes without further authorizations from the patient.

- Students of all disciplines should not be taking or storing photographs of patients under any circumstances.
- Photographs should not be taken with cell phones, under any circumstances. It is too easy with phones to send images to unauthorized people.
- In all images or recordings, care must be taken to respect the dignity, ethnicity and religious beliefs of the patient.
- Photographs may be used for identification purposes.

Imaging for Educational and Training:

- Authorization (consent) from the patient or their authorized agent must be obtained prior to photography or videotaping. The consent should explicitly outline the intended use and disclosure of patient identifiable information. No patient identifying information should be associated with such photography or videotaping unless specifically authorized by a competent adult. The signed authorization should be filed with the patient's medical record.
- Arrangements for obtaining the appropriate authorizations/consents should be made through the Chief Nursing Officer or designee.
- The Chief Nursing Officer or designee will also ensure that confidentiality agreements or commitments are obtained from the group or persons performing the image.
- Educational, training, or publicity videos or photography will remain the property of Grace Cottage Hospital.

Marketing/Public Relations purpose:

- GCH Development and Community Relations will obtain written consent on an approved consent form when videoing or photographing patients, staff, and visitors.

SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 4 OF: 4
	EFFECTIVE:
APPROVED BY:	REVISED:
AUTHORED BY: Elaine Swift, Quality Director	

Consent:

- The patient's informed consent must be obtained in writing using the GCH Consent for Videorecording/Photography or Photography Release Form before images or recordings are taken.
- Patients must be fully informed of the purpose of the image/recording and be given a clear explanation of how the image may be used.
- Staff should make careful consideration of the appropriateness of photographing children. A signed consent form is required by the parent or legal guardian.

Storage and Use:

- GCH will designate a safe, secure, and inaccessible storage for all images/videos of patients and/or staff members.

Risk Management Considerations:

- Imaging should not interfere with patient care or be detrimental to the patient (per patient/caregiver assessment). Any imaging that may record an untoward event (as determined by the attending provider) automatically comes under the custody of the Risk Management Department and should be forwarded to them immediately.

Any questions regarding this policy should be referred to the Risk Management/Quality Management Department.

References:

- Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individual Identifiable Health Information 45 CFR Part 164
- American Health Information Management Association. 2001.

attachment 1 B

How to up load Camera photos to Cerner

Updated on 3/17/14



attachment / B

How to upload camera photos to Cerner

Contents

Get pictures off the camera and into the computer	2
Upload Photos into Cerner.....	6
Deleting the photos off the computer itself	9

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attachment 1B

Get pictures off the camera and into the computer

- 1) Take the pictures you need on the camera
- 2) Bring photos back to the Nursing Triangle office.

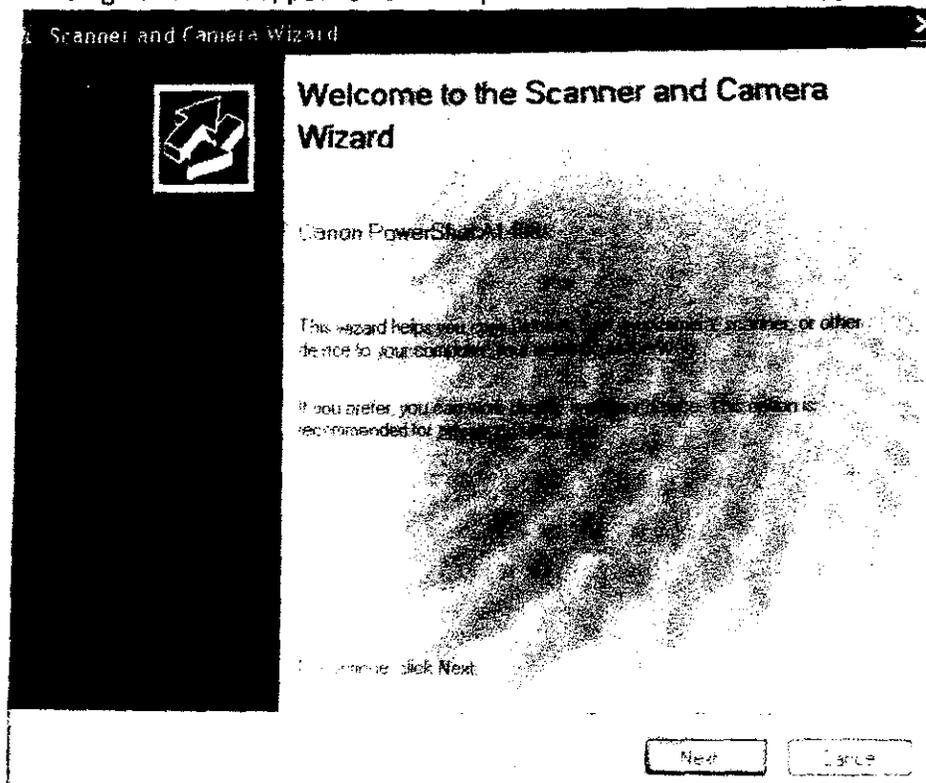
A handwritten signature in black ink, appearing to be 'T. E. A.' or similar, located in the bottom right corner of the page.

Attachment 1B

- 3) Plug in the transparent cord on the front of the computer into the USB slot (on the upper right side of the camera, from the perspective of the camera viewfinder facing you.)



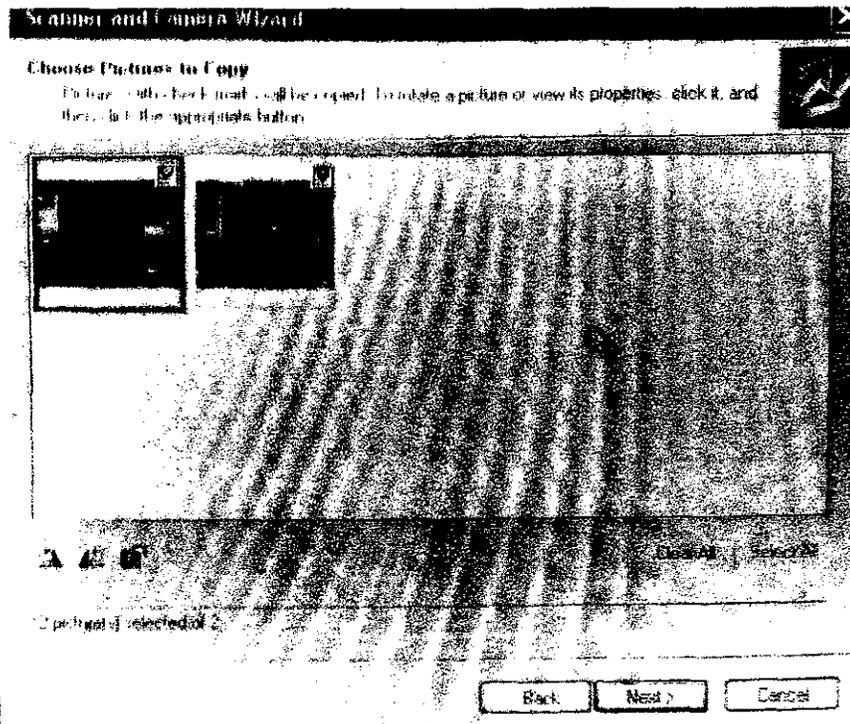
- 4) A dialog box should appear on the computer screen as shown below, just click "Next"



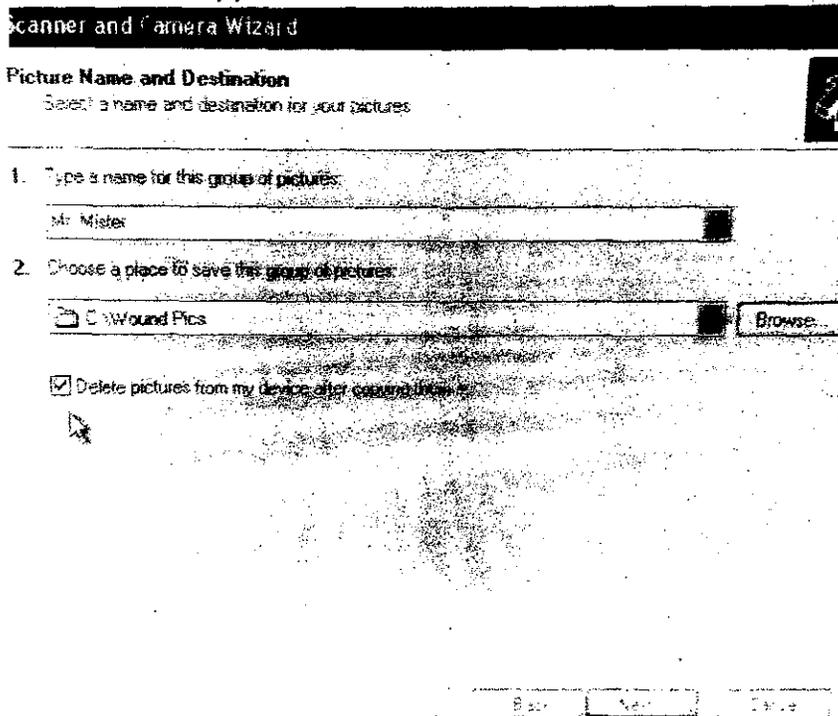
- 5) Make sure that the checkbox next to every picture you want to import is checked and then click next.

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attachment 1B



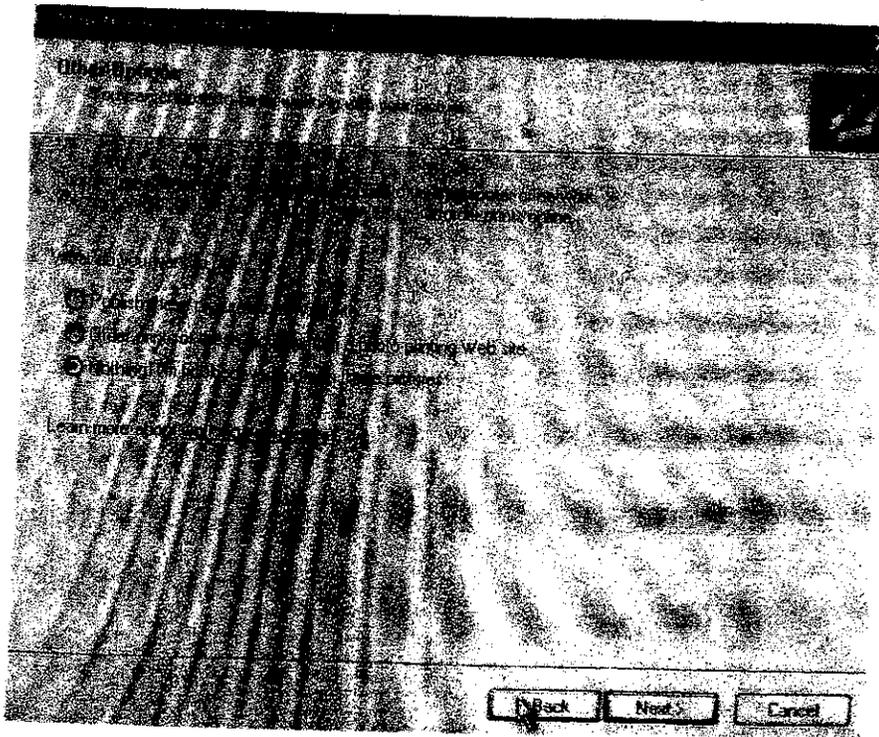
- 6) Type in the patients name and possibly the date into the field "Type a name for this group of pictures" and make sure that "Choose a place to save this group of pictures" is listed as "C:\Wound Pics". Make sure to check the box called "Delete pictures from this device after copying them" this will ensure they are only on the computer and not on the camera afterwards. Finally press "Next"



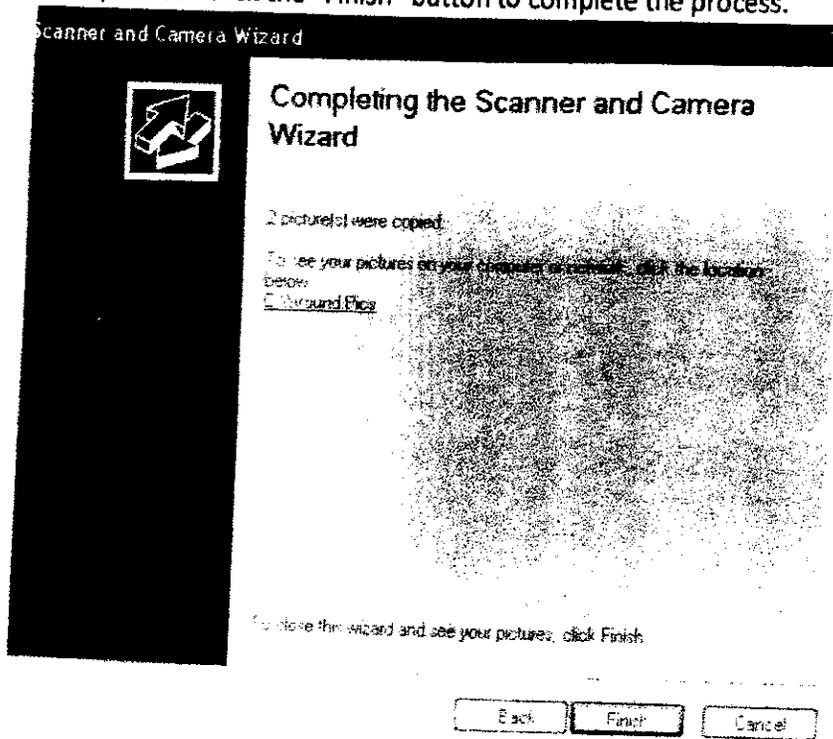
- 7) When asked "What do you want to do?", choose "Nothing" and click "Next"

attachment

1B



8) Finally we can click the "Finish" button to complete the process.

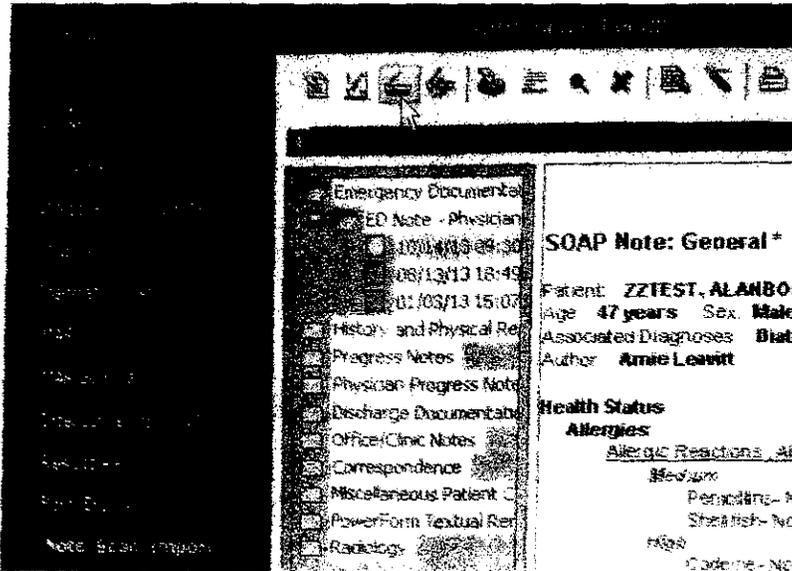


RPH

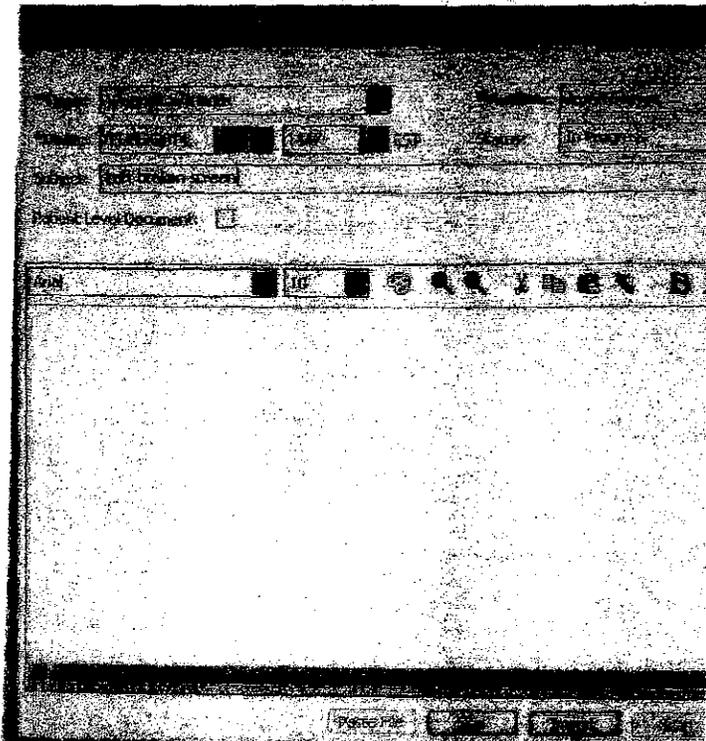
Upload Photos into Cerner

Attachment 1B

- 1) First open up PowerChart and then open the patients chart on the correct encounter.
- 2) Click "Note / Scan / Import" and then click the little icon that looks like a scanner in the top left corner as shown below.



