

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

PRINTED: 03/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471307	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/18/2012
NAME OF PROVIDER OR SUPPLIER PORTER HOSPITAL, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 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		
C2402	<p>489.20(q) POSTING OF SIGNS</p> <p>[The provider agrees,] in the case of a hospital as defined in §489.24(b), to post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area) a sign (in a form specified by the Secretary) specifying the rights of individuals under section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and to post conspicuously (in a form specified by the Secretary) information indicating whether or not the hospital or rural primary care hospital (e.g., critical access hospital) participates in the Medicaid program under a State plan approved under Title XIX.</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview the Critical Access Hospital (CAH) failed to post signs in all areas specifying the rights of individuals, who present to the ED (Emergency Department) seeking health care services for emergency medical conditions or for women in labor. Findings include:</p>	C2402		10/12/12

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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C2402	Continued From page 1	C2402			
C2406	<p>During tour of the Emergency Department (ED) on 9/17/12 at 11:00 AM the only EMTALA sign posting was observed in the patient waiting room. No other area of the department including the ambulance entrance, admitting area or treatment areas had signs posted specifying the rights of individuals with respect to examination and treatment for emergency medical conditions and women in labor. This was confirmed, at the time of tour, by the ED Nurse Manager.</p> <p>489.24(a) and 489.24(c) MEDICAL SCREENING EXAM</p> <p>Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must (i) provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and</p> <p>(b) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the</p>	C2406		10/15/12	

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C2406	<p>Continued From page 2</p> <p>hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.</p> <p>(2) Nonapplicability of provisions of this section. Sanctions under this section for inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1) (B) of the Act.</p> <p>(c) Use of Dedicated Emergency Department for Nonemergency Services If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.</p>	C2406			

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C2406	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review the CAH failed to assure that an appropriate MSE (Medical Screening Examination), to determine whether or not an Emergency Medical Condition (EMC) existed, was conducted for Patient #1 who presented to the ED (Emergency Department) complaining of difficulty breathing and right upper quadrant pain radiating to their back. Findings include: Per record review on 9/17/12, Patient #1 arrived in the Emergency Department (ED) on 5/31/12 at 00:59 with a chief complaint of difficulty breathing, only comfortable when standing and right upper quadrant pain radiating to their back. Vital signs at 01:07 include: B/P 150/85, Pulse 102, respirations 12, temp 36.4 and pulse oximetry 98% (oxygen level) on room air. Acuity level at the time of Triage was assessed to be "4" using the Emergency Severity Index scoring of 1-5 (level 1 is acute-level 5 is minor). However the nurse failed to obtain a pain rating from Patient #1, as per hospital policy Emergency Department Triage Policy and Procedure (last revised 9/2011) which is required for correctly determining level of acuity.</p> <p>At approximately 0133 Physician #1 begins a Medical Screening Exam (MSE) of Patient #1 and documents the onset of symptoms began at 14:00, with the patient initially unable to take a deep breath and the "Severity of Pain: in the emergency department the pain is unchanged". After a physical exam and review of systems Physician #1 notes; " Cardiovascular: "Positive for chest pain, worse with inspiration sharp with cough, with movement, Negative for edema,</p>	C2406		

