



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

Mr. Mick Brant, Administrator
Grace Cottage Hospital Swing Bed Unit
185 Grafton Road
Townshend, VT 05353

Provider ID #:

Dear Mr. Brant:

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 requirements for Swing Beds in a Critical Access Hospital.

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

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota RN".

Pamela M. Cota, RN, MS
Licensing Chief

PC:jl

Enclosure

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

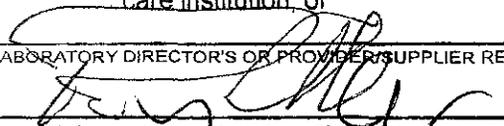
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PRINTED: 03/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 472300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED C 02/27/2014
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NAME OF PROVIDER OR SUPPLIER GRACE COTTAGE HOSPITAL SWING BED UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 185 GRAFTON ROAD TOWNSHEND, VT 05353
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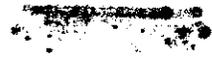
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C 000	INITIAL COMMENTS	C 000		
C 367	<p>An onsite complaint investigation was conducted on 2/25/14 - 2/27/14 by the Division of Licensing and Protection. As a result of the investigation of complaint # 11364 the Critical Access Hospital/Swing Bed requirements were not met. The following regulatory violations were identified:</p> <p>485.645(d)(1) PRIVACY & CONFIDENTIALITY</p> <p>The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:</p> <p>Resident rights - privacy and confidentiality (§483.10(e)):</p> <p>"The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident;</p> <p>(2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;</p> <p>(3) The resident's right to refuse release of personal and clinical records does not apply when-</p> <p>(i) The resident is transferred to another health care institution; or</p>	C 367	<p>see attachment #1 Plan of correction (blacked out)</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 3/24/2014
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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.

PMC



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C 367	<p>Continued From page 1</p> <p>(ii) Record release is required by law."</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the CAH failed to maintain the confidentiality and privacy of 1 applicable patient involving the utilization of non-hospital employees to assist with the provision of care. (Patient #1); and privacy was not maintained when a photo of a resident's wound is maintained on a staff members personal cell phone for 1 applicable resident (Patient #2). Findings include:</p> <p>1. Per record review, on 2/26/14, a photograph of Patient #2's pressure wound was taken and stored on Physician #2's personal cell phone, on 12/31/13, potentially exposing the patient's private and confidential medical information to those who 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</p>	C 367	<p>See attachment #1 Issue 1 Plan of correction ()</p>	
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C 367	<p>Continued From page 2</p> <p>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> <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</p>	C 367	<p>see attachment 1 Issue #2 Plan of correction (_____)</p>	

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C 367	Continued From page 3 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 and then although not employed by the CAH, Rescue, Inc staff proceeded to conduct a physical assessment of the patient to rule out an potential injury.	C 367		
C 381	485.645(d)(3) RESTRAINTS [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:] Resident behavior and facility practices - restraints (§483.13(a)): "The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms." This STANDARD is not met as evidenced by: Based on staff interview and record review, staff failed to follow a systematic process of evaluating and care planning least restrictive interventions prior to the use of manual and chemical restraints for 1 applicable patient (Patient #1); and failure of staff to effectively utilize alternative interventions prior to the administration of chemical restraint for a 96 year old patient. (Patient #5). Findings include:	C 381	see attachment 2 Plan of Correction (_____)	

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C 381	<p>Continued From page 4</p> <p>1. 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 "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" patient extremities by the Deputy, the Charge Nurse and other nursing staff during the administration of an involuntary emergency medication. Although Patient #1 was demonstrating some medical symptoms and became a risk to him/herself and others, there was no evidence in the Care Plan or Interdisciplinary Team meeting addressing the use of a manual restraint and/or the administration of involuntary emergency</p>	C 381	<p>see attachment 2 Issues # 1 & #2 Plan of correction (Page 2)</p>	