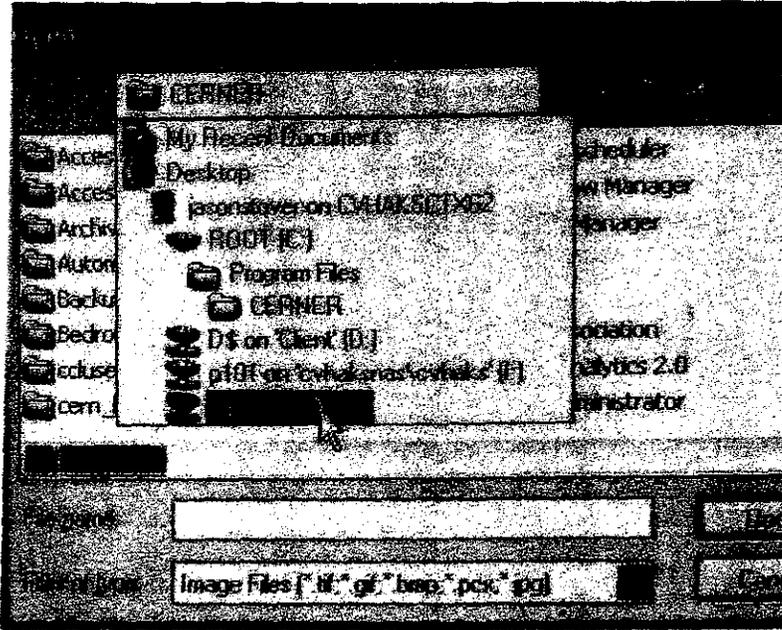
- 3) Under type, select an appropriate note type (In this case I chose Wound Care Note.) Make sure the date specifies the date the photo was taken and in the subject line, describe exactly what the photo is of. Now you can go ahead and click "Import" at the bottom of the box.



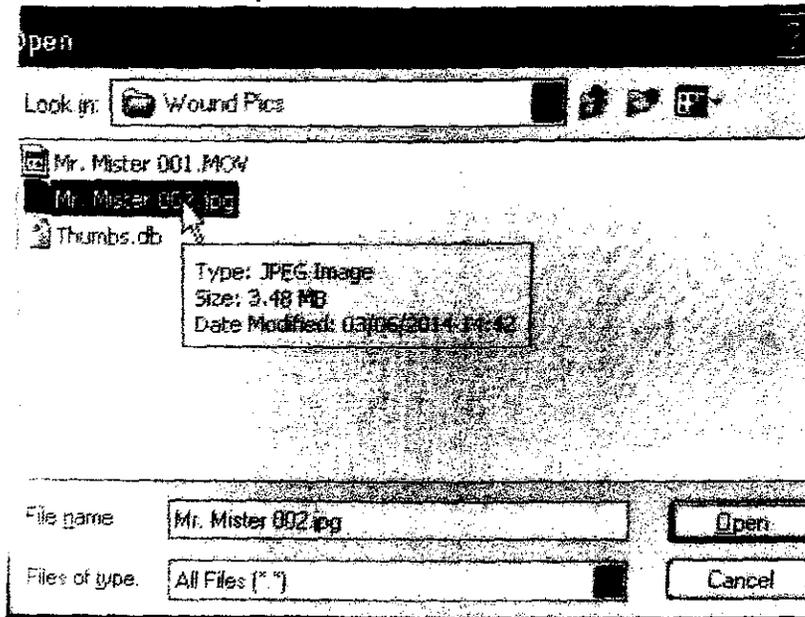
[Handwritten signature]

Attachment 1 B

- 4) A Dialog box will now appear, asking you where the file is located. Click on the dropdown box at the top and then select "C\$ on 'Client' (V:)". If you get an error message, just click "OK" to ignore it.



- 5) Next, double left-click on "Wound Pics". This will open the folder and allow you to see all the photos that were captured.



[Handwritten signature]

Attachment 1B

- 6) Next you can hold down the "CTRL" button in the lower left corner of your keyboard, while left clicking once on every photo you wish to import. Once all the photos are highlighted blue, click "Open" to pull them in.
- 7) Finally your photos will have been imported and you can click the "Sign" button on the bottom to make the pictures visible in Cerner to everyone. They can now be found under either "Note / Scan / Import" or "Document Viewer".

Add Document: 277131 4744801457169 414740

*Type:	Wound Care Note	*Author:	Jason Stover		
*Date:	03/06/2014	1447	EST	Status:	In Progress
Subject:	Left broken screen				

Patient Level Document:

The screenshot shows a document viewer window. The main area displays a dark, grainy image of a broken screen. Below the image is a toolbar with navigation arrows, a page indicator showing 'Page 1 of 1', a search icon, and other document management icons. Below the toolbar is a text area with 'Arial' font and '10' size. At the bottom right, there are 'Sign' and 'Import' buttons.

Handwritten signature

Attachment 1B

Deleting the photos off the computer itself.

- 1) Click the "Start" button in windows, located in the bottom left hand corner of your screen. It will either be a green button saying the word start, or it will be a blue circle with the Microsoft logo in it (this depends on what version of windows is installed on your computer.)
- 2) When the start menu pops up, you will either click on "My Computer" (if the start button was green.) or "Computer" (if the start button was a blue circle) only one of the two will exist.
- 3) When the file dialog box opens, Double left-click on "Local Disk (C:)"
- 4) Then double left-click on "Wound Pics"
- 5) You should now be seeing the photo(s) that you took here.
- 6) Press "CTRL-A" (First hold down the CTRL button in the bottom left corner of your keyboard and then press the letter A without letting go of CTRL. After clicking the A button you can let go of both keys.) This will highlight every photo blue.
- 7) Next press the "Delete" key or some keyboards have it shown as "Del". This is usually located somewhere towards the upper-right hand corner of the keyboard.
- 8) A box will appear asking if you are sure you want to delete them, choose "Yes".
- 9) Now you can close the box by clicking the red x in the upper right corner of the windows.
- 10) Lastly you should empty the recycling bin on the computer by going to the desktop and right-clicking on the icon that looks like a trash can and left-clicking "Empty Recycling Bin"

JWA

Important Issues from the recent Licensing & Protection Survey

Jeanne Fortier <jfortier@gracecottage.org>

Wed, Mar 19, 2014 at 7:49 PM

To: Deborah Cole <dcole@gracecottage.org>, Robin Ekstrom <rekstrom@gracecottage.org>, Caryn Francis <cfrancis@gracecottage.org>, Eileen Kepler <ekepler@gracecottage.org>, Melody Lively <mlively@gracecottage.org>, Katherine Melvin <kmelvin@gracecottage.org>, Patricia Morrill <pmorrill@gracecottage.org>, Nathan Olmstead <nolmstead@gracecottage.org>, Walter Rae <wrae@gracecottage.org>, Stacy Switzer <sswitzer@gracecottage.org>, Amy Visser-Lynch <avisserlynch@gracecottage.org>, Candy Wilkinson <cwilkinson@gracecottage.org>, Barbara Williams <bwilliams@gracecottage.org>, Mariann Zajchowski <mzajchowski@gracecottage.org>, Melissa Scribner <mscribner@gracecottage.org>, Christina Aguiar <caguiar@gracecottage.org>, Kery Capponcelli <kcapponcelli@gracecottage.org>, Darlene Clark <dclark@gracecottage.org>, Alana Mammone <amammone@gracecottage.org>, Jodi Perkins <jperkins@gracecottage.org>, Conn Rose <crose@gracecottage.org>, Michelle Ruggiero <mruggiero@gracecottage.org>, Crystal Durocher <cdurocher@gracecottage.org>, Christopher Boucher <cboucher@gracecottage.org>, Daniel Herlocker <dherlocker@gracecottage.org>, Andrew Semegram <asemegram@gracecottage.org>, Holly Meyer <hmeyer36@comcast.net>, Janice Sheppard <jsheppard@gracecottage.org>, Julie Douglass <jdouglass@gracecottage.org>, Rebecca Fletcher-Rogers <rfletcher-rogers@gracecottage.org>, Heidi Tkaczyk <htkaczyk@gracecottage.org>, Lorraine Gleason <lgleason@gracecottage.org>

As you may or not be aware we had a recent visit from the State Dept of Health, Division of L&P. They came in to follow up on a complaint made to them on behalf of a patient regarding the care he/she received (or was receiving). We were not told the source of the complaint. It has to remain anonymous to us. The surveyors were here for 3 days and looked at several policies and reviewed the records of five patients - both current and recently discharged. They found several deficiencies - areas in which we were either not abiding by our own policies, or abiding by Federal and/or State regulations. In a nutshell the issues are:

1. Failure to implement fall risk protocols per policies (no bed alarms placed on admission for 2 high risk patients who then went on to have falls).
2. Failure to implement pressure ulcer prevention measures for a patient identified as high risk who then went on to develop a pressure ulcer.
3. Failure to obtain a physician ordered wound culture.
4. Failure to initiate alteration in skin integrity care plan on admission for a patient that clearly had it.
5. Lack of a standardized process for documenting care (re: wound assessments and interventions - some on I-view, some as text notes...they could not follow the healing process). They also found discrepancies in the way we were staging the same patient's pressure ulcer - some had it as a 2 some had it as a 3 or 4.)
5. Failure to protect patient privacy by using non-hospital personnel to provide patient care (i.e. Rescue) and taking a photo of a patient's wound with a personnel cell phone.
6. Failure to follow our own policies for fall precautions, skin breakdown and involuntary procedures (use of physical and chemical restraint).
7. Lack of policies for Use of Non-Hospital Personnel (Sheriff/Rescue - when, how, why); no policy for Photographing Wounds (and appending photos to the medical record); no policy for Use of Sitters (for patients at high risk for falls or hurting self), and no policy to clearly define who should accompany patients that leave the facility for outside appointments (when do we send someone with them and who - RN, LPN, Aide).
8. Lack of adequate staff on night shift.

So, we'll be having staff meetings next week to go into more detail and discuss what we are going to do to bring us back into compliance.

In the meantime, PLEASE:

1. Follow our policies - re-read the ones on Fall Prevention, Preventing Skin Breakdown and Involuntary

Procedures. Implement and DOCUMENT the interventions required.

2. Do not use Rescue staff for anything other than a true emergency in the Emergency Department.
3. Report any hospital acquired pressure ulcers to Janice and Stacy. AND file an electronic Occurrence Report right away.
4. Review and use the pressure ulcer staging material I put together and Janice placed on every computer cart.
5. Plan to attend one of the staff meetings on March 26 or 28.
6. Plan to attend one of Stacy's wound care educational sessions on April 2 or 3. (Stacy is our new wound care nurse and recently completed 4 days of wound care training in Connecticut! :-). We will be rolling out a new plan to improve our wound prevention/management.

Thanks for all your hard work these last several months. I know it's been tough with the high census and staff shortages. I appreciate how well you've pulled together to get the work done and regardless of the shortcomings cited by the surveyors, I know you do a good job and really care for our patients.

Thank you!

Jeanne

—
Jeanne Fortier, RN MBA
Interim Chief Operating Officer
Chief Nursing Officer
Grace Cottage Hospital
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Townshend, VT 05353
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attachment 1c
page 2 of 2



ATTACHMENT #2 – GRACE COTTAGE HOSPITAL – PROVIDER # 471300

Tag C250 – 485.631 Staffing and Staff Responsibilities

Tag C250 – Staffing and Staff Responsibilities

Plan of Correction:

“See tag C253”

Tag C250 – 485.631(a)(3) Staffing

Tag C253, Issue #1 – Short staffing

Plan of Correction:

Adjustments are being made to bring the night shift nursing staff back up to 4; 1 RN for Emergency Department and 3 (at least 2 – RN/LPN and 1 RN/LPN/LNA) for the inpatient unit.

- The 4th staff position had been eliminated in March 2013 as part of an organization wide reduction in force. The position will be reinstated as soon as additional staff can be recruited, hired, and oriented. Position(s) posted 3/24/14. (attachment #2A)
- Until positions are filled: 1 – the evening shift LNA hours will be changed from 2:00PM – 10:30PM to 4:00PM – 2:30 AM. The day shift LNA currently comes in at 6:00AM. 2 – A rotating on-call schedule will be established among the RNs and LPNs to have 1 of them on call nightly from 11:00PM – 7:00AM effective 3/31/14.
- The hospital has entered into discussions with Hunter North Security Company and is considering adding contracted security at night. Parallel discussions are happening internally regarding hiring a night shift maintenance/multi-purpose employee instead of contracted security. Decision pending target date is 4/30/14.

Addendum: 3/31/2014

The CNO or designee will monitor night shift staffing and censuses on a daily basis also looking at how busy the ER was. This will be tracked on a tracking sheet kept by the CNO. (See Night On-Call Review form attachment 2B)

Tag C253, Issue #2 – PT/OT Staffing

Plan of Correction:

The PT dates cited are 1/4/14 and 1/5/14 respectively. This is a Saturday/Sunday; weekend PT/OT coverage has been limited since February of 2013 when 2 inpatient therapy staff were laid off as a result of the Administrative RIF requirement. This left coverage of 1 staff (1PT, 1OT) on both Sat/Sun which does not allow for daily treatment if census is above 8.



Attachment 2 continued

As a result of data collection for several months, the Rehab director was able to demonstrate the need for additional staffing on weekends (return to pre-RIF level for PT). On 1/24/14, a full time inpatient PT was hired back and now provides additional weekend coverage.

The OT date cited is 2/9/14, a Sunday. While re-hire of permanent OT staff has not happened, there now is a per diem OT who works every other weekend, and a regular full time staff OT is assigned to provide additional coverage on the opposite weekend.

Addendum: 3/31/2014

The Rehab Director or designee will monitor staffing levels to ensure they are adequate to meet the patient needs. Any deviation will be reported to the Rehab Department Medical Director and the Quality Director for review and tracking.

CASO, CAS3 POC accepted 4/10/14 FMCintosh RN/PMC

A handwritten signature in black ink, appearing to be 'J. Smith' or similar, located at the bottom right of the page.

**Grace Cottage Hospital
Notice of Job Vacancy**

Job Title: Registered Nurse - 2 Positions Available

Department: Nursing Department

Unit: Inpatient Care Unit

Full-Time or Part-Time: Full Time or Part Time

Shift: Night Shift

Requirements: Graduate of an accredited school of nursing.
Current Vermont RN license in good standing.
Experience in an acute care setting preferred; however will consider new graduates.
Current BLS certification.
Computer skills and familiarity with using an electronic medical record essential.
Excellent customer service skills.
Strong team player.

Job Responsibilities: Duties include patient assessments/reassessments, development of the patient's plan of care, implementation of physician's orders including medication administration and treatments, evaluation of patient's response to treatment and nursing interventions with appropriate follow-through.

Posting Date: March 23, 2014

Closing Date: Open until filled

Please direct all inquiries regarding these positions to Jan Thomas, Human Resources, Grace Cottage Hospital, (802) 365-3605 or 233



attachment 2B

NIGHT ON-CALL REVIEW

DATE: _____

FLOOR CENSUS

AT 11PM:

AT 7AM: _____

ED CENSUS

AT 11PM:

AT 7AM: _____

SATFFING:

11p-3a

3a-7a

RNs _____

RNs _____

#LPNs _____

#LPNs _____

LNA hours

LNA hours

WAS ON-CALL NURSE CALLED IN?

YES _____

NO _____

WHY/WHY NOT?

Use other side if needed.

ON-CALL NURSE:

HOW LONG WERE YOU HERE?

DO YOU FEEL YOU WERE UTILIZED APPROPRIATELY? IF "NO", PLEASE EXPLAIN:

Please leave completed form for Jeanne in "triangle office" box.



ATTACHMENT #3 – GRACE COTTAGE HOSPITAL – PROVIDER # 471300

Tag C270 – 485.635 Provision of Services

Tag C270

Plan of Correction:

Refer to tags: 271, 273, 278, 294, 295, 298, 302 and 306.

Tag C271 – 485.635 (a)(1) Patient Care Policies

Tag C271, Issue #1 – Failure to provide care in accordance with skin breakdown prevention policy

Plan of Correction:

See plan for improving pressure ulcer prevention and wound care management, attachment #3A.

Addendum: 4/2/2014

The new plan to prevent pressure ulcers and improve wound care at GCH was reviewed with the staff by the CNO at the mandatory nursing meetings, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The hospital policy on prevention of pressure ulcers and skin breakdown is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the policy and will adhere to it. All RN and LPN staff will complete the Elsevier e-learning pressure ulcer prevention module by 4/30/2014. This will be tracked by the nurse educator.

Any hospital acquired pressure ulcer will have an occurrence report filed and this will be sent to the wound care nurse and nurse manager for follow up and reported out at the hospital Quality Committee meetings.