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C2406	<p>Continued From page 4</p> <p>palpations, paroxysmal nocturnal dyspnea" (sudden difficulty breathing while sleeping in a reclining position). Pulses in both legs were evaluated and were within normal limits. Respiratory assessment for Patient #1, the physician concludes: " Positive for shortness of breath, negative for cough, orthopnea (abnormal breathing condition), sputum production, wheezing". Per interview on 9/18/12 at 8:15 AM, when asked if s/he assessed Patient #1's breath sounds by auscultation, Physician #1 stated s/he believed they had, however there was no evidence in the documentation to confirm this assessment was performed.</p> <p>Physician #1 ordered an EKG, chemistry studies, hepatic panel, Troponin I (to rule/out acute coronary ischemia), D-Dimer (a test to rule/out the presence of a clot), hematology and Chest X-rays. Results included: Troponin I was negative at <0.04, the patient ' s electrolytes were below normal, the EKG results were " No acute ischemic changes" and the chest x-ray was determined to be normal. Results also noted the D-Dimer was elevated at 959 with the laboratory noting the cutoff for ruling out a Pulmonary Embolism and Deep Vein Thrombosis (blood clot) is < 500 ng/mlFEU.</p> <p>Physician #1's differential diagnosis for the patient included: coronary artery disease, cholelithiasis, chest wall pain and pulmonary embolism. S/he also states at 03:21: "Assessment and Plan; chest wall pain reproduces symptoms. Although D-Dimer elevated, there is no tachypnea or tachycardia." However, there was no documented evidence during the course of treatment Patient #1 was</p>	C2406			

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C2406	<p>Continued From page 5</p> <p>placed on continuous cardiac monitoring and no further vital signs were taken by nursing since triage. At 1:53 the patient was administered 81 mg of Aspirin. Two minutes prior to discharge, at 03:27, Patient #1 was administered Potassium Chloride 40 mEq (to treat a low Potassium level) and Percocet 5 mg-325 mg 2 tablets for the patient ' s persistent pain. At 03:29 Patient #1 was discharged from the ED to home. Physician #1 recommended follow-up with patient's primary care provider (PCP) the following day noting "Condition is stable" "Problem is new" and "Symptoms unchanged".</p> <p>Upon discharge Patient #1's symptoms persisted and s/he sought treatment on the afternoon of 5/31/12 with their primary care provider who noted Patient #1 was experiencing symptoms of shortness of breath and continued pain. The patient was emergently transported via EMS ambulance from the PCP's office to a tertiary facility with a diagnosis of pulmonary embolism (PE) and right pulmonary effusion requiring acute hospitalization and anticoagulation treatment.</p> <p>Per interview on 9/18/12 at 8:15 AM, when asked why a CT scan was not ordered as part of the MSE to assist in determining whether or not Patient #1 had an emergency medical condition associated with a PE, Physician #1 stated the patient was allergic to the contrast dye used for the CT scan. Physician #1 confirmed s/he had not completely ruled out a PE, stating in ".....a normal situation s/he would have had a CT scan with contrast". When asked if a Ventilation-perfusion scan (V/Q scan) was then considered, the physician noted this test was not performed at night because it required nuclear</p>	C2406		

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C2406	Continued From page 6 medicine. Although s/he has worked in the ED since 1993, Physician #1 acknowledged s/he was unaware whether or not the Radiology department at the hospital had a protocol for pre-medicating a patient with a known allergy to contrast dye prior to a CT scan. Per interview on 9/18/12 at 8:30 AM the ED Medical Director, stated "We do have a protocol for that; I looked into that when looking at this case and radiology does have a protocol for administration of medication prior to CT scan for patients who are allergic to dyes". In addition, Physician #1 further stated s/he had in fact ordered a CT scan but then canceled it. However, in his review of Patient #1 ' s record, the Medical Director acknowledged there was no evidence a CT scan was ever ordered for Patient #1. Per interview on 9/18/12 at 1:08 PM the lead CT technologist confirmed the Radiology Department protocol for patients with known allergy to contrast dye consists of pre-medicating the patient with methyprednisolone 32 mg orally 12 hours and 2 hours prior to the procedure. Although diagnostic testing was available, Physician #1 failed to consult with radiology on what the protocol was for ordering a CT Scan for a patient with contrast dye allergy. A Medical Screening Exam, appropriate to Patient #1 ' s presenting signs, symptoms and laboratory test results was not provided. Physician #1 failed to determine whether or not an Emergency Medical Condition (Pulmonary Embolism) existed and failed to assure stability of Patient #1 ' s medical condition prior to discharging the patient to their home on 5/31/12.	C2406			
C2407	489.24(d)(1-3) STABILIZING TREATMENT	C2407			10/16/12

