

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 18, 2013

Mr. Paul Bengtson, Administrator
Northeastern Vermont Regional Hospital Swing Bed U
1315 Hospital Drive
Saint Johnsbury, VT 05819

Dear Mr. Bengtson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 26, 2013**. 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,



Pamela M. Cota, RN
Licensing Chief

PC:jl



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

PRINTED: 04/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47U023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER NORTHEASTERN VERMONT REGIONAL HOSPITAL SWING BED U	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 000	INITIAL COMMENTS	C 000		
C 379	<p>During the Critical Access Hospital Survey at Northeastern Vermont Regional Hospital, a recertification survey for Swing Beds was completed on 3/26/13. The following regulatory violation was identified:</p> <p>485.645(d)(2) CONTENTS OF TRANSFER/DISCHARGE NOTICE</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>Transfer, and discharge rights (§483.12(a)(6)):</p> <p>"The written notice specified in paragraph (a)(4) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement that the resident has the right to appeal the action to the State;</p> <p>(v) The name, address and telephone number of the State long term care ombudsman;</p> <p>(vi) For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act, and</p>	C 379	<p>C379 485.645(d)(2) CONTNNTS OF TRANSFER/DISCHARGE NOTICE Transfer, and discharge rights (483.12(a)(6))</p> <p>All seven elements must be included in a written notification to each resident, regardless of payment source, prior to transfer or discharge from the Swing Bed Program. The requirement was not met as reported by the surveyors.</p> <p>The current policy titled "Discharge Planning-Swing Bed Program" is being revised to include all seven elements listed under this standard. A notification Letter is being developed and will be included as part of the policy. The approved Notification Letter will be included in each Swing Bed Admission packet. Care Managers will document the required information on the form and issue the notification to each Swing Bed Patient prior to transfer or discharge from the NVRH Swing Bed Program. It is anticipated that this will be fully implemented by 4/24/13.</p> <p>Colleen Sinon, VP Quality Management Programs, will be responsible for implementation of the new policy and process as well as monitoring for compliance. All Swing Bed Admissions will be reviewed to assure that the written Transfer/Discharge Notification has been issued to all patients prior to discharge.</p> <p>4/16/13 C379 DOC created Audrey Rymns</p>	4/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert Bay</i>	TITLE CEO	(X8) DATE 4/15/13
--	--------------	----------------------

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.

MLL

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

PRINTED: 04/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47U023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2013
NAME OF PROVIDER OR SUPPLIER NORTHEASTERN VERMONT REGIONAL HOSPITAL SWING BED U		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 379	<p>Continued From page 1</p> <p>(vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act."</p> <p>This STANDARD is not met as evidenced by: Based upon record review and interview, the facility failed to develop, implement, and provide swing bed residents a written notice whenever a transfer or discharge is initiated by the facility and did not provide this notice to one swing bed resident upon discharge. (Resident #5). Findings include:</p> <p>1) Per record review of Resident #5's medical record and confirmed during an interview with the Vice President of Quality Management Programs on 3/26/13 at 4:06 PM, a written notice that includes the following information is not provided to swing bed residents whenever a transfer or discharge is initiated by the facility and this written notice was not provided to swing bed Resident #5 upon discharge on 2/24/13.</p> <p>(i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement that the resident has the right to appeal the action to the State; (v) The name, address and telephone number of the State long term care ombudsman; (vi) For nursing facility residents with</p>	C 379	<p>Response located on page 1 of 3</p> <p>C 379 POC accepted Linda Cummings, RN MS 4/16/13</p>	

Paul R. Bengtson CEO 4/15/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47U023	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER NORTHEASTERN VERMONT REGIONAL HOSPITAL SWING BED U	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 379	<p>Continued From page 2</p> <p>developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and (vii) For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>2) Per record review and confirmed during an interview with the Vice President of Quality Management Programs on 3/26/13 at 4:06 PM, a written notice that includes the following information is not provided to swing bed residents whenever a transfer or discharge is initiated by the facility:</p>	C 379	<p>Response located on page 1 of 3</p> <p>4/16/13</p> <p>C379</p> <p>POC accepted</p> <p>J. Cummings</p>	
-------	---	-------	--	---

Paul R. Bangerter CEO 4/15/13