Hospital acquired pressure ulcers will be discussed weekly at the interdisciplinary team meetings. The charge nurse will review all new admissions to ensure the Braden Scale has been completed and appropriate care plans in place as necessary. Patients identified as high risk on the Braden Scale will have regular chart review performed by the nurse manager or designee, to ensure preventive interventions are implemented. (see charge nurse new admission checklist 3C)

Tag C271, Issue #2 – No bed alarm and patient left in bathroom

Plan of Correction:

Staff advised of issue via "all message" email on 3/19/14. See attachment #3B. Nursing staff will be reeducated regarding the Morse Fall Scale policy and procedures at 3/26/14 and 3/28/14 staff meetings. Two nurses involved (no alarm placed and patient left on toilet) were counseled by the Nursing Manager.



Attachment 3 continued

Addendum: 4/2/2014

The GCH policy on Fall Prevention and use of the Morse Scale was reviewed with the staff by the CNO at the mandatory nursing meeting, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The policy is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the policy and will adhere to it. All nursing staff will complete the Elsevier Fall Prevention e-learning education module by 4/30/2014. This will be tracked by the nurse educator.

Falls will be discussed weekly at the interdisciplinary team meetings. All patients assessed as a high risk patient will have hourly rounding documented using the attached Hourly Rounding Checklist (attachment 3D). The checklist will be scanned into the EMR and reviewed by the nurse manager for the appropriate follow up.

Tag C271, Issue #3 – Nurse who failed to implement alarm on admit

Plan of Correction:

The nurse has been counseled. All staff reminded in "all email" on 3/19/14 and will be re-educated at the nursing staff meeting on 3/26&28/14. See Tag C271 Issue 2 above.

Tag C271, Issue #4 – Involuntary Procedures & Restraints

Plan of Correction:

A team has been formed to review the current policy on Involuntary Procedures and Restraints, which occurred on 2/21/14, and to understand our failure to follow the policy and how the situation could have been handled differently including other alternative interventions. Several informal discussions have occurred during and post CMS survey of 2/25 – 27/14 and the first formal meeting was held 3/21/14 with the CNO, CMO (also representing the QI Dept.), the nurse manager, and the provider and RN involved in the 2/21/14 incident. Staff have been informed of our failure to follow our policy (emailed 3/19/14, see attachment #3B) and further informed (email 3/24/14) that the policy is outdated in places and should not be used without guidance from the CNO or CMO. This team will be updating our current policy; the target date of completion is the May Medical Staff meeting, 5/8/14.

Addendum: 4/2/2014

The current Involuntary Procedures & Use of Restraints policy was reviewed with the staff by the CNO at the mandatory nursing meeting, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The policy is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the policy and will adhere to it and will not implement it without discussion with CNO or CMO.

RN and LPN nursing staff will complete the Elsevier Restraints Use e-learning education module by 4/30/2014, tracked by the nurse educator.

The CNO or CMO will notify the Quality Department when the Involuntary Procedures & Restraints policy is used to schedule the restraint use debriefing meeting.

A handwritten signature in black ink, appearing to be the initials 'MHA' or similar, located at the bottom right of the page.

Attachment 3 continued

ER Medical staff will be educated at the ER committee meeting on 4/2/14 by the CMO regarding the need to call the CMO and/or CNO prior to implementation of involuntary procedures or restraints, and need to utilize the certificate of need and order sheet.

Medical staff will be educated at the Medical Staff meeting on 4/10/14 by the CMO.

Any provider not in attendance will be educated directly by the Quality Director.

C270, C271 POC accepted 4/10/14 FmuntoshRN/PMC

A handwritten signature in black ink, appearing to be 'Fmuntosh'.

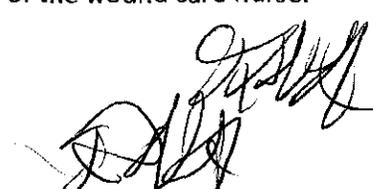
Plan for Improving Pressure Ulcer Prevention and Wound Care Management at Grace Cottage Hospital

Grace Cottage Hospital will immediately begin the implementation of a formal pressure ulcer prevention/wound care program utilizing the services of one of our RN nursing staff members. She is on track to becoming wound care certified through the National Alliance of Wound Care and Ostomy. She attended a four day Wound Care Education Institute program February 10-14, 2014 and will sit for her certification exam no later than September 2014.

Introduction of the program to the nursing staff occurred March 19, 2014 via an "all nursing" e-mail and will be formally reviewed at the March staff nurses' meetings scheduled for March 26 and 28, 2014. Staff education regarding pressure ulcer prevention, assessment, staging, wound care & products, and documentation will be presented by the wound care nurse on April 2 and 3, 2014.

Elements of the program include:

- All patients are assessed on admission by a RN for condition of skin (part of "head-to-toe" admission assessment) and for risk of developing pressure ulcers (utilizing the Braden Scale). Findings are documented in the EMR on the Adult Admission Assessment Form. This is past and current practice.
- If appropriate, a Nursing Care Plan for skin care will be initiated on admission. This is past and current practice. Charge nurses are now auditing admission charts for the presence of appropriate care plans at the time of admission.
- If indicated, nursing interventions for pressure ulcer prevention will be initiated and documented on the patient's EMR. This is past and current practice.
- Any patient admitted with wounds other than a clean, healing, surgical incision will:
 - have cultures taken of any draining wounds. (Protocol order approved by the Medical Staff February 13, 2014.) Order for culturing draining wounds will automatically drop electronically to the Nursing Task Bar in the EMR as part of admission order set. (This is in process with our EMR vendor.)
 - have an assessment performed by the wound care nurse on her next working day. (Effective April 7, 2014)
 - have wound care interventions implemented per the recommendation of the wound care nurse as approved by the provider. (Effective April 7, 2014) Nursing Care Plan will be updated by the wound care nurse to reflect any changes in care.
 - have re-assessments of wounds per the wound care instructions, depending on type of dressings and scheduled changes, etc. This is past and current practice.
 - have weekly visits and re-assessments by the wound care nurse. (Effective April 7, 2014) Nursing Care Plan will be updated by the wound care nurse to reflect any changes in care. This re-assessment and care plan update will occur by the nurse manager in the absence of the wound care nurse.



- may have photographs taken to document condition of wound on admission and again as needed during the patient's stay. Patient/guardian permission should be obtained. Photographs will be uploaded to the patient's EMR.
- Documentation of wound assessments, re-assessments and interventions will be documented (text format) on an electronic nursing progress note. Each entry will appear on the same note in a consecutive format. (Effective April 7, 2014)
- In the event that an inpatient develops a pressure ulcer during his/her stay, nursing will complete an electronic occurrence report before the end of the shift on which the ulcer was discovered. Such reports are submitted to the Quality Department who will then send the report on to the nurse manager and the wound care nurse for follow-up. The patient will be seen and assessed as soon as possible by the wound care nurse (or nurse manager if wound care nurse is unavailable). (Effective March 24, 2014)
 - Care, interventions and documentation will follow the same steps as outlined above for patients that present with wounds.
 - All hospital acquired pressure ulcers will be tracked, trended and reported to the Quality Committee.
 - Nursing staff re-education will occur as indicated.
- Pressure ulcer prevention and wound care will be monitored as part of the inpatient care unit QI chart review. (Effective April 7, 2014)

A handwritten signature in black ink, appearing to be 'J. J. J.', located at the bottom right of the page.

attachment 3D

HIGH FALLS RISK* HOURLY ROUNDING

patient sticker

* Round on any patient with Morse Scale of 45 or greater

Date:

(check all that apply)	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00	
Re-oriented to surroundings																									
Room clutter free																									
Call bell & personal items w/in reach																									
Reminded to call for assistance																									
Diversional activities provided																									
Toileting offered																									
Bed/chair alarm																									
inplace																									
activated																									
Bed in low position																									
2 side rails up																									
Non-skid slippers																									
Fall risk bracelet																									
Falling star on doorjam																									
Bedside mats if warranted																									
Sitter present																									
Under observation at Nurses' Station																									
Staff initials																									

Scan completed form into patient's EMR.

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Wed, Mar 19, 2014 at 7:49 PM

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5. Failure to protect patient privacy by using non-hospital personnel to provide patient care (i.e. Rescue) and taking a photo of a patient's wound with a personnel cell phone.
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7. Lack of policies for Use of Non-Hospital Personnel (Sheriff/Rescue - when, how, why); no policy for Photographing Wounds (and appending photos to the medical record); no policy for Use of Sitters (for patients at high risk for falls or hurting self), and no policy to clearly define who should accompany patients that leave the facility for outside appointments (when do we send someone with them and who - RN, LPN, Aide).
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4. Review and use the pressure ulcer staging material I put together and Janice placed on every computer cart.
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Thank you!

Jeanne

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Chief Nursing Officer
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PO Box 216 - 185 Grafton Road
Townshend, VT 05353
(802) 365-3613
jfortier@gracecottage.org

Attachment 3B
page 2 of 2



ATTACHMENT #4 – GRACE COTTAGE HOSPITAL – PROVIDER # 471300

Tag C273 – 485.635(a)(3)(i) Patient Care Policies

Tag C273, Issue #1 – No policy for use of Rescue, Inc. Services

Plan of Correction:

A policy will be developed by the CNO, CMO, and QI Director that will describe the services that may be provided by outside contracted personnel (Rescue, Inc. and Windham County Sherriff). The policy will be completed and sent to the Quality Committee on 4/23/14 for review and forwarded to the Medical Staff Meeting on 5/8/14.

Rescue, Inc., Interim Chief, Drew Hazelton was informed on 3/20/14 that his employees are not to render care in the inpatient unit.

Addendum: 4/2/2014

The issue of not using Rescue Inc. personnel was reviewed with the staff by the CNO at the mandatory nursing meetings, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The hospital policy, once developed, will be posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the plan and will adhere to it.

ER Medical staff will be educated at the ER committee meeting on 4/2/14 by the CMO and the General Medical Staff will be educated at the Medical Staff Meeting on 4/10/14.

Any time Rescue Inc./EMS personnel are used for anything other than transition in care (during drop off or pick up) an occurrence report will be filed with the quality department for review and appropriate follow up as will be stated in the policy.

Tag C273, Issue #2 – No policy for use of Sheriff

Plan of Correction:

A policy will be developed by the CNO, CMO, and QI Director that will describe the services that may be provided by outside contracted personnel (Rescue, Inc. and Windham County Sheriff). The policy will be completed and sent to the Quality Committee on 4/23/14 for review and forwarded to the Medical Staff Meeting on 5/8/14.

Addendum: 4/2/2014

All nursing staff was apprised not to use the sheriff for direct care. This was discussed with the staff by the CNO at the mandatory nursing meetings, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated.

The hospital policy, once developed, will be posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the plan and will adhere to it.



Attachment 4 continued

Policy and procedure will include the requirement to complete and occurrence report whenever law enforcement is called to the facility, for Quality Department follow up.

ER Medical staff will be educated at the ER committee meeting on 4/2/14 by the CMO and the General Medical Staff will be educated at the Medical Staff Meeting on 4/10/14.

Tag C273, Issue #3 – No policy regarding transport of patients to other facilities

Plan of Correction:

A Policy has been developed (see attachment #4A) and will go to QI Committee on 4/23/14 and forwarded to the Medical Staff Meeting on 5/8/14. It will be presented to the nursing staff on 3/26 and 3/28/14.

Addendum 4/2/2014

The Transport policy was discussed with the staff by the CNO at the mandatory nursing meetings, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated.

The hospital policy is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the plan and will adhere to it.

The worksheet (attachment 4C) currently used by the unit secretary for coordinating off site appointments includes transport mode and accompaniment. These forms will be reviewed before transport by the charge nurse or nurse manager, for appropriateness.

Tag C273, Issue #4 – No policy regarding photographing, videorecording, or recording devices

Plan of Correction:

A Photographing, Videorecording, or Recording Device Policy has been completed. The Quality Director educated the Medical Staff at the 3/13/14 Medical Staff meeting regarding prohibition of cell phone and/or personal device use for picture taking of patients and patient's wounds. The Medical Staff was instructed to use the camera that is on the Med/Surg unit to document wound care or other pertinent pictures needed for treatment, care and reporting. The camera, instructions for the camera operation and uploading the photos into patient's electronic medical record are stored in the triangle shaped room on the unit effective 3/19/14. This information was relayed to the Medical Staff at the March Medical Staff meeting. The new policy "Photographing, Video Recording, or Recording Device Policy" will be distributed at the 4/10/14 Medical Staff meeting. See attachment #4B. This policy will be reviewed with nursing staff on 3/26 & 28/14 and again during pressure ulcer prevention/wound care education sessions on 4/2&3/14.



Attachment 4 continued

Addendum: 4/2/2014

Policy was reviewed with the staff by the CNO at the mandatory nursing meetings, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The policy is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand and will adhere to the policy.

The medical staff will sign off that they will adhere to the policy and refrain from using personal devices for photography. This will be shown by the attendance sheet from the Medical Staff meeting on April 10, 2014. Any physician not in attendance will be spoken to directly by the Quality Director.

C273 POC accepted 4/10/14 Fmeintosh RN/PMC

A handwritten signature in black ink, appearing to be 'Fmeintosh'.

SUBJECT: Transport of Inpatients Needing Services at Other Facilities	REFERENCE # 2.0101
DEPARTMENT: Nursing	PAGE: 1 OF: 2
AUTHORED BY: Jeanne Fortier, RN Chief Nursing Officer	EFFECTIVE:
APPROVED BY: Quality Committee Medical Staff	REVISED:

PURPOSE:

At times Grace Cottage Hospital inpatients are scheduled for outpatient follow-up appointments, tests and/or procedures. This policy defines which patients may go to such appointments, how they will be transported and should accompany them.

POLICY:

Acute Inpatients:

If an acute inpatient is in need of a consultation, a procedure, or testing that GCH is unable to provide onsite, that patient must be **transferred** to another inpatient facility that is capable of providing the needed service and will attend to the patient's acute care needs. Note: Such patients may be **transferred back** to GCH after the consultation, procedure or test. Transportation will be via ambulance with the appropriate level of EMS in attendance.

Acute inpatients are not to be sent for procedures, testing or consultations rendered in an outpatient setting.

Swing Bed/Skilled Level Inpatients:

If a Swing Bed or Skilled Level inpatient is in need of a consultation, a procedure, or testing that GCH is unable to provide onsite, that patient will be given a **leave of absence** from GCH in order to obtain the needed service.

Appropriate transportation and accompaniment must be arranged.

Private car with responsible adult family member or friend – patient must be medically stable, must demonstrate safety awareness and compliance with all safety precautions. Patient must have the functional capacity to get in and out of the vehicle safely by self or with minimal assistance. A wheelchair or walker may be sent with the patient for use at the appointment if appropriate. The family member or



SUBJECT: Transport of Inpatients Needing Services at Other Facilities	REFERENCE # 2.0101
DEPARTMENT: Nursing	PAGE: 2 OF: 2
AUTHORED BY: Jeanne Fortier, RN Chief Nursing Officer	EFFECTIVE:
APPROVED BY: Quality Committee Medical Staff	REVISED:

friend must be able and willing to assist patient. Under such circumstances, no GCH escort is necessary.

Wheelchair Van with responsible adult family member or friend – Wheelchair bound patients or those that are not fully ambulatory (with or without a walker) may be transported via wheelchair van in a wheelchair. If the patient is medically stable, demonstrates safety awareness and compliance with all safety precautions and has an adult family member or friend that is willing and able to accompany and assist the patient, no GCH escort is necessary.

Wheelchair Van with GCH Escort* - Wheelchair bound patients or those that are not fully ambulatory (with or without a walker) may be transported via wheelchair van in a wheelchair. If the patient is medically stable, but does not demonstrate safety awareness or is non-compliant with safety precautions, or if they have no responsible adult family member or friend to accompany them, a GCH escort will be provided.

Ambulance – medically stable bedbound patients or those that are unable to sit in a wheelchair for long periods of time should be transported by ambulance with the appropriate level of EMS. If the ambulance crew will be staying with the patient EMS for the duration of the consult, testing or procedure, then no GCH escort is necessary. If not, send a GCH escort.

***GCH Escorts:**

For medically stable Swing Bed/Skilled Level Inpatients may use LNA, Activities, Social Service or other appropriate GCH personnel as an escort, as determined by the Nurse Manager or Charge Nurse in consultation with the attending physician.

Medically *unstable* Swing Bed/Skilled Level Inpatients should be considered in the category of Acute for the purpose of this policy.

