

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

September 26, 2013

Paul Bengtson, Administrator  
Northeastern Vermont Regional Hospital  
1315 Hospital Drive  
Saint Johnsbury, VT 05819

Dear Mr. Bengtson:

The Division of Licensing and Protection completed a survey at your facility on **August 28, 2013**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **September 26, 2013**.

Sincerely,



Frances L. Keeler, RN, MSN, DBA  
Assistant Division Director  
Director State Survey Agency

FK:jl

Enclosure



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

RECEIVED  
Division of  
PRINTED: 09/12/2013  
FORM APPROVED  
SEP 23 13  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  471303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	Licensing and Protection (X3) DATE SURVEY COMPLETED  C 08/28/2013
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NAME OF PROVIDER OR SUPPLIER  NORTHEASTERN VERMONT REGIONAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1315 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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C 000	INITIAL COMMENTS  An unannounced on-site visit was conducted by the Division of Licensing and Protection on 8/26/13 and 8/27/13 to investigate complaint #10581. The investigation concluded on 8/28/13 and the following regulatory violations were identified related to the complaint.	C 000		
C 200	485.618 EMERGENCY SERVICES  The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.  This CONDITION is not met as evidenced by: Based on patient and staff interviews and record review the facility failed to conduct assessments to identify the reason for low oxygen saturation (O2 sat) levels, requiring the use of supplemental oxygen, and failed to conduct ongoing assessment of the patient's O2 sats thereby failing to assure appropriate oxygenation status of Patient #1, who presented to the Emergency Department (ED) on two separate occasions within a 12 hour period, prior to discharge from each ED visit. Findings include: Per record review Patient #1 had a history of a neurologic disorder for which s/he received medications, including; Valium 30 - 50 mg per day (to control muscle spasms), Scopolamine Transdermal patch (to treat nausea), Promethazine (for chronic nausea), and diphenhydramine (used to control abnormal movements), all of which included drowsiness as a side effect; as well as multiple other drugs. The patient underwent a surgical procedure of the right knee on 7/29/31 and was discharged home following the procedure with a prescription for Dilaudid (Narcotic pain medication - can also	C 200	C200: 485.618 EMERGENCY SERVICES  The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.  Based on patient and staff interviews combined with chart review for patient #1, surveyors found the facility to have failed to conduct assessments to identify the reasons for low oxygen saturation which required the use of supplemental oxygen and failed to conduct ongoing assessments to assure that the patient's oxygen saturation levels were in a range that provided appropriate oxygenation.  The records for Patient #1's Emergency Department visits on 7/31/13 and 8/1/13 lack documentation to support that the assessments had been completed both in the Nursing notes and Physician documentation.  <u>Corrective Action Plan:</u> 1. Emergency Department developed a new policy titled: <u>Vital Signs in the Emergency Department</u> , Approved on 9/17/13. The policy will be discussed and implemented at the 9/26/13 ED Nursing Staff meeting.  Debra Bach, RN, MSN, CEN, Emergency Services Director is responsible for Monitoring Nursing performance according to policy and enforcing compliance with required documentation. (Policy attached)  Response continued on page 2 of 12	9/20/13 Cassidy VP Director

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  P. R. Bunting	TITLE  CEO	(X6) DATE  9/20/13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 200 Continued From page 1  
cause drowsiness) every 4 hours as needed for pain relief.  
Patient #1 presented to the ED at 5:09 PM on the evening of 7/31/13 via ambulance with a chief complaint, identified in the ED physician note, as somnolence and fatigue. An EMS report, dated 7/31/13, indicated the ambulance had been dispatched for Patient #1 because of low O2 sats post surgery. The note stated that a visiting nurse and rescue personnel were at the patient's home on the ambulance's arrival; the patient's O2 sat had been reported by rescue members as 89%, and supplemental O2 was initiated at 3L per minute via nasal cannula (NC). Patient #1 was lethargic with slurred speech and complaining of weakness and nausea and his/her temperature was 100.1. The report further indicated the patient reported regular use of Dilaudid, 2 mg by mouth (PO) every 4 hours since his/her surgery 2 days prior, in addition to the use of all other meds. A nursing triage assessment, at 5:09 PM on 7/31/13, noted the patient's recent knee surgery and stated, "groggy today, with a fever, low saO2 per EMS....pt with slurred words". The record indicated Patient #1's O2 sat was 93% on 3L O2 via NC at the time of triage. A subsequent O2 sat of 95% on 2L of O2 via NC was documented at 7:15 PM and there is no evidence of any further assessment of the patient's O2 saturation level (both with and without the use of oxygen) prior to discharge home. Per Physician #1's (ED Attending physician) note, the diagnosis was identified as UTI (Urinary Tract Infection) and fatigue. Despite the fact that Physician #1 noted, in the Discharge Plan/Instructions, that Patient #1 seemed to be over sedated, and recommended s/he take only as much of the Dilaudid as really needed, and despite the patient's obvious use of supplemental

