

Division of Licensing and Protection
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June 10, 2014

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

Dear Mr. Allbee:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 20, 2014**. Please post this document in a prominent place in your facility.

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

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

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

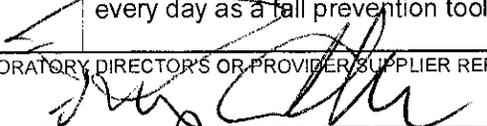
RECEIVED
Division of
JUN - 2 14
PRINTED: 05/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED R-C 05/20/2014
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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 000}	INITIAL COMMENTS	{C 000}		
	An onsite follow up investigation was conducted on 5/19/14 - 5/20/14 by the Division of Licensing and Protection. As a result of the investigation the Critical Access Hospital was determined not to be in compliance with the standard regarding Quality Assurance .			
{C 337}	485.641(b)(1) QUALITY ASSURANCE	{C 337}		
	The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that-			
	all patient care services and other services affecting patient health and safety are evaluated.			
	This STANDARD is not met as evidenced by: Based on interview and record review the CAH failed to monitor and evaluate patient care services 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 identifying patients with a high fall risk and implementing prevention interventions. Findings include: Per interview with the facility ' s Chief Nursing Officer [CNO], the Quality Director, and the Nurse Manager on 5/20/14 at 12:04 P.M. the facility ' s policy and procedure for new admissions includes the admitting Nurse assessing the patient ' s risk of falls, and if assessed as a high risk, implementing hourly observations of the patient every day as a fall prevention tool. A list of high		Plan of correction (see attachments) (1, 1A, 1B)	
			POC accepted T Dougherty / F Keene RN MSN DPA 6/6/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CNO	(X6) DATE May 30, 2014
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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}	Continued From page 1 risk patients is then compiled, updated, and reviewed each morning with nursing staff. Per record review on 5/20/14, a sampling of patient fall risk lists and corresponding hourly rounding sheets from 4/29/14 through 5/7/14 were reviewed for completeness and accuracy with multiple errors noted. Per the record review and confirmed during interview with the CND, Quality Director, and the Nurse Manager, 7 patients during the 9 days sampled were identified as high fall risks but the preventative hourly rounding was not done. 39 of 107 hourly rounding sheets contained blank hours with no documentation, and 8 rounding sheets had no date to indicate when they were done. Additionally, 6 times between 4/7/14 & 5/7/14 fall risk patients are identified not as fall risks but as patients with alterations in skin integrity. Per interview with the CND, Quality Director, and the Nurse Manager on 5/20/14, the CND stated it was the Nurse Manager's responsibility to monitor the fall risk lists and hourly rounding reports. The Nurse Manager reported h/she was unaware that hourly rounding was not being done on the 7 patients identified as high fall risks, and if there were problems with any data the Charge Nurse was to report them to h/her. The CND and Nurse Manager confirmed there was no process in place to review the data and identify errors from the hourly rounding sheets and fall risk lists. The CND confirmed the documentation on both the fall risk lists and the hourly rounding sheets was 'inconsistent' and stated 'we need to come up with a way' of tracking and monitoring the data.	{C 337}			

Plan of Correction for L&P Survey of May 20, 2014

Tag C337 Quality Assurance

Issue: Failure to monitor and evaluate the policies and procedures for identifying high fall risk patients and the implementation of hourly rounding.

Evidenced by:

1. Not all patients noted on the daily list of patients that have been identified as high fall risk had hourly rounding documentation sheets.

Plan of correction: The process was out of synch. The new day's individual patient rounding sheets were being placed in the patients' room by the day LNA based on whether the patient had a sheet for the 24 hour period that was ending; while the list of patients at high risk for falls was not being prepared until later that day after the day charge nurse reviewed all current patient charts and checked Morse scale scores. To remedy this, the process has been changed so that the night shift charge RN (or designee) reviews all patient charts prior to 7am and compiles the list of high fall risk patients. Using that list he/she then prepares the individual patient rounding documentation forms that will start at 7AM.

2. Some of the daily lists of high fall risk patients were compiled on an alteration in skin integrity patient list form. Occasionally staff used the forms interchangeably.