Attachment 4C

Date of Appointment:		Patient:	
Appointment(s)			
Location:			
Procedure:		Provider:	
Time:		Floor:	
Special Instructions/reason for appointment:			
Procedure:		Provider:	
Time:		Floor:	
Special Instructions/Reason for appointment:			
Procedure:		Provider:	
Time:		Floor:	
Special Instructions/Reason for appointment:			
Transportation			
Ambulance/Private Car/ W-C Van (Circle one)		LOA approved by MD?	
Company/Person transporting:		Time for pick-up:	
Given directions if needed?		Who did you talk to?	
Necessary documents faxed/sent for appt:		Reminder call given on:	
Checklist			
___ Confirm appointments time /date		Initial/time/date: _____ Day before: _____	
___ Confirm that the appointment is medical necessity		Initial/ time/ date: _____	
___ Appointment card given		Initial/time/date: _____	
___ Appropriate to/from transportation forms completed by physician		Initial/time/date: _____	
___ Confirm transportation method /medical necessity/insurance approval		Initial/time/date: _____	
___ Necessary documents faxed/sent with patient for appointment		Initial/date/time: _____	
___ GCH Staff Accompanying? Yes ___ No ___		Initial/date/time: _____	
Staff name _____			
Communication:			
D/c date: _____			
Returning from the appointment			
Different transportation on return?		Person/Company:	
Time of pickup:		Time of arrival:	
Medical note obtained from appointment:		Nurse who received results:	
Date:		Scanned in Cerner:	
Daily checks (initial and date)			

ROA

attachment 4B
page 1 of 4

SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 1 OF: 4
	EFFECTIVE:
APPROVED BY:	REVISED:
AUTHORED BY: Elaine Swift, Quality Director	

POLICY: Grace Cottage Hospital (GCH) must take reasonable steps to protect patients, visitors, and staff members from unauthorized photography, video or audio recordings, or other images. Due to the sensitive nature of patient information and to protect patient privacy, the facility must follow the guidelines and procedures outlined below before allowing, or prior to, photographing, video or audio recording, or otherwise imaging of patients, visitors or staff members.

PURPOSE:

1. To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and any and all other federal regulations and interpretive guidelines.
2. To establish guidelines for situations where patients and/or staff members may or may not be photographed, video or audio recorded or otherwise imaged within GCH.

DEFINITIONS:

- Audio Recordings: recording an individual's voice using a videorecording device (e.g., video cameras, cellular telephones), tape recorders, or other technologies capable of capturing audio.
- Authorization: A written form executed by the patient or the patient's legal representative.
- Consent: the patient's or patient's legal representative's written acknowledgement and/or agreement of the use and/or disclosure of protected health information for treatment, payment, or health operations purposes or other reasons permitted by the HIPAA Privacy Rule.
- Photography: recording an individual's likeness (e.g. image, picture) using photography (e.g. cameras, cellular telephones), video recording (e.g. video cameras, cellular telephones), digital imaging (e.g. digital cameras, web cameras), or other technologies capable of capturing an image (e.g. Skype™). This does not include medical imaging such as CTs, or images of specimens.

SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 2 OF: 4
APPROVED BY:	EFFECTIVE:
AUTHORED BY: Elaine Swift, Quality Director	REVISED:

- **Staff Member:** employees, volunteers, trainees, and other persons whose conduct, in the performance of work for GCH, is under the direct control of GCH, whether or not they are paid by GCH.

PROCEDURE: As a general rule and to protect the privacy rights of staff and patients, video and other imaging of treatment and procedures are prohibited at GCH. Patient initiated videorecording of treatment and procedures has the potential to interfere with the provision of appropriate medical and nursing care. Additionally, such activity may intrude on the privacy interests of other patients, individuals and staff. It is therefore the policy of GCH to prohibit the use of video cameras during such treatment and procedures.

However, GCH does recognize that there may be instances where such imaging is necessary or desired. This section describes the limited circumstances in which photography and/or audio recordings may be used to capture or record the likeness or voice of a patient or staff member.

Imaging by patients, family members and/or visitors:

- Consent from the patient is not needed for photography or videorecording done by the patient's family members or friends provided the patient is alert and competent at the time (implied consent). Under no circumstances should a photo or video be taken during patient treatment or procedure.
- Permission of any staff captured on film is needed. Staff will note the imaging and their permission in the medical record.

Imaging by hospital or medical staff for documenting patient care:

- Any imaging done by or using equipment owned, leased or rented by GCH will become the property of GCH. Patients should provide consent for such imaging which will be filed as a portion of the patient's EMR. The staff member taking the image(s) is responsible for obtaining the consent.
- Photographs taken to document abuse and neglect, domestic violence, elder abuse, rape, and similar disclosures required by law do not require consent from the patient or authorized agent. Copies of such photographs may be submitted with the required report to the investigating agency (originals filed in the patient's

SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 3 OF: 4
APPROVED BY:	EFFECTIVE:
AUTHORED BY: Elaine Swift, Quality Director	REVISED:

EMR) but should not be used for other purposes without further authorizations from the patient.

- Students of all disciplines should not be taking or storing photographs of patients under any circumstances.
- Photographs should not be taken with cell phones, under any circumstances. It is too easy with phones to send images to unauthorized people.
- In all images or recordings, care must be taken to respect the dignity, ethnicity and religious beliefs of the patient.
- Photographs may be used for identification purposes.

Imaging for Educational and Training:

- Authorization (consent) from the patient or their authorized agent must be obtained prior to photography or videotaping. The consent should explicitly outline the intended use and disclosure of patient identifiable information. No patient identifying information should be associated with such photography or videotaping unless specifically authorized by a competent adult. The signed authorization should be filed with the patient's medical record.
- Arrangements for obtaining the appropriate authorizations/consents should be made through the Chief Nursing Officer or designee.
- The Chief Nursing Officer or designee will also ensure that confidentiality agreements or commitments are obtained from the group or persons performing the image.
- Educational, training, or publicity videos or photography will remain the property of Grace Cottage Hospital.

Marketing/Public Relations purpose:

- GCH Development and Community Relations will obtain written consent on an approved consent form when videoing or photographing patients, staff, and visitors.

SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 4 OF: 4
	EFFECTIVE:
APPROVED BY:	REVISED:
AUTHORED BY: Elaine Swift, Quality Director	

Consent:

- The patient's informed consent must be obtained in writing using the GCH Consent for Videorecording/Photography or Photography Release Form before images or recordings are taken.
- Patients must be fully informed of the purpose of the image/recording and be given a clear explanation of how the image may be used.
- Staff should make careful consideration of the appropriateness of photographing children. A signed consent form is required by the parent or legal guardian.

Storage and Use:

- GCH will designate a safe, secure, and inaccessible storage for all images/videos of patients and/or staff members.

Risk Management Considerations:

- Imaging should not interfere with patient care or be detrimental to the patient (per patient/caregiver assessment). Any imaging that may record an untoward event (as determined by the attending provider) automatically comes under the custody of the Risk Management Department and should be forwarded to them immediately.

Any questions regarding this policy should be referred to the Risk Management/Quality Management Department.

References:

- Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individual Identifiable Health Information 45 CFR Part 164
- American Health Information Management Association. 2001.

ATTACHMENT #5 – GRACE COTTAGE HOSPITAL – PROVIDER # 471300

Tag C278 – 485.635(a)(3)(vi) Patient Care Policies

Tag C278 – No wound culture obtained

Plan of Correction:

The wound culture order was missed by the patient's nurse. We have requested our EMR vendor to make a task appear on the "Nursing Task Bar" to "Culture Draining Wounds on all admissions". This will serve as a reminder to the nurse. We have a Medical Staff approved protocol to culture all draining wounds on any patient.

Addendum: 4/2/14

"Wounds Cultured if Indicated" has been added to the charge nurse new admission checklist (see attachment 5A).

Follow up with EMR vendor confirms that tasks will drop as requested.

C278 POC accepted 4/10/14 F. McIntosh RN/PMU

A handwritten signature in black ink, appearing to be 'F. McIntosh'.

ATTACHMENT #6 – GRACE COTTAGE HOSPITAL – PROVIDER # 471300

Tag C294 – 485.635(d) Nursing Services

Tag C294, Issue #1a – Pressure ulcer care

Plan of Correction:

Refer to Plan for improving Pressure Ulcer prevention and wound care management, see attachment #6A.

Addendum: 4/2/2014

The new plan to prevent pressure ulcers and improve wound care at GCH was reviewed with the staff by the CNO at the mandatory nursing meetings, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The hospital policy on prevention of pressure ulcers and skin breakdown is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the policy and will adhere to it. All RN and LPN staff will complete the Elsevier e-learning pressure ulcer prevention module by 4/30/2014 tracked by the nurse educator.

Any hospital acquired pressure ulcer will have an occurrence report filed and this will be sent to the wound care nurse and nurse manager for follow up and reported out at the hospital Quality Committee meetings.

Hospital acquired pressure ulcers will be discussed weekly at the interdisciplinary team meetings. The charge nurse will review all new admissions to ensure the Braden Scale has been completed and appropriate care plans in place as necessary (see charge nurse new admission checklist 6B). Patients identified as high risk on the Braden Scale will have regular chart review performed by the nurse manager or designee, to ensure preventive interventions are implemented.

Tag C294, Issue #1b – Delay in updating care plan

Plan of Correction:

We have checked with our EMR vendor and have had a filter removed so we can see the history on nursing care plans, i.e. initial dates and updated dates.

Addendum: 4/2/2014

Staff has been reminded at staff meeting to open and update care plans on admission and with a change in patient condition. Opening of and personalization of appropriate care plans are now reviewed by the charge nurse on admission with follow up by the nurse manager. Care plans are also reviewed and updated weekly at the interdisciplinary team meeting.

Tag C294, Issue #2 and Issue #3 – No bed alarm on admission

Plan of Correction:



Attachment 6 continued

Involved staff have been counseled regarding the need to fully implement all needed fall prevention interventions. All nursing staff has been informed of our failure to follow our fall prevention protocols. Morse Fall Risk Assessment and Fall Prevention policy and procedures will be reviewed at the 3/26/14 and 3/28/14 nursing staff meetings. Charge nurses will now review charts of all new admissions for fall risk assessments, initiation of care plans and implementation of interventions, attachment 6B.

Addendum: 4/2/2014

The GCH policy on Fall Prevention and use of the Morse Scale was reviewed with the staff by the CNO at the mandatory nursing meeting, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The policy is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the policy and will adhere to it. All nursing staff will complete the Elsevier Fall Prevention e-learning education module by 4/30/2014. This will be tracked by the nurse educator.

Falls will be discussed weekly at the interdisciplinary team meetings. All patients assessed as a high risk patient will have hourly rounding documented using the attached Hourly Rounding Checklist. The checklist will be scanned into the EMR and reviewed by the nurse manager for the appropriate follow up. (Attachment: Hourly Rounding Checklist 6C)

C294 POC accepted 4/10/14 Fmeintsh RN/pmc

A handwritten signature in black ink, appearing to be 'Fmeintsh'.

Plan for Improving Pressure Ulcer Prevention and Wound Care Management at Grace Cottage Hospital

Grace Cottage Hospital will immediately begin the implementation of a formal pressure ulcer prevention/wound care program utilizing the services of one of our RN nursing staff members. She is on track to becoming wound care certified through the National Alliance of Wound Care and Ostomy. She attended a four day Wound Care Education Institute program February 10-14, 2014 and will sit for her certification exam no later than September 2014.

Introduction of the program to the nursing staff occurred March 19, 2014 via an "all nursing" e-mail and will be formally reviewed at the March staff nurses' meetings scheduled for March 26 and 28, 2014. Staff education regarding pressure ulcer prevention, assessment, staging, wound care & products, and documentation will be presented by the wound care nurse on April 2 and 3, 2014.

Elements of the program include:

- All patients are assessed on admission by a RN for condition of skin (part of "head-to-toe" admission assessment) and for risk of developing pressure ulcers (utilizing the Braden Scale). Findings are documented in the EMR on the Adult Admission Assessment Form. This is past and current practice.
- If appropriate, a Nursing Care Plan for skin care will be initiated on admission. This is past and current practice. Charge nurses are now auditing admission charts for the presence of appropriate care plans at the time of admission.
- If indicated, nursing interventions for pressure ulcer prevention will be initiated and documented on the patient's EMR. This is past and current practice.
- Any patient admitted with wounds other than a clean, healing, surgical incision will:
 - have cultures taken of any draining wounds. (Protocol order approved by the Medical Staff February 13, 2014.) Order for culturing draining wounds will automatically drop electronically to the Nursing Task Bar in the EMR as part of admission order set. (This is in process with our EMR vendor.)
 - have an assessment performed by the wound care nurse on her next working day. (Effective April 7, 2014)
 - have wound care interventions implemented per the recommendation of the wound care nurse as approved by the provider. (Effective April 7, 2014) Nursing Care Plan will be updated by the wound care nurse to reflect any changes in care.
 - have re-assessments of wounds per the wound care instructions, depending on type of dressings and scheduled changes, etc. This is past and current practice.
 - have weekly visits and re-assessments by the wound care nurse. (Effective April 7, 2014) Nursing Care Plan will be updated by the wound care nurse to reflect any changes in care. This re-assessment and care plan update will occur by the nurse manager in the absence of the wound care nurse.



- may have photographs taken to document condition of wound on admission and again as needed during the patient's stay. Patient/guardian permission should be obtained. Photographs will be uploaded to the patient's EMR.
- Documentation of wound assessments, re-assessments and interventions will be documented (text format) on an electronic nursing progress note. Each entry will appear on the same note in a consecutive format. (Effective April 7, 2014)
- In the event that an inpatient develops a pressure ulcer during his/her stay, nursing will complete an electronic occurrence report before the end of the shift on which the ulcer was discovered. Such reports are submitted to the Quality Department who will then send the report on to the nurse manager and the wound care nurse for follow-up. The patient will be seen and assessed as soon as possible by the wound care nurse (or nurse manager if wound care nurse is unavailable). (Effective March 24, 2014)
 - Care, interventions and documentation will follow the same steps as outlined above for patients that present with wounds.
 - All hospital acquired pressure ulcers will be tracked, trended and reported to the Quality Committee.
 - Nursing staff re-education will occur as indicated.
- Pressure ulcer prevention and wound care will be monitored as part of the inpatient care unit QI chart review. (Effective April 7, 2014)



Charge Nurse Check of All New Admissions

Jeanne Fortier <jfortier@gracecottage.org>

Sun, Mar 23, 2014 at 9:34 AM

To: Janice Sheppard <jsheppard@gracecottage.org>, Amy Visser-Lynch <avisserlynch@gracecottage.org>, Mariann Zajchowski <mzajchowski@gracecottage.org>, Eileen Kepler <ekepler@gracecottage.org>, Stacy Switzer <sswitzer@gracecottage.org>, Melody Lively <mlively@gracecottage.org>, Melissa Scribner <mscribner@gracecottage.org>, Robin Ekstrom <rekstrom@gracecottage.org>, Barbara Williams <bwilliams@gracecottage.org>, Deborah Cole <dcole@gracecottage.org>, Walter Rae <wrae@gracecottage.org>, Nathan Olmstead <nolmstead@gracecottage.org>, Andrew Semegram <asemegram@gracecottage.org>

As of today, Sunday March 23, 2014 we are re-instituting the Charge Nurse Checklist for New Admissions. Copy attached. It will be kept on a clip board at the nurses station. Janice will be reviewing and auditing admissions. Findings will be reported to the QI Department as a quality improvement process.

Thanks for your help.

Jeanne

Jeanne Fortier, RN MBA
Interim Chief Operating Officer
Chief Nursing Officer
Grace Cottage Hospital
PO Box 216 - 185 Grafton Road
Townshend, VT 05353
(802) 365-3613
jfortier@gracecottage.org

 **Charge RN New Admit Check List.xlsx**
12K



attachment 6c

HIGH FALLS RISK* HOURLY ROUNDING

patient sticker

*** Round on any patient with Morse Scale of 45 or greater**

Date:

(check all that apply)	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
Re-oriented to surroundings																								
Room clutter free																								
Call bell & personal items w/in reach																								
Reminded to call for assistance																								
Diversional activities provided																								
Toileting offered																								
Bed/chair alarm																								
Inplace																								
activated																								
Bed in low position																								
2 side rails up																								
Non-skid slippers																								
Fall risk bracelet																								
Falling star on doorjam																								
Bedside mats if warranted																								
Sitter present																								
Under observation at Nurses' Station																								
Staff initials																								

Scan completed form into patient's EMR.

ATTACHMENT #7 – GRACE COTTAGE HOSPITAL – PROVIDER # 471300

Tag C295 – 485.635(d)(1) Nursing Services

Tag C295, Issue #1a – Failure to implement bed alarm on admission

Plan of Correction:

Involved staff have been counseled regarding the need to fully implement all needed fall prevention interventions. All nursing staff has been informed of our failure to follow our fall prevention protocols. Morse Fall Risk Assessment and Fall Prevention policy and procedures will be reviewed at the 3/26 & 28/14 nursing staff meetings. Charge nurses will now verify that all admissions have been screened for Fall Risk on admission and proper interventions initiated.

Addendum: 4/2/2014

The GCH policy on Fall Prevention and use of the Morse Scale was reviewed with the staff by the CNO at the mandatory nursing meeting, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The policy is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the policy and will adhere to it. All nursing staff will complete the Elsevier Fall Prevention e-learning education module by 4/30/2014 as tracked by the nurse educator.

Falls will be discussed weekly at the interdisciplinary team meetings. All patients assessed as a high risk patient will have hourly rounding documented using the attached Hourly Rounding Checklist(Attachment 7B). The hourly rounding checklist will be implemented 4/7/14 and used for monitoring and tracking fall prevention intervention. The checklist will be scanned into the EMR and reviewed by the nurse manager for the appropriate follow up.

Tag C295, Issue #1b – Patient left in bathroom

Plan of Correction:

Involved staff member has been counseled regarding leaving patient alone in the bathroom. She will pull the bathroom bell cord in the future.

