

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

RECEIVED
Division of LICENSING
JUL 29 12
PRINTED: 04/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	Licensing and Protection (X3) DATE SURVEY COMPLETED C 04/13/2012
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NAME OF PROVIDER OR SUPPLIER NORTHWESTERN MEDICAL CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 133 FAIRFIELD STREET SAINT ALBANS, VT 05478
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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 the facility failed to assure the ongoing supervision and evaluation of care needs and implementation of physician orders in accordance with accepted professional standards of nursing practice for 1 patient. (Patient #1). Findings include: 1. Per record review there was no evidence that Patient #1, who was admitted to the hospital on 8/6/11, for treatment of multiple medical issues, including difficulty swallowing and poor nutritional status, received any enteral feedings (feedings via a tube) in accordance with physician orders. The patient, who had undergone a nutritional consult and swallow evaluations on more than one occasion during his/her hospitalization had a physician progress note, dated 8/15/11, that stated s/he had been treated for acute respiratory distress secondary to recurrent aspiration pneumonia. The note identified the patient at great risk for aspiration, and physician orders, dated 8/15/11 at 9:36 AM, instructed nursing to "Place NG (nasogastric) tube"continue to keep NPO (nothing by mouth)....."nutrition consult". A subsequent physician order for enteral feedings was noted at 10:55 AM on 8/15/11 and stated "Jevity (nutritional supplement) 30 ml/hr". Per review of nursing notes there is no evidence of when the NG tube was placed, and no nursing evaluation of the patient referencing the NG tube prior to a note, dated 8/16/11, at 3:34 AM, which stated "Pt noted to be without feeding tube." The	A 395	A-395 Update policy entitled, "Enteral Tube Nursing Care, Feeding and Medication Administration" to include that the provider is notified when patient is unable to receive the tube feeding. Electronic medical record documentation improved to reflect documentation requirements and facilitate intervention steps. ICU and Medical Surgical Nursing staff will be educated To the revisions of the policy At the July department Meetings Nursing Quality Council will review 100 percent of the medical records of patient on tube feedings for appropriate documentation for the months of August, September, October and November 2012.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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A 395	Continued From page 1 note went on to say that the NG tube was discovered to be out of place approximately an hour after it's insertion and was subsequently re-inserted. Although an X-ray, completed on the morning of 8/16/11, determined appropriate placement of the tube at that time, there was no evidence of any further nursing evaluation pertaining to the NG tube prior to 8/17/11. A physician progress note, dated 8/16/11, indicated that an NG tube had been placed with the plan to initiate feedings. Although an addendum to the 8/16/11 physician progress note, at 8:01 PM, revealed that the NG tube had become displaced and several attempts to reinsert it had been unsuccessful, there was no evidence that the patient had ever received any of the nutritional supplement, Jevity, in accordance with the physician orders of 8/15/11. The Nurse Manager agreed, during interview, at 3:30 PM on 4/10/12, that there was no evidence of ongoing evaluations pertaining to NG tube placement/enteral feedings and no evidence that Patient #1 had received the nutritional supplement in accordance with physician orders.	A 395			
A 822	482.43(c)(5) PREPARATION FOR DISCHARGE As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care. This STANDARD is not met as evidenced by: Based on patient representative interview, staff interviews and record review the facility failed to assure that the patient/family members were adequately counseled, prepared and kept informed of the progress regarding the plan for post-hospital care for 2 patients. (Patients #1 and	A 822			

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A 822	Continued From page 2 #5). Findings include: Per record review Patient #1 was admitted to the hospital on 8/6/11, was placed on Comfort Care on 8/18/11, and discharged to a LTC (Long Term Care) facility on 8/19/11, without adequate preparation of the patient/family, for the discharge plan, including counseling, support and preparation regarding end of life care provided by a Palliative Care Nurse. The patient, who was admitted with diagnoses that included; pneumonia, atrial fibrillation, (heart rhythm irregularity), acute renal failure, gastrointestinal infection, and poor nutritional status, continued to have a decline in health over a 12 day period. Per review, daily Nursing Discharge Information notes, dated 8/16/11 through 8/19/11, identified Hospice as part of the discharge disposition plan, and a SW (Social Worker) Progress Note, dated 8/18/11, revealed a decision, on that date, by the patient and family members, for the patient to receive Comfort Care measures only. Physician orders, dated 8/18/11, included; "Comfort Measures Only", and, Consult Palliative Care Nurse. Per review of facility Policies and Procedures a policy titled Palliative Care: Comfort Care, most recently revised in May, 2010, stated that if a patient ... is deemed appropriate for comfort care, that comfort care is provided according to comfort care orders and the following procedure, to include: #5. In addition to following comfort care orders, the nurse or designee will: a) initiate the palliative care plan with special attention to comfort, skin care, decubitus prevention, mouth care, and family support, b) obtain comfort care cart and furniture ... c) Order courtesy food/drink cart for family ... d) arrange for private room if	A 822	A-822 The Palliative Care Team will be re-activated in August by Oncology Case Manager/ Social Worker. Our Palliative Care physician Champion will attend the July 24, 2012 hospitalist meeting to educate hospitalists on the differences among hospice, palliative care and comfort care patients. Chronic Disease Manager will review 100 percent of medical records of patients on hospice, palliative care and comfort care to determine accuracy of documentation regarding discharge plan, including counseling, support and preparation regarding end of life care for the months of August, September, October and November 2012.	

