

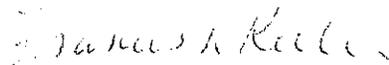
November 27, 2013

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 revisit survey at your facility on **October 29, 2013**. Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **November 26, 2013**.

Sincerely,



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

Enclosure



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

RECEIVED PRINTED: 11/15/2013
Division of FORM APPROVED
NOV 25 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 _____	(X3) DATE SURVEY COMPLETED R-C 10/29/2013
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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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{C 000}	INITIAL COMMENTS	{C 000}	C302: 485.638(a)(2) RECORDS SYSTEMS	
C 302	<p>An unannounced on-site revisit was conducted by the Division of Licensing and Protection on October 28 and 29, 2013. Regulatory violations were cited.</p> <p>485.638(a)(2) RECORDS SYSTEMS</p> <p>The records are legible, complete, accurately documented, readily accessible, and systematically organized.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to insure that the medical record for patient # 3 was complete and accurate.</p> <p>Based on record review patient # 3 presented to the facility emergency department on 10/16/13 with a primary complaint of sudden onset left sided chest pain. The registered nurse providing care to the patient initiated the emergency room chest pain protocol assessment but did not complete the assessment per electronic medical record [EMR] documentation. Per interview with the nurse who did not complete the assessment s/he disclosed that s/he was likely called out of the patient's room while conducting the assessment and upon return continued with the physical assessment but did not get back into the EMR to conclude the documentation. S/he stated that the chest pain protocol was completed but the documentation was not. The registered nurse stated that providing patient care was of primary responsibility and s/he could not imagine not having completed the entire assessment. S/he admitted that a component of the documentation supporting his/her chest pain assessment was missing from the patient record. On 10/29/13 at</p>	C 302	<p><i>The records are legible, complete, accurately documented, readily accessible, and systematically organized.</i></p> <p>Based on staff interviews and record review the facility failed to insure that the medical record for Patient #3 was complete and accurate.</p> <p>Patient #3 arrived with a chief complaint of chest pain and was assessed by nursing. The electronic record for Patient #3's Emergency Department visit on 10/29/13 lacked documentation to support that the chest pain assessment had been completed.</p> <p>Corrective Action Plan:</p> <p>1. Concurrent review of nursing documentation to assure completion at the end of each shift will be implemented. ED Director scheduled Nursing staff to attend one of two mandatory staff meetings provided, 11/26/13 or 11/27/13, to review documentation requirements and discuss the new RN nursing documentation audit that will be fully implemented on 11/28/13.</p> <p>2. The RN is responsible for completing the documentation on each patient prior to the end of an assigned shift. Medical Records staff will continue retrospective review of the records and notify staff when corrections or clarification is required. The correction or clarification must be completed within 24 hours of the notification. The ED Director will retrospectively monitor compliance according to policy. Please refer to the policy titled "<u>Emergency Department RN Nursing Documentation Audit</u>".</p>	<p>11/22/13 Call VP Quality Nursing</p> <p>11/20/13 Call VP Quality Nursing</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul R. Bergeron</i>	TITLE CEO	(X6) DATE 11/22/13
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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 302	Continued From page 1 10:30 AM the Emergency Department Director confirmed that the documentation in the EMR was not completed in this patient's electronic medical record.	C 302	Continued from page 1 of 4 C302: 485.638(a)(2) RECORDS SYSTEMS Corrective Action Plan (cont.): Debra Bach, RN, MSN, CEN, Emergency Services Director, is responsible for ongoing monitoring of nursing performance and compliance with required documentation. (Policy attached)	11/20/13 Chief VP Debra Bach magn	
C 306	485.638(a)(4)(iii) RECORDS SYSTEMS [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-] all orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics and progress notes describing the patient's response to treatments; [and] This STANDARD is not met as evidenced by: Based on record review and on staff interview the facility failed to insure that the medical records for patients #1 and #2 were properly maintained to provide complete necessary clinical information. Based on record review patient #1 presented to the emergency department on 10/15/13 with a chief complaint of chest pain. The registered nurse providing care for the patient initiated the emergency department standing orders protocol for chest pain. The chest pain protocol includes allowing the registered nurse to begin using oxygen at specified parameters per RN assessment of the patient condition. The RN started the patient on two liters of oxygen per	C 306	C306: 485.638(a)(4)(iii) RECORDS SYSTEMS <i>All orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress such as temperature graphics and progress notes describing the patient's response to treatments [and]</i> Based on staff interviews and record review the facility failed to insure that the medical record for Patients #1 and #2 were properly maintained to provide complete necessary clinical information. The electronic record for Patient #1's Emergency Department visit on 10/15/13 and Patient #2 on 9/30/13 lacked the electronic co-signature of the physician for use of oxygen to support that the nurse had administered oxygen according to the standing orders and verify that the physician was aware that the patient received oxygen therapy.	POC accepted J. Vellea / F. Kelly RN 11/26/13	
			Continued on page 3 of 4		

