

Division of Licensing and Protection
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To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

January 5, 2016

Mr. Kevin Donovan, Administrator
Mt Ascutney Hospital
289 County Road
Windsor, VT 05089-9000

Dear Mr. Donovan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 9, 2015**. 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,



Suzanne Leavitt, RN, MS
Assistant Division Director
Director State Survey Agency



Fax 8022412348

Dec 22 2015 09:56am P003/009

PRINTED: 12/21/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/09/2015
NAME OF PROVIDER OR SUPPLIER MT ASCUTNEY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 289 COUNTY ROAD WINDSOR, VT 05089	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS An unannounced on-site survey was completed by the Vermont Division of Licensing and Protection on 12/9/15 to investigate a complaint (#14088). The following regulatory violations were found.	C 000		
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on staff interview and record review, the CAH (Critical Access Hospital) failed to provide care and services in accordance with established policies for 2 of 5 applicable patients in the sample. (Patients #1 and #3) Findings include: 1. Per review of CAH policy Falls - Prevention and Management last revised on 6/14, staff failed to initiate "Post-Fall Management" interventions for Patient #3 who sustained 6 falls during 42 days of hospitalization. Patient #3 was admitted on 7/1/15 with end stage Lymphoma. At the time of admission and per CAH policy, Patient #3 was assessed to be at risk for falls using the Conley's Falls Risk assessment with a score of "6" (a score of 2 or greater or a fall during hospitalization should initiate fall prevention strategies). Per Falls - Prevention and Management policy, nursing staff were to develop a Care Plan in an effort to "...eliminate or mitigate contributory factors and develop fall prevention strategies appropriate to patient's identified risk," however a Care Plan was not developed to address Patient #3's continued falls. There was also a failure to document in the patient's record when s/he sustained falls on 7/11/15, 7/15/15,	C 271	C271 - Patient Care Policies Policy - Falls Prevention The Clinical Incident Prevention Team Policy will be revised to reflect that all falls will be reviewed by the Clinical Incident Prevention Team (CIP) team. Revision to this policy will be presented for approval to the Quality Council at the January 28th meeting. While awaiting policy approval, all falls will be reviewed by the Quality team and the CIP team. Process The following process will be implemented for every Inpatient. Patient Care/EMR Documentation • Upon admission, the Conley Fall Risk Assessment will be completed as part of the Admission Assessment process. • Subsequent to admission, the Conley Fall Risk Assessment will be completed a minimum of daily • For any patient with a score of two or greater on the Conley Fall Risk Assessment or post a documented fall during the current admission, a Fall Risk Plan of Care is required. • Interventions will be customized to individual patients needs as indicated by the assessment of patient condition, equipment and environment and will be updated each shift and as needed based on changes in patient condition. • All interventions documented "not met" require a comment. • Post any fall, all steps as outlined in the Patient Falls Policy will be followed including the completion of the Cerner Ad Hoc Post Fall Assessment which will become part of the patient's permanent health record.	2/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Kevin W. Donohue* TITLE President and Chief Executive Officer (X6) DATE 12/30/15