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C2407	<p>Continued From page 7</p> <p>(1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either-</p> <p>(i) within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.</p> <p>(ii) For for transfer of the individual to another medical facility in accordance with paragraph (e) of this section.</p> <p>(2) Exception: Application to inpatients.</p> <p>(i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual</p> <p>(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.</p> <p>(iii) A hospital is required by the conditions of participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.</p> <p>(3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's</p>	C2407		

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C2407	<p>Continued From page 8</p> <p>behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the CAH failed to assure stability of the medical condition prior to discharge for Patient #1, as evidenced by the facility's failure to complete an appropriate Medical Screening Exam to determine if an emergency medical condition existed. Findings include:</p> <p>Per record review on 9/17/12 , Patient #1 arrived in the Emergency Department (ED) on 5/31/12 at 00:59 with a chief complaint of difficulty breathing, only comfortable when standing and right upper quadrant pain radiating to their back. Vital signs at 01:07 include: B/P 150/85, Pulse 102, respirations 12, temp 36.4 and pulse oximetry 98% (oxygen level) on room air.</p> <p>At approximately 0133 Physician #1 begins a Medical Screening Exam (MSE) of Patient #1 and</p>	C2407		

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C2407	<p>Continued From page 9</p> <p>documents the onset of symptoms began at 14:00, with the patient initially unable to take a deep breath and the "Severity of Pain: in the emergency department the pain is unchanged". After a physical exam and review of systems Physician #1 notes; " Cardiovascular: "Positive for chest pain, worse with inspiration sharp with cough, with movement, Negative for edema, palpations, paroxysmal nocturnal dyspnea" (sudden difficulty breathing while sleeping in a reclining position). Pulses in both legs were evaluated and were within normal limits. Respiratory assessment for Patient #1, the physician concludes: " Positive for shortness of breath, negative for cough, orthopnea (abnormal breathing condition), sputum production, wheezing". Per interview on 9/18/12 at 8:15 AM, when asked if s/he assessed Patient #1's breath sounds by auscultation, Physician #1 stated s/he believed they had, however there was no evidence in the documentation to confirm this assessment was performed.</p> <p>Physician # 1 ordered an EKG, chemistry studies, hepatic panel, Troponin I (to rule/out acute coronary ischemia), D-Dimer (a test to rule/out the presence of a clot), hematology and Chest X-rays. Results included: Troponin I was negative at <0.04, the patient ' s electrolytes were below normal, the EKG results were " No acute ischemic changes" and the chest x-ray was determined to be normal. Results also noted the D-Dimer was elevated at 959 with the laboratory noting the cutoff for ruling out a Pulmonary Embolism and Deep Vein Thrombosis (blood clot) is < 500 ng/mIFEU.</p> <p>Prior to Patient #1's discharge, Physician #1's</p>	C2407			

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C2407	<p>Continued From page 10</p> <p>differential diagnosis for the patient included: coronary artery disease, cholelithiasis, chest wall pain and pulmonary embolism. S/he also states at 03:21"Assessment and Plan; chest wall pain reproduces symptoms. Although D-Dimer elevated, there is no tachypnea or tachycardia." However, there was no documented evidence during the course of treatment Patient #1 was placed on continuous cardiac monitoring and no further vital signs were taken by nursing since triage. Physician #1 failed to provide any further interpretation why the D-Dimer results for patient #1 was elevated. At 1:53 the patient was administered 81 mg of Aspirin. Two minutes prior to discharge, at 03:27, Patient #1 was administered Potassium Chloride 40 mEq (to treat a low Potassium level) and Percocet 5 mg-325 mg 2 tablets for the patient ' s persistent pain. At 03:29 Patient #1 was discharged from the ED to home. Physician #1 recommended follow-up with patient's primary care provider the following day noting "Condition is stable" "Problem is new" and "Symptoms unchanged".</p> <p>Per interview on 9/18/12 at 8:15 AM, when asked why a CT scan was not ordered as part of the MSE to assist in determining whether or not Patient #1 had an emergency medical condition associated with a PE, Physician #1 stated the patient was allergic to the contrast dye used for the CT scan. The physician confirmed s/he had not completely ruled out a PE, stating in ".....a normal situation s/he would have had a CT scan with contrast". When asked if a Ventilation-perfusion scan (V/Q scan) was then considered, the physician noted this test was not performed at night because it required nuclear medicine. Although s/he has worked in the ED</p>	C2407			

