VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 6, 2014

Mr. James Daily, Administrator
Porter Hospital, Inc
115 Porter Drive
Middlebury, VT 05753

Dear Mr. Daily:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 31, 2013.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela Cota, RN
Licensing Chief

PC:jl

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

PRINTED: 01/16/2014
FORM APPROVED
OMB NO. 0938-0391

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 12/31/2013

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 An unannounced on-site investigation was conducted on 12/30/13 and 12/31/13, by the Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid services to determine compliance with the Conditions of Participation for Emergency Services and Provision of Services. The following regulatory violations were identified related to complaint #10945.	C 000	C271 1.The hospital's policies and procedures related to suspected abuse reporting were reviewed to ensure that they are compliant with current legal requirements.	
C 270	485.635 PROVISION OF SERVICES Provision of Services This CONDITION is not met as evidenced by: Based on record review and staff interviews the Condition of Participation for Provision of Services is not met as evidenced by: The CAH failed to assure that care and services were provided in accordance with established policies and procedures. Refer to C-0271 The CAH failed to assure nursing conducted ongoing reassessments of a patient's condition. Refer to C-0296	C 270	The findings related to this deficiency were reviewed in detail with the hospital Nursing staff and Providers directly involved with the patient's care. A meeting was held on 1/15/2014 which was attended by the hospital's Interim CNO, the ED Nurse Manager, and the counseling service management team and staff. The following items were reviewed at this meeting: • The preliminary survey findings, which correspond with the findings on this statement of deficiencies; • The hospital's policies related to suspected abuse reporting; POC accepted 2/4/14 Fleeler/PMC	
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to assure care and services were consistently provided in accordance with	C 271		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James R Daily | TITLE: President | (X6) DATE: 2/5/2014

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 271	Continued From page 1 established policies and procedures for 2 patients. (Patients #1 and #8). Findings include: 1. Per review the facility's policy, Abuse - Elderly or Disabled, dated March of 2013, stated; "As per Vermont State statute all health care practitioners are required to report suspected abuse, neglect or exploitation of the elderly or disabled adult within 24 hours....III. Procedure: A. Suspected abuse.....of elderly or disabled adults; reports..1. Any of the following individuals having received information of abuse.....shall report or cause a report to be made within 24 hours:...a. all employees, contractors and grantees of the Agency of Human Services who are involved in caregiving, a physician.....mental health professional, social worker...B. It is the responsibility of the nurse or social worker to report to the Nursing Office and to the following agency: Adult Protective Services. The policy also identifies; "B. Indicators of possible abuse;....1. Physical Abuse: a. Any patient who reports an abusive incident..." Per record review, conducted on 12/30/13, staff failed to report an allegation of patient mistreatment by staff to the appropriate State Agency (SA), in accordance with their policies and procedures. Patient #1 presented to the ED (Emergency Department) on 11/8/13 with an acute psychiatric condition and spent 5 days in the ED while awaiting involuntary bed placement to an available inpatient psychiatric unit. The patient had a psychological consult by a QMHP (Qualified Mental Health Professional), dated 11/13/13, that indicated, "[s/he] is mistrustful of staff, worrying that [s/he] is being poisoned, as well experiencing unwanted sexual activity." The note further stated "(these are not happening)." Per interview, at 11:29 AM on 12/13/13, the ED	C 271	• The contractual agreement between the hospital and the counseling service, as it pertains to their agreement to comply with the hospital's policies and procedures; • The current process of communication between counseling service and hospital staff.	