C 200 Continued from page 1 of 12  
  
**C200: 485.618 EMERGENCY SERVICES**  
  
*The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.*  
  
Corrective Action Plan (cont.):  
2. New process for Physician notification as outlined in the Vital Signs in the Emergency Department was developed. Thirty minutes prior to discharge the Nurse assigned will complete the final set of vital signs and notify the physician of any abnormal vital signs. Notification will be documented in the EMR. This is mandatory for all patients with ESI Levels of 1,2,3.  
(Screen shot of the EHR attached)  
  
Debra Bach, RN, MSN, CEN, emergency Services Director and Dr. William Sargent Medical Director, are working collaboratively and are jointly responsible for ongoing documentation compliance monitoring of Nursing and Provider performance according to policy.

9/20/13  
Case  
VP Division

AOC approved  
for C-200  
9/26/13  
Bonnie Howe RW

PCR Bayle CEO 9/20/13

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C 200	Continued From page 2 oxygen while in the ED there was no evidence that the patient's low O2 sat had been addressed by Physician #1, and the patient was discharged home, at 7:31 PM, with a prescription for an antibiotic to treat the UTI. Patient #1 returned to the ED via ambulance 10 hours later, at 5:13 AM on 8/1/13 with a chief complaint of headache and nausea. The EMS report stated that rescue personnel reported an O2 sat of 90% and O2 was initiated at 3L via NC by EMS prior to transport to the hospital. The patient was complaining of nausea and headache and reported to EMS personnel that s/he had not taken the routine Phenergan for the chronic nausea as s/he had been instructed in the ED the previous evening not to take medications because of the over sedation s/he had experienced. The patient's ED nursing admission assessment, at 5:19 AM, indicated an O2 sat of 90% on room air. A subsequent oxygen assessment note, at 5:54 AM, stated "pt arrives on 2L nc via EMS, O2 sat on ra 90%, pt left on 2L nc". There is no further assessment of the patient's O2 saturation prior to discharge home. The patient was seen again by Physician #1 whose note indicates the patient seemed a little more alert than when s/he had been in the ED the evening prior. The note stated Patient #1 received a single dose of Phenergan IM and showed enough improvement to be discharged home. Again, despite the use of supplemental oxygen for what had been identified as low O2 sats, there is no evidence the issue was addressed by the physician during the ED visit, and the patient was discharged home, without supplemental oxygen, at 6:41 AM on 8/1/13. Per interview, at 7:09 PM on 8/26/13, Patient #1 stated concern regarding the failure of ED staff to address the low oxygen saturation levels during	C 200	Response located on page 1 and 2 of 12	