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

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C 271	Continued From page 1 7/27/15 and 8/1/15 as per policy. The omissions of a Care Plan for falls and nursing note documentation was confirmed by the Director of Patient Care Services on 12/ 8/15 at 2:10 PM. 2. a. Per review of the medical record for Patient #1 on 12/8/15, nursing staff failed to accurately document the reason for the use of medical restraints in accordance with the hospital's Policy/Procedure titled "Restraints", revised 1/16. The policy stated that nurses are responsible for documenting the reason for the restraint and evidence of less restrictive interventions previously attempted and ineffective. Per review of the documentation for the 3 restraint dates in July for Patient #1, nurses included incorrect reasons for the restraints, per physician orders and failed to adequately show evidence of all ineffective but previously tried interventions utilized prior to restraint application. This was confirmed with during interviews with a Charge RN (Registered Nurse) and CNO (Chief Nursing Officer) on the days of 12/8/15 and 12/9/15. 2.b. Per record review regarding a fall that occurred on 7/8/15 for Patient #1, nurses failed to document the event in the Quantros Safety Risk Management (SRM) System completely and accurately, per policy "Adverse Events and Near-Misses", III Procedure, A.1. "When entering a report..... as much detail as possible is encouraged". Staff failed to include important information including the time of the fall, where the patient was last observed prior to the unwitnessed fall, what were contributing factors including any medications administered and what were recommendations for improvement. Inaccurate information stated that the care plan reflected fall prevention when there was no care plan for fall prevention. Factors that led to the	C 271	Administrative • Within 24 hours post every patient fall, a member of the nursing team is required to complete a Quantros Risk Management Report. • Each fall will be fully investigated by the nurse manager or designee within 72 hours of a fall. • The nurse manager's or designee's follow-up will be added to the original Quantros and is to include the; who what, where, when why and how of the fall. The report will also include follow-up actions taken regarding equipment, environment and/or any staff intervention and will reflect any changes made to the patient's plan of care as appropriate. • If a patient has fallen multiple times during a contiguous admission, a multidisciplinary 'huddle' will be pulled together to discuss opportunities for mitigating the risk of further falls. This team will consist of the Nurse Manager or Designee, Quality/Risk, Provider, Care Management and others as indicated. The outcome of the 'huddle' will be documented in the Quantros as well as represented in the Plan of Care. • Falls will be noted on the Daily Safety Huddle tracking form to improve the awareness of this risk issue at an organizational level. • The falls risk policies, assessment, interventions and documentation will become an annual competency evaluation for staff on the Acute/Swing, Rehab and ED units. Education • A mandatory, face-to-face, didactic experiential education session will be provided to all nursing staff within one month of the CMS acceptance of this COP response plan. • This education will; review the intent and expectations as outlined in our policy, will emphasize the documentation requirements		

Alvin [Signature] 12.30.15

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C 271	Continued From page 2 event failed to mention that the alarm was not put on the bed after changing linens. The report was reviewed by QA and referred to the Nurse Manager for investigation, Although the Nurse Manager did provide staff re-education and follow up after the fall, inaccuracies and incomplete data were not addressed at the nursing or QA level of event follow up. 2. c. Per review, nurses failed to conduct a fall assessment as part of the admission assessment for Patient #1, who had right sided weakness after a recent stroke. Per the policy, "Falls-Prevention and Management", 6/14, II Policy, C. All inpatients at MAHHC are assessed upon admission using the Conley's Falls Assessment. D. All patients will have standard appropriate interventions initiated per the Conley's Fall Risk Assessment." Per review of the admission assessment for the patient dated 6/19/15, there was no fall assessment completed as required and per review of the care plan, there was no written care plan for fall risk. The patient did experience a fall on 7/8/15 and there was no alarm in place at the time of the fall. These concerns were confirmed with the Charge Nurse and CNO on 12/9/15.	C 271	both at admission and dally, cover the development of a customized Risk for Falls plan of care including the proper documentation of Goals, Interventions and Outcomes, review the use of the Ad Hoc Conley Fall Risk Assessment and the Post Fall Assessment PowerForms. • A ULearn electronic learning module will be issued to all nursing staff in the Acute/Swing, Rehab and ED approximately six months post the classroom training to reassess base knowledge and for reinforcement of practice expectations. • Fall Risk Awareness and Follow-up will be made a critical element of General Orientation for all new hires. • All new nursing hires will receive face-to-face education during orientation regarding expectations of nursing assessments, care and documentation regarding falls prevention and follow-up. See Attachment A for the continuation for this Plan of Correction.		
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 staff interview and record review, nurses failed to develop and keep current a care plan to address the identified needs for 3 of 5 inpatients in the sample. (Patients #1, #3 and #4). Findings include: 1. Per review of the care plan for Patient #1 on	C 298	C298 - Nursing Services Policy - Assessment, Care Plan and Discharge Documentation - Acute, Swing, Rehabilitation Unit A proposal to modify the 2016 Quality Council Annual Plan to include Care Plans as a quality indicator for the Acute/Swing and Rehab units in 2016 will presented to the Quality Council at the January 28, 2016 meeting. The policy entitled Assessment, Care Plan and Discharge Documentation - Acute, Swing, and Rehabilitation Unit is to be followed for every inpatient.	3/1/16	

