

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

PRINTED: 07/10/2013
FORM APPROVED
OMB NO. 0938-0391

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| 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 12/04/2012 |
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| NAME OF PROVIDER OR SUPPLIER PORTER HOSPITAL, INC | STREET ADDRESS, CITY, STATE, ZIP CODE 115 PORTER DRIVE MIDDLEBURY, VT 05753 |
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| C 000 | INITIAL COMMENTS A full CAH survey was conducted from 12/2/12 - 12/4/12, subsequent to a complaint survey completed on 10/2/12. During the complaint survey, the Conditions of Participation (COPs) for Federal, State & Local Laws, Emergency Services and Period Evaluation & QA Review were not met. The full survey, completed on 12/4/12, included a Life Safety survey and investigation of 1 complaint. The Condition of Surgical Services was not met and the following regulatory violations were found. | C 000 | | |
| C 225 | 485.623(b)(4) MAINTENANCE [The CAH has housekeeping and preventive maintenance programs to ensure that- the premises are clean and orderly; This STANDARD is not met as evidenced by: Based on observation and staff interview, the Critical Access Hospital (CAH) failed to ensure that the premises were clean and orderly. Findings include; 1. Per observation on 12/4/12 at 9:32 A.M., ceiling exhaust vents in the bathrooms of rooms 233 and 236 on the obstetrics unit were heavily soiled with dust. This was confirmed by facility plant operations staff at the time of the observation. 2. While touring operating room #2 on 12/4/12 at 8:55 AM, with the Director of Surgical Services, powder-like dust was observed on the ventilation faceplates covering 2 out take air vents located | C 225 | | 3/19/13 |

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 225 | Continued From page 1 on the lower walls of the operating room. The Director acknowledged maintenance staff are assigned to perform cleaning of the air vents on a routine schedule, however confirmed the vents presently had dust on the faceplates. | C 225 | | |
| C 241 | <p>485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL</p> <p>The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review the facility's governing body failed to assure that all policies and procedures governing the care and services provided to surgical patients were periodically evaluated and revised to ensure the provision of quality care in a manner consistent with accepted standards of practice. Findings include:</p> <p>The governing body failed to ensure CAH staff were reviewing, revising or developing surgical services policies and procedures that directs staff in the provision of patient care. Per interview on 12/4/12 at 1:45 PM, the Vice President of Patient Care Services confirmed s/he is responsible to ensure the policies and procedures for surgical services are consistently updated to reflect current standards of professional and clinical practice. S/he acknowledged the policies and</p> | C 241 | | 3/19/13 |

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| C 241 | Continued From page 2 procedures were outdated and required extensive revisions as evidenced by a review on 12/3/12 and 12/4/12 of two manuals with policies originating over 34 years ago and did not reflect the present processes used by surgical staff and physicians. Examples of outdated policies and procedures include: "Procedure: Surgical Hand Scrubs with Drying of Hands and Arms of Scrubbed Personnel" was originally written on 6/1978 with the last revision noted to be on 5/1994. The outdated policy states "between surgical procedures, only a five minute scrub is necessary". Presently, personnel required to scrub prior to an operative procedure are using a waterless surgical scrub sanitizer in between surgical cases after the initial hand scrub has been performed at the beginning of the surgical case schedule, however there are no policies to direct staff with this pre-surgical process. "Radiation Safety in Operating Room" was originally developed in 1986 and was last revised in 1994, which fails to reflect present additional radiological equipment used in the operating rooms and the precautions and safety features required to protect both the patient and staff. The "Procedure for Routine Cleaning of Operating Room" was revised in 1995 and last reviewed in 2004. The outdated cleaning solution (Lysol) and processes included in the outdated policies do not reflect present standards of professional practice and infection control organization recommendations to ensure all environmental surfaces/equipment in the operating rooms are effectively cleaned. (I.E.. "Surface Disinfection: New processes and Products" Rutala and Weber 6/10/06; Disinfection, Sterilization and Antisepsis (APIC/ Association for Professionals in Infection Control and Epidemiology, Inc.) | C 241 | | | |

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| C 241 | Continued From page 3 Per interview, on the afternoon of 12/3/12, the newly appointed Director of Surgical Services confirmed the policies and procedures were outdated and obsolete. In addition, it was also confirmed by the Director policies and procedures had not been written for the reprocessing, after patient use, of lumen instruments, specifically the flexible endoscopes. | C 241 | | | |
| C 296 | 485.635(d)(2) NURSING SERVICES A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH. This STANDARD is not met as evidenced by: Based on record review and interview the hospital failed to appropriately re-assess pain following administration of medication for 2 of 6 patients, and failed to re-assess VS (vital signs) for one patient whose initial VS were elevated, during visits to the Emergency Department (ED). (Patients # 3, #5 & #7) Findings include: 1. Patient #3 presented to the ED on 5/15/12 with complaints of abdominal pain and loose stools. Nursing triage assessment on 5/15/12 at 13:00 stated "... appears distressed.. folded over in w/c.." The vital sign sheet documented Patient #3's pain as 10 of 10 using the numerical pain scale. Per review of the nursing ED notes, Morphine 4 milligrams was administered intravenously at 13:20 for pain in the right and left upper quadrant of the abdomen. Following administration of morphine, nursing failed to re-evaluate Patient #3's level of pain to determine | C 296 | | 3/19/13 | |

