

Division of Licensing and Protection

103 South Main Street
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

April 7, 2015

Mr. Thomas Huebner, Director
Rutland Regional Medical Center
160 Allen St
Rutland, VT 05701-4560

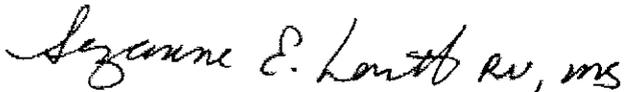
Provider ID #: 470005

Dear Mr. Huebner:

The Division of Licensing and Protection completed a survey at your facility on February 25, 2015. The purpose of the survey was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on April 3, 2015.

Sincerely,



Suzanne Leavitt, RN, MS
Assistant Division Director
Director State Survey Agency

Enclosure

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

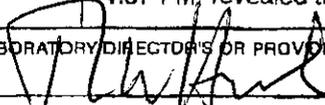
PRINTED: 03/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/25/2015
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NAME OF PROVIDER OR SUPPLIER RUTLAND REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 160 ALLEN ST RUTLAND, VT 05701
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(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
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A 000	INITIAL COMMENTS An unannounced on-site investigation was conducted by the Division of Licensing and Protection on 2/23/15 - 2/25/15 to determine compliance with the Conditions of Participation for Emergency Services, Quality Assessment and Performance Improvement, Discharge Planning and Patient Rights. The following regulatory violations, related to #12920 and 12989, were identified. Based on information obtained at the time of the on-site investigation it was determined the Conditions of Participation: Discharge Planning was not met.	A 000	A 144 Patient Rights: Care in Safe Setting In order to ensure that the physical and emotional comfort and safety of patients who are discharged home are met, the Hospital has taken the following actions: • The Emergency Department (ED) Medical Director provided individual counseling to the physician (physician #1) and the ED Nurse Director provided individual counseling to the nurses (nurse #1, #2 and #3) involved in the care of this patient (patient #1). Nurses #2 and #3 were counseled on patient rights related to the Pain Management and Discharge from the Emergency Department policies and the requirement to follow these protocols, Nurse #1 was counseled on patient rights related to the Pain Management policies and the requirement to follow these protocols. -Continued on next page-	
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on staff interviews and record review staff failed to ensure the physical and emotional comfort and safety of 1 of 13 applicable patients who was discharged home, alone, following a traumatic MVC (motor vehicle collision). (Patient #1). Findings include: Per record review Patient #1 was evaluated and treated, in the ED (Emergency Department) for injuries sustained following a motor vehicle collision on 1/26/15. The patient arrived in the ED via ambulance with complaints of left wrist and left hip pain. X-rays of the left wrist identified fractures of both the radius and ulnar bones. A pain assessment completed by RN (Registered Nurse) #1, during triage upon arrival in the ED at 4:57 PM, revealed that the patient identified the	A 144		Completed 3-17-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE President	(X6) DATE 3/25/15
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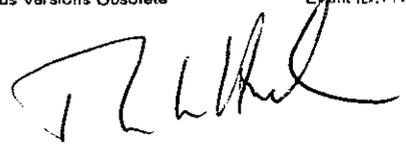
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 the program is a read available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 144	Continued From page 1 wrist pain as 10/10 (on a scale of 1-10 with 10 being the worst pain). Although the patient had also complained of pain in the left hip there was no evidence of any assessment of the hip to clearly identify the intensity of pain or aggravating or alleviating factors associated with the pain. The patient received pain medication at 7:39 PM and again at 10:04 PM during two separate procedures to realign the fractured wrist bone/s. Although pain assessments were conducted during recovery from the sedative used during the second procedure, between 10:14 PM and 11:00 PM, and the patient identified wrist pain as 8/10 each time, there was no evidence that interventions to reduce pain, including pain medication, were offered, and no further pain assessments were conducted prior to the patient's discharge almost 2.5 hours later at 1:22 AM. In addition, and although there had been no assessment of the left hip pain Patient #1 had identified on arrival in the ED, a nurse's note, at 12:45 AM on 1/27/15, stated; "Pt was having some difficulty ambulating from stretcher to wheelchair....." A note by Physician #1 stated; 'patient was hesitant to go home at the end of visit. [S/he] reported [s/he] could not walk, and [his/her] complaint was hip pain, but was able to bear weight and was able to be transitioned into a wheelchair. X-rays show no fracture, dislocation, and there was no pain to palpation on exam and no pain to ROM on PE....' There was no further indication of what was causing the hip pain, and there was no evidence that a trial of ambulation had occurred, prior to discharge, to determine if walking would aggravate the hip pain, potentially prohibiting ambulation and increasing the risk to patient safety. The patient, who lived alone, was discharged home in the company of a family member, at 1:22 AM on 1/27/15, and was given 2	A 144	<ul style="list-style-type: none"> Revised the "Discharge from Emergency Department" policy and procedure to ensure that an assessment of pain is done at the time of patient discharge. In addition, this policy also requires that any necessary additional patient assessments will be performed as indicated at the time of discharge; these may include ambulatory challenge, toleration of drinking/eating, and/or social assessment. Developed a discharge checklist to accompany the "Discharge from Emergency Department" policy and procedure to ensure that all of the patient's concerns have been addressed and noted for, but not limited to: Post-discharge follow up, signs and symptoms to be mindful of during recovery, medicines prescribed, and provisions for returning to the ED, and any patient or family's concerns about going home. Added a new 1.0 Full Time Equivalent (1 full time position) to the existing Social Work staff. This addition will allow the Social Work department to now provide on call coverage on Saturdays and Sundays for consultation with complex patient discharge. 	Completed 3-23-15	
				Completed 3-23-15	
				Position approved and posted 3-20-15	

