

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

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Division of  
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PRINTED: 01/17/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  471302	(X2) MULTIPLE CONSTRUCTION, Licensing and Protection A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/11/2012
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NAME OF PROVIDER OR SUPPLIER  MT ASCUTNEY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 289 COUNTY ROAD WINDSOR, VT 05089
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS  An unannounced complaint investigation was completed on 1/11/12 by the Division of Licensing and Protection. The following regulatory violation was found.	C 000	<i>Internal Investigation</i>  An internal investigation and fact-finding was done with individuals and departments involved. Education and expectations were made clear with staff in this process that mediation reconciliation be complete and accurately documented in the medical record. Follow up was done with patient. Results of fact-finding and lessons learned was reported through Hospital governance structure as follows:  - Medical Executive Committee: 9/1/11, with follow-up on 10/13/11 - Medical Staff Peer Review: 9/22/11, with follow-up on 10/18/11 - Board of Trustees: 10/4/11 - Nursing Leadership: 10/17/11  Follow-up: - Medical Executive: 1/12/12 - QI Committee: 1/26/12 - ED Committee: 1/27/12  Action Plan: At the Medical Executive Committee on 1/12/12, an Interdisciplinary Task Force on Medication Reconciliation was established to evaluate and recommend a systemic process to ensure legible, complete, accurately documented medication reconciliation for the continuum of care at MAHHC, i.e., Clinic, ED, and inpatient. This group of doctors, nurse practitioners, nurses, and a pharmacist will convene no later than 2/3/12.  Monitoring: 1. Minutes of the Task Force meetings will delineate progress. 2. Quality department will audit charts for all units to ensure medication reconciliation is completed.	
C 302	485.638(a)(2) RECORDS SYSTEMS  The records are legible, complete, accurately documented, readily accessible, and systematically organized.  This STANDARD is not met as evidenced by: Based on staff interviews and record review, the hospital failed to assure that the medical record for 1 of 10 records reviewed was completely and accurately documented. (Patient #1) Findings include:  Per record review and confirmed by staff interviews, the medical record for Patient #1 contained inaccurate medication reconciliation information and failed to document telephone calls made to a surgeon from another hospital, completed by the Emergency Room (ER) Provider during the patient's visit on 6/1/11.  Per a telephone interview on 1/7/11 at 12:30 PM, the patient's family member stated that they had provided the medications the patient was taking from home for review by the Emergency Room nurse upon admission to the ER on 6/1/11 and had informed the nurse that only brand name medications were to be administered to the patient due to adverse side effects. The family stated that medications listed/ordered inpatient were incorrect. The family stated that staff were informed that the medication Celecoxib was ordered in error and nurses failed to note this fact	C 302		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Kevin W. Donovan Chief Executive Officer	(X6) DATE January 27, 2012
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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.

*Amc*

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C 302	<p>Continued From page 1</p> <p>and bring it to the physician's attention to be discontinued and the correct medication ordered. Per review of the MAR for the 2 days of the inpatient stay (6/2/11 - 6/3/11), the incorrect medication remained on the MAR until discharge 6/3/11. Nurses documented the patient's refusal of Celecoxib in the medical record for 6/2/11 and 6/3/11, however, they failed to document why. During interview on 1/10/12 at 3:20 PM, the President of Patient Services confirmed that nurses should have documented why Patient # 1 refused to take the medication(s) ordered during the hospital stay.</p> <p>During interview on 1/10/12 at 1:20 PM, the Physician Assistant (PA) who provided the medical exam to the patient in the ER, confirmed that he/she had failed to document telephone conversations with the patient's surgeon from a procedure performed at an out of state hospital the preceding week. He/she confirmed that they did consult together via telephone but there is no evidence of that in the ER medical record for 6/1/11.</p>	C 302	<p>3. Quality department will monitor and report through governance structure, the goals delineated below.</p> <p>At Quality Council 2012 Goals include:</p> <ol style="list-style-type: none"> <li>1. Improve medication reconciliation at admission and discharge from the hospital. Target will be set at 100% for inpatient, ED, and OR. Monitoring to begin by 2/28/12.</li> <li>2. Evaluate and improve patient/family understanding of medication reconciliation at discharge from Hospital. Outcome will be measured by decrease in readmissions due to medication error/misunderstanding. Monitoring to begin by 2/28/12.</li> <li>3. Physician Practices to develop medication reconciliation process at completion of outpatient visit. Monitoring to begin by 9/30/12 (related to EMR implementation).</li> </ol> <p>Additionally, Nursing Leadership set the expectation that when a patient refuses a medication, the reason for refusal will be documented and the provider informed. Random monthly documentation audits of the EMR will identify any medications not given or refused, the reason, and provider follow-up as necessary. Results of the audits will be reported through governance structure to include Nursing Leadership, Medical Executive Committee and Quality Council.</p> <p>The PA staff of the ED was clearly informed of the need to document consultation with external providers in the medical record. The issue was discussed at the ED Committee meeting. Monitoring will be the focus of 100% chart review for documentation of content, nature, and results of PA discussion with consultants. Results of chart review will be reported through governance structure via ED Committee to Medical Executive Committee.</p>	

C302 POC accepted 01/12/12 MBH/mw/PC/ctarw