

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

PRINTED: 10/22/2014
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 _____	(X3) DATE SURVEY COMPLETED C 06/04/2014
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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 000	INITIAL COMMENTS An unannounced on-site investigation was conducted on 6/2/14 - 6/4/14, as authorized by the Centers for Medicare and Medicaid Services to determine compliance with the Conditions of Participation (CoP) for Nursing Services, Medical Staff, Outpatient Services and Quality Assessment and Performance Improvement (QAPI). Regulatory violations were identified, related to complaint #11652, regarding the CoPs for Nursing Services, Outpatient Services and QAPI.	A 000		
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established.	A 286		

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 286	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview, staff failed to utilize the facility's established event reporting system, regarding a self identified medical error and patient complaint, as a means to assess adverse events and identify opportunities for improvement and changes that would lead to improvement in patient care and safety. Findings include:</p> <p>Per review, the facility's Event Reporting policy, last reviewed in February 2013, stated as it's purpose; "To provide a framework for aggregate reporting of events, trending of system issues and identification of areas for improvement. To maintain a culture of safety." The procedure included: "...Tracking 1. Events are reported by hospital staff or physician by describing details of the event.... Analysis Department manager reviews the Confidential Report Form, investigates event as needed, documents his/her action taken on back, including details of investigation performed and plan of action, initials, and forwards completed form to Risk Management within 72 hours from receiving the report."</p> <p>Per record review, Patient #1, whose medical history included cardiac bypass surgery, Atrial Fibrillation (cardiac arrhythmia) and SVT (supraventricular tachycardia - rapid heart rate), was admitted to the Outpatient Cardiac Rehabilitation (Rehab) Program on 2/19/14, to begin a comprehensive rehab program to meet his/her self determined goals to: "Improve</p>	A 286		
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A 286	<p>Continued From page 2</p> <p>strength; learn safe aerobic exercise skills." A focused health history, physical assessment and EKG (electrocardiogram) were completed on 2/19/14, by Medical Provider #1 to evaluate the patient's health status and Patient #1 began a physical exercise program on that date. The patient participated in 3 classes on 2/19/14, 2/21/14 and 2/24/14, respectively and did not return to the program. During monthly chart review, by the Cardiac Rehab Program Medical Director, conducted on 3/5/14, a discrepancy was noted in the interpretation of the EKG that had been completed on Patient #1 on 2/19/14. The Medical Director noted an abnormal heart rate pattern that had not been identified by Medical Provider #1 on 2/19/14.</p> <p>During interview, at 8:35 AM on 6/3/14, the Cardiac Rehab Medical Director confirmed that s/he had identified, during chart review on 3/5/14, the discrepancy in the interpretation of the EKG completed on Patient #1 on 2/19/14. S/he stated the patient did have an abnormal heart rhythm that had not been identified by Medical Provider #1 and further indicated that s/he would "probably" have referred Patient #1 to his/her cardiologist for evaluation prior to beginning the exercise program, because it would be difficult to monitor the abnormal heart rhythm during exercise. S/he also confirmed that, although the error in interpretation had been identified on 3/5/14, s/he had not completed an event report and further acknowledged that s/he had received no training or information regarding the facility's event reporting process.</p> <p>During an interview on the afternoon of 6/4/14 Medical Provider #1 confirmed that although s/he had become aware of the error in EKG interpretation for Patient #1 on 3/5/14 s/he did not utilize the established event reporting system to</p>	A 286		
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A 286	Continued From page 3 report the error. S/he further confirmed that although s/he had been made aware, on 5/28/14, of a complaint regarding Patient #1 and related to care and services, s/he had not utilized the event report system, or otherwise caused a report to be made to the facility until surveyors presented to the facility on 6/2/14. During interview, at 1:50 PM on 6/4/14, the Quality and Risk Manager confirmed that both the EKG interpretation error and the knowledge of a patient complaint should have been reported in accordance with the established policy and procedure for quality assessment and improvement purposes.	A 286		
A 386	482.23(a) ORGANIZATION OF NURSING SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Based on staff interview and record review the organizational structure for Nursing Services did not include clear delineation of nursing leadership delegated as responsible for the quality of nursing care and services provided to patients in the Outpatient Cardiac Rehabilitation (Rehab) Program. Findings include: Per review, the most current annual performance evaluations, for the year 2013, for the two full	A 386		