Tag C295, Issue #2 – Failure to prevent pressure ulcer

Plan of Correction:

A plan to prevent pressure ulcers and improve wound care management will be implemented, attachment 7a.

A handwritten signature in black ink, appearing to be 'J. Kelly', is located at the bottom center of the page.

Attachment 7 continued

Addendum: 4/2/2014

The new plan to prevent pressure ulcers and improve wound care at GCH was reviewed with the staff by the CNO at the mandatory nursing meetings, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The hospital policy on prevention of pressure ulcers and skin breakdown is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the policy and will adhere to it. All RN and LPN staff will complete the Elsevier e-learning pressure ulcer prevention module by 4/30/2014 and tracked by the nurse educator.

Any hospital acquired pressure ulcer will have an occurrence report filed and this will be sent to the wound care nurse and nurse manager for follow up and reported out at the hospital Quality Committee meetings.

Hospital acquired pressure ulcers will be discussed weekly at the interdisciplinary team meetings. The charge nurse will review all new admissions to ensure the Braden Scale has been completed and appropriate care plans in place as necessary (see charge nurse new admission checklist 7C). Patients identified as high risk on the Braden Scale will have regular chart review performed by the nurse manager or designee, to ensure preventive interventions are implemented.

Tag C295, Issue #3 – Failure to implement bed alarm

Plan of Correction:

Involved staff have been counseled regarding the need to fully implement all needed fall prevention interventions. All nursing staff has been informed of our failure to follow our fall prevention protocols. Morse Fall Risk Assessment and Fall Prevention policy and procedures will be reviewed at the 3/26 & 28/14 nursing staff meetings. Charge nurses will now verify that all admissions have been screened for Fall Risk on admission and proper interventions initiated.

Addendum: 4/2/2014

The GCH policy on Fall Prevention and use of the Morse Scale was reviewed with the staff by the CNO at the mandatory nursing meeting, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The policy is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the policy and will adhere to it. All nursing staff will complete the Elsevier Fall Prevention e-learning education module by 4/30/2014 and is tracked by the nurse educator.

Falls will be discussed weekly at the interdisciplinary team meetings. All patients assessed as a high risk patient will have hourly rounding documented using the attached Hourly Rounding Checklist. The hourly rounding checklist will be implemented 4/7/14 and used for monitoring and tracking fall prevention intervention. The checklist will be scanned into the EMR and reviewed by the nurse manager for the appropriate follow up.

C295 POC accepted 4/10/14
FMcIntosh RN/PMU



attachment 7B

patient sticker

HIGH FALLS RISK* HOURLY ROUNDING

* Round on any patient with Morse Scale of 45 or greater

Date:

(check all that apply)	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
Re-oriented to surroundings																								
Room clutter free																								
Call bell & personal items w/in reach																								
Reminded to call for assistance																								
Diversional activities provided																								
Toileting offered																								
Bed/chair alarm in place																								
activated																								
Bed in low position																								
2 side rails up																								
Non-skid slippers																								
Fall risk bracelet																								
Falling star on doorjam																								
Bedside mats if warranted																								
Sitter present																								
Under observation at Nurses' Station																								
Staff initials																								

[Handwritten signature]

Scan completed form into patient's EMR.

Plan for Improving Pressure Ulcer Prevention and Wound Care Management at Grace Cottage Hospital

Grace Cottage Hospital will immediately begin the implementation of a formal pressure ulcer prevention/wound care program utilizing the services of one of our RN nursing staff members. She is on track to becoming wound care certified through the National Alliance of Wound Care and Ostomy. She attended a four day Wound Care Education Institute program February 10-14, 2014 and will sit for her certification exam no later than September 2014.

Introduction of the program to the nursing staff occurred March 19, 2014 via an "all nursing" e-mail and will be formally reviewed at the March staff nurses' meetings scheduled for March 26 and 28, 2014. Staff education regarding pressure ulcer prevention, assessment, staging, wound care & products, and documentation will be presented by the wound care nurse on April 2 and 3, 2014.

Elements of the program include:

- All patients are assessed on admission by a RN for condition of skin (part of "head-to-toe" admission assessment) and for risk of developing pressure ulcers (utilizing the Braden Scale). Findings are documented in the EMR on the Adult Admission Assessment Form. This is past and current practice.
- If appropriate, a Nursing Care Plan for skin care will be initiated on admission. This is past and current practice. Charge nurses are now auditing admission charts for the presence of appropriate care plans at the time of admission.
- If indicated, nursing interventions for pressure ulcer prevention will be initiated and documented on the patient's EMR. This is past and current practice.
- Any patient admitted with wounds other than a clean, healing, surgical incision will:
 - have cultures taken of any draining wounds. (Protocol order approved by the Medical Staff February 13, 2014.) Order for culturing draining wounds will automatically drop electronically to the Nursing Task Bar in the EMR as part of admission order set. (This is in process with our EMR vendor.)
 - have an assessment performed by the wound care nurse on her next working day. (Effective April 7, 2014)
 - have wound care interventions implemented per the recommendation of the wound care nurse as approved by the provider. (Effective April 7, 2014) Nursing Care Plan will be updated by the wound care nurse to reflect any changes in care.
 - have re-assessments of wounds per the wound care instructions, depending on type of dressings and scheduled changes, etc. This is past and current practice.
 - have weekly visits and re-assessments by the wound care nurse. (Effective April 7, 2014) Nursing Care Plan will be updated by the wound care nurse to reflect any changes in care. This re-assessment and care plan update will occur by the nurse manager in the absence of the wound care nurse.



attachment 7A

page 1 of 2

- may have photographs taken to document condition of wound on admission and again as needed during the patient's stay. Patient/guardian permission should be obtained. Photographs will be uploaded to the patient's EMR.
- Documentation of wound assessments, re-assessments and interventions will be documented (text format) on an electronic nursing progress note. Each entry will appear on the same note in a consecutive format. (Effective April 7, 2014)
- In the event that an inpatient develops a pressure ulcer during his/her stay, nursing will complete an electronic occurrence report before the end of the shift on which the ulcer was discovered. Such reports are submitted to the Quality Department who will then send the report on to the nurse manager and the wound care nurse for follow-up. The patient will be seen and assessed as soon as possible by the wound care nurse (or nurse manager if wound care nurse is unavailable). (Effective March 24, 2014)
 - Care, interventions and documentation will follow the same steps as outlined above for patients that present with wounds.
 - All hospital acquired pressure ulcers will be tracked, trended and reported to the Quality Committee.
 - Nursing staff re-education will occur as indicated.
- Pressure ulcer prevention and wound care will be monitored as part of the inpatient care unit QI chart review. (Effective April 7, 2014)



ATTACHMENT #8 – GRACE COTTAGE HOSPITAL – PROVIDER # 471300

Tag C298 – 485.635(d)(4) Nursing Services – Care Plans

Tag C298, Issue #1 – No care plan for skin integrity initiated until 1/10/14

Plan of Correction:

On admission, the shift charge nurse will check the patient's chart for all appropriate care plans using tool, attachment #8A. On his/her next working day, the nurse manager will review the charge nurse admissions check list and follow-up on outstanding items. Nursing care plans are also reviewed by the interdisciplinary team weekly (Fridays).

Addendum: 4/2/2014

If needed, care plans will be added.

Tag C298, Issue #2 – Individualized care plan for fall risk

Plan of Correction:

A Fall Prevention Team has been developed. The team consists of Nursing, Rehab, and Quality staff members. All falls are reported and reviewed by the CNO and Rehab Director. Falls with injury and second falls will be reviewed by the fall team. Occurrence reports will be used for tracking. The Fall Prevention Team will promote a facility wide team approach to falls prevention and will determine appropriate interventions for fall prevention and patient safety. Communication and education with staffing, patient, and family members will be completed as necessary. The Chief Medical Officer and/or patient's provider will be consulted for advice and recommendations as needed. Falls will be discussed at the weekly care plan meeting, so communication between the multi-disciplinary care team members can occur regarding fall risk patients and to ensure patient care plans are updated as needed. A representative from the Quality department attends the weekly Swing Bed meeting where patient care and treatment is also discussed. Falls will be reported monthly instead of quarterly to the Quality committee.

Addendum: 4/2/2014

Charge nurses are checking care plans for all new admits to ensure individualization and verifying the same on the new admission checklist. On the nurse manager's next working day they will review the checklist and follow up on outstanding issues. The care plans are reviewed weekly at the interdisciplinary team care plan meeting and updated as needed. Care plan review is part of the Fall Prevention team review.

C298 POC accepted 4/10/14 FMcIntosh RN/PMU



ATTACHMENT #9 – GRACE COTTAGE HOSPITAL – PROVIDER # 471300

Tag C302 – 485.638(a)(2) Records Systems

Tag C302, Issue #1 – Inconsistent documentation of pressure ulcer

Plan of Correction:

Reference Data has been made readily available (photos and descriptions) of all stages of pressure ulcers, see attachment #9A, and nursing staff has been informed of such via email 3/19/14.

The wound care nurse will include staging and documentation in her classes on 4/2 & 3/14. Staff will be encouraged to photograph wounds and upload pictures to the patient's EMR per new photographing policy and procedure. Beginning 4/7/14, nursing will document wound assessments and care in a continuous progress note with each entry appearing in a dated consecutive format.

Addendum: 4/2/2014

The wound care nurse (nurse manager in his/her absence) will be reviewing the staff documentation as part of his/her weekly wound care rounds and will follow up/re-educate as needed.

Tag C302, Issue #2 – Restraint use forms not completed

Plan of Correction:

A team has been formed to review the use of our current policy on Involuntary Procedures and Restraints to understand our failure to follow the policy, including proper documentation, and how the situation could have been handled differently including other alternative interventions. Several informal discussions have occurred during and post CMS survey of 2/25 – 27/14 and the first formal meeting was held 3/21/14 with the CNO, CMO (also representing the QI Dept.), the nurse manager, and the provider and RN involved in the 2/21/14 incident. Staff have been informed of our failure to follow our policy (emailed 3/19/14) and further informed (email 3/24/14, attachment 9B) that the policy is outdated in places and should not be used without guidance from the CNO or CMO. This team will be updating our current policy; the target date of completion is the May Medical Staff meeting, 5/8/14.

Addendum: 4/2/2014

The current Involuntary Procedures & Use of Restraints policy was reviewed with the staff by the CNO at the mandatory nursing meeting, where attendance was recorded. Additional meetings and sessions are occurring with the CNO until 100% of nursing staff have been educated. The policy is posted in the Nurses' Report Room with a staff sign off sheet as attestation they understand the policy and will adhere to it and will not implement it without discussion with CNO or CMO.

RN and LPN nursing staff will complete the Elsevier Restraints Use e-learning education module by 4/30/2014, tracked by the nursing educator.

The CNO or CMO will notify the Quality Department when the Involuntary Procedures & Restraints policy is used to schedule the restraint use debriefing meeting.



Attachment 9 continued

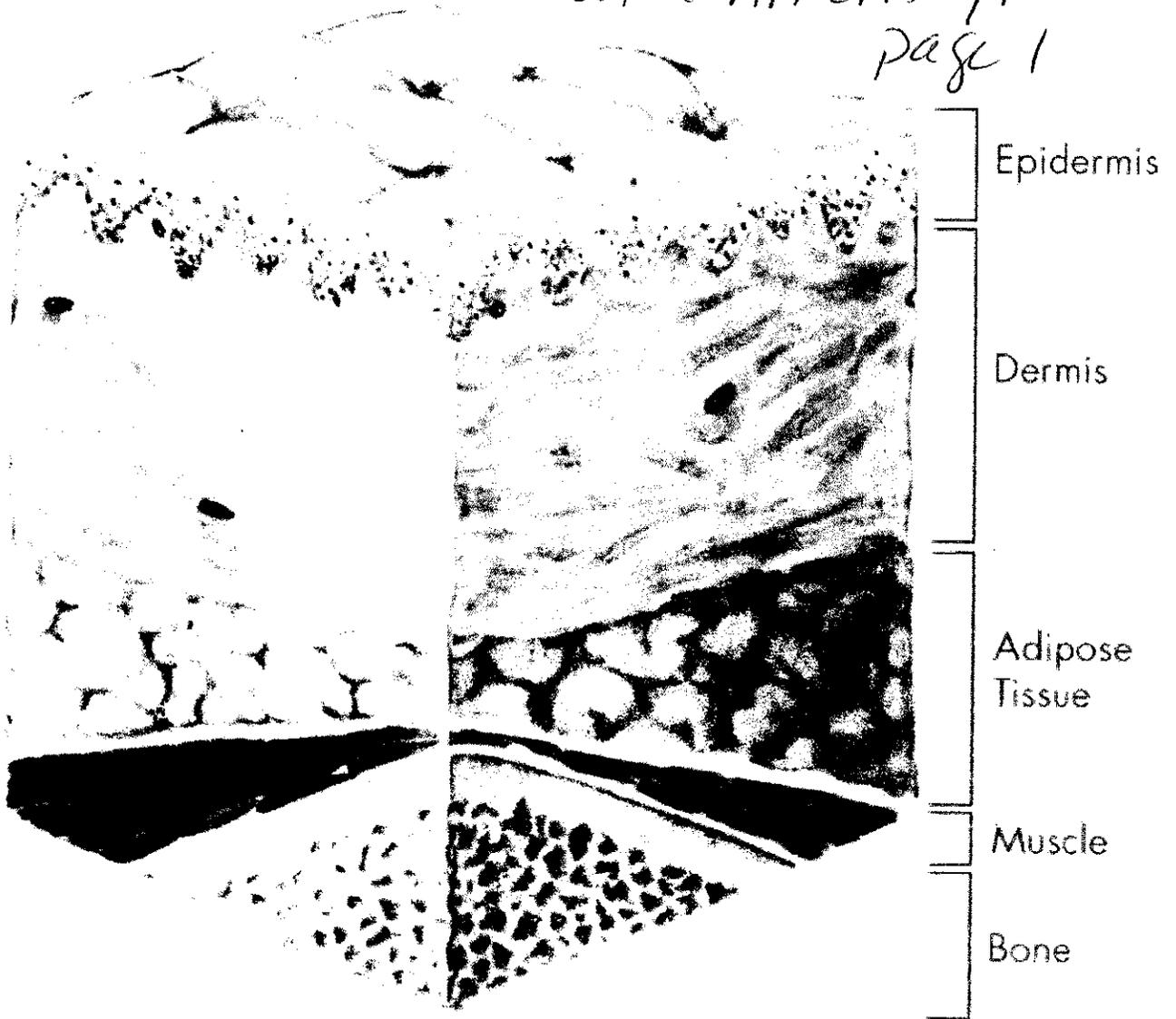
ER Medical staff will be educated at the ER committee meeting on 4/2/14 and general Medical Staff at the Medical Staff meeting on 4/10/14 by the CMO regarding the need to call the CMO and/or CNO prior to implementation of involuntary procedures or restraints and need to utilize the certificate of need and order sheet.

Any provider not in attendance will be spoken to directly by the Quality Director.

C302 POC accepted 4/10/14 FmclutshRN/PMU

A handwritten signature in black ink, appearing to be the initials 'FmclutshRN'.

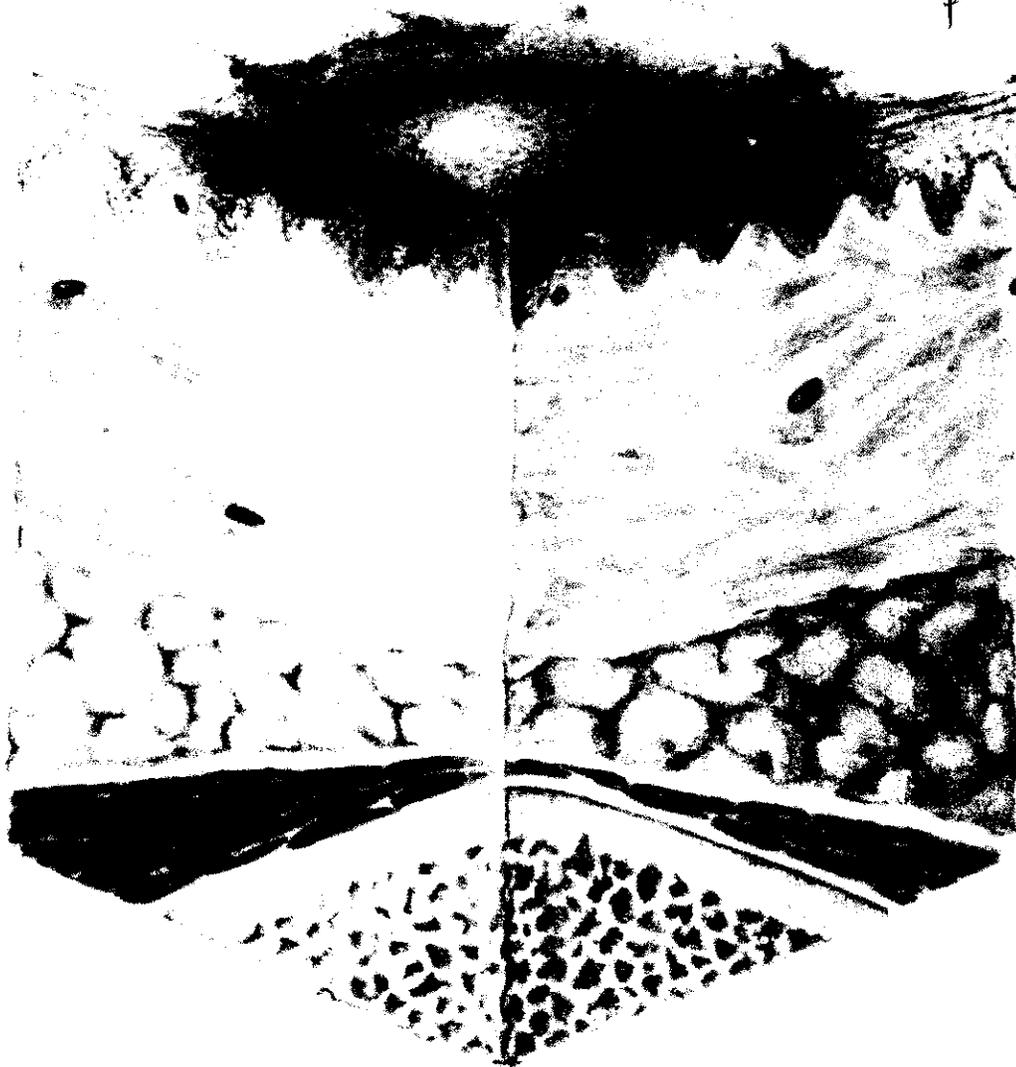
attachment 9A
page 1



NATIONAL
PRESSURE
ULCER
ADVISORY
PANEL

Normal

attachment 9A
page 2



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ULCER
ADVISORY
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STAGE 1

Category/Stage I: Non-blanchable erythema

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.