*By unit 43 115
B. Bone / SS*



3/25/15

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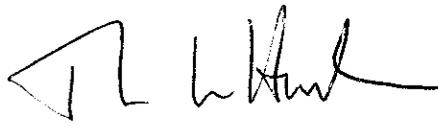
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A 144	<p>Continued From page 2</p> <p>Percocet (narcotic pain reliever) tablets at that time, to be used at home. The Discharge Instructions provided to the patient were specific to the wrist injury and use of splint and sling that had been applied, and did not address hip pain.</p> <p>During interview, at 7:15 AM on 2/25/17, RN #2, who was responsible for providing direct care to Patient #1, acknowledged the lack of evidence of pain assessments and stated that the patient had complained, at the time of discharge, of spasms in his/her left hip causing pain, and had expressed concerns about going home as s/he was concerned about not being able to ambulate. S/he stated that s/he had reported this to Physician #1 who had evaluated the patient and determined the patient was ready for discharge. RN #2 stated that s/he had observed Patient #1 take a step or two to transfer from the wheel chair to the car, at discharge, but had not observed the patient ambulate any further. RN #3, who had also interacted with Patient #1 around the time of his/her discharge, confirmed, during interview on 2/25/15 at 7:40 AM, that the patient had been quite hesitant to go home. RN #3 also stated that s/he had not observed Patient #1 ambulate. S/he stated that the family member who escorted the patient had returned to the ED, after leaving with the patient, and verbalized that s/he did not know what to do about getting Patient #1 from the car into his/her home. RN #3 stated that s/he provided a wheel chair to the family member for use in transferring Patient #1 from the car into his/her home.</p> <p>Physician #1 confirmed, during interview at noon on 2/26/15, that Patient #1 had expressed hesitancy, at discharge, at going home related to pain in his/her hip. The physician stated that a</p>	A 144	<ul style="list-style-type: none"> All Emergency Department Nurses, Physicians, and Physician Assistants will receive education and communication about the revisions to the "Discharge from the Emergency Department" policy and procedure, including the new patient discharge assessment and discharge checklist. This education will occur during staff meetings and daily huddles. It will also be reinforced through email notification and during staff rounding. Staff understanding of the new policy and procedure will be documented as part of this process. Measures of Effectiveness: Each month, all patients returning to the Emergency Department in less than 72 hours after their prior discharge will have a quality review done. In addition, a minimum of 10 Emergency Department patient charts will be reviewed by the ED Medical Director and Performance Improvement Manager each month on an ongoing basis. From those reviews, we will ensure that all patients have their discharge checklist and plans completed, and confirm that discharge instructions were completed in accordance with Hospital "Discharge from the Emergency Department" policy. Additionally, a review will be done to ensure that all identified concerns were appropriately addressed. The reviews will be incorporated in the Hospital's quality assurance and performance improvement program and the results shared with the ED Physicians, Nurses, and Leadership. 	To be completed by 4-15-15
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Handwritten signatures and dates:
 3/25/15
 B. Home 182