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| C 296 | <p>Continued From page 4</p> <p>the medication's effectiveness. On 5/15/12 at 18:48, Morphine 4 mg was again administered intravenously without evidence of a pain assessment. A nursing reassessment note at 18:37 just prior to morphine being given stated " Patient appears in no apparent distress at this time." No additional pain assessments were conducted while Patient #3 was in the ED. Patient #3 was transferred from the ED at 20:50 for admission as an inpatient..</p> <p>Per interview on 12/4/12 at 10:00 AM, the ED Nurse Manager confirmed that nursing failed to use the numerical pain scale to assess Patient #3's level of pain following administration of Morphine. The ED Nurse Manager confirmed that nursing notes written between 13:20 and 18:37 were "general assessment notes" that did not provide adequate information about Patient #3's level of pain.</p> <p>2. Patient #5 presented to the ED on 12/1/12 with abdominal pain. ED nursing notes on 07:47 stated "Pain: Complains of pain in abdomen. Pain currently is 10 out of 10 on a pain scale." Dilaudid 1 mg intravenously was administered at 07:47. At 08:10, ED nursing notes stated "Reassessment: Patient states symptoms have improved. Pain: Complains of pain in abdomen. Pain currently 5 out of 10 on a pain scale." Per record review, no re-evaluation of Patient #5's pain was done after the last note at 8:10 AM and 12:59 PM when Patient #5 was transferred to another facility.</p> <p>Per interview on 12/4/12 at 9:40 AM, the ED Nurse Manager stated Patient #5's pain was still too high (5 out of 10) and nursing should have</p> | C 296 | | |

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| C 296 | Continued From page 5 continued to assess the patient's level of pain. The ED Nurse Manager said there was no ED policy on pain assessments but preferred to have the numerical pain scale documented on the vital sign sheet. 3. Per record review Patient #7 presented to the ED at 7:24 PM on the evening of 11/5/12 with complaints of abnormal mood swings and behaviors following ingestion of a hallucinogen 5 days prior to admission. Despite the elevated BP (blood pressure), of 168/93, noted on admission at 7:26 PM, there is no evidence that the patient's BP had been reassessed prior to discharge more than 12 hours later at 8:00 AM on 11/6/12. The lack of reassessment of Patient #7's BP was confirmed, during interview at 9:37 AM on 12/4/12, by the ED Nurse Manager who stated that the BP should have been reassessed prior to the patient's discharge. | C 296 | | | |
| C 302 | 485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to assure that patient medical records were complete to include dates and times in 2 of 31 records reviewed. (Patients #3 & #10) Findings include: 1. Per record review, the "PCA (Patient Controlled Analgesia) And/Or Continuous Infusion Standing Orders" sheet for Patient #3 contained the physician's signature but lacked the | C 302 | | | 3/19/13 |

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| C 302 | Continued From page 6 date and time of the order. This was confirmed on 12/4/12 at 9:30 AM during an interview with the Vice President of Patient Services and the ED Physician who treated the patient on 5/15/12. 2. Per record review the Patient Transfer Form for Patient #10, who presented to the ED on the evening of 11/5/12 and was transferred to another facility on 11/6/12, lacked the time of decision to transfer, as well as the time the physician signed the form. In addition, although the Transfer Consent contained the patient's signature there was no date or time the signature was entered. This was confirmed by the Vice President of Patient Services during interview at 9:30 AM on 12/4/12. | C 302 | | | |
| C 304 | 485.638(a)(4)(i) RECORDS SYSTEMS For each patient receiving health care services, the CAH maintains a record that includes, as applicable-- identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient; This STANDARD is not met as evidenced by: Based on record review and staff interview, the hospital failed to assure that consent forms were properly executed and complete in 4 of 31 records reviewed. (Patient # 3, 10, 28 & 29) Findings include: | C 304 | | | 3/19/13 |

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| C 304 | Continued From page 7 1. Patient #3's surgical consent form of 5/16/12 contained the physician's signature and date but lacked the time completed by the physician. This was confirmed on 12/4/12 at 9:30 AM during an interview with the Vice President of Patient Services and the ED Physician who treated the patient on 5/15/12. 2. Patients #28 and #29 surgical consent forms of 12/3/12 included the physician's signature and date but lacked the time the consent was completed by the physician. This was confirmed on 12/3/12 at 1:50 PM by the PACU (Post Anesthesia Care Unit) supervisor. 3. Per record review for Patient #10, who presented to the ED on the evening of 11/5/12 and was transferred to another facility on 11/6/12, although the Transfer Consent contained the patient's signature there was no date or time the signature was entered. This was confirmed by the Vice President of Patient Services during interview at 9:30 AM on 12/4/12. | C 304 | | | |
| C 308 | 485.638(b)(1) PROTECTION OF RECORD INFORMATION The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use. This STANDARD is not met as evidenced by: Based on observations and interview, patient medical records were not stored in a manner that maintains confidentiality and safeguards against loss and destruction. Findings include: 1. During observations on tour with the Director of | C 308 | | 3/19/13 | |