Attached 9A
page 3



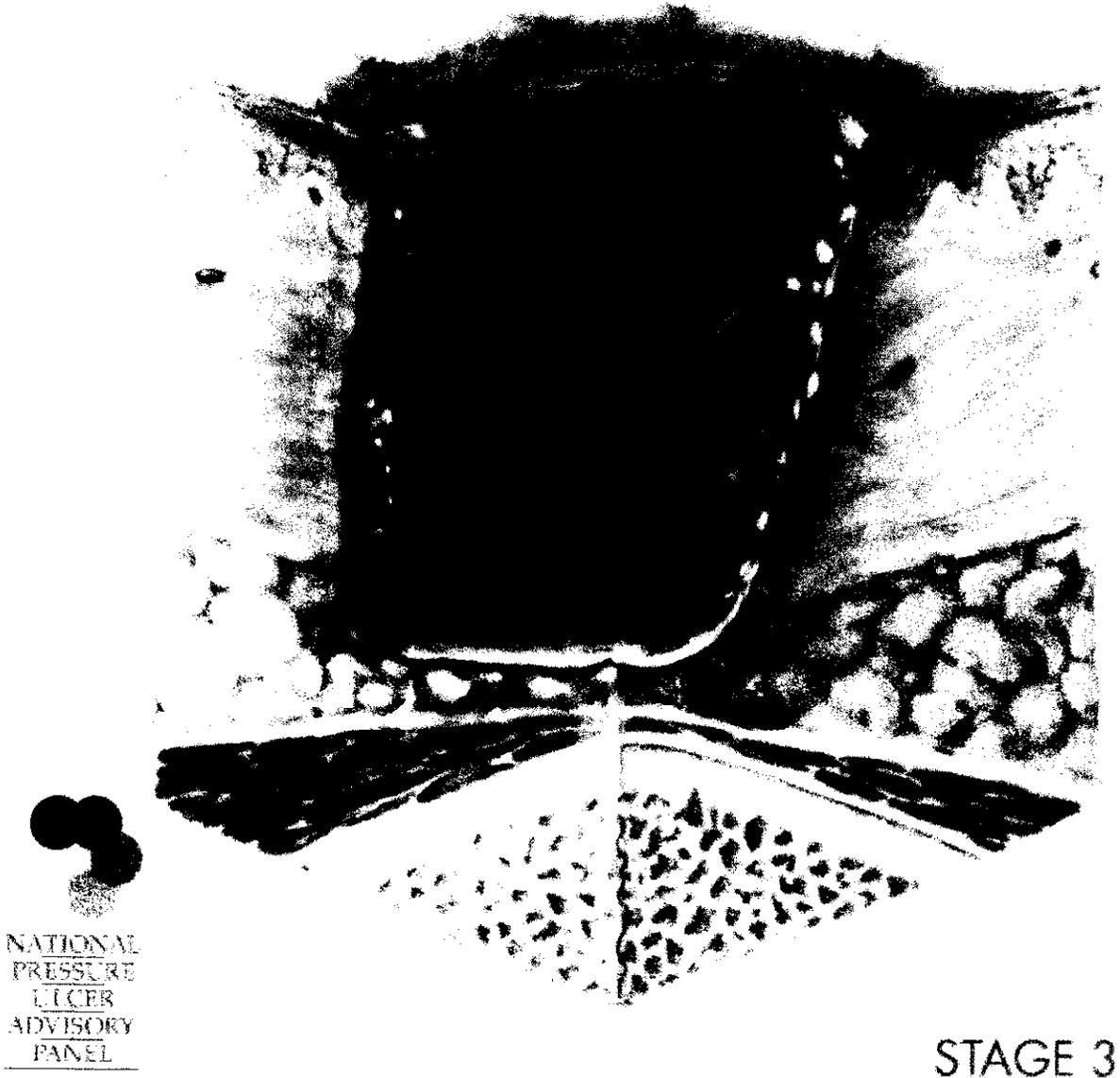
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STAGE 2

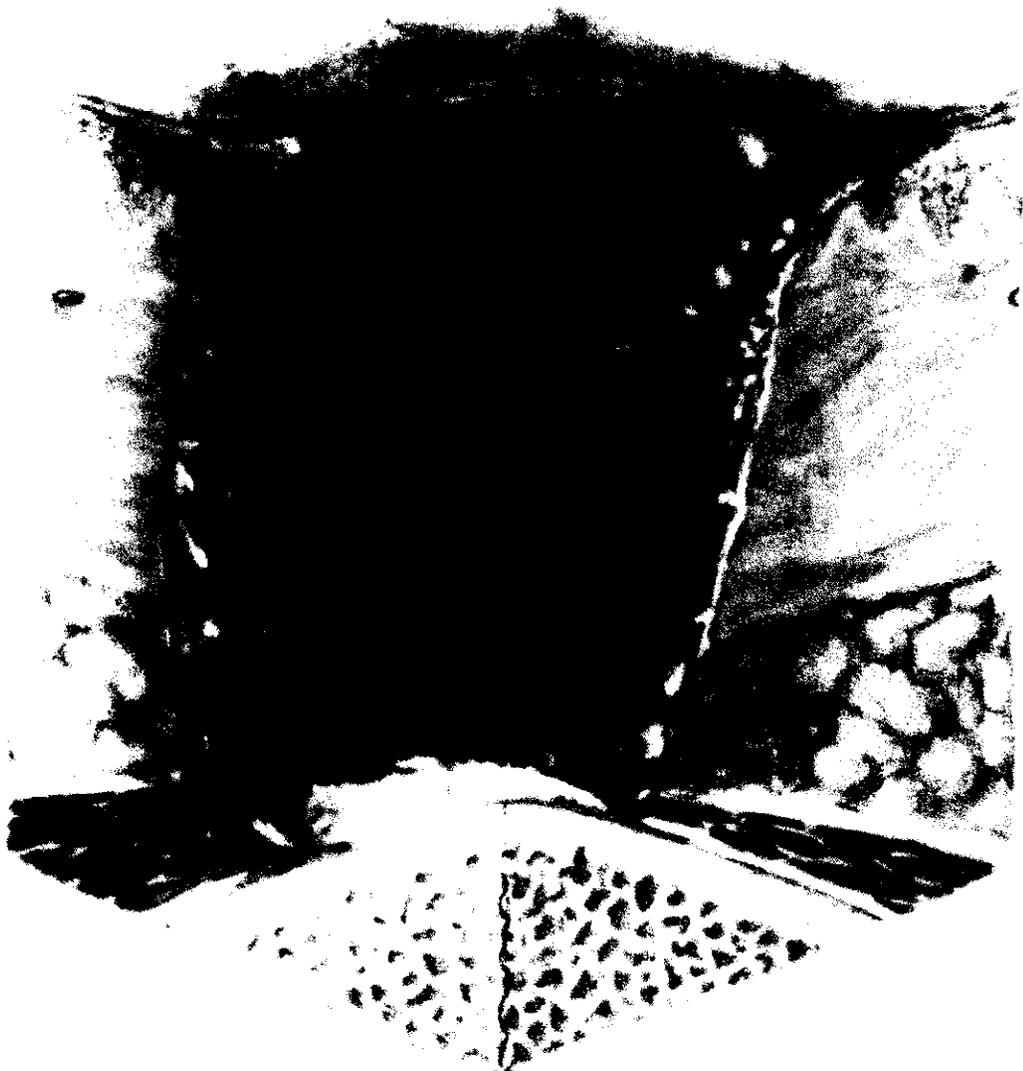
Category/Stage II: Partial thickness

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanguinous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.

*Bruising indicates deep tissue injury.

**Category/Stage III: Full thickness skin loss**

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are *not* exposed. Slough may be present but does not obscure the depth of tissue loss. *May* include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

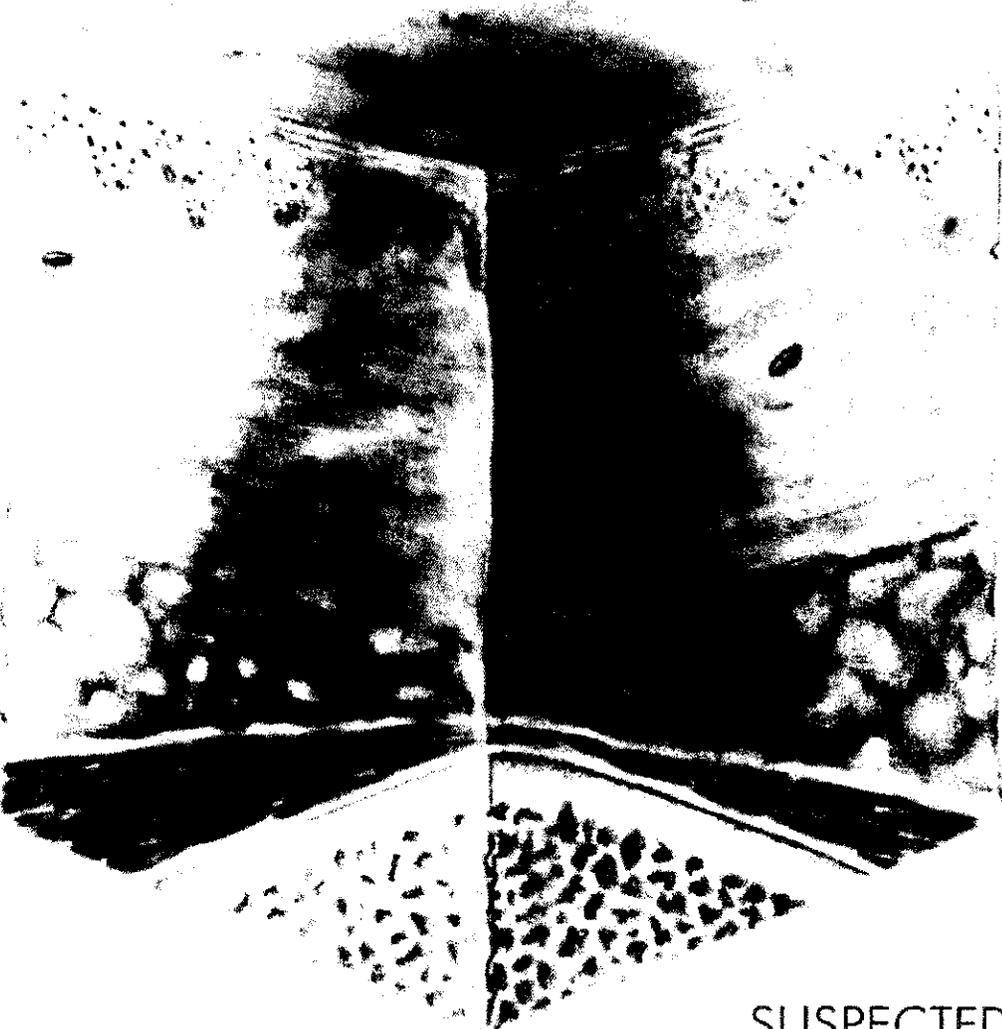


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STAGE 4

Category/Stage IV: Full thickness tissue loss

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.



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SUSPECTED DEEP TISSUE INJURY

Suspected Deep Tissue Injury – depth unknown

Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or *shear*. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.



Additional Categories/Stages for the USA

Unstageable/Unclassified: Full thickness skin or tissue loss – depth unknown

- Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

Use of Involuntary Procedures (Chemical, Physical Restraints)

Jeanne Fortier <jfortier@gracecottage.org>

Sun, Mar 23, 2014 at 5:13 PM

To: Janice Sheppard <jsheppard@gracecottage.org>, Amy Visser-Lynch <avisserlynch@gracecottage.org>, Nathan Olmstead <nolmstead@gracecottage.org>, Walter Rae <wrae@gracecottage.org>, Deborah Cole <dcole@gracecottage.org>, Barbara Williams <bwilliams@gracecottage.org>, Christopher Boucher <cboucher@gracecottage.org>, Andrew Semegram <asemegram@gracecottage.org>, Daniel Herlocker <dherlocker@gracecottage.org>, Melody Lively <mlively@gracecottage.org>, Mariann Zajchowski <mzajchowski@gracecottage.org>, Eileen Kepler <ekepler@gracecottage.org>, Stacy Switzer <sswitzer@gracecottage.org>, Melissa Scribner <mscribner@gracecottage.org>, Robin Ekstrom <rekstrom@gracecottage.org>

Cc: Chris Schmidt <cschmidt@gracecottage.org>, Richard Meyer <rmeyer@gracecottage.org>, Moss Linder <mlinder@gracecottage.org>, Maurice Geurts <mgeurts@gracecottage.org>, Kimona Alin <kalin@gracecottage.org>, Timothy Shafer <tshafer@gracecottage.org>, Ewa Amold <eamold@gracecottage.org>, Dan Ballentine <dballentine@gracecottage.org>, Karen Cusato <kcusato@gracecottage.org>, Warren Montgomery <wmontgomery@gracecottage.org>, Donald Jackson <djackson@gracecottage.org>, Elaine Swift <eswift@gracecottage.org>

The State had issues with our current policy. We have pulled together a team to work on the necessary revisions. If you are in a situation where you feel you need to utilize it, DO NOT do so without contacting Jeanne or Dr Meyer. We'll walk you through it.

Jeanne home = 802-490-2172 cell = 802-258-7848

Dr Meyer home = 603-399-4908 cell = 603-209-2833

Thank you,
Jeanne

—
Jeanne Fortier, RN MBA
Interim Chief Operating Officer
Chief Nursing Officer
Grace Cottage Hospital
PO Box 216 - 185 Grafton Road
Townshend, VT 05353
(802) 365-3613
jfortier@gracecottage.org

ATTACHMENT #10 – GRACE COTTAGE HOSPITAL – PROVIDER # 471300

Tag C306 – 485.638(a)(4)(iii) Records Systems

Tag C306, Issue #1 – Inability to follow healing process

Plan of Correction:

Beginning 4/7/14, nursing will document wound assessments and care in a continuous progress note with each entry appearing in a dated consecutive format.

Addendum: 4/2/2014

The wound care nurse (nurse manager in their absence) will be reviewing the staff documentation as part of her weekly wound care rounds and will follow up/re-educate as needed.

Tag C306, Issue #2 – No wound culture obtained

Plan of correction:

The wound culture order was missed by the patient's nurse. We have requested our EMR vendor to make a task appear on the "Nursing Task Bar" to "Culture Draining Wounds on all admissions". This will serve as a reminder to the nurse. We have a Medical Staff approved protocol to culture all draining wounds on any patient.

Addendum: 4/2/14

"Culture Draining Wounds" will be added to the charge nurse new admission checklist (see attachment 10A).

Follow up with EMR vendor confirms that tasks will drop as requested.

C306 POC accepted 4/10/14 FMCint-sh RN/PMU



ATTACHMENT #11– Grace Cottage Hospital – Provider #471300

Tag C330 – 485.61 PERIODIC EVALUATION AND QA REVIEW

Refer to C337

Tag C337 – 485.61(B)(1) QUALITY ASSURANCE

All patient care services and other services affecting patient health and safety are evaluated

Tag C337, Issue #1 – Skin Breakdown and no quality review of medical records

Plan of Correction:

Grace Cottage Hospital has initiated pressure ulcer reporting via the internal occurrence reporting system. Occurrence reporting will be completed by nursing for inpatients that develop a pressure ulcer. Pressure ulcer occurrence reports will be forwarded to the nurse manager and wound care nurse for follow-up, including initiation of appropriate nursing care plan interventions if not already in place. Pressure ulcers may be photographed. Hospital acquired pressure Ulcers will be tracked, trended, and reported monthly to the Quality Committee by the CNO or designee. Nursing QI chart review report will be forwarded to the Quality Director.