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C 271	Continued From page 2 Nurse Manager stated the facility had not been aware of the allegation of sexual misconduct against Patient #1 by staff until notified by APS on 11/15/13. The Nurse Manager stated that once they were made aware an investigation was conducted. S/he further stated s/he was not aware of any notification by the QMHP to staff regarding the allegation made by Patient #1 on 11/13/13, and indicated that s/he would expect any contracted personnel providing services to patients to report to staff any allegation of mistreatment. During interview, at 2:31 PM on 12/31/13, the acting CNO (Chief Nursing Officer) stated that the facility has a contract with a local organization that provides psychological/psychiatric services for patients, and members of that organization who provide services to patients in the facility are expected to provide those services in accordance with the facility's established policies and procedures. The acting CNO further stated that the QMHP should have reported Patient #1's allegation of sexual misconduct to the ED provider or nurse. 2. The facility's policy regarding Patient Rights and Responsibilities, dated October, 2013, stated "...It is the responsibility of every employee to ensure the patient's rights are maintained." It further stated; "As a Patient You Have the Right:....To refuse treatment to the extent permitted by law - including declining or withdrawing life-sustaining treatment or resuscitation measures, and to be informed of the medical consequences." Per record review, conducted on 12/30/13, Patient #1 presented to the ED (Emergency Department) on 11/8/13 at 7:02 PM, with an acute	C 271	A follow up meeting was held on 1/21/2014, which was attended by the hospital's Interim CNO, the ED Nurse Manager, Director of Security, ED Nursing staff, ED Medical Director, and all counseling service Management and staff. The meeting included a discussion of the newly revised process for communication between counseling staff and hospital Providers, to include a revised, written communication tool titled "Consultation Sheet" to be utilized by counseling staff for all initial evaluations and follow up reassessment visits; further detail regarding this communication tool described below: The hospital form titled "Consultation Sheet" as noted above was reviewed and revised to include the following documentation and process changes:	

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C 271	Continued From page 3 psychiatric condition. A nurse's note, dated 11/8/13 indicated the patient was restrained using Twice as Tuff cuffs to both wrists and ankles, at 9:45 PM on that evening, related to aggressiveness and ongoing threats of harm to others. A subsequent note, at 10:07 PM stated the "Patient was restrained with Ativan, per order." The record indicated the patient received 2 mg of Ativan IM (intramuscularly) at that time. Patient #1 remained in 4 point restraints, with 1:1 observation by staff, and a note at 11:30 PM stated; "Pt refused Vital Signs The patients respirations are regular, The patients skin is Pink warm, and dry, patient threatening to harm others." A subsequent note, at 11:45 PM indicated that the patient refused to take Zyprexa (antipsychotic) orally and was informed by staff that if s/he "did not cooperate with the plan of care the medication would be administered IM." The note further stated, "States that s/he wants to do what ever it takes to 'Get the hell out of here'.....Pt took medication orally." The patient received 10 mg of Zyprexa PO (by mouth) at 11:45 PM. A physician note, dated 11/9/13 at 1:32 AM, stated that the patient was "somewhat calmer after 2 mg IM Ativan, agree to take 10 mg PO Zyprexa after told we were going to administer IM." Despite the patient's initial refusal to take the Zyprexa at 11:45 PM, s/he did accept it orally, however, only after being informed that it would be administered IM if not taken PO. During interview, at 2:31 PM on 12/31/13, the acting CNO (Chief Nursing Officer) confirmed that patients do have the right to refuse treatment. S/he also acknowledged that telling the patient if s/he did not agree to take a medication orally, it	C 271	• A line was added which will require documentation of the name of the hospital staff receiving hand off report from the counseling service staff; • Signature, date and time lines for both the counseling service staff and hospital Provider to sign at the time the hand off report is given, which shall confirm a verbal hand off has occurred and any questions regarding the patient's status have been answered; • An area added titled "Consultation Plan" to improve documentation and clarity of the counseling service's recommended treatment plan and required follow up for the patient;	2/10/2014

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C 271	Continued From page 4 would be administered IM, could be perceived by the patient, whose wrists and ankles were already restrained, as threatening or intimidating. 3. Per review, staff failed to provide ongoing reassessment of a patient's condition, including vital signs, in accordance with established policies and procedures. The facility policy, Emergency Department Triage Policy and Procedure, dated February, 2013, stated the following: for a triage ESI (Emergency Severity Index) level of 3 (conditions that could potentially progress to a serious problem requiring emergency intervention. May be associated with significant discomfort or affecting ability to function at work or activities of daily living), reassessment should be conducted every 30 minutes. The policy further stated; "1. There should be a nursing reassessment on all patients at the time intervals recommended for practitioner assessment. This is to ensure that patients are reassessed to confirm that their status has not changed. Reassessment will include documentation of the patient's vital signs." Per record review Patient #8 presented to the ED on 11/11/13, at 5:10 PM, complaining of anxiety with symptoms including nausea and feeling jittery. At the time of triage, at 5:13 PM, the patient's BP (blood pressure) was elevated at 160/90 and his/her ESI was assessed as a level 3 (urgent). The patient was given Ativan 1 mg PO (by mouth), at 5:49 PM and although a re-evaluation was conducted, by the provider, at 6:30 PM and the patient had stated that s/he felt much better, there was no evidence that the patient's BP had been reassessed prior to discharge at 6:40 PM. During interview, at 2:31 PM, the acting CNO	C 271	• The form will be scanned into the EMR as a permanent part of the patient's record. • Use of the revised form will be implemented by 2/10/14; a copy of the form with changes highlighted was forwarded to all ED and counseling service staff for review, with questions regarding use of the form to be forwarded to the ED Nurse Manager for follow up.	