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C 381	<p>Continued From page 5</p> <p>medication prior to their use or after they were implemented on 2/21/14.</p> <p>2. 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. 16:00 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". On 2/15/14 at 22:35 states "Pt. confused. Not safe in room without close supervision so moved outside of nurses station. Pt. requesting frequently that s/he be assigned a private room...". A nursing progress note for 2/16/14 states: " "Pt confused and restless for most of the day, attempting to get up with out assistance. Pt has bed and chair alarms on and in place and was moved to the nurses station for further supervision.....Pt. medicated with Lorazepam (Ativan) this evening with minimal effect and Temazepam before bed ". Per review of the Medication Administration Record (MAR) for 2/16/14 the 96 year old was medicated with : Temazepam (an intermediate-acting benzodiazepine class of psychoactive drug) 15 mg orally at 00:11 and at 21:49 and in addition received Ativan (an antianxiety benzodiazepine drug) 0.5 mg orally at 19:56. Both medications can cause sedation. There was a lack of well defined medical symptoms for the use of the psychoactive medication, nursing notes consistently only described Patient #5 as</p>	C 381	<p>see attachment 2 + # Issues 1 + 2 Plan of correction (_____)</p>	
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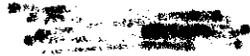
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C 381	Continued From page 6 "confused and restless". After both Tamazepam and Ativan were administered to Patient #5 on 2/16/14 a nursing progress note for 2/17/14 for (11:00 - 23:00 shift) states " Patient very drowsy at beginning of shift. Difficult to wake. When able to wake noted patient had delayed swallowing and was coughing with liquids and could not swallow pills whole.....Patient gradually became more alert through shift.....". There was no evidence to demonstrate prior to medicating and sedating Patient #5 nursing staff had initiated other alternatives to chemical restraint which placed the patient at high risk for aspiration and higher risk for falls. Beside moving Patient #5 to the Nurses station, no attempt was made to assign the 96 year old a sitter/attendant to remain with the patient in his/her own room. In addition, Patient #5 objected to being placed in public view at the nurses station stating on 2/16/14 " I just want to go to my room."	C 381		
C 395	485.645(d)(6) COMPREHENSIVE CARE PLANS [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (k), and (l), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b)).] Comprehensive care plans (§483.20(k)(1)) "The facility must develop a comprehensive care	C 395	<i>see attachment 3 Plan of correction ([REDACTED])</i>	

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C 395	<p>Continued From page 7</p> <p>plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following-</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and</p> <p>(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4)."</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the CAH staff failed to develop comprehensive care plans to meet the identified needs to attain and maintain physical, mental and psychosocial well being to include the management of behaviors and the prevention of falls and skin breakdown for 2 applicable Patients. (Patients # 1, # 2,) Findings include:</p> <p>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</p>	C 395	<p>see attachment 3 Issue # 1 Plan of Correction (_____)</p>	
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C 395	<p>Continued From page 8</p> <p>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 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</p>	C 395	<p>see attachment 3 Plan of Correction Issue #2 _____</p>	
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C 395	Continued From page 9 Falls Plan of Care" was initiated on 1/21/14, no other interventions were discussed or incorporated into Patient #1's 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. The Care Plan failed to identify Patient #1's individualized needs, noting interventions were generic.	C 395		
C 397	485.645(d)(6) SERVICES PROVIDED [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (k), and (l), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b)).] Comprehensive care plans (§483.20(k)(3)(i)) "The services provided or arranged by the facility must- (i) Meet professional standards of quality; and ..." This STANDARD is not met as evidenced by: Based on interview and record review, CAH staff failed to meet professional standards of quality when not following physician orders for wound culture for 1 applicable Patient (Patient #5) and	C 397	<i>see attachment 4 Plan of correction (page 1)</i>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47Z300	(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 SWING BED UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 185 GRAFTON ROAD 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 397	<p>Continued From page 10</p> <p>failure to demonstrate sufficient evidence of interventions to prevent skin breakdown for 1 applicable resident. (Resident #2) 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 12/20/13 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 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</p>	C 397	<p>See attachment 4 Plan of correction Issue # 1 ()</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

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C 397	<p>Continued From page 11</p> <p>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>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 a 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.</p>	C 397	<p><i>see attachment 4 Plan of correction Issue #2 (redacted)</i></p>	
C 402	<p>485.645(d)(7) SPECIALIZED REHAB SERVICES</p> <p>[The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:]</p> <p>Specialized rehabilitative services (§483.45 of this chapter):</p> <p>"(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must-</p> <p>(1) Provide the required services; or</p> <p>(2) Obtain the required services from an outside</p>	C 402	<p><i>see attachment 5 Plan of correction (redacted)</i></p>	

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

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C 402	<p>Continued From page 12</p> <p>resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services."</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the CAH failed to ensure specialized rehabilitation services were provided as ordered for 2 applicable Patients. (Patients #2 and #3). Findings include:</p> <ol style="list-style-type: none"> 1. 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 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". 2. 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: 	C 402	<p>see attachment 5 Plan of correction Issue # 1 (_____)</p> <p>see attachment 5 Plan of correction Issue # 2 (_____)</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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C 402	Continued From page 13 "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 402			

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ATTACHMENT #1 – GRACE COTTAGE HOSPITAL SWING BED – PROVIDER #472300

Tag C367 – 485.645(d)(1) Privacy and Confidentiality

Tag C367, Issue #1 – Photograph taken with cell phone

Plan of Correction:

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 hospital 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 records 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 (see attachment #1A, policy#1.0075).