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A 386	<p>Continued From page 4</p> <p>time Registered Nurses (RN) responsible for providing nursing care in the Outpatient Cardiac Rehab Program lacked evidence of input regarding clinical practice by any clinical staff with the expertise to accurately assess clinical nursing practice. Each evaluation had been completed by the Director of Outpatient Clinics and Patient Access Services who confirmed, during interview on the morning of 6/2/14, that s/he did not have a clinical background. S/he further confirmed that there was no nurse manager, or any other ongoing nursing clinical oversight of nursing care provided to patients in the Cardiac Rehab Program.</p> <p>Although each evaluation included evidence that self-directed universal core competencies, related to knowledge of facility policies and procedures directing patient care, had been completed by each of the two RNs, there was no evidence that feedback had been elicited from a clinical staff member with delegated authority and responsibility for assuring quality of nursing care, that each of the RN's clinical practice had been evaluated to assure that nursing care was consistently provided in accordance with professional standards of nursing practice and the facility's established policies and procedures that direct nursing care.</p> <p>During a telephone interview on the afternoon of 6/4/14, the Chief Nursing Officer (CNO), stated that a new performance management system had been implemented in the Fall of 2013 and one way to provide oversight would be to have the Managers send the CNO any reviews, however, s/he acknowledged that s/he hadn't had a chance to access those yet. S/he further stated that the clinical evaluation process has been in transit.</p>	A 386		

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A 386	Continued From page 5 The CNO stated that, although the Director of Outpatient Clinics and Patient Access Services did not report directly to the CNO, they did meet on a monthly basis to discuss strategies regarding the Cardiac Rehab Program, and the Director would bring any nursing related questions to the CNO's attention. S/he also stated that some clinical oversight in the Cardiac Rehab Program is provided by the Medical Director who visits on a monthly basis to conduct chart reviews. The CNO further stated that although s/he does conduct monthly rounds at the Cardiac Rehab unit to connect with staff, and speak with patients, "we do recognize that we have to expand our clinical oversight."	A 386		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interviews, the facility failed to ensure nursing supervision of nursing personnel performance to assure the quality of nursing care provided to 2 patients in the Outpatient Cardiac Rehabilitation (Rehab) Program. Findings include: Per record review Registered Nurse (RN) #1 and #2 provided nursing services that were not in accordance with the facility's policy for Cardiac	A 392		

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A 392	Continued From page 6 Rehabilitation Phase II, dated 2/13, which stated, as part of the procedure process; "At the initial visit, a medical provider completes a focused health history and assess the patient's cardiopulmonary, musculoskeletal systems and cardiac risk factors. They discuss and/or develop patient goals." Despite the fact that Nurse Practitioner (NP) #1, a mid-level medical provider, was employed in the Outpatient Cardiac Rehab Program, RN #1 and RN #2 each conducted the focused health history and physical assessment for Patients #8 and #9, on each of their initial visits to the Outpatient Cardiac Rehab Program. (This assessment process is one of the factors utilized to determine the patient's appropriateness for participation in an exercise program.) During interview on 6/4/14 commencing at 2:45 PM, RN #1 confirmed that s/he had completed the initial focused health history and physical assessment of Patient #8 on 1/6/14. S/he stated that the focused health history and physical assessments conducted on a patient's initial visit had routinely been conducted by NP #1 who was on leave from the facility for the period between October 2013 - December 2013. RN #1 stated, that rather than finding a medical provider replacement for NP #1 during his/her absence, as RN #1 and other staff had assumed would happen, some of the nursing staff had been approached by the Director of Outpatient Clinics and Patient Access Services and asked if they, the RNs, would conduct the initial health history and physical assessments during NP #1's leave. RN #1 also stated s/he was not aware of any involvement by nursing leadership in this decision. RN #1 further confirmed that although NP #1 is currently employed at the Cardiac Rehab unit, some of the RNs continue, on	A 392		