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A 144	<p>Continued From page 3</p> <p>physical assessment of the hip did not produce pain or identify limitations, the x-ray had not shown any fracture or dislocation and the patient had been able to bear weight. S/he further stated that s/he had assumed, that the home in which the patient resided, included the presence of other people. Physician #1 stated that, although s/he had not documented it, s/he had given the patient the option of remaining in the hospital. However, because inpatient beds were full at the time, the patient was informed that s/he would have to remain on an ED stretcher, and therefore the patient reportedly made the decision to go home. Physician #1 further stated that, in terms of adequate pain management, it is his/her general practice to address pain with patients each time s/he sees them throughout their ED visit and therefore s/he would have done the same for Patient #1. S/he stated the patient was given pain medication for home use after discharge.</p> <p>Per record review Patient #1 returned to the ED, via ambulance, at 1:20 PM on 1/27/15, approximately 12 hours after his/her discharge from the ED. ED physician documentation included: '....presents by ambulance with increased pain in the left hip and inability to ambulate at home.....Family has concerns of patient ambulating at home and being able to take care of [him/herself]...--will obtain a CT to look for any signs of occult fracture or other traumatic injury explaining [his/her] pain.' Diagnostic testing revealed a 2 vertebral fractures in the patient's back. The patient was admitted to the hospital for pain control and conservative treatment of the spinal vertebral fractures, to include Physical Therapy (PT) and Occupational Therapy (OT). An OT evaluation note, dated</p>	A 144	<ul style="list-style-type: none"> • In addition, the ED Nurse Director will ensure ongoing review of 10 patient charts per day to ensure completion of the revised discharge checklist for 30 days beginning April 15, 2015. Additionally, the ED Nurse Director will ensure ongoing review of 10 patient charts per month to ensure the effectiveness of the revised discharge checklist and adherence to the pain assessment policy. • In addition, two questions will be added to the list of post-discharge follow up telephone calls made to Emergency Department patients. These questions will ask patients if the care team provided them with enough information and education to prepare them for their discharge, and ask if all of their concerns were addressed. The patient responses to these questions will be reviewed by the ED Nurse Director and ED Medical Director to monitor the effectiveness of the revised discharge process. Results will be shared at ED staff and physician meetings. <p>All of the above beginning no later than April 15, 2015.</p> <p>Responsible parties: Chief Nursing Officer, ED Nurse Director, ED Medical Director, Performance Improvement Manager.</p> <p><i>MC inserted 4/3/15 B. Lane 15</i></p>	

Rutland *3/25/15*

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A 144	Continued From page 4 1/28/15, stated that the patient had commented: "I couldn't walk into my bathroom or anything when I went home [after ED]." The patient was discharged on 1/30/15 to a SAR (Subacute Rehabilitation) facility. Per interview, at 1:02 PM on 2/25/15, the Medical Director of the ED stated s/he had reviewed Patient #1's record, after concerns had been raised by surveyors. S/he acknowledged the lack of pain assessment and lack of evidence that the patient had showed ample evidence of ability to ambulate prior to discharge and stated; " it's evident the ambulatory challenge was not aggressive enough for this patient." Based on the information obtained there is a lack of ongoing assessment, and pain relieving interventions, of Patient #1's wrist injury. In addition, although a physical assessment had been conducted of the patient's left hip, there is no evidence of assessment of the intensity of the hip pain, no evidence of the possible source of hip pain and no assessment of an adequate trial of ambulation to determine if it would aggravate the hip pain. And, despite the fact that the patient had reportedly refused the offer, by Physician #1, to remain in the ED, there was no evidence that pain management, adequate to promote physical comfort and safety, had been addressed with the patient prior to discharge.	A 144	A 799 Discharge Planning In order to ensure that there is a written discharge planning policy in place that applies to all patients, including the need to ensure that prior to discharge, patients receive an appropriate screening and discharge planning evaluation, the Hospital has taken the following actions: • The Discharge Planning policy was revised to ensure that there is an effective discharge planning process in place that addresses all patients' needs for post-hospital services. This includes an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital. • A Discharge Risk Screening tool has been developed to identify which patients may be likely to suffer an adverse health impact without an adequate discharge plan and therefore need a discharge planning evaluation. When a patient is hospitalized, the direct care nurse completing the nursing history and physical will complete the discharge risk screening for every patient. Based upon the results of the screening, a Case Management consult will be ordered if criteria are met so that a Case Manager initiates a discharge planning evaluation. Nursing can also	Completed 3-23-15
A 799	482.43 DISCHARGE PLANNING The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by:	A 799	order a Case Management and/or Social Work consult independent of the screening results if they believe the patient is in need of one. <i>PDC updated 4-3-15</i>	Screening tool developed 3-23-15; Tool added to electronic medical record for use by 4-13-15.