*Per R. Bentley CEO 9/20/13*

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C 200	<p>Continued From page 3</p> <p>the two ED visits on 7/31/13 and 8/1/13, respectively. The patient stated that during the time of the ED visits, s/he was extremely groggy and cannot recall all the specifics of the visits, however the patient stated that family members present during some portions of the events were concerned that the patient's condition had not been fully addressed. Following return home from the second ED visit Patient #1's family members transported him/her to a second health care facility for evaluation, because they felt the patient's condition had not improved.</p> <p>Per review of records the patient was seen in the ED at Hospital #2 at 1:22 PM on 8/1/13. The record indicated the patient was and alert to person, place and time and appeared distressed on presentation to the ED. Further notes identified the patient as extremely dehydrated, with a headache, likely due to dehydration. The plan was to hydrate, discontinue the Dilaudid, and switch to oxycodone. A nursing note at 7:12 PM on 8/1/13 indicated O2 had been initiated at 3 L due to pulse oximetry reading of 78-84% on room air. The note stated the patient was very sleepy, but aroused by voice. A subsequent nurse's note, at 10:16 PM, indicated a decision was made to admit Patient #1 due to O2 sats of 90% on room air. The Discharge Summary stated; "Unable to obtain more history due to somnolence. Complicated pt with [neurologic disorder] treated with large doses of benzos and other meds. S/P arthroscopic surgery started using Dilaudid. Pt admitted for over sedation from diazepam and Dilaudid - during stay oxycodone and Dilaudid d/c (discontinued) and somnolence improved." Discharged 8/2/13.</p> <p>Per interview, at 3 on 8/27/13, RN #1, who provided direct care for Patient #1 during her ED visit on 7/31/13, confirmed that there was no</p>	C 200	Response located on page 1 and 2 of 12	
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*Paul R. Bentley CEO 9/20/13*

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C 200 Continued From page 4  
evidence O2 sats were obtained from the patient on room air prior to the patient's discharge on both visits and that there was no evidence that the patient was discharged home with supplemental oxygen. S/he stated s/he was not aware of any P&P (policies & procedures) regarding specific parameters related to reassessments of oxygen saturation status. RN #1 stated s/he thought reassessment should be done at the nurse's discretion, anytime there is a change in the patient's condition. However, s/he stated that, as a standard of practice, all patients receiving supplemental O2 should always have O2 sat checked while on room air prior to discharge. The CNO (Chief Nursing Officer) and the Director of Quality Programs, both confirmed, during interview at 4:20 PM on 8/27/13, the lack of specific nursing P&P regarding reassessment of oxygen saturations and both agreed O2 sats should have been assessed without use of oxygen prior to the patient's discharge. During telephone interview, at 6:39 PM on 8/27/13, Physician #1 confirmed there was no evidence in Patient #1's medical record that the low O2 sats had been addressed prior to discharge on either of the patient's two ED visits, for which s/he was the Attending physician.

C 296 485.635(d)(2) NURSING SERVICES  
  
A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.  
  
This STANDARD is not met as evidenced by:  
Based on patient and staff interviews and record review nursing staff failed to conduct ongoing

C 200  
  
Response located on page 1 and 2 of 12

C 296  
**C296 485.635(d)(2) NURSING SERVICES**  
*A registered nurse or, where permitted by state law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.*  
  
Based on patient and staff interviews along with record review surveyors determined that the STANDARD was not met. Nursing staff failed to conduct ongoing reassessment for one patient who received supplemental oxygen during treatment.  
  
Continued on page 6 of 12

*Peer Bengtson CEO 9/20/13*

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C 296 Continued From page 5  
reassessment of the oxygen needs of one patient for whom supplemental oxygen was provided during treatment in the Emergency Department. Findings include:  
  
Patient #1 presented to the ED at 5:09 PM on the evening of 7/31/13 via ambulance with a chief complaint, identified in the ED physician note, as somnolence and fatigue. An EMS report, dated 7/31/13, indicated the ambulance had been dispatched for Patient #1 because of low oxygen saturation (O2 sat) post surgery. The note stated that a visiting nurse and rescue personnel were at the patient's home on the ambulance's arrival; the patient's O2 sat had been reported by rescue members as 89%, and O2 was initiated at 3L per minute via nasal cannula (NC). Patient #1 was lethargic with slurred speech and complaining of weakness and nausea and his/her temperature was 100.1. The report further indicated the patient reported regular use of Dilaudid, 2 mg by mouth (PO) every 4 hours since his/her surgery 2 days prior, in addition to the use of all other routine medications, including valium. A nursing triage assessment, at 5:09 PM on 7/31/13, noted the patient's recent knee surgery and stated, "groggy today, with a fever, low saO2 per EMS.....pt with slurred words". The record indicated Patient #1's O2 sat was 93% on 3L O2 via NC at the time of triage. A subsequent O2 sat of 95% on 2L of O2 via NC was documented at 7:15 PM and there is no evidence of any further assessment of the patient's O2 saturation level prior to discharge home.  
Patient #1 returned to the ED via ambulance 10 hours later, at 5:13 AM on 8/1/13 with a chief complaint of headache and nausea. The EMS report stated that rescue personnel reported an O2 sat of 90% and O2 was initiated at 3L via NC