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A 392	<p>Continued From page 7</p> <p>occasion, to conduct the initial focused health history and physical assessments on patients, as the NP is not employed on a full time basis.</p> <p>The non-clinical Director of Outpatient Clinics and Patient Access Services and the Vice President of Quality both stated during interview on the morning of 6/2/14, that the role of the RN in the Cardiac Rehab Program included conducting the initial focused health history and physical assessments of patients enrolled in the program.</p> <p>During interview on the afternoon of 6/4/14, the Risk Manager stated the job description for RN III had been revised in October of 2013. Per review, this job description included the following: "Provides professional nursing care for outpatients referred to the Cardiac Rehabilitation program including exercise, cardiac monitoring and patient education" and describes essential functions to include: "Assessment, Performs admission assessment".</p> <p>During interview on the afternoon of 6/4/14 the VP of Quality, identified as the RN who was currently providing coverage for the CNO who was not on-site at the facility, and the Director of Outpatient Clinics and Patient Access Services acknowledged they had not been aware of the discrepancy in the Cardiac Rehabilitation Phase II Policy and Procedure and the RN III job description.</p> <p>The failure to identify the discrepancy between the currently established Cardiac Rehabilitation Phase II Policy and Procedure and the RN III job description, that directs the procedure for conducting the initial health history and physical assessment of patients,</p>	A 392		

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A 392	Continued From page 8 as well as the failure to identify ongoing nursing practice that is not provided in accordance with the facility's policy and procedure, indicates there is a lack of ongoing nursing supervision and oversight for assuring the quality of nursing care and services provided to patients in the Outpatient Cardiac Rehab Program.	A 392		
A1079	482.54(b) OUTPATIENT SERVICES PERSONNEL The hospital must -- (1) Assign one or more individuals to be responsible for outpatient services. (2) Have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered, based on the scope and complexity of outpatient services This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to assure the presence of qualified personnel at all times to meet the needs of all patients in the Outpatient Cardiac Rehabilitation (Rehab) Program. Findings include: Per record review the facility's policy for Cardiac Rehabilitation Phase II, dated 2/13, stated, as part of the procedure process; "At the initial visit, a medical provider completes a focused health history and assess the patient's cardiopulmonary, musculoskeletal systems and cardiac risk factors. They discuss and/or develop patient goals." Despite the fact that Nurse Practitioner (NP) #1, a mid-level medical provider, was employed in the	A1079		

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A1079	<p>Continued From page 9</p> <p>Outpatient Cardiac Rehab Program, RN #1 and RN #2 each conducted the focused health history and physical assessment for Patients #8 and #9, on each of their initial visits to the Outpatient Cardiac Rehab Program. (This assessment process is one of the factors utilized to determine the patient's appropriateness for participation in an exercise program.)</p> <p>During interview on 6/4/14 commencing at 2:45 PM, RN #1 confirmed that s/he had completed the initial focused health history and physical assessment of Patient #8 on 1/6/14. S/he stated that the focused health history and physical assessments conducted on a patient's initial visit had routinely been conducted by NP #1 who was on leave from the facility for the period between October 2013 - December 2013. RN #1 stated, that rather than finding a medical provider replacement for NP #1 during his/her absence, as RN #1 and other staff had assumed would happen, some of the nursing staff had been approached by the Director of Outpatient Clinics and Patient Access Services and asked if they, the RNs, would conduct the initial health history and physical assessments during NP #1's leave. RN #1 further confirmed that although NP #1 is currently employed at the Cardiac Rehab unit, some of the RNs continue, on occasion, to conduct the initial focused health history and physical assessments on patients, as the NP is not employed on a full time basis.</p> <p>NP #1 confirmed, during interview at 11:35 AM on 6/4/14, that s/he had been on leave between October and December, 2013. S/he further confirmed that s/he is employed in the Cardiac Rehab unit 3 days per week, and stated that some RN staff members do conduct the initial</p>	A1079		

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A1079	<p>Continued From page 10 focused health history and physical assessment of new patients.</p> <p>The non-clinical Director of Outpatient Clinics and Patient Access Services and the Vice President of Quality both confirmed, during interview at 10:34 AM on 6/4/14, that the role of the RN in the Cardiac Rehab Program included conducting the initial focused health history and physical assessments of patients enrolled in the program.</p> <p>Despite the currently established Cardiac Rehabilitation Phase II policy and procedure that directed the initial health history and physical assessments of patients entering the Cardiac Rehab Program would be conducted by a medical provider, a medical provider was not always available to complete those assessments.</p>	A1079		
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