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C 29B	<p>Continued From page 3</p> <p>12/8/15, the plan failed to address several of the identified needs for the patient, who had experienced an acute decline in health status due to a significant stroke. The patient had ongoing pain, had a gastric feeding tube for nutritional intake, was unable to verbalize needs, experienced a fall due to body control issues and had symptoms of delirium. The care plan failed to include these issues (falls, nutrition, pain management, communication and delirium), including measurable goals and specific interventions to address these needs.</p> <p>2. Per review of the care plans for Patient #3, there was a failure to address the ongoing issue of the patient's repeated falls. During hospitalization from 7/1/15 - 8/11/15, Patient #3 sustained 6 falls from a wheelchair and/or bed while experiencing periods of delirium, confusion, pain and unsteady gait. The care plan did not reflect the patient's ongoing problems related to falls or address any fall prevention interventions.</p> <p>3. Per review of the care plan for Patient #4, there was a failure to revise the care plan after the patient's admission on 11/19/15. Patient #4 was admitted and initially treated for heart failure. However, after a poor response to treatment it was determined Patient #4 would be transitioned to end of life care receiving only comfort measures. There was no indication in the care plan that Patient #4 was transitioned to receive only comfort measures, including adequate symptom management and provision of family support during the patient's final days.</p>	C 29B	<p>Process</p> <p>The following process will be implemented for every inpatient.</p> <p>Patient Care/EMR Documentation</p> <ul style="list-style-type: none"> • Within eight hours of admission, a comprehensive care plan will be designed by a member of the nursing care team focused around each patient's unique list of active diagnosis and organized by the specific needs of the patient. • The care plan will contain patient specific Goals, Interventions and Outcomes for each active problem. • One goal of the care plan is as a means of communicating and organizing the actions of the constantly changing clinical picture of the patient and as a communication tool between nursing staff. To meet this objective, the care plan will be reviewed and kept current each shift by a member of the nursing care team with intimate knowledge of the patient picture. • All Interventions documented "not met" require a comment. <p>Education</p> <ul style="list-style-type: none"> • A series of mandatory, face-to-face, didactic experiential education sessions will be provided to all nursing staff within sixty (60) days of the CMS acceptance of this COP response plan. • This education will; review the intent and expectations as outlined in our policy, emphasize clear documentation of individualized goals and interventions as well as the expectation that care plans are complete and up-to-date. <p>See Attachment B for the continuation for this Plan of Correction.</p>	
C 302	485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately	C 302		

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C 302	Continued From page 4 documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on staff interview and record review, nurses failed to assure that medical records were complete and accurately documented for 1 of 5 applicable patients in the sample. (Patient #3.) Findings include: 1. Per review of the CAH Incident reporting system, the Quantros Safety Report, there were dates and times of 6 falls sustained by Patient #3 during 42 days of hospitalization from 7/11/15 - 8/11/15. There was a failure by nursing staff to document in the patient's record the actual events and circumstances associated with 4 of the 6 falls sustained by Patient #3 on 7/11/15, 7/15/15, 7/27/15 and 8/1/15. The omissions of documentation were confirmed by the Director of Patient Care Services on 12/ 8/15 at 2:10 PM.	C 302	C302 - Records Systems Policy - Falls Prevention The Clinical Incident Prevention Team Policy will be revised to reflect that all falls will be reviewed by the Clinical Incident Prevention Team (CIP) team. Revision to this policy will be presented for approval to the Quality Council at the January 28th meeting. While awaiting policy approval, all falls will be reviewed by the Quality team and the CIP team. Process The following process will be implemented for every inpatient: Patient Care/EMR Documentation • Upon admission, the Conley Fall Risk Assessment will be completed as part of the Admission Assessment process. • The Conley Fall Risk Assessment will completed a minimum of once a shift. See Attachment C for for the continuation for this Plan of Correction.	2/1/16
C 337	485.641(b)(1) QUALITY ASSURANCE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that all patient care services and other services affecting patient health and safety are evaluated. This STANDARD is not met as evidenced by: Based on staff interview and record reviews, the hospital failed to assure a process whereby the Quality Assurance Department evaluated all	C 337	C337 - Quality Assurance Process The following process will be implemented for each inpatient that experiences a fall or has been restrained. All aspects of the Quality Assurance Program will be followed for each of these populations. Administrative • The Quality/Risk Manager or Designee will review each Quantros report related to slips/falls and restraint use to ensure that the initial report and follow-up documentation is complete and comprehensive with sufficient follow-up to prevent further events. Additionally each Quantros will be surveilled to ensure that the appropriate policies are being followed for patients experiencing a fall or who have been restrained.	2/1/16