The Quality Director or designee will attend the weekly care plan meeting so treatment and care regarding patients with pressure ulcers can be discussed with the multi-disciplinary care team members and to ensure appropriate measures are being done. A representative for the Quality department also attends the weekly Swing Bed meeting where patient care and treatment is also discussed.

Addendum 3/28/2014

All hospital acquired pressure ulcers will be logged and tracked on the Quality Department's Pressure Ulcer Review Spreadsheet. Pressure Ulcer incidents are reported at the Quality Committee meeting.

Tag C337, Issue #2 – Fall Prevention

Plan of Correction:

A Fall Prevention Team has been developed. The team consists of Nursing, Rehab, and Quality staff members. All falls are reported and reviewed by the CNO and Director of Rehab. All falls with injury or an occurrence of a second fall will reviewed by the Fall Preventive Team. Occurrence reports will be used for tracking. The Fall Prevention Team will promote a facility wide team approach to falls prevention and will determine appropriate interventions for fall prevention and patient safety. Communication and education with staffing, patients, and family members will be completed as necessary. The Chief Medical Officer and/or patient's provider will be consulted for advice and recommendations as needed. Falls will be discussed at the weekly care plan meeting, so communication between the multi-disciplinary care team members can occur regarding fall risk patients and to ensure patient care plans are updated as needed. A representative from Quality department attends the



Attachment 11 continued

weekly Swing Bed meeting where patient care and treatment is also discussed. Falls will be reported monthly instead of quarterly to the Quality Committee (effective 4/23/2014).

Addendum 4/10/14

The records of the Fall Prevention Team reviews are documented and stored in the Quality Department. Falls will be reviewed monthly at the Quality Committee.

Tag C337, Issue #3 – Quality review related to the use of restraints and involuntary medication and PI Plan of Correction:

The Quality Director, Chief Medical Officer, and CNO or designees will review patient records when restraints are used on a patient. A debriefing will be completed per policy. Findings will be discussed at the monthly Quality Committee meeting. Performance improvement (PI) opportunities will be identified and Quality Department staff will involve appropriate staff regarding PI initiatives.

Addendum 4/2/2014

The CNO or CMO will notify the Quality Department whenever Involuntary Procedure and Use of Restraints Policy is implemented.

All debriefing reports, including attendance will be stored in the Quality Department.

Tag C337, Issue # 4 – Failure to establish a policy and procedure to direct staff in the utilization of non-employed staff

Plan of Correction:

A policy and procedure will be created by the Quality Director, CNO, and CMO, forwarded for approval to the Quality Committee on 04/23/2014 and Medical Staff Committee 05/8/2014.

Addendum 4/2/2014

Once the policy is approved it will be discussed at the Department Head meeting and given to each department head to review with their staff. The policy will have a requirement to file an occurrence report any time when Rescue Inc./EMS personnel are used for anything other than transition in care (during drop off or pick up) or any time law enforcement is used. The Quality Department will follow up for appropriateness.

Tag C337, Issue #5 - Failure to develop a patient care policy regarding transport of patients

Plan of Correction:

A new policy and procedure has been developed (attachments #11A). Staff education will be completed at nursing meeting 03/26 and 03/28/2014 and at Medical Staff meeting 04/10/2014

Addendum 4/2/2014 The Quality Department has asked the CNO to provide proof of policy education. This attendance log will be kept in the Quality Department.

A handwritten signature in black ink, appearing to be 'RMA', is located at the bottom center of the page.

Attachment 11 cont.

The Medical Staff will be educated on 4/10/14 attendance will be recorded by Medical Staff minutes. The Quality Director will follow up with any medical staff not in attendance.

The worksheet currently used by the unit secretary for coordinating off site appointments includes transport mode and accompaniment. These forms will be reviewed before transport by the charge nurse or nursing manager, for appropriateness.

Tag C337, Issue #6 - Policy and procedure to guide staff in the use of patient pictures/images

Plan of Correction:

A Photographing, Videorecording, or Recording Device Policy has been completed. The Quality Director educated the Medical Staff at the 03/13/2014 Medical Staff meeting regarding prohibition of cell phone and/or personal device use for picture taking of patients and patient's wounds. The Medical Staff was instructed to use the camera that is on the Med/Surg unit to document wound care or other pertinent pictures needed for treatment, care, and reporting. The camera, instructions for the camera operation and uploading the photos into the patient's electronic medical record are stored in the triangle shaped room on the unit. This information was relayed to the Medical Staff at the March Medical Staff meeting. Nursing administration will educate the nursing staff on the implementation of the policy and procedures of photographing patients. The new policy "Photographing Video recording or Recording Device Policy" will be distributed at the April 10, 2014 Medical Staff meeting. (attachment #11 B)

A spreadsheet with completion dates and responsible parties has been developed for all outstanding plan of correction items (see attached). The CNO, CMO and Quality Director are meeting weekly to ensure adherence to the work plan.

C330, C337 POC accepted 4/10/14 FMedntshRw/PMU



SUBJECT: Transport of Inpatients Needing Services at Other Facilities	REFERENCE # 2.0101
DEPARTMENT: Nursing	PAGE: 1 OF: 2
AUTHORED BY: Jeanne Fortier, RN Chief Nursing Officer	EFFECTIVE:
APPROVED BY: Quality Committee Medical Staff	REVISED:

PURPOSE:

At times Grace Cottage Hospital inpatients are scheduled for outpatient follow-up appointments, tests and/or procedures. This policy defines which patients may go to such appointments, how they will be transported and should accompany them.

POLICY:

Acute Inpatients:

If an acute inpatient is in need of a consultation, a procedure, or testing that GCH is unable to provide onsite, that patient must be **transferred** to another inpatient facility that is capable of providing the needed service and will attend to the patient's acute care needs. Note: Such patients may be **transferred back** to GCH after the consultation, procedure or test. Transportation will be via ambulance with the appropriate level of EMS in attendance.

Acute inpatients are not to be sent for procedures, testing or consultations rendered in an outpatient setting.

Swing Bed/Skilled Level Inpatients:

If a Swing Bed or Skilled Level inpatient is in need of a consultation, a procedure, or testing that GCH is unable to provide onsite, that patient will be given a **leave of absence** from GCH in order to obtain the needed service.

Appropriate transportation and accompaniment must be arranged.

Private car with responsible adult family member or friend – patient must be medically stable, must demonstrate safety awareness and compliance with all safety precautions. Patient must have the functional capacity to get in and out of the vehicle safely by self or with minimal assistance. A wheelchair or walker may be sent with the patient for use at the appointment if appropriate. The family member or



SUBJECT: Transport of Inpatients Needing Services at Other Facilities	REFERENCE # 2.0101
DEPARTMENT: Nursing	PAGE: 2 OF: 2
AUTHORED BY: Jeanne Fortier, RN Chief Nursing Officer	EFFECTIVE:
APPROVED BY: Quality Committee Medical Staff	REVISED:

friend must be able and willing to assist patient. Under such circumstances, no GCH escort is necessary.

Wheelchair Van with responsible adult family member or friend – Wheelchair bound patients or those that are not fully ambulatory (with or without a walker) may be transported via wheelchair van in a wheelchair. If the patient is medically stable, demonstrates safety awareness and compliance with all safety precautions and has an adult family member or friend that is willing and able to accompany and assist the patient, no GCH escort is necessary.

Wheelchair Van with GCH Escort* - Wheelchair bound patients or those that are not fully ambulatory (with or without a walker) may be transported via wheelchair van in a wheelchair. If the patient is medically stable, but does not demonstrate safety awareness or is non-compliant with safety precautions, or if they have no responsible adult family member or friend to accompany them, a GCH escort will be provided.

Ambulance – medically stable bedbound patients or those that are unable to sit in a wheelchair for long periods of time should be transported by ambulance with the appropriate level of EMS. If the ambulance crew will be staying with the patient EMS for the duration of the consult, testing or procedure, then no GCH escort is necessary. If not, send a GCH escort.

***GCH Escorts:**

For medically stable Swing Bed/Skilled Level Inpatients may use LNA, Activities, Social Service or other appropriate GCH personnel as an escort, as determined by the Nurse Manager or Charge Nurse in consultation with the attending physician.

Medically *unstable* Swing Bed/Skilled Level Inpatients should be considered in the category of Acute for the purpose of this policy.



SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 1 OF: 4
APPROVED BY:	EFFECTIVE:
AUTHORED BY: Elaine Swift, Quality Director	REVISED:

POLICY: Grace Cottage Hospital (GCH) must take reasonable steps to protect patients, visitors, and staff members from unauthorized photography, video or audio recordings, or other images. Due to the sensitive nature of patient information and to protect patient privacy, the facility must follow the guidelines and procedures outlined below before allowing, or prior to, photographing, video or audio recording, or otherwise imaging of patients, visitors or staff members.

PURPOSE:

1. To facilitate compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR Parts 160 and 164, and any and all other federal regulations and interpretive guidelines.
2. To establish guidelines for situations where patients and/or staff members may or may not be photographed, video or audio recorded or otherwise imaged within GCH.

DEFINITIONS:

- **Audio Recordings:** recording an individual's voice using a videorecording device (e.g., video cameras, cellular telephones), tape recorders, or other technologies capable of capturing audio.
- **Authorization:** A written form executed by the patient or the patient's legal representative.
- **Consent:** the patient's or patient's legal representative's written acknowledgement and/or agreement of the use and/or disclosure of protected health information for treatment, payment, or health operations purposes or other reasons permitted by the HIPAA Privacy Rule.
- **Photography:** recording an individual's likeness (e.g. image, picture) using photography (e.g. cameras, cellular telephones), video recording (e.g. video cameras, cellular telephones), digital imaging (e.g. digital cameras, web cameras), or other technologies capable of capturing an image (e.g. Skype™). This does not include medical imaging such as CTs, or images of specimens.

TSW 2/10

SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 2 OF: 4
APPROVED BY:	EFFECTIVE:
AUTHORED BY: Elaine Swift, Quality Director	REVISED:

- Staff Member: employees, volunteers, trainees, and other persons whose conduct, in the performance of work for GCH, is under the direct control of GCH, whether or not they are paid by GCH.

PROCEDURE: As a general rule and to protect the privacy rights of staff and patients, video and other imaging of treatment and procedures are prohibited at GCH. Patient initiated videorecording of treatment and procedures has the potential to interfere with the provision of appropriate medical and nursing care. Additionally, such activity may intrude on the privacy interests of other patients, individuals and staff. It is therefore the policy of GCH to prohibit the use of video cameras during such treatment and procedures.

However, GCH does recognize that there may be instances where such imaging is necessary or desired. This section describes the limited circumstances in which photography and/or audio recordings may be used to capture or record the likeness or voice of a patient or staff member.

Imaging by patients, family members and/or visitors:

- Consent from the patient is not needed for photography or videorecording done by the patient's family members or friends provided the patient is alert and competent at the time (implied consent). Under no circumstances should a photo or video be taken during patient treatment or procedure.
- Permission of any staff captured on film is needed. Staff will note the imaging and their permission in the medical record.

Imaging by hospital or medical staff for documenting patient care:

- Any imaging done by or using equipment owned, leased or rented by GCH will become the property of GCH. Patients should provide consent for such imaging which will be filed as a portion of the patient's EMR. The staff member taking the image(s) is responsible for obtaining the consent.
- Photographs taken to document abuse and neglect, domestic violence, elder abuse, rape, and similar disclosures required by law do not require consent from the patient or authorized agent. Copies of such photographs may be submitted with the required report to the investigating agency (originals filed in the patient's

SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 3 OF: 4
	EFFECTIVE:
APPROVED BY:	REVISED:
AUTHORED BY: Elaine Swift, Quality Director	

EMR) but should not be used for other purposes without further authorizations from the patient.

- Students of all disciplines should not be taking or storing photographs of patients under any circumstances.
- Photographs should not be taken with cell phones, under any circumstances. It is too easy with phones to send images to unauthorized people.
- In all images or recordings, care must be taken to respect the dignity, ethnicity and religious beliefs of the patient.
- Photographs may be used for identification purposes.

Imaging for Educational and Training:

- Authorization (consent) from the patient or their authorized agent must be obtained prior to photography or videotaping. The consent should explicitly outline the intended use and disclosure of patient identifiable information. No patient identifying information should be associated with such photography or videotaping unless specifically authorized by a competent adult. The signed authorization should be filed with the patient's medical record.
- Arrangements for obtaining the appropriate authorizations/consents should be made through the Chief Nursing Officer or designee.
- The Chief Nursing Officer or designee will also ensure that confidentiality agreements or commitments are obtained from the group or persons performing the image.
- Educational, training, or publicity videos or photography will remain the property of Grace Cottage Hospital.

Marketing/Public Relations purpose:

- GCH Development and Community Relations will obtain written consent on an approved consent form when videoing or photographing patients, staff, and visitors.

SUBJECT: PHOTOGRAPHING, VIDEORECORDING OR RECORDING DEVICE POLICY	Reference #1.0075
DEPARTMENT: ADMINISTRATION	PAGE: 4 OF: 4
APPROVED BY:	EFFECTIVE:
AUTHORED BY: Elaine Swift, Quality Director	REVISED:

Consent:

- The patient's informed consent must be obtained in writing using the GCH Consent for Videorecording/Photography or Photography Release Form before images or recordings are taken.
- Patients must be fully informed of the purpose of the image/recording and be given a clear explanation of how the image may be used.
- Staff should make careful consideration of the appropriateness of photographing children. A signed consent form is required by the parent or legal guardian.

Storage and Use:

- GCH will designate a safe, secure, and inaccessible storage for all images/videos of patients and/or staff members.

Risk Management Considerations:

- Imaging should not interfere with patient care or be detrimental to the patient (per patient/caregiver assessment). Any imaging that may record an untoward event (as determined by the attending provider) automatically comes under the custody of the Risk Management Department and should be forwarded to them immediately.

Any questions regarding this policy should be referred to the Risk Management/Quality Management Department.

References:

- Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individual Identifiable Health Information 45 CFR Part 164
- American Health Information Management Association. 2001.

PLAN OF CORRECTION TRACKING SPREADSHEET - ACUTE - 471300

TAG NUMBER	ISSUE	PLAN OF CORRECTION	RESPONSIBLE PERSON(S)	TARGET COMPLETION OATE	COMPLETED
C151	Issue #1 - Photograph of wound	Speak with responsible Provider about refraining from taking photos with cell phone	CMO/CNO	02/27/14	Yes
C151	Issue #1 - Photograph of wound	Complete Photographing, Video recording, or Recording Oevice Policy	Elaine S	3/24/2014	Yes
C151	Issue #1 - Photograph of wound	Educate Medical Staff regarding prohibition of taking pictures with cell phones	Elaine S. Or. Meyer	03/13/14	Yes
C151	Issue #1 - Photograph of wound	Educate Medical Staff regarding use and location of hospital cameras	Elaine S.	03/13/14	Yes
C151	Issue #1 - Photograph of wound	Educate nursing staff on implementation of Photographing Policy	Jeanne F., Janice S.	3/19 (email)3/26/14 & 3/28/14 (staff meeting)	Yes
C151	Issue #1 - Photograph of wound	Photographing, Video recording, or Recording Oevice Policy distributed to the Medical Staff.	Elaine S. Or. Meyer	ER provider meeting 4/2/14 and Med. Staff 4/10/2014	4/2 - yes
C151	Issue #2 - Use of Rescue, Inc. personnel	Notify nursing by email not to use Rescue, Inc. personnel for anything other than a true emergency situation in the EO	Jeanne F., .	03/19/14	Yes
C151	Issue #2 - Use of Rescue, Inc. personnel	Educate Medical Staff regarding use of Rescue	CMO	ER provider meeting 4/2/14 and Med. Staff 4/10/2014	4/2- yes
C151	Issue #2 - Use of Rescue, Inc. personnel	Oevelop a policy regarding the use of non-hospital personnel	Or. Meyer, Elaine S.	04/22/14	

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C151	Issue #2 - Use of Rescue, Inc. personnel	Present Use of non-hospital personnel policy to Quality Committee	Elaine S.	04/23/14	
C250-53	Issue #1 - Short Staffing	Post nursing position(s) to adjust the night shift nursing staff back to 4	Jeanne F., Janice S.	03/24/14	Yes
C250-53	Issue #1 - Short Staffing	Adjust nursing aid shifts and institute on call schedule until additional staff can be recruited, hired, and oriented	Jeanne F., Janice S.	03/31/14	Yes
C250-53	Issue #1 - Short Staffing	Develop a tool to monitor night staffing census and call	Jeanne	03/31/14	yes
C250-53	Issue #1 - Short Staffing	evaluate to hire contracted security at night or a night shift maintenance/multi-purpose employee	Jeanne, Elaine, Stephen	04/30/14	
C253	Issue #2 - PT/OT Staffing	Hire additional full time PT to cover weekends	Crystal M.	01/24/14	Yes
C253	Issue #2 - PT/OT Staffing	Arrange to have OT coverage on the weekends	Crystal M.	3/24/2014	Yes
C271	Issue #1 - Failure to provide care in accordance with skin breakdown prevention policy	Develop plan for improving prevention of pressure ulcers and wound care management	Jeanne	3/21/2014	yes
C271	Issue #2 - No bed alarm and patient left in bathroom	Notify nursing staff in email that reeducation of Morse Fall Scale policy and procedure will take place at March nursing staff meetings	Jeanne F., Janice S.	03/19/14	Yes

