STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	471307		C 09/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTER HOSPITAL, INC	115 PORTER DRIVE MIDDLEBURY, VT 05753

(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		
	An unannounced onsite complaint investigation was completed by the Division of Licensing and Protection on 9/19/12 as authorized by Centers for Medicare and Medicaid Services. For the Conditions of Participation: Infection Control and Periodic Evaluation and Quality Assurance Review the following regulatory violations were identified:			
C 278	485.635(a)(3)(vi) PATIENT CARE POLICIES	C 278		
	[The policies include the following:]			
	a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.			
	This STANDARD is not met as evidenced by: Based on observations and staff interview, the Critical Access Hospital (CAH) failed to ensure infection control practices where properly implemented and maintained in the Emergency Department (ED). Findings include:			
	During tour of the ED, at 11:00 AM on 9/17/12, the following observations were made:			
	a. There were 3 patient commodes with multiple areas of rust colored stains throughout the metal frames, stored in the Soiled Utility Room. Per interview with the ED Nurse Manager, who was present at the time of tour, the patient commodes are cleaned by staff and stored in the Soiled Utility Room for future patient use. The Nurse Manager confirmed that it was difficult to tell whether the commodes were clean or dirty at the time of observation and further stated that there			

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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C 278	Continued From page 1 was no system currently in place to let staff know whether or not equipment had been cleaned. b. A pan partially filled with a yellow solution was noted sitting in the sink in the Soiled Utility Room. The ED Nurse Manager acknowledged at the time of observation, a solution of Endozime (an enzymatic detergent used during the process of cleaning surgical instruments) had been mixed with water in the pan. Endozime manufacturer's directions stated a specific amount of the detergent is to be mixed with 1 gallon of water in order to ensure effective cleaning of surgical instruments. However, there was no indication of measurement for the amount of water mixed with the Endozime nor the time the solution was mixed to ensure the proper dilution, stability and effectiveness of the solution and whether the solution should be reused. Also noted were several instruments sitting in liquid solution in a plastic wash basin on the counter in the Soiled Utility Room. Inside surfaces of the basin were heavily stained, the plastic had deteriorated leaving a porous surface creating a potential infection control risk.	C 278		
C 337	485.641(b)(1) QUALITY ASSURANCE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that- all patient care services and other services affecting patient health and safety are evaluated. This STANDARD is not met as evidenced by:	C 337		

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C 337	Continued From page 2 Based on staff interview and record review, the CAH quality assurance program failed to initiate corrective action and interventions when an opportunity for improvement in Emergency Department patient care services was identified. Findings include: Per interview on 9/18/12 at 8:15 AM, the Medical Director for the Emergency Department (ED) confirmed s/he failed to ensure all ED practitioners were aware of the Radiology Department's protocol for performing CT Scans on patients with contrast dye allergies. Per record review, Patient #1 was treated in the ED on 5/31/12 by Physician #1 for symptoms and laboratory results suggestive of a Pulmonary Embolism (PE). Per interview on 9/18/12 at 8:15 AM, Physician #1 stated normally a CT scan would have been ordered to rule out a PE, however the patient was allergic to the contrast dye and s/he was not aware if the Radiology Department had a protocol for treating patients with this specific allergy, nor did s/he investigate the possibility. Consequently, the PE diagnosis was not ruled out prior to discharge from the ED, resulting in Patient #1 being emergently admitted to another hospital on 5/31/12 with acute symptoms and diagnosis of PE. The Medical Director failed to utilize the events of 5/31/12 to assure all practitioners providing care and services in the ED where aware of the Radiology protocol for patients with contrast dye allergies. In addition, as of 9/18/12 the circumstances of this specific case had not been reviewed by the Medical Director with all ED practitioners in an effort to identify opportunities for improvement and potential changes to enhance quality of patient care services provided	C 337		

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C 337	Continued From page 3 in the ED.	C 337		