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C 337	<p>Continued From page 5</p> <p>patient care and services related to patient falls. This practice affected 2 of 5 patients in the applicable sample. (Patients #1 and #3). Findings include:</p> <ol style="list-style-type: none"> Per staff interview regarding Patient #1, Quality staff confirmed on 12/8/15 and 12/9/15 that they had not reviewed a fall event report for accuracy and thoroughness of investigation of the fall event for Patient #1. Based on review of the medical record and the Quantros Safety Report created regarding the patient's fall from bed on the evening of 7/8/15, the report was inaccurate and incompletely documented. The event review process included follow up by the Nurse Manager with nursing staff. The event review by the Manager failed to note the lack of completion of a fall assessment at the time of admission to the hospital on 6/19/15; it also failed to note the lack of a care plan to address the high risk for a fall, and to assess the quality of the investigation, and to act on the incomplete documentation on the event report itself. Per interviews with the Director of Quality on 12/8/15 and 12/9/15, the Director stated that s/he reviews all event reports and if there is a negative outcome, there is a full review of the event, including a root cause analysis. If there was no injury from a fall, the event report would be referred to the appropriate department manager to review and complete any needed follow up actions. There is no final QA department review of the event to see if all of the preventive plans had been put into place and interventions utilized regarding fall prevention. A hospital wide quarterly meeting also reviews all falls. However, this meeting includes review of all event reports, and does not provide a timely review of falls prevention and reduction actions to effect an improvement in patient quality of care. 	C 337	<p>Administrative (Continued)</p> <ul style="list-style-type: none"> The Quality/Risk Manager or Designee will follow-up as appropriate to ensure that recommendations are implemented and each Quantros will be updated with the results of such follow-up. A member of the Quality Department will collate the data and monitor for trends across things like location, personnel, equipment. This data will then be reported as outlined in the Audit and Accountability section. Analysis of the data will be used to identify solutions when possible to mitigate future risks. <p>Education</p> <ul style="list-style-type: none"> Re-education on the 'how to' and benefits of appropriate completion of Quantros Risk Management reports will be conducted by a member of the Quality Department to the Leadership Council. This will facilitate better follow-up and reporting from the Quantros system. <p>Audit and Accountability</p> <ul style="list-style-type: none"> Monthly a member of the Quality Department will collate the fall and restraint data from across the organization and present it to the CIP Team. Quarterly the CIP Team will report a summary of all fall and restraint data to the Quality Council. Annually the Quality Council will report a summary of all fall and restraint data to the Board of Trustees. <p><i>Account marked</i></p>	
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C 337	Continued From page 6 2. Per interview on 12/9/15 with the Director of Quality, s/he confirmed that there was no follow up quality review of falls reported via the Quantros reporting system unless there was an injury or negative outcome; thus the multiple falls (6) sustained by Patient #3, who was not injured, were not reviewed by Quality to help identify the lack of appropriate post fall actions taken. Per record review, nursing staff had failed to implement the hospital's "Post Fall Management" interventions and develop a care plan to address the patient's ongoing fall risk and history of previous falls.	C 337			

Attachment A***CMS Survey Conducted December 9, 2015******Plan of Correction*****C271 – Patient Care Policies (Continued from form OMB No. 0938-0391)*****Audit and Accountability***

- 100% of all falls will be audited by a member of the nursing care team utilizing an internal *Post Fall Audit* tool
- The completed audit tool will be handed off to the nurse manager or designee who will ensure the follow-up actions taken regarding equipment, environment and/or staff interventions (education needs or performance issues) have been completed along with validating appropriate follow-up was done with the patient and/or family.
- The nurse manager or designee will forward the completed *Post Fall Audit* tools to the Quality Department
- Monthly a member of the Quality Department will collate the fall data from across the organization and present it to the CIP Team
- Quarterly the CIP Team will report a summary of all fall data to the Quality Council
- Annually the Quality Council will report a summary of all fall data to the Board of Trustees

Policy – Use of Restraints

The *Clinical Incident Prevention Team Policy* will be revised to reflect that the Clinical Incident Prevention Team (CIP) team is responsible for reviewing the use of restraints in the facility. The policy on *Use of Restraints* is to be followed for all patients who have been restrained at Mt. Ascutney Hospital and Health Center.