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 C367, Issue #2 – Use of Rescue with Sheriff

Plan of Correction:

A new policy and procedure for use of non-hospital employees (i.e. Rescue, Inc.) will be developed. The target date for completion of this policy is 4/23/14 to be presented to the Quality Committee and then to the Medical Staff on 5/8/14.

Nursing staff was notified, via email on 3/19/14, not to use Rescue, Inc. personnel in the inpatient setting.

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



Attachment 1 continued

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 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.

C367 POC accepted 4/10/13 FMcintoshRN/pme

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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.



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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.



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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.



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ATTACHMENT #2 – GRACE COTTAGE HOSPITAL SWING BED – PROVIDER #47Z300

Tag C381 – 485.645(d)(3) Restraints

Tag C381, Issues #1 & #2 – Use of restraints

Plan of Correction:

A team has been formed to review the use of our current policy on Involuntary Procedures and Use of Restraints, which occurred on 2/16/14 and 2/21/14 and understand our failure to follow the policy and how the situations 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 physician 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 #2A) 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 by 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.

ER Medical staff will be educated at the ER committee meeting on 4/2/14 and at the general Medical Staff meeting on 4/10/14 by the CMO regarding the need to call the CMO and/or CNO prior to implementation of the policy and need to utilize the certificate of need and order sheet. Any provider not in attendance at the meetings will be educated directly by the Quality Director.

C381 POC accepted 4/10/14 FmclntoshRN/AME





attachment 2 A page 1

Jeanne Fortier <jfortier@gracecottage.org>

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>, Carryn 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>, Kerry 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
(802) 365-3613
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attachment dA page 2



ATTACHMENT #3 – GRACE COTTAGE HOSPITAL SWING BED – PROVIDER #47Z300

Tag C395 – 485.645(d)(6) Comprehensive Care Plans

Tag C395, Issue #1 – Timely development and revision of care plans

Plan of Correction:

On admission, the shift charge nurse will check the patient's chart for all appropriate care plans and note their presence using the attached tool, attachment #3A. 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). A plan for the prevention of pressure ulcers and improvement in wound care management has been developed (refer to Tag C397). As part of this plan, the wound care nurse will be following all patients with wounds and regularly updating care plans as appropriate.

Tag C395, Issue #2 – Care plan not individualized

Plan of Correction:

The charge nurse will be reviewing care plans on all new admissions to ensure they are appropriate and personalized. The nurse manager will review the charge nurse admission check list regularly and follow up as needed. This process will be incorporated into the inpatient unit QI program. Nursing care plans are also reviewed by the interdisciplinary team weekly (Fridays).

C395 POC accepted 4/10/14 FmeIntosh RN/PMC



ATTACHMENT #4 – GRACE COTTAGE HOSPITAL SWING BED – PROVIDER #47Z300

Tag C397 – 485.645(d)(6) Services Provided

Tag C397, Issue #1 – Prevention of pressure ulcers

Plan of Correction:

A plan for improving Pressure Ulcers prevention and wound care management is being implemented (see attachment #4A).

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 nursing 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). 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 C397, Issue #2 – Missing wound culture

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 every nurse to obtain needed/ordered cultures. 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 4B).

On their next working day, the Nurse Manager will follow up on any outstanding items identified on the checklist.

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

C397 POC accepted 4/10/14 FMcIntosh RN/PML



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 in 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)



ATTACHMENT #5 – GRACE COTTAGE HOSPITAL SWING BED – PROVIDER #47Z300

Tag C402 – 485.645(d)(7) Specialized Rehab Services

Tag C402, Issue #1 – Missed PT sessions

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.

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 their schedule includes weekend coverage as well.

Tag C402, Issue #2 – Missed OT session

Plan of Correction:

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 regular full time OT staff are assigned to overtime as needed to provide coverage on the other weekend.

Addendum: 4/2/2014

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.

C#02 POC accepted 4/10/14 Pmclintosh RN/PMC

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.