Plan of correction: The two forms are now different colors – one white, one yellow. They are also now compiled at two different times. High fall risk list are now prepared by night shift before 7AM and alteration in skin integrity lists are compiled after 7AM by day shift.

3. Some of the individual patient documentation forms lacked dates.

Plan of correction: All staff have been reminded as they are preparing and using the sheets to assure there is a date on them. At the end of each 24 hour period these forms are scanned into the patients' EMRs by the Unit Secretary and then filed in a notebook. He/she has been instructed to look for missing dates prior to scanning and filing, and if the date can be verified by the person who had removed the sheets, to enter the dates.

4. Some of the individual patient documentation forms had blank columns indicating that rounding was not happening consistently. In addition there was no clearly defined process to monitor the initiation of hourly rounding and compliance with it.

Plan of correction: A new process to monitor and audit the hourly rounding program for all patients identified as high fall risk has been developed:

- a. Each day the Unit Secretary will review the previous day's hourly fall risk rounding sheets. If any of the sheets have missing documentation, she will note the date, patient's name, specific hours for which the data is missing and the name of the assigned nurse utilizing the "Fall Risk Hourly Rounding Compliance Audit" tool. **(Attachment 1-A)**
- b. Every Monday, Wednesday and Friday the Nurse Manager, or her designee will collect the audit forms and review them looking for and noting any explainable variances - i.e., patient out of building on LOA; patient in Therapy gym, etc. She will also look for and identify trends such as same nurse or same shift with frequent omissions, etc. If there are numerous omissions on individual days, she will also look at staffing and census for those days to determine if there is correlation.
- c. Based on the Nurse Manager's findings she will follow up with individual staff and take appropriate corrective action(s).
- d. Audit results will be summarized and shared at staff nurse meetings and also reported quarterly to the Hospital's Quality Committee.

A new policy and procedure **(Attachment 1-B)** has been developed and initiated that clearly defines the hourly rounding program for patients at high risk for falls, the expectations of the staff and the quality monitoring activities to assure compliance. Staff have been informed of the surveyor's findings from the May 20, 2014 visit and this plan of correction via an e-mail sent on 5/29/2014. A hard copy of the policy is now posted in the Nursing Report Room for all staff to review and sign-off that they have read and understand it.

All pieces of the plan of correction will be fully implemented by June 2, 2014.

SUBJECT: HOURLY ROUNDING ON HIGH FALL RISK PATIENTS	REFERENCE # 2.0102
DEPARTMENT: NURSING	PAGE: 1 OF: 2
APPROVED BY: Jeanne Fortier, RN COO/CNO	EFFECTIVE: 6/2/2014 REVISED:

PURPOSE:

To help prevent patient falls for those patents identified as high fall risk.
To ensure staff compliance with the hourly rounding fall prevention initiative.

POLICY:

1. All patients will be screened for fall risk on admission and with any changes in their condition.
2. Any patient scoring 45 or higher on the Morse Fall Risk scale will be placed on hourly rounding.
3. Any nursing staff member can perform and document the hourly rounding.

PROCEDURE:

1. Upon admission, the admitting RN will screen the patient for his/her risk of falling and initiate appropriate fall prevention interventions in accordance with GCH policy # 2.0062, "Fall Prevention and Morse Fall Risk Scale".
2. If the new admission scores 45 or above on the Morse scale, the admitting RN will add the patient to the daily high fall risk list and place the hourly fall rounding documentation sheet in the patient's room.
3. As part of the current charge nurse review of all new admissions, the charge nurse will ensure that hourly rounding has been initiated.
4. Prior to 7AM, the night shift charge nurse, or his/her designee (may be a staff RN or LPN), will review all current inpatients' Electronic Medical Records (EMRs) and identify those with Morse scale scores of 45 or above. The names of those patients will be noted on the daily fall risk list and a new, individual hourly rounding sheet will be prepared for each of them.
5. After the 6AM hourly fall risk rounds are completed, the past 24 hours' hourly rounding sheets will be taken down and replaced with the new sheets, which start at 7AM.
6. Sheets from the past 24 hours will be given to the Unit Secretary who will scan them into the patients' EMRs. Hard copies will be saved for a minimum of three months and then shredded.