C 296 Continued from page 5 of 12  
  
**C296 485.635(d)(2) NURSING SERVICES**  
*A registered nurse or, where permitted by state law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH.*  
  
The records for Patient #1's Emergency Department visits on 7/31/13 and 8/1/13 lack Nursing documentation to support that assessment and reassessments of oxygen needs had been completed.  
  
**Corrective Action Plan:**  
1. Existing protocol dated 12/10, titled: **Oxygen: Management of the Patient Using** was reviewed and revised. In the Planning section number three was revised to require SaO2 readings 30 minutes after O2 is initiated or for any changes in FIO2. Readings are also required 30 minutes after O2 has been discontinued. Effective date 9/17/13  
  
This hospital wide protocol supports the new Emergency Department policy titled:  
**Vital Signs in the Emergency Department** (policy attached)  
  
The Chief Nursing Officer (CNO) and Debra Bach, RN, MSN, CEN, Emergency Services Director, are jointly responsible for ongoing documentation compliance and monitoring of Nursing clinical performance according to policy and established patient care standards.  
  
*POC approved for C-296  
9/26/13 Bonnie Howe NU*

*9/10/13  
Case  
VP  
Dennis  
rmt*

*Paul R. Bentley CEO 9/20/13*

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C 296 Continued From page 6  
by EMS prior to transport to the hospital. The patient was complaining of nausea and headache and reported to EMS personnel that s/he had not taken the routine Phenergan for the chronic nausea as s/he had been instructed in the ED the previous evening not to take medications because of the over sedation s/he had experienced. The patient's ED nursing admission assessment, at 5:19 AM, indicated an O2 sat of 90% on room air. A subsequent oxygen assessment note, at 5:54 AM, stated "pt arrives on 2L nc via EMS, O2 sat on ra 90%, pt left on 2L nc". There is no further assessment of the patient's O2 saturation prior to discharge home. The ED physician note stated that Patient #1 received a single dose of Phenergan IM and showed enough improvement to be discharged home. Again, despite the use of supplemental oxygen for what had been identified as low O2 sats, there is no evidence the issue was addressed by the physician during the ED visit, and the patient was discharged home, without supplemental oxygen, at 6:41 AM on 8/1/13. Per interview, at 7:09 PM on 8/26/13, Patient #1 stated concern regarding the failure of ED staff to address the low oxygen saturation levels during the two ED visits on 7/31/13 and 8/1/13, respectively. The patient stated that during the time of the ED visits, s/he was extremely groggy and cannot recall all the specifics of the visits, however the patient stated that family members present during some portions of the events were concerned that the patient's condition had not been fully addressed. Per review of records the patient was seen in the ED at Hospital #2 at 1:22 PM on 8/1/13. The record indicated the patient O2 had been initiated at 3 L due to pulse oximetry reading of 78-84% on room air and the patient was subsequently

C 296  
  
Response located on page 6 of 12

*Paul R. Bennett CEO 9/20/13*

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C 296	Continued From page 7 admitted due to O2 sats of 90% on room air. Per interview, at 3 on 8/27/13, RN #1, who provided direct care for Patient #1 during his/her ED visit on 7/31/13, confirmed that there was no evidence O2 sats were obtained from the patient on room air prior to the patient's discharge on both visits and that there was no evidence that the patient was discharged home with supplemental oxygen. S/he stated s/he was not aware of any P&P (policies & procedures) regarding specific parameters related to reassessments of oxygen saturation status. RN #1 stated s/he thought reassessment should be done at the nurse's discretion, anytime there is a change in the patient's condition. However, she stated that, as a standard of practice, all patients receiving supplemental O2 should always have O2 sat checked while on room air prior to discharge. The CNO (Chief Nursing Officer) and the Director of Quality Programs, both confirmed, during interview at 4:20 PM on 8/27/13, the lack of specific nursing P&P regarding reassessment of oxygen saturations, and both agreed that reassessment of oxygen saturation status should have been conducted, without oxygen, prior to the patient's discharge.	C 296	Response located on page 6 of 12	
C 337	485.641(b)(1) QUALITY ASSURANCE  The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that all patient care services and other services affecting patient health and safety are evaluated.	C 337	C337 485.641(b)(1) QUALITY ASSURANCE  <i>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.</i>  Continued on page 9 of 12	