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A 822	<p>Continued From page 3 available."</p> <p>A subsequent physician order, dated 8/19/11 at 3:00 PM , stated; D/C (discharge) to SNF (skilled nursing facility).</p> <p>A SW Progress Note, dated 8/19/11 at 4:24 PM, indicated that Patient #1' s family members had visited two separate LTC facilities on 8/19/11, to assess for suitability for the patient ' s placement and had refused them. The note further stated the family did agree to discharge to LTC facility #3, which was "the only facility that could accommodate today " and, although the family had also asked about placement at a hospice residence facility the "manager unavailable this afternoon to discuss case".</p> <p>Patient #1 was discharged on the evening of 8/19/11, without a consult by a Palliative Care Nurse, to LTC facility #2, where the patient expired less than 7 hours later.</p> <p>During interview, at 11:33 AM on 4/9/12, Patient Representative #1 stated that Patient #1 and the family members had agreed to place the patient on Comfort Care on 8/18/12 which they understood to mean the patient would remain in the hospital for end of life care, and which the representative stated they had been informed would most likely occur within days. Representative #1 stated that the patient/family members had been informed by staff of the "points of care" for comfort care at the hospital, which included; private room, availability of ongoing continuous presence of family members, and availability of refreshment cart.. S/he stated family members were "shocked" when they visited the patient the following day, on the</p>	A 822	<p>A medical staff Grand Rounds CME program is planned for 2013 to educate clinical staff on Palliative Care best practices.</p>	

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A 822	Continued From page 4 afternoon of 8/19/12, and were informed that the patient was to be discharged. The representative stated that the family had spoken with the physician that afternoon and discharge had not been discussed. S/he stated a SW spoke with them after the physician left, and informed them Patient #1 would be discharged that day. The representative stated that, although family members then had requested a delay in discharge until they could investigate placement options, such as a hospice residence, they were told by the SW that the patient had to be discharged that afternoon because the physician had already written the order. Representative #1 stated that the family felt Patient #1 was being "pushed" out and ultimately felt they had to agree to placement in the LTC facility that the patient was subsequently discharged to. Per interview, at 4:00 PM on 4/10/12, SW #2, who had worked with the patient/family for the first time on the afternoon of 8/19/11, confirmed that when s/he approached the family following the physician's visit with them, that afternoon, "the family was surprised at the discharge plan", and s/he felt that it hadn't been clear to the family that Patient #1 was to be discharged, "it felt like I was giving them new information." SW #2 stated that family members had visited 2 LTC facilities on the afternoon of 8/19/11, had refused placement there and then agreed to placement at LTC facility #3, which was the only other facility that was able to accept Patient #1 on that date. S/he further stated that, although the family had asked about placement at a local respite care facility, the manager at that facility was not available that afternoon to discuss the case and the discharge order had already been written.	A 822			

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A 822	Continued From page 5 SW #2 stated that s/he does not recall any conversation with the physician regarding the family 's confusion about the discharge, or their request for a delay in discharge. S/he also stated that it is the responsibility of the SW to assure consults with a Palliative Care Nurse are completed, and confirmed that the physician ordered consult with a Palliative Care Nurse had not occurred prior to the discharge of Patient #1. 2. Per record review staff failed to assure a SS (Social Services) consult was conducted in accordance with the physician order, for Patient #5, who was admitted on 3/16/12, with an altered mental status and whose medical conditions included; history of COPD (chronic obstructive pulmonary disease), acute respiratory failure, pneumonia, CHF (congestive heart failure), depression and chronic back pain. Per review of Nursing Discharge Information documentation the discharge disposition identified the patient would be discharged to home with oxygen and a referral to Home Health Services. The Nursing Discharge Information document, dated 3/17/12, stated that Patient #5 had a "fear of being alone" and the provider was aware. Although a physician order, dated 3/17/12 stated, "Social Services consulted (done 3/16/12)", there was no evidence that a consult had been conducted by Social Services. During interview, at 4:00 PM on 4/10/12, the SW confirmed the consult had not been completed prior to Patient #5 s discharge. S/he stated that s/he had been the only SW on duty on 3/17/12, and, although s/he had been aware of the request for consult, s/he had been very busy and had to prioritize his/her workload. The SW further stated that Patient #5 did not have immediate needs that day and so did not make it to the top of the SW's	A 822		

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A 822	Continued From page 6 list.	A 822		
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