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C 271	Continued From page 5 (Chief Nursing Officer) confirmed the lack of reassessment of Patient #8's BP and stated that staff had not reassessed the vital signs in accordance with the policy and procedure.	C 271	All ED Nursing staff and Providers, as well as the counseling service staff and management, will receive education related to the new form and hand off communication process by 2/10/14. In addition, the policy related to abuse reporting was forwarded for review by all staff and management at the counseling service, with a document to be signed by all staff members to acknowledge that they have read, understood, and will follow the policy in question as per their contract with the Hospital.	2/10/2014
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 confirmed through staff interviews staff failed to conduct ongoing assessments of a patient who presented to the ED (Emergency Department). (Patient #8). Findings include: Per record review Patient #8 presented to the ED on 11/11/13, at 5:10 PM, complaining of anxiety with symptoms including nausea and feeling jittery. At the time of triage, at 5:13 PM, the patient's BP (blood pressure) was elevated at 160/90 and his/her acuity was assessed as a level 3 (urgent). The patient was given Ativan 1 mg PO (by mouth), at 5:49 PM and although a re-evaluation was conducted, by the provider, at 6:30 PM and the patient had stated that s/he felt much better, there was no evidence that the patient's BP had been reassessed prior to discharge at 6:40 PM. During interview, at 2:31 PM, the acting CNO (Chief Nursing Officer) confirmed the lack of reassessment of Patient #8's BP and stated his/her BP should have been re-assessed prior to discharge.			

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			Following implementation of the new process as noted above, concurrent record audits by the ED Nursing staff will be performed of all patients requiring a counseling service consult or visit to ensure the consultation sheet is complete for all interactions with patients, and that hand off communication to the Provider has occurred. It will be the ED Nursing staff's responsibility to ensure the form has been completed and hand off communication has occurred for all patients to which they are assigned. Counseling service staff will notify the ED Nursing staff at the time of completion of the counseling service visit, which will trigger Nursing staff to verify completion of the form.	

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			The consultation sheet will be considered to be complete if all fields and signatures are present, and the hand off communication has been confirmed. Forms found to lack complete documentation and/or evidence indicating hand off communication to the Provider by the counseling service has not occurred will be addressed with the counseling staff and Provider immediately upon discovery.	
			The ED Nurse reviewing the consultation form will initial, date, and time the form to indicate it has been reviewed, with a copy of the form forwarded to the ED Nurse Manager for purposes of validation. Concurrent record audits by Nursing staff will be initiated on 2/10/14, and shall continue for 100% of patient records for a period of not less than 90 days from implementation of this corrective action.	2/10/14

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			The ED Nurse Manager will validate completion of 100% of the forms for the first 30 days, then 50% of the forms for days 31-60, then 25% of the forms for days 61-90 to ensure compliance with this newly implemented documentation and process. The ED Nurse Manager shall continue to conduct quarterly audits of not less than 25 patient records on an ongoing basis, until such time that it is determined by the Quality Coordinating Committee of the Board that compliance with this corrective action has been achieved and the frequency of audits and reporting may then be adjusted at the QCC's discretion. In addition, the acting CNO will review and validate all audit material to ensure compliance with this process.	

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			Results of the audits will be reported by the ED Nurse Manager to the Quality and Safety Committee on a monthly basis, with adjustments to increase the audit schedule based on the outcome of the reviews and at the discretion of the Quality and Safety Committee. Any barriers identified related to completion of the forms or any step in this process will also be reported to the Quality and Safety Committee on a monthly basis, with review of the barriers and implementation of further corrective action to ensure success of this plan. Results of the audit process will be forwarded by the Director of Quality to the Quality Coordinating Committee of the Board on a monthly basis for the first three months, and then on an ongoing quarterly basis, until such time that it is determined by the Quality Coordinating Committee that the corrective actions have been effective and the frequency of reporting may then be decreased.	