[Handwritten signature] 3/25/15

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A 799	Continued From page 5 Based on information obtained through staff interview and record review it has been determined the Condition of Participation: Discharge Planning was not met as evidenced by the hospitals failure to ensure, that prior to the discharge of a hospitalized patient, identified as a vulnerable adult with significant injury of unknown origin, received an appropriate screening and discharge planning evaluation.	A 799	A799 Discharge Planning continued:	Screening tool developed 3-23-15; Tool added to electronic medical record for use by 4-13-15.	
A 800	Refer to Tags: A - 800 & A - 806 482.43(a) CRITERIA FOR DISCHARGE EVALUATIONS The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to ensure that prior to the discharge of a hospitalized patient, identified as a vulnerable adult with significant injury of unknown origin, received an appropriate screening and discharge planning evaluation for 1 of 13 patients. (Patient #2) Findings include: On 1/16/15 at approximately 2:00 PM, Patient #2, age 83 with a history of dementia, arrived via ambulance from home to the Emergency Department (ED). The ED physician note states: "Patient presents here with significant abdominal ecchymosis of unknown cause. X-ray revealed significant pelvic fractures. Pan scan CT done to evaluate for other injuries given limited history, reveal bleeding in abdomen from pelvic fractures with patient who is significantly anemic. will need blood transfusions.....Adult protective services	A 800	• Revised the Patient Safety Screen in the Hospital electronic medical record so that reports made to Adult Protective Services, Department for Children and Families or other external reporting agencies are recorded and reported in a prominent location. This revision will ensure that the information will flow to the Social Work department, and be available to all providers and others involved in the patients care and discharge planning. • Added a new 1.0 Full Time Equivalent (1 full time position) to the existing Social Work staff. This addition will allow the Social Work department to now provide on call coverage on Saturdays and Sundays for consultation with complex patient discharges. • The Managers of Case Management and Social Work will conduct quarterly meetings between the Hospital and the local area Skilled Nursing Facilities and Home Health Providers for the purpose of reviewing the effectiveness of Hospital patient's discharge plans. • All inpatient nurses will receive education and communication about revisions to the Discharge Planning policy including the new risk assessment screen. This education will occur through the Hospital's on line learning system ("Healthstream"). • Additional reinforcement of this education to all inpatient nurses will be done through staff training sessions with their Department Clinical Managers.	Position approved and posted 3-20-15 Beginning April 2015 To be completed by 4-10-15 To be completed by 4-30-15	

RC August 4.3.15
[Signature]
3/25/15

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A 800	<p>Continued From page 7</p> <p>discharge preparation assures that the patient is properly placed at the appropriate level of care for his/her continuing needs. Patient Discharge preparation is the joint responsibility of and results from, the collaborative efforts of physicians, nurses, case manager, social workers and members of the Patient Care Team." Per interview on 2/23/15 at 2:30 PM the Director of Case Management/ Utilization Review/Social Services confirmed 5 days per week there is a daily process for evaluating patients for discharge planning, noting Case Managers play an important role in developing individual discharge plans. Also noting the hospital is in the development of a unit based model, Case Managers partake in daily rounds at which time each patient is discussed, evaluating their discharge status and preparing a discharge plan in collaboration with social workers, physicians, nursing and patient and/or family. It was also confirmed by the Director that weekend coverage is limited to 1 Case Manager for the entire hospital limiting the availability to evaluate all patients who may be considered for discharge. However, upon request by Nursing or a Physician the Case Manager can provide an assessment of potential discharge plans and assist both nursing and patient and/or family to assure a discharge plan is safe and appropriate.</p> <p>On 1/17/15, family requested Patient #2 be discharged. Per interview on 2/24/15 at 10:50 AM Nurse #1, assigned to Patient #2 on 1/17/15, stated the Orthopedic Specialist had provided a verbal order for Patient #2 to be discharged. Nurse #2 confirmed that although information was available regarding the APS referral, made as a result of the significant injuries Patient #2 sustained, the consults for both Social Services</p>	A 800	<p>A800 Criteria for Discharge Evaluations:</p> <p>In order to ensure that the hospital identifies at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning, the Hospital has taken the following actions:</p> <p>In order to ensure that there is a written discharge planning policy in place that applies to all patients, including the need to ensure that prior to discharge, patients receive an appropriate screening and discharge planning evaluation, the Hospital has taken the following actions:</p> <ul style="list-style-type: none"> The Discharge Planning policy was revised to ensure that there is an effective discharge planning process in place that addresses all patients' needs for post-hospital services. This includes an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital. A Discharge Risk Screening tool has been developed to identify which patients may be likely to suffer an adverse health impact without an adequate discharge plan and therefore need a discharge planning evaluation. When a patient is hospitalized, the direct care nurse completing the nursing history and physical will complete the discharge risk screening for every patient. Based upon the results of the screening, a Case Management consult may be ordered so that a Case Manager initiates a discharge planning evaluation. 	Completed 3-23-15
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By report
4.3.15
3 June 15

[Signature] 3/25/15

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A 800	Continued From page 8 and Wound Care Specialist, s/he failed to consider contacting the Case Manager regarding these significant factors prior to discharging Patient #2. In addition, a referral to the Home Health Agency was not made by Nurse #2 nor was there any assurance the necessary equipment was in place at home prior to discharge and whether private home care staff were proficient and/or appropriate to continue to provide care to this vulnerable individual. Per interview on 2/24/15 at 3:10 PM, the Clinical Manager for Utilization Review and also a Case Manager stated "...typically I don't see the physician as qualified for forming a discharge plan, I see them as part of the discharge plan". The Clinical Manager further stated given the injuries sustained at home, a pending referral to APS for possible abuse and/or neglect, it would have been beneficial for nursing to have consulted with the available