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| C 308 | Continued From page 8 Health Information Systems on 12/3/12 at 10:00 AM, 2 of 4 file rooms had medical records stored on top shelves that were not covered. The open shelves were located near the sprinkler system and not safeguarded from potential loss and destruction. | C 308 | | | |
| C 320 | 485.639 SURGICAL SERVICES Surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body of the CAH in accordance with the designation requirements under paragraph (a) of this section. This CONDITION is not met as evidenced by: Based on staff interview and record review the facility failed to assure that policies and procedures guiding the provision of care for surgical services were periodically evaluated and revised to reflect current standard of practice. Findings include: Per review on 12/3/12 and 12/4/12, the policies and procedures for Surgical Services to include the operating rooms, post anesthesia care unit (PACU) and central sterile supply had not been kept current. Two manuals provided by the the recently appointed Director of Surgical Services included policies and procedures with some | C 320 | | 3/19/13 | |

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| C 320 | Continued From page 9 originating over 34 years ago and did not reflect the present processes used by surgical staff and physicians providing patient care within Perioperative (surgical) services. Examples of outdated policies and procedures include: "Procedure: Surgical Hand Scrubs with Drying of Hands and Arms of Scrubbed Personnel" was originally written on 6/1978 with the last revision noted to be on 5/1994. The outdated policy states "between surgical procedures, only a five minute scrub is necessary". Presently, personnel required to scrub prior to an operative procedure are using a waterless surgical scrub sanitizer in between surgical cases after the initial hand scrub has been performed at the beginning of the surgical case schedule. However there are no policies and procedures directing staff with this more recent pre-surgical process. "Radiation Safety in Operating Room" was originally developed in 1986 and was last revised in 1994, which fails to reflect present additional radiological equipment used in the operating rooms and the precautions and safety features required to protect both the patient and staff. The "Procedure for Routine Cleaning of Operating Room" was revised in 1995 and last reviewed in 2004. The outdated cleaning solution (Lysol) and processes included in the outdated policies do not reflect present standards of professional practice and infection control organization recommendations to ensure all environmental surfaces/equipment in the operating rooms are effectively cleaned. (I.E.. "Surface Disinfection: New processes and Products" Rutala and Weber 6/10/06; Disinfection, Sterilization and Antisepsis (APIC/ Association for Professionals in Infection Control and Epidemiology, Inc.) Per interview, on the afternoon of 12/3/12, the newly appointed | C 320 | | |

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| C 320 | Continued From page 10 Director of Surgical Services confirmed the policies and procedures were outdated and obsolete. In addition, s/he was also confirmed policies and procedures had not been written for the reprocessing of lumen instruments after patient use specifically the flexible endoscopes. Per interview on 12/4/12 at 1:45 PM, the Vice President of Patient Care Services confirmed s/he is responsible to ensure the policies and procedures for surgical services are consistently updated to reflect current standards of professional and clinical practice. S/he acknowledged the policies and procedures were outdated and required extensive revisions. | C 320 | | | |
| C 334 | 485.641(a)(1)(iii) PERIODIC EVALUATION [The evaluation is done at least once a year and includes review of--] the CAH's health care policies. This STANDARD is not met as evidenced by: Based on record review and interview the CAH failed to ensure policies and procedures for surgical services were reviewed at least annually and updated and revised as appropriate. The CAH Quality Assurance/Performance Improvement (QA/PI) review failed to ensure surgical services policies and procedures were reviewed at least annually to evaluate if revisions and updates were necessary. Per review on 12/3/12 and 12/4/12, manuals presently representing the department of surgical services | C 334 | | | 3/19/13 |

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| C 334 | <p>Continued From page 11</p> <p>(operating rooms, post anesthesia care unit and central sterile supply) included outdated policies and procedures dating back over 34 years and failed to reflect the present processes used by surgical staff and physicians providing patient care within surgical services. Per interview on the afternoon of 12/3/12, the newly appointed Director of Surgical Services confirmed the polices and procedures were outdated and did not meet the present standards and recommendations to include AORN (Association of Perioperative Registered Nurses), APIC (Association for Professionals in Infection Control and Epidemiology or AMII (Association for the Advancement of Medical Instrumentation).</p> <p>Per interview on 12/4/12 at 1:45 PM regarding the QA/PI program and review of the CAH identified improvement processes, the Vice President of Patient Care Services confirmed s/he is responsible to ensure the policies and procedures for surgical services are consistently updated to reflect new practices, products, disinfection and sterilization. S/he acknowledged the policies and procedures were outdated and required extensive revisions.</p> | C 334 | | |