Paul R. Bayton CEO 11/22/13

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C 306	<p>Continued From page 2</p> <p>nasal cannula. Per record review the emergency department physician responsible for authorizing the use of the oxygen via the standing orders did not sign off the order. On October 29, 2013 at 1000 AM the Emergency Department Director confirmed that the physician did not sign off on the orders.</p> <p>Patient # 2 presented to the emergency department on 9/30/13 with a chief complaint of chest pain. The registered nurse who assessed the patient initiated the chest pain protocol and administered oxygen at two liters via nasal cannula. Per record review the emergency department physician did not sign off on the orders to administer the oxygen. On October 29, 2013 at 1040 AM the Emergency Department Director confirmed that there was not a physician order signature for approving the administration of oxygen.</p> <p>Per interview with the Emergency Department Director on October 29, 2013 it was disclosed that the standing order protocols utilized by the nursing staff in the emergency department prior to the launching of the electronic medical record used to be consistently co-signed by the physician as a paper record. The ED Director stated that the advent of the electronic medical record has caused some confusion with the staff in regard to obtaining the physician signature when utilizing standing orders. Per interview with an emergency department physician at 11:00 AM on October 29, 2013, it was disclosed that s/he rarely orders oxygen because the standing orders protocol is in place, but that s/he is fully aware of the patient receiving the oxygen by way of direct visualization and communication with the nursing staff.</p>	C 306	<p>Continued from page 2 of 4</p> <p>C306: 485.638(a)(4)(iii) RECORDS SYSTEMS</p> <p>Corrective Action Plan:</p> <p>1. Standing Orders will be entered into the electronic medical record (CPOE) by the Provider or the RN administering the medication or treatment such as oxygen therapy. The order will automatically go to the Provider for electronic signature (e-sig) which serves as acknowledgement that the provider was aware of the medications, therapies and treatments received by the patient during the episode of care. (screen shots attached)</p> <p>Debra Bach, RN, MSN, CEN, Emergency Services Director and Dr. William Sargent, Medical Director, are working collaboratively and are jointly responsible for ongoing monitoring of Nursing and Provider documentation compliance according to policy.</p>	<p>11/27/13 Cau PP Sargent</p>
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Paul R. Bengtson CEO 11/22/13

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Emergency Department RN Nursing Documentation Audit

The following process needs to be completed on a daily basis prior to leaving your shift. It is my expectation that each staff member will develop a workflow process to ensure this is completed in a timely fashion. This process has been developed to ensure all nursing documentation is completed in full prior to leaving each shift; this is not only good practice, but ensures our compliance with regulatory standards.

Key Concepts:

- The nurse assigned to the care of each patient is ultimately responsible for the completion of the record.
- Your patients automatically go to your “my list”
- If other staff need to complete documentation on your patient, this should be communicated to them and added to their “my list” by changing the assigned nurse to their initials.
- Every chart must be audited, real time.
- A tool has been developed to assist in auditing charts. This tool is a report which has all orders, assessments and intentions for each patient on it. This report can be ‘previewed’ and does not need to be printed; however can be printed if necessary (please make sure this information is appropriately placed for shredding).

Process:

- Utilizing your “my list”, a review of each chart must be completed, ensuring all documentation is complete and accurate.
- Once you have confirmed completion, the patient should be removed from your “my list” and changed from “nurse review” to “tobedeparted”.
- Medical Records will continue to do their reviews while coding; however, it will be the expectation that all corrections will be made to the chart within 24 hours of notification.
- The Nurse Director will perform audits at random to ensure compliance with the process.
- Feedback to be presented via the ED Dashboard

EFFECTIVE IMMEDIATELY!!!!

Effective immediately all Standing Orders initiated by nursing, i.e. oxygen, POS, etc. MUST BE entered into the computer!

Enter Default Provider and Source

Provider	Source
BAKER, STANLEY	Emergency Verbal
KRAUS, DANA	Hospital Policy
Provider Group	Lab
Other Provider	Nurse
	OR Verbal
	Pharmacist
	Pyxis
	RAD
	SCH
	Standing Order
	TVO Readback
	Written

The provider ordering -> Standing Order ->