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			The CNO and Director of Quality will be responsible for ensuring this portion of the corrective action plan is implemented and followed as written. C 271 2. The hospital's policies, procedures, and associated regulatory requirements associated with this survey finding were reviewed. Both the medical record and the associated survey results related to this finding were reviewed with both the ED Nursing staff and counseling agency Provider involved with this patient's care. In addition, the previously noted meeting on 1/21/2014 with counseling service staff and management, which was also attended by the ED Nurse Manager, ED Medical Director, ED Nursing staff, and the acting CNO, included the following discussion and review items:	

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			• The contractual agreement between the hospital and the counseling service in question as it pertains to the counseling service's agreement to comply with hospital policies and regulatory requirements while providing services to hospital patients; • A review of the hospital's Patient Rights Policy, to include the section related to the right to refuse treatment; • A summary of the survey results as they pertain to this finding; • Regulatory requirements associated with this finding; • The need for increased staff hospital and counseling service staff education related to the hospital's patient rights policy and associated regulatory requirements.	

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			As a result of the above noted review and meeting, the following actions will be taken: • All ED Nursing staff and Providers will complete a mandatory education module related to Patient Rights, with a focus on the patient's right to refuse treatment. All staff must complete the module by 2/15/2014. Staff will direct any questions related to the policy or its applicability to a patient care situation directly to the ED Nurse Manager or the Nursing Supervisor in his absence;	2/15/2014

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			• All counseling service staff will review the hospital's Patient Rights policy, and sign an attestation stating they have read, understand, and will comply with this policy. All counseling service staff must complete the review and attestation by 2/15/2014. Counseling service staff will direct any questions related to the policy or its applicability to a patient care situation directly to the ED Nurse Manager or the Nursing Supervisor in his absence; • The above noted review of the Patient Rights policy and associated attestation will be required as part of the orientation process for all consulting and contractual ED staff and Providers;	

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			• A mandatory education module related to Patient Rights will be included as part of the annual educational requirements for all ED Nursing staff, ED Providers, and consulting and contractual staff; The ED Nurse Manager or his designee will be scheduled to concurrently monitor 100% of all restrained ED patient records for maintained compliance with the patient rights policy every day that he works for at least the first 30 days of this corrective action plan. Findings of concern shall be addressed immediately with the staff involved with the patient's care. Concurrent record audits will continue for the remaining 60 days of this corrective action plan of at least 50% of all restrained ED patient records.	2/15/2014

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			In addition, the ED Nurse Manager or his designee shall conduct medical record reviews of 100% of all chemically and/or physically restrained ED patients to ensure compliance with the patient rights policy on an ongoing basis, to continue for not less than 90 days from the implementation of this corrective action plan, with audits scheduled of not less than 25% of restrained patient records to continue of a quarterly basis. Weekly validation reviews by the acting CNO shall be scheduled for the first 90 days of this corrective action plan, followed by quarterly validation reviews, to ensure continued compliance with this plan. The ED Nurse Manager shall report results of the concurrent monitoring and medical record reviews to the Quality and Safety Committee on a monthly basis for the first 90 days of this corrective action plan, and then quarterly as part of his quarterly departmental report.	

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			The frequency of both the auditing schedule and reporting requirement may be altered at the discretion of the Committee based on the results of the audits. In addition, the Director of Quality will provide monthly reports for the first 90 days of this corrective action plan, and then on an ongoing quarterly basis to the Quality Coordinating Committee of the Board, with the frequency of audits and reporting subject to change at the discretion of the Quality Coordinating Committee. The CNO and Director of Quality will be responsible for ensuring this portion of the corrective action plan is implemented and followed as written.	

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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 271 3. The medical record and associated policies related to this finding were reviewed by the ED Nurse Manager directly with the staff involved with this patient's care. A summary of the findings associated with this survey was also reviewed by the ED Nurse Manager and acting CNO with ED Nursing staff at the ED staff meeting held on 1/13/2014. Both the policy related to ED patient assessments and reassessments and the associated EMR documentation fields were reviewed and have been updated to facilitate improved compliance and documentation of patient reassessments, as well as follow up on any abnormal vital signs. In addition, the policy now includes a provision that all patients require a vital signs assessment within 30 minutes prior to discharge from the ED. All ED Nursing staff shall complete a mandatory educational module which shall include the following elements:	