Process

The following processes will be implemented for every patient for whom a restraint is utilized.

Patient Care/EMR Documentation

- Restraint Documentation will be completed using the *Ad Hoc Restraint PowerForms* or the *Interactive View Restraint Documentation Bands*.
- Prior to restraint use, an assessment will be made to evaluate for use of 'lesser restrictive alternatives' and the assessment of and any associated interventions will be documented.
- All elements as outlined in the *Use of Restraints* policy will be implemented and documented against, within required timelines
- All restrained patients are required to have a *Restraint Plan of Care* as part of their Plans of Care

- Ongoing documentation regarding the status of an intervention in the restraint care plan is expected and documentation of the reasons why interventions were not met is required
- Changes will be made in the patient's plan of care as indicated by the assessment of patient condition

Administrative

- Within 8 hours of the use of a restraint, a member of the nursing team is required to complete a *Quantros Risk Management Report*.
- Each use of a restraint will be fully investigated by the nurse manager or designee within 24 hours of use
- The nurse manager's or designee's follow-up will be added to the original *Quantros* and is to include the; who what, where, when why and how of the use of a restraint. The report will also include follow-up actions taken regarding alternative measures to restraint use, communications with patient and/or family regarding the restraint policy and/or any staff intervention and will reflect any changes made to the patient's plan of care as appropriate.
- Any patient for whom a restraint was used will be noted on the *Daily Safety Huddle* tracking form to improve the awareness of this risk issue at an organizational level.
- The use of restraints policies, assessment, interventions and documentation will become an annual competency evaluation for staff on the Acute/Swing, Rehab and ED units.

Education

- A mandatory, face-to-face, didactic experiential education session will be provided to all nursing staff within one month of the CMS acceptance of this COP response plan.
- This education will; review the intent and expectations as outlined in our policy, will emphasize the documentation requirements both at admission and daily utilizing the *Ad Hoc Restraint PowerForms* or the *Interactive View Restraint Documentation Bands*, there will be a concentrated focus on the evaluation of the use of alternative lesser restrictive measures and the difference between using restraints for medical versus behavioral needs. The education will also cover the development of a customized *Restraint Plan of Care* including the proper documentation of Goals, Interventions and Outcomes.
- A ULearn electronic learning module will be issued to all nursing staff in the Acute/Swing, Rehab and ED approximately six months post the classroom training to reassess base knowledge and for reinforcement of practice expectations.
- All new nursing hires will receive face-to-face education during orientation regarding expectations of nursing assessments, care and documentation regarding restraint consideration, initiation, monitoring, discontinuation and follow-up.
- The *Use of Restraints* policy and all accompanying information will become part of the annual competency evaluation for nursing staff on the Acute/Swing, Rehab and ED units.

Audit and Accountability

- 100% of all patients who have been restrained regardless of duration will be audited by a member of the nursing care team utilizing an internal *Restraint Use Audit* tool.

- The completed audit tool will be handed off to the nurse manager or designee who will ensure the follow-up actions taken regarding equipment, environment and/or staff interventions (education needs or performance issues) have been completed along with validating appropriate follow-up was done with the patient and/or family.
- The nurse manager or designee will forward the completed *Restraint Use Audit* tools to the Quality Department.
- Monthly a member of the Quality Department will collate the restraint data from across the organization and present to the CIP Team.
- Quarterly the CIP Team will report a summary of all restraint data to the Quality Council.
- Annually the Quality Council will report a summary of all restraint data to the Board of Trustees.