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C2407	<p>Continued From page 11</p> <p>since 1993, Physician #1 acknowledged s/he was unaware whether or not the Radiology department at the hospital had a protocol for pre-medicating a patient with a known allergy to contrast dye prior to a CT scan. Per interview on 9/18/12 at 8:30 AM the ED Medical Director, stated "We do have a protocol for that; I looked into that when looking at this case and radiology does have a protocol for administration of medication prior to CT scan for patients who are allergic to dyes". In addition, Physician #1 further stated s/he had in fact ordered a CT scan but then canceled it. However, in his review of Patient #1 ' s record, the Medical Director acknowledged there was no evidence a CT scan was ever ordered for Patient #1. Per interview on 9/18/12 at 1:08 PM the lead CT technologist confirmed the Radiology Department protocol for patients with known allergy to contrast dye consists of pre-medicating the patient with methyprednisolone 32 mg orally 12 hours and 2 hours prior to the procedure.</p> <p>Although diagnostic testing was available, Physician #1 failed to consult with the radiology department to investigate what the protocol was for ordering a CT Scan for a patient with contrast dye allergy. A Medical Screening Exam, appropriate to Patient #1 ' s presenting signs, symptoms and laboratory test results was not conducted. Physician #1 had failed to determine whether or not an Emergency Medical Condition (Pulmonary Embolism) existed and failed to assure stability of Patient #1 ' s medical condition prior to discharging the patient to their home on 5/31/12. Upon discharge Patient #1's symptoms persisted and s/he sought treatment on the afternoon of 5/31/12 with their primary care</p>	C2407			

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C2407	Continued From page 12 provider (PCP) who noted Patient #1 was experiencing symptoms of shortness of breath and continued pain. The patient was emergently transported via EMS from the PCP's office to a tertiary facility with a diagnosis of pulmonary embolism (PE) and right pulmonary effusion requiring acute hospitalization and anticoagulation treatment.	C2407			
C2409	489.24(e)(1-2) APPROPRIATE TRANSFER (1) General If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless - (i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer. (B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks	C2409		10/12/12	

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C2409	<p>Continued From page 13 and benefits upon which it is based; or</p> <p>(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its bylaws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.</p> <p>(2) A transfer to another medical facility will be appropriate only in those cases in which -</p> <p>(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;</p> <p>(ii) The receiving facility</p> <p>(A) Has available space and qualified personnel for the treatment of the individual; and</p> <p>(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment.</p> <p>(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification</p>	C2409		

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C2409	<p>Continued From page 14 (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and</p> <p>(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.</p> <p>This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview the facility failed to ensure an appropriate transfer by failing to complete a written certificate of transfer for 1 patient. Findings include:</p> <p>Per record review there was no evidence that a transfer certificate had been completed for Patient #20, who arrived at the ED in cardiac arrest on 5/26/12, and who was transferred, an hour and 16 minutes after arrival, in unstable condition to a tertiary care center. Although there was a note, dictated by the attending physician, which stated; "I was able to talk to (patient's) mother who will go to DHMC to be with (patient).</p>	C2409		

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C2409	Continued From page 15 She is aware of (patient's) critical status", there was no evidence that the family member had been informed of the risks of transfer. In addition there was no evidence of what, if any, patient information had been sent with the patient to the receiving hospital. This was confirmed by the Vice President of Patient Care Services during interview at 4:11 PM on 9/18/12.	C2409			