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			• Above noted policy changes as they relate to vital signs assessments and reassessment associated with the patient's triage severity rating; • Above noted changes to the EMR as they relate to vital sign assessments, reassessments, and reporting/follow up associated with abnormal assessment findings; • Factors that affect the frequency of vital sign monitoring in the Emergency Department. The above noted education module will require completion by 2/15/2014, and will subsequently be included in the orientation process for all new ED Nursing staff, as well as being incorporated into the annual competencies and education of all ED Nursing staff.	2/15/2014

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			All ED Nursing staff shall be required to complete one concurrent record review of a peer's patient's record per shift. The record review will consist of the following elements: • Compliance with the time standard for reassessments as per the newly revised policy; • Vital signs assessments within 30 minutes prior to discharge; • Appropriate follow up and reporting to the ED Provider of abnormal vital signs or other significant assessment findings.	2/15/2014

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			The above noted concurrent reviews by ED Nursing staff shall continue during each shift that is worked for at least the first 90 days of this corrective action plan. Findings of concern shall be forwarded immediately to the ED Nurse Manager or the Nursing Supervisor in his absence for immediate follow up and correction. The results of all record reviews shall be forwarded to the ED Nurse Manager for further validation review and follow up. The ED Nurse Manager or his designee shall validate compliance with this corrective action plan through validation of 100% of all records reviewed by Nursing staff for the first 30 days of this corrective action plan, 50% of all records reviewed for days 31-60, and then 25% of all records reviewed for days 61-90.	

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			The ED Nurse Manager will then continue to monitor 25 patient records on a quarterly basis to ensure continued compliance with this corrective action plan on an ongoing basis. In addition, the acting CNO shall further validate compliance with this corrective action plan through monthly validation audits of not less than 25% of the patient records reviewed for the first 90 days of this corrective action plan, followed by ongoing validation of 25% of the records reviewed on a quarterly basis.	

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			The ED Nurse Manager will provide a monthly report related to the reviews and validation audits, as well as any barriers to compliance with this corrective action plan, to the Quality and Safety Committee for the first 90 days of this corrective action plan, with reports to then continue on a quarterly basis as part of his regularly scheduled departmental reports. The review and audit schedule, as well as required actions associated with identified barriers to compliance, may be adjusted at the discretion of the Quality and Safety Committee based on the reported results.	

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			The Director of Quality shall provide report to the Quality Coordinating Committee of the Board on a monthly basis for the first 90 days of this corrective action plan related to the above noted reviews, audits, and identified barriers to compliance and associated corrective actions taken. Reports to the Quality Coordinating Committee shall then continue on a quarterly basis. The review and audit schedule, as well as required actions associated with identified barriers to compliance, may be adjusted at the discretion of the Quality Coordinating Committee of the Board based on the reported results. The CNO and Director of Quality will be responsible for ensuring this portion of the corrective action plan is implemented and followed as written.	

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			C 296 The medical record and associated policies related to this finding were reviewed by the ED Nurse Manager directly with the staff involved with this patient's care. A summary of the findings associated with this survey was also reviewed by the ED Nurse Manager and acting CNO with ED Nursing staff at the ED staff meeting held on 1/13/2014. Both the policy related to ED patient assessments and reassessments and the associated EMR documentation fields were reviewed and have been updated to facilitate improved compliance and documentation of patient reassessments, as well as follow up on any abnormal vital signs. In addition, the policy now includes a provision that all patients require a vital signs assessment within 30 minutes prior to discharge from the ED. All ED Nursing staff shall complete a mandatory educational module which shall include the following elements:	

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			The above noted concurrent reviews by ED Nursing staff shall continue during each shift that is worked for at least the first 90 days of this corrective action plan. Findings of concern shall be forwarded immediately to the ED Nurse Manager or the Nursing Supervisor in his absence for immediate follow up and correction. The results of all record reviews shall be forwarded to the ED Nurse Manager for further validation review and follow up. The ED Nurse Manager or his designee shall validate compliance with this corrective action plan through validation of 100% of all records reviewed by Nursing staff for the first 30 days of this corrective action plan, 50% of all records reviewed for days 31-60, and then 25% of all records reviewed for days 61-90.	

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			The ED Nurse Manager will then continue to monitor 25 patient records on a quarterly basis to ensure continued compliance with this corrective action plan on an ongoing basis. In addition, the acting CNO shall further validate compliance with this corrective action plan through monthly validation audits of not less than 25% of the patient records reviewed for the first 90 days of this corrective action plan, followed by ongoing validation of 25% of the records reviewed on a quarterly basis.	

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