

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

PRINTED: 07/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>470024</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/01/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHWESTERN MEDICAL CENTER INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>133 FAIRFIELD STREET</b> <b>SAINT ALBANS, VT 05478</b>		
(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
A 000	INITIAL COMMENTS  An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection, on 2/27/12-2/29/12, as authorized by the Centers for Medicare and Medicaid Services. The investigation was completed on 3/1/12 with the following regulatory deficiencies identified.	A 000		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE  A registered nurse must supervise and evaluate the nursing care for each patient.  This STANDARD is not met as evidenced by: Based on staff interviews and record review nursing staff failed to assure consistent, ongoing care in accordance with physician orders, facility policies and procedures and standards of clinical practice for 1 patient. (Patient #1). Findings include:  Per record review nursing staff failed to provide consistent ongoing monitoring and treatment to prevent decubitus ulcers for Patient #1, who had been admitted to the medical surgical unit on 11/28/11 following back surgery that morning. Review of a physician's Discharge Summary stated that the patient ".....did develop two decubitus blisters in the hospital which were treated locally and we did obtain a visiting nurse to dress this."  The facility Skin/Wound Care Policy and Care Guidelines, last reviewed 6/04, stated under the General Skin Care/Prevention; Care Guidelines: consider the following interventions; "For patients with impaired mobility/limited activity: Turn and/or reposition [every] 2 hours with proper	A 395		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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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A 395	<p>Continued From page 1</p> <p>alignment.....Use Total Care Bed or other pressure reducing mattress.....If the patient develops a reddened area, keep the area pressure free until it returns to normal". "Note: If the patient has a reddened area that does not fade within 30 minutes (Stage 1 decubitus), use these guidelines to monitor and treat it": for "reddened area, intact skin; protect skin with moisture barrier ointment".</p> <p>Per record review a physician order, dated 11/28/11, included; "Decubitus (pressure ulcer) precautions", and, "turn, cough and deep breath every 2 hours while awake". Review of nurses notes indicated Patient #1's activity and mobility had been limited as a result of confinement to bed for 2 days post surgery. Although the patient's care plan problem list, on 11/28/11, included Impaired Skin Integrity, with a goal to exhibit optimal tissue integrity, the care plan interventions did not include turn and/or reposition every 2 hours or use of a pressure reducing mattress. Despite the identified risk factors, the physician orders and the facility's policy reflecting clinical standards of nursing practice, there was no evidence that the skin protection measures and interventions utilized by staff consistently included to turn and reposition the patient or apply barrier ointment to the skin. There was documentation on two occasions only, at 10:07 AM and 3:27 PM on 11/29/11, that turn and/or reposition every 2 hours was implemented as a skin protection intervention.</p> <p>A Nurse's Note, dated 12/1/11 at 8:28 AM, indicated, in the physical assessment, that the patient had a skin problem area on the buttocks identified as a "reddened" "blister". During</p>	A 395		

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A 395	<p>Continued From page 2</p> <p>interview, at 5:18 PM on 2/29/12, Nurse #1, who was responsible for oversight of care for Patient #1 during part of the evening on 11/30/11, stated that the patient had mentioned, that evening that his/her bottom was "a little sensitive". The nurse stated that, although s/he had assessed the patient and noted a "pink" area on the patient's buttocks, s/he did not document the finding, did not reassess the area prior to end of his/her shift and did not apply any moisture barrier ointment to the patient's buttocks at that time. Nurse #1 further stated that during a physical assessment of Patient #1 on the morning of 12/1/11, although a blister had developed on the patient's buttocks, s/he did not treat the area at that time. The nurse also stated s/he was not aware of whether a pressure reducing mattress had been used for Patient #1. A subsequent nurse's note, by Nurse #2, (the Charge Nurse), 5 and a half hours later, at 1:55 PM on 12/1/11, stated; "Patient has a blister that is open the size of a half dollar to right buttock. The left buttock has a pea size open area where a blister popped. On the inner right buttock crease lined with small blisters. Duoderm applied to the popped blisters of the right and left buttocks. During interview, at 11:54 AM on 3/1/12, Nurse #2, stated that s/he had been directed by the Nurse Unit Manager, on 12/1/11, to address a concern voiced by Patient #1 to a visitor, about "sores on [patient's] bottom". S/he confirmed that s/he had assessed the patient, observed the open areas of skin and applied a protective dressing.</p> <p>During interview, at 12:51 PM on 2/28/12, Nurse Manager of the Medical/Surgical Unit confirmed the lack of documentation of nursing interventions and stated that s/he would have expected to see</p>	A 395		
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A 395	Continued From page 3 documentation of interventions including turning and/or repositioning every two hours. The Nurse Manager also stated s/he did not know whether a pressure reducing mattress had been used for the patient.	A 395		
A 396	Reference: Lippincott Manual of Nursing Practice, 8th edition, pg. 187 482.23(b)(4) NURSING CARE PLAN  The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient.  This STANDARD is not met as evidenced by: Based on staff interview and record review nursing staff failed to develop and revise the care plan to meet the needs of 1 patient. (Patient #1). Findings include:  Per record review nursing staff failed to include all appropriate interventions to prevent decubitus ulcers for Patient #1, who had been admitted to the medical surgical unit on 11/28/11 following back surgery that morning. Review of a physician's Discharge Summary stated that the patient ".....did develop two decubitus blisters in the hospital....."  The facility Skin/Wound Care Policy and Care Guidelines, last reviewed 6/04, stated; Policy statement: 1. All patients admitted....will be screened for skin problems upon admission using the Braden Scale. Skin assessments will continue every shift thereafter. 2. For patients with identified skin problems, a plan of care will be	A 396		

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A 396	Continued From page 4 initiated and documentation of progress will be completed daily.....Ongoing assessment: 2. ....patients who have scores of 19 and below will have a care plan initiated, and turning schedule if appropriate." Under the General Skin Care/Prevention; Care Guidelines: consider the following interventions; "For patients with impaired mobility/limited activity: Turn and/or reposition [every] 2 hours with proper alignment.hours with proper alignment.....Use Total Care Bed or other pressure reducing mattress....."  Per record review a physician order, dated 11/28/11, stated; "Decubitus (pressure ulcer) precautions", and, "turn, cough and deep breath every 2 hours while awake". Review of nurses notes indicated Patient #1's activity and mobility had been limited as a result of confinement to bed for 2 days post surgery. Although the patient's care plan problem list, on 11/28/11, included Impaired Skin Integrity, with a goal to exhibit optimal tissue integrity, prior to the identification of skin issues on 12/1/11, the care plan did not include turn and/or reposition every 2 hours, or use of a pressure reducing mattress as skin protection measures. There was documentation on two occasions only, at 10:07 AM and 3:27 PM on 11/29/11, that turn and/or reposition every 2 hours was implemented as a skin protection intervention. In addition, although the Braden Scale assessment, conducted on 11/30/11 at 11:12 AM, identified a score of 19, the care plan interventions were not revised in response to that assessment, to include turning and/or repositioning in accordance with the policy, until an issue with skin integrity had been identified on 1 12/1/11.	A 396			

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A 396	Continued From page 5  During interview, at 12:51 PM on 2/28/12, the Nurse Manager of the Medical/Surgical Unit confirmed the lack of documentation and stated that s/he would have expected to see documentation of turning and/or repositioning every 2 hours as a care plan intervention. S/he further stated that s/he did not know if a pressure reducing mattress had been used for the patient.	A 396		
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