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C271	Issue #2 - No bed alarm and patient left in bathroom	Re-educate nursing staff on Morse Fall Scale policy and procedure	Jeanne F., Janice S.	3/26/14 & 3/28/14	
C271	Issue #2 - No bed alarm and patient left in bathroom	Council two nurses involved in incident	Janice S.	Feb check date	yes
C271	Issue #3 - Nurse who failed to implement alarm on admit	Council nurse involved in incident	Janice S.	Feb check date	yes
C271	Issue #3 - Nurse who failed to implement alarm on admit	Notify nursing staff in email about implementing alarm on admit and that reeducation will take place at March nursing staff meeting	Jeanne F., Janice S.	03/19/14	Yes
C271	Issue #3 - Nurse who failed to implement alarm on admit	Re-educate nursing staff on implementing alarm on admit	Jeanne F., Janice S.	3/26/14 & 3/28/14	
C271	Issue #3 - Nurse who failed to implement alarm on admit	Implement hourly rounding on high risk pts.	Jeanne, Janice	04/07/14	
C271	Issue #4 - Involuntary Procedures & Restraints	Form team to review current policy on Involuntary Procedures and Restraints	Dr. Meyer, Dr. Shafer, Jeanne F.	3/16/14 & 3/21/14	Yes
C271	Issue #4 - Involuntary Procedures & Restraints	Hold formal meeting to review 2/21/14 incident	Dr. Meyer, Dr. Shafer, Jeanne F.	03/21/14	yes
C271	Issue #4 - Involuntary Procedures & Restraints	Send email informing staff of failure to follow our policy	Jeanne F.	03/19/14	Yes
C271	Issue #4 - Involuntary Procedures & Restraints	Bring current policy to ER Medical Staff Committee to educate on calling CMO/CNO before implementing and to use the cert. of need and order sheet.	Dr. Meyer	04/02/14	Yes

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C271	Issue #4 - Involuntary Procedures & Restraints	Inform Med. Staff on calling CMO/CNO before implementing and to use the cert. of need and order sheet.	Dr. Meyer, Elaine S.	04/10/14	
C271	Issue #4 - Involuntary Procedures & Restraints	Send email informing staff that our policy is outdated & to seek guidance until policy is updated	Jeanne F.	03/24/14	Yes
C271	Issue #4 - Involuntary Procedures & Restraints	Update our current Involuntary Procedures and Restraints Policy	Dr. Meyer, Dr. Shafer, Jeanne F.	05/08/14	
C273	Issue#1 - No policy for use of Rescue Inc Services	Educate ER Medical Staff regarding the issue of not using Rescue Inc.	Dr Meyer	ER provider meeting 4/2/14 and Med. Staff 4/10/2014	4/2 yes
C273	Issue #1 - No policy for use of Rescue, Inc. Services	Develop policy for services provided by outside contracted personnel	Dr. Meyer, Jeanne F., Elaine S.	04/23/14	
C273	Issue #1 - No policy for use of Rescue, Inc. Services	Present completed policy for services provided by outside contracted personnel to Quality Committee for review	Dr. Meyer, Jeanne F., Elaine S.	04/23/14	
C273	Issue #1 - No policy for use of Rescue, Inc. Services	Present completed policy for services provided by outside contracted personnel to the Medical Staff at Medical Staff Meeting for review	Dr. Meyer, Jeanne F., Elaine S.	05/08/14	
C273	Issue #1 - No policy for use of Rescue, Inc. Services	Inform Drew Hazelton, Rescue, Inc. Interim Chief, that his employees are not to render care in the inpatient unit.	Jeanne	03/20/14	Yes
C273	Issue #2 - No policy for use of Sherriff	Develop policy for services provided by law enforcement	Dr. Meyer, F., Elaine S.	04/22/14	

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C273	Issue #2 - No policy for use of Sherriff	Present completed policy for services provided by law enforcement to Quality Committee for review	Dr. Meyer, Jeanne F., Elaine S.	04/23/14	
C273	Issue #2 - No policy for use of Sherriff	Present completed policy for services provided by law enforcement to the Medical Staff at Medical Staff Meeting	Dr. Meyer, Jeanne F., Elaine S.	05/08/14	
C273	Issue #3 - No policy regarding transport of patients to other facilities	Develop policy for transport of inpatients needing services at other facilities	Jeanne F.	3/21/2014	yes
C273	Issue #3 - No policy regarding transport of patients to other facilities	Present completed policy for transport of inpatients needing services at other facilities to nursing staff	Jeanne F.	3/26/14 & 3/28/14	yes
C273	Issue #3 - No policy regarding transport of patients to other facilities	Present completed policy for transport of inpatients needing services at other facilities to Medical Staff at Medical Staff Meeting	Jeanne F.	04/10/14	
C273	Issue #3 - No policy regarding transport of patients to other facilities	Present completed policy for transport of inpatients needing services at other facilities to Quality Committee	Jeanne F.	04/23/14	
C273	Issue #4 - No policy regarding photographing, video cording, or recording devices	Draft Photograph, Video recording, or Recording Device Policy	Elaine S	3/24/2014	yes
C273	Issue #4 - No policy regarding photographing, video recording, or recording devices	Educate Medical Staff regarding prohibition of taking pictures with cell phones	Elaine S., Jeanne F.	03/13/14	Yes

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C273	Issue #4 - No policy regarding photographing, video recording, or recording devices	Educate Nursing Staff on implementation of photographing policy	Jeanne F., Janice S.	3/26/14 & 3/28/14 and 4/2/14 & 4/3/14	yes
C273	Issue #4 - No policy regarding photographing, video recording, or recording devices	New Photographing Policy distributed at ER Med Staff and Medical Staff Meeting	Elaine S.	04/10/14	4/2 Yes
C278	No wound culture obtained	Request EMR vendor to add "Culture Draining Wounds on all admissions" task on the Nursing Task Bar	Janice ., Angie C.	3/1/2014	yes
C278	No wound culture obtained	Addition of "Culture Draining Wounds" task to Nursing Task Bar	Angie C. Janice	4/7/2014	yes
C294	Issue #1a - Pressure ulcer care	Develop PU plan	Jeanne	3/21/2014	yes
C294	Issue #1a - Pressure ulcer care	Educate Nursing staff on implementation of pressure ulcer plan	Jeanne, Stacy, Janice	3/26 and 3/28, 4/2 and 4/3	yes
C294	Issue #1a - Pressure ulcer care	Implement plan for improving pressure ulcer prevention	Jeanne, Janice, Stacy	4/7/2014	
C294	Issue #1b - Delay in updating care plan	Request EMR vendor to remove filter so nursing can see history on nursing care plans	Janice, Angie	3/1/2014	yes
C294	Issue #2 and #3 - No bed alarm on admission	Council two staff involved regarding the need to fully implement all needed fall prevention interventions	Janice S.	done immediately post falls	yes
C294	Issue #2 and #3 - No bed alarm on admission	Inform nursing staff of our failure to follow fall prevention protocols	Jeanne F.	email 3/19	yes

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C294	Issue #2 and #3 - No bed alarm on admission	Review Morse Fall Risk Assessment and Fall Prevention policy and procedures at nursing staff meetings	Jeanne F.	3/26/14 & 3/28/14	yes
C294	Issue #2 and #3 - No bed alarm on admission	Initiate charge nurse review of all new admissions for fall risk assessments, initiation of care plans and implementation of interventions	Jeanne, Janice	3/26/14 & 3/28/15	yes
C294 and C295	bed alarm issues	Implement hourly rounding with high risk fall pts	Jeanne, Janice	04/07/14	
C295	Issue #1a - Failure to implement bed alarm on admission	Council staff involved regarding the need to fully implement all needed fall prevention interventions	Janice	done immediately post falls	yes
C295	Issue #1a - Failure to implement bed alarm on admission	Inform nursing staff of our failure to follow fall prevention protocols	Jeanne F.	done immediately post falls	yes
C295	Issue #1a - Failure to implement bed alarm on admission	Review Morse Fall Risk Assessment and Fall Prevention policy and procedures at nursing staff meetings	Jeanne F.	3/26/14 & 3/28/14	yes
C295	Issue #1a - Failure to implement bed alarm on admission	Initiate charge nurse review of all new admissions for fall risk assessments, initiation of care plans and implementation of interventions	Jeanne, Janice	03/31/14	yes
C295	Issue #1b - Patient left in bathroom	Council staff involved regarding leaving the patient alone in the bathroom	Janice S.	immediately post fall	yes

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C295	Issue #2 - Failure to prevent pressure ulcer	Implement plan for improving pressure ulcer prevention	Jeanne, Janice, Stacy	4/7/2014	
C295	Issue #2 - Failure to prevent pressure ulcer	Develop Pressure ulcer plan	Jeanne	3/21/2014	yes
C295	Issue #2 - Failure to prevent pressure ulcer	Educate Nursing staff on implementation of pressure ulcer plan	Jeanne	3/26/14 & 3/28/14 and 4/2 and 4/3	yes
C295	Issue #3 - Failure to implement bed alarm	Counsel staff regarding the need to fully implement all needed fall prevention interventions	Janice	immediately post fall	yes
C295	Issue #3 - Failure to implement bed alarm	Inform nursing staff of our failure to follow fall prevention protocols	Jeanne F.	3/19- email and 3/26 and 3/28	yes
C295	Issue #3 - Failure to implement bed alarm	Review Morse Fall Risk Assessment and Fall Prevention policy and procedures at nursing staff meetings	Jeanne F.	3/26/14 & 3/28/14	yes
C295	Issue #3 - Failure to implement bed alarm	Initiate charge nurse review of all new admissions for fall risk assessments, initiation of care plans and implementation of interventions	Jeanne, Janice	3/26/14 & 3/28/15	yes
C298	Issue #1 - No care plan for skin integrity initiated until 1/10/14	Implement use of tool by shift change nurse to check for all admissions for appropriate care plans	Jeanne, Janice	3/26/14 & 3/28/16	yes
C298	Issue #2 - Individualized care plan for fall risk	charge nurse checklist on admission and care plan team weekly	Jeanne, Janice, care plan team	3/31/2014	ongoing
C302	Issue #1 - Inconsistent documentation of pressure ulcer	Make reference data of all stages of pressure ulcers readily available to nursing staff	Jeanne F.	03/19/14	Yes

C302	Issue #1 - Inconsistent documentation of pressure ulcer	Notify nursing staff in email that reference data for all stages of pressure ulcers is readily available	Jeanne F.	03/19/14	Yes
C302	Issue #1 - Inconsistent documentation of pressure ulcer	Initiation of nursing documented wound care assessments and care in continuous progress note with each entry appearing in dated consecutive format	Janice, Stacy	04/07/14	
C302	Issue #2 - Restraint use forms not completed	Form team to review current policy on Involuntary Procedures and Restraints	Dr. Meyer, Dr. Shafer, Jeanne F.	03/16/14	Yes
C302	Issue #2 - Restraint use forms not completed	Hold formal meeting to review 2/21/14 incident	Dr. Meyer, Dr. Shafer, Jeanne F.	03/21/14	Yes
C302	Issue #2 - Restraint use forms not completed	Send email informing staff of failure to follow our policy	Jeanne F.	03/19/14	Yes
C302	Issue #2 - Restraint use forms not completed	Bring current policy to ER Medical Staff Committee to educate on calling CMO/CNO before implementing and to use the cert. of need and order sheet.	CMO/CNO	04/02/14	yes
C302	Issue #2 - Restraint use forms not completed	Inform Med. Staff on calling CMO/CNO before implementing and to use the cert. of need and order sheet.	CMO, Elaine	04/10/14	
C302	Issue #2 - Restraint use forms not completed	Send email informing staff that our policy is outdated & to seek guidance until policy is updated	Jeanne F.	03/24/14	Yes
C302	Issue #2 - Restraint use forms not completed	Update our current Involuntary Procedures and Restraints Policy	Dr. Meyer, Dr. Shafer, Jeanne F.	05/07/14	

C306	Issue #1 - Inability to follow healing process	Initiation of nursing documented wound care assessments and care in continuous progress note with each entry appearing in dated consecutive format	Janice, Stacy	04/07/14	
C306	Issue #2 - No wound culture obtained	Request EMR vendor to add "Culture Draining Wounds on all admissions" task on the Nursing Task Bar	Angie C. Janice	3/1/2014 in place by 4/7/14	
C337	Issue #1 - Skin breakdown and no quality review of medical records	Initiation of pressure ulcer reporting via internal occurrence reporting system	Heather, Janice	3/26 and 3/28, 4/2 and 4/3	yes
C337	Issue #1 - Skin breakdown and no quality review of medical records	Initiation of pressure ulcer tracking, trending and reporting	Elaine	4/7/2014	done
C337	Issue #2 - Fall Prevention	Form Fall Prevention Team to review all falls with injury or 2nd occurrence falls	Elaine, Jeanne	3/24/2014	yes
C337	Issue #2 - Fall Prevention	Initiation of falls being discussed at the weekly care plan meeting	Jeanne, Elaine	3/14/2014	yes-ongoing
C337	Issue #3 - Quality review related to the use of restraints and involuntary medication and PI	Initiation of patient record review and debriefing when restraints are used	Dr. Meyer, Jeanne F., Elaine S.	3/21/2014	yes
C337	Issue #4 - Failure to establish a policy and procedure to direct staff in the utilization of non-employed staff	Draft policy and procedure for use of non-hospital employees	Dr. Meyer, Elaine S.	04/22/14	
C337	Issue #4 - Failure to establish a policy and procedure to direct staff in the utilization of non-employed staff	Use of Non-Hospital Employees Policy presented to Quality Committee	Elaine S. Dr Meyer	04/23/14	

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C337	Issue #4 - Failure to establish a policy and procedure to direct staff in the utilization of non-employed staff	Use of Non-Hospital Employees education presented to the ER Medical Staff and Medical Staff and education around filing an occurrence report when they are used.	CMO	4/2 and 4/10	4/2 yes
C337	Issue #4 - Failure to establish a policy and procedure to direct staff in the utilization of non-employed staff	Use of Non-Hospital Employees Policy presented to the Medical Staff	Dr. Meyer	5/8/2014	
C337	Issue #4 - Failure to establish a policy and procedure to direct staff in the utilization of non-employed staff	Educate the Department Head on the use of non-hospital employees and the filing of the occurrence report	Elaine, Jeanne	May Dept Head Meeting	
C337	Issue #5 - Failure to develop a patient care policy regarding transport of patients	Develop policy for transport of inpatients needing services at other facilities	Jeanne F.	3/21/2014	yes
C337	Issue #5 - Failure to develop a patient care policy regarding transport of patients	Present completed policy for transport of inpatients needing services at other facilities to nursing staff	Jeanne F.	3/26/14 & 3/28/14	yes
C337	Issue #5 - Failure to develop a patient care policy regarding transport of patients	Present completed policy for transport of inpatients needing services at other facilities to Medical Staff at Medical Staff Meeting	Jeanne F.	04/10/14	
C337	Issue #6 - Policy and procedure to guide staff in the use of patient pictures/images	Draft Photograph, Video recording, or Recording Device Policy	Elaine	3/24/2014	yes

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C337	Issue #6 - Policy and procedure to guide staff in the use of patient pictures/images	Educate Medical Staff regarding prohibition of taking pictures with cell phones	Elaine S., Jeanne F.	03/13/14	Yes
C337	Issue #6 - Policy and procedure to guide staff in the use of patient pictures/images	Educate Nursing Staff on implementation of photographing policy	Jeanne F., Janice S.	3/26/14 & 3/28/14	yes
C337	Issue #6 - Policy and procedure to guide staff in the use of patient pictures/images	New Photographing Policy distributed at Medical Staff Meeting	Elaine S.	04/10/14	
		Elsevier modules completed - Pressure ulcer prevention - RN, LPN	Jeanne, Amy	4/30/2014	
		Elsevier modules completed - Restraint Use RN, LPN	Jeanne, Amy	4/30/2014	
		Policy Posted and Signed Off - Pressure Ulcer Prevention - RN, LPN	Jeanne, Janice	4/30/2014	
		Policy Posted and Signed Off - Involuntary Procedure and Use of Restraints- RN, LPN	Jeanne, Janice	4/30/2014	
		Photographing, Video Recording, or Recording Device Policy- RN, LPN	Jeanne, Janice	4/30/2014	
		Transport of Inpatients needing services at other facilities- RN, LPN	Jeanne, Janice	4/30/2014	
		Policy Posted and Signed Off - Fall Prevention and Use of Morse Scale -	Jeanne, Janice	4/30/2014	
		Policy Posted and Signed Off - Transport of Inpatients needing services at other facilities	Jeanne, Janice	4/30/2014	

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