Attachment B***CMS Survey Conducted December 9, 2015******Plan of Correction*****C298 – Nursing Services (Continued from form OMB No. 0938-0391)****Policy - Assessment, Care Plan and Discharge Documentation – Acute, Swing, Rehabilitation Unit*****Audit and Accountability***

- All *Plans of Care* for each inpatient will be reviewed at least once a day by a member of the nursing care to ensure relevance to the patient's current active problems, to ensure that all interventions that are not met have a corresponding comment and that all goals and objectives are being appropriately addressed.
- Within 72 hours of admission, utilizing an internal *Care Plan Evaluation Audit* tool the nurse manager or their designee will randomly audit the care plans of each admission for relevance to active problems, customization, further clarification of interventions that are not met and usability as a communication tool between nursing shifts around a patients active problems.
- Monthly the nurse managers will present a summary of their care plan audits to the Nursing Leadership Committee.
- Quarterly the nurse managers will report a summary of their care plan audits to the Quality Council
- Annually the Quality Council will report a summary of all care plan audits to the Board of Trustees

Attachment C

*CMS Survey Conducted December 9, 2015**Plan of Correction***C302 - Records Systems (Continued from form OMB No. 0938-0391)****Policy - Falls Prevention**

The *Clinical Incident Prevention Team Policy* will be revised to reflect that all falls will be reviewed by the Clinical Incident Prevention Team (CIP) team. Revision to this policy will be presented for approval to the Quality Council at the January 28th meeting. While awaiting policy approval, all falls will be reviewed by the Quality team and the CIP team.

Process

The following process will be implemented for every inpatient.

Patient Care/EMR Documentation

- For any patient with a score of two or greater on the *Conley Fall Risk Assessment* or post a documented fall during the current admission, a *Fall Risk Plan of Care* is required.
- Interventions will be customized to individual patients needs as indicated by the assessment of patient condition, equipment and environment and will be updated each shift and as needed based on changes in patient condition.
- All Interventions documented "not met" require a comment.
- Post any fall, all steps as outlined in the *Patient Falls Policy* will be followed including the completion of the *Cerner Ad Hoc Post Fall Assessment* which will become part of the patient's permanent health record.

Administrative

- Within 24 hours post every patient fall, a member of the nursing team is required to complete a *Quantros Risk Management Report*.
- Each fall will be fully investigated by the nurse manager or designee within 72 hours of a fall
- The nurse manager's or designee's follow-up will be added to the original *Quantros* and is to include the; who what, where, when why and how of the fall. The report will also include follow-up actions taken regarding equipment, environment and/or any staff intervention and will reflect any changes made to the patient's plan of care as appropriate.
- If a patient has fallen multiple times during a contiguous admission, a multidisciplinary 'huddle' will be pulled together to discuss opportunities for mitigating the risk of further falls. This team will consist of the Nurse Manager or Designee, Quality/Risk, Provider, Care Management and others as indicated. The outcome of the 'huddle' will be documented in the *Quantros* as well as represented in the Plan of Care.

- Falls will be noted on the *Daily Safety Huddle* tracking form to improve the awareness of this risk issue at an organizational level.
- The falls risk policies, assessment, interventions and documentation will become an annual competency evaluation for staff on the Acute/Swing, Rehab and ED units.

Education

- A mandatory, face-to-face, didactic experiential education session will be provided to all nursing staff within one month of the CMS acceptance of this COP response plan.
- This education will; review the intent and expectations as outlined in our policy, will emphasize the documentation requirements both at admission and daily, cover the development of a customized *Risk for Falls* plan of care including the proper documentation of Goals, Interventions and Outcomes, review the use of the *Conley Fall Risk Assessment* and the *Post Fall Assessment*.
- A ULearn electronic learning module will be issued to all nursing staff in the Acute/Swing, Rehab and ED approximately six months post the classroom training to reassess base knowledge and for reinforcement of practice expectations.
- Fall Risk Awareness and Follow-up will be made a critical element of General Orientation for all new hires.
- All new nursing hires will receive face-to-face education during orientation regarding expectations of nursing assessments, care and documentation regarding falls prevention and follow-up.

Audit and Accountability

- 100% of all falls will be audited by a member of the nursing care team utilizing an internal *Post Fall Audit* tool
- The completed audit tool will be handed off to the nurse manager or designee who will ensure the follow-up actions taken regarding equipment, environment and/or staff interventions (education needs or performance issues) have been completed along with validating appropriate follow-up was done with the patient and/or family.
- The nurse manager or designee will forward the completed *Post Fall Audit* tools to the Quality Department.
- Monthly a member of the Quality Department will collate the fall data from across the organization and present it to the CIP Team.
- Quarterly the CIP Team will report a summary of all fall data to the Quality Council.
- Annually the Quality Council will report a summary of all fall data to the Board of Trustees.