Plan of Correction Outstanding Work Items TRACKING SPREADSHEET - SWING BED 47Z300					
TAG NUMBER	ISSUE	PLAN OF CORRECTION	RESPONSIBLE PERSON(S)	TARGET COMPLETION DATE	COMPLETED
SWING BED 47Z300					
C367	Issue #1 - Photograph taken with cell phone	Draft Photograph, Video recording, or Recording Device Policy	Elaine S.	03/24/14	Yes
C367	Issue #1 - Photograph taken with cell phone	Educate Medical Staff regarding prohibition of taking pictures with cell phones	Elaine S., Dr. Meyer	03/13/14	Yes
C367	Issue #1 - Photograph taken with cell phone	Educate Nursing Staff on implementation of photographing policy and post policy for review and sign off	Jeanne F., Janice S.	3/26/14 & 3/28/14	Yes
C367	Issue #1 - Photograph taken with cell phone	New Photographing Policy distributed at Medical Staff Meeting	Elaine S.	04/10/14	
C367	Issue #2 - Use of Rescue with Sheriff	Draft policy and procedure for use of non-hospital employees	Dr. Meyer, Elaine S.	04/22/14	
C367	Issue #2 - Use of Rescue with Sheriff	Use of Non-Hospital Employees Policy presented to Quality Committee	Elaine S.	04/23/14	
C367	Issue #2 - Use of Rescue with Sheriff	Use of Non-Hospital Employees Policy presented to the Medical Staff	Dr. Meyer	05/08/14	
C367	Issue #2 - Use of Rescue with Sheriff	Notify nursing by email not to use Rescue, Inc. personnel in inpatient setting	Jeanne F., Janice S.	03/19/14	Yes
C381	Issue #1 and #2 - Use of Restraints	Form team to review current policy on Involuntary Procedures and Restraints	Dr. Meyer, Dr. Shafer, Jeanne F.	3/16/14	Yes
C381	Issue #1 and #2 - Use of Restraints	Hold formal meeting to review 2/21/14 incident	Dr. Meyer, Dr. Shafer, Jeanne F.	03/21/14	Yes
C381	Issue #1 and #2 - Use of Restraints	Send email informing nursing staff of failure to follow our policy	Jeanne F.	03/19/14	Yes

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C381	Issue #1 and #2 - Use of Restraints	Send email informing nursing staff that our policy is outdated & to seek guidance until policy is updated	Jeanne F.	03/24/14	Yes
C381	Issue #1 and #2 - Use of 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
C381	Issue #1 and #2 - Use of 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	
C381	Issue #1 and #2 - Use of Restraints	Update our current Involuntary Procedures and Restraints Policy	Dr. Meyer, Dr. Shafer, Jeanne F.	05/07/14	
C395	Issue #1 - Timely development of care plans	Implementation of tool for charge nurses to note presence of care plans	Jeanne F	03/24/14	Yes
C395	Issue #2 - Care Plan not individualized	Implementation of tool for charge nurses to note personalization of care plans	Jeanne F	03/24/14	Yes
C397	Issue #1 - Prevention of pressure ulcers	Educate staff for improving pressure ulcer prevention	Jeanne F	3/26 and 3/28	Yes
C397	Issue #1 - Prevention of pressure ulcers	Educate staff for improving pressure ulcer prevention	Jeanne F	ongoing until 100%	
C397	Issue #1 - Prevention of pressure ulcers	Conduct staff edu on pressure ulcer prevent. And wound care management	Stacy S.	4/2 and 4/3	Yes
C397	Issue #2 - Missing wound culture	Request EMR vendor to add "Culture Draining Wounds on all admissions" task on the Nursing Task Bar	Janice S, Angie C.	03/01/14	Yes
C397	Issue #2 - Missing wound culture	Addition of "Culture Draining Wounds" task to Nursing Task Bar	Angie C. Janice	04/07/14	
C402	Issue #1 - Missed PT sessions	Hire additional full time PT to cover weekends	Crystal M.	01/24/14	Yes

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C402	Issue #2 - Missed OT session	Arrange to have OT coverage on the weekends	Crystal M.	03/24/14	Yes
		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	
		Policy Posted and Signed Off - Photographing, Video Recording, or Recording Device Policy- RN, LPN	Jeanne, Janice	4/30/2014	
		Policy Posted and Signed Off - Transport of Inpatients needing services at other facilities- RN, LPN	Jeanne, Janice	4/30/2014	
		Prevention and Use of Morse Scale - RN, LPN	Jeanne, Janice	4/30/2014	

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