*Per R. Beyer* 9/20/13  
CEO

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C 337 Continued From page 8

This STANDARD is not met as evidenced by:  
Based on patient and staff interview and record review the facility failed to evaluate, in a timely manner, the quality of care and services provided to one patient who voiced concerns about their care. Findings include:

Per record review Patient #1 had a history of a neurologic disorder for which s/he received multiple medications whose side effects included drowsiness. The patient presented to the ED (Emergency Department) at 5:09 PM on the evening of 7/31/13 via ambulance with a chief complaint, identified in the ED physician note, as somnolence and fatigue. An EMS report, dated 7/31/13, indicated the ambulance had been dispatched for Patient #1 because of low O2 sats post surgery. The note stated that a visiting nurse and rescue personnel were at the patient's home on the ambulance's arrival; the patient's O2 sat had been reported by rescue members as 89%, and supplemental O2 was initiated at 3L per minute via nasal cannula (NC). Patient #1 was lethargic with slurred speech and complaining of weakness and nausea and his/her temperature was 100.1. A nursing triage assessment, at 5:09 PM on 7/31/13, noted the patient's recent knee surgery and stated, "groggy today, with a fever. low saO2 per EMS.....pt with slurred words". The record indicated Patient #1's O2 sat was 93% on 3L O2 via NC at the time of triage. A subsequent O2 sat of 95% on 2L of O2 via NC was documented at 7:15 PM and there is no evidence of any further assessment of the patient's O2 saturation level (both with and without the use of oxygen) prior to discharge home. Per Physician #1's (ED Attending physician) note, the diagnosis was identified as UTI (Urinary Tract

C 337

Continued from page 8 of 12

**C337 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.*

Surveyors determined that the Standard was not met based on patient and staff interview along with record review for one patient. The facility failed to evaluate, in a timely manner, the quality of care and services provided to one patient who voiced concerns about their care.

**Corrective Action Plan:**

1. The complaint was reviewed by a physician as part of the existing complaints process on the scheduled date. Patient #1 was immediately sent a response letter and apology for the delay on August 29, 2013. The physician reviewing the complaint referred the case for further review to the regularly scheduled Medical Staff QA Committee on September 5, 2013. Input was received from physician members of the committee following review of the Outpatient Surgical record, two ED visits, and the records from hospital #2. Patient #1 was contacted by phone at her/his request and a final letter was sent with findings dated 9/17/13.

(letters attached)

Continued on page 10 of 12

9/20/13  
Cory  
Upd  
info

Per Benj... CEO 9/20/13

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

PRINTED: 09/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  471303	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/28/2013
NAME OF PROVIDER OR SUPPLIER  NORTHEASTERN VERMONT REGIONAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1315 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 337	Continued From page 9 Infection) and fatigue. Despite the fact that Physician #1 noted, in the Discharge Plan/Instructions, that Patient #1 seemed to be over sedated, and recommended s/he take only as much of the Dilaudid as really needed, and despite the patient's obvious use of supplemental oxygen while in the ED there was no evidence that the patient's low O2 sat had been addressed by Physician #1, and the patient was discharged home, at 7:31 PM. Patient #1 returned to the ED via ambulance 10 hours later, at 5:13 AM on 8/1/13 with a chief complaint of headache and nausea. The EMS report stated that rescue personnel reported an O2 sat of 90% and O2 was initiated at 3L via NC by EMS prior to transport to the hospital. The patient was complaining of nausea and headache and reported to EMS personnel that s/he had not taken the routine Phenergan for the chronic nausea as s/he had been instructed in the ED the previous evening not to take medications because of the over sedation s/he had experienced. The patient's ED nursing admission assessment, at 5:19 AM, indicated an O2 sat of 90% on room air. A subsequent oxygen assessment note, at 5:54 AM, stated "pt arrives on 2L nc via EMS, O2 sat on ra 90%, pt left on 2L nc". There is no further assessment of the patient's O2 saturation prior to discharge home. The patient was seen again by Physician #1 whose note indicated the patient seemed a little more alert than when s/he had been in the ED the evening prior. The note stated Patient #1 received a single dose of Phenergan IM and showed enough improvement to be discharged home. Again, despite the use of supplemental oxygen for what had been identified as low O2 sats, there is no evidence the issue was addressed by the physician during the ED visit,	C 337	Continued from page 9 of 12 <b>C337 485.641(b)(1) QUALITY ASSURANCE</b> <i>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.</i>  Surveyors determined that the Standard was not met based on patient and staff interview along with record review for one patient. The facility failed to evaluate, in a timely manner, the quality of care and services provided to one patient who voiced concerns about their care.  <b>Corrective Action Plan (cont.):</b> 2. The process for managing Emergency Department complaints has been revised to assure that complaints related to quality of care concerns can be assigned for physician review and action within 24 hours. Three ED physicians have been assigned to support the timely clinical review of all cases involving quality of care concerns.  The assistant Medical Director is the first contact, if not available the Medical Director is the second contact and the Physician assigned to Emergency Department Medical Staff QA Reviews is the third contact.  Colleen Sinon, VP Quality Management Programs is responsible for monitoring the timeliness of reporting the complaints related to quality of care concerns to the assigned physician for review within 24 hours and providing the individual with acknowledgement within 3 days and findings within 30 days of receiving a complaint.  POC approved for C-337 9/26/13 Bonnie Howe RN	9/20/13 Call VP Quality Management

Peer Buxton CEO 9/20/13

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C 337 : Continued From page 10  
and the patient was discharged home, without supplemental oxygen, at 6:41 AM on 8/1/13. Per interview, at 7:09 PM on 8/26/13, Patient #1 stated concern regarding the failure of ED staff to address the low oxygen saturation levels during the two ED visits on 7/31/13 and 8/1/13, respectively. The patient stated that during the time of the ED visits, s/he was extremely groggy and cannot recall all the specifics of the visits, however the patient stated that family members present during some portions of the events were concerned that the patient's condition had not been fully addressed. The patient stated s/he subsequently sought care at another hospital where s/he was admitted. S/he further stated s/he had expressed his/her concerns regarding lack of care in the ED at NVRH to the VP of Quality Programs there on 8/7/13 and had further expressed a desire to file a formal complaint regarding the issue.  
Per review of records the patient was seen in the ED at Hospital #2 at 1:22 PM on 8/1/13. The record indicated the patient was and alert to person, place and time and appeared distressed on presentation to the ED. Further notes indicated O2 had been initiated at 3 L due to pulse oximetry reading of 78-84% on room air and the patient was admitted at 10:16 PM, due to O2 sats of 90% on room air.  
The failure to conduct reassessment of Patient #1's O2 sats, both with and without use of supplemental oxygen, on both visits to the ED, was confirmed by the RN providing direct care during one ED visit, the ED Physician who provided care during both ED visits, the CNO (Chief Nursing Officer) and the VP of Quality Programs during separate interviews on 8/26/13 and 8/27/13.  
Per interview, at 7:31 AM on 8/27/13, the VP for

C 337

Response located on page 10 of 12

*Peer Breyer CEO 9/20/13*

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C 337 Continued From page 11  
Quality Programs confirmed that Patient #1 had verbalized concerns, on or about 8/7/13, about the care provided to him/her during ED visits on 7/31/13 and 8/1/13 and that the patient had later called to request the issue be considered a formal complaint. The VP of Quality further confirmed that although s/he had reviewed the patient's record there had been no further evaluation, to date, by anyone regarding the issue. S/he stated neither the ED physician involved in the case, the ED Medical Director, nor the physician responsible for assessing quality had been made aware of the case as of the date of survey.

C 337  
Response located on page 10 of 12

*Peer Bay ~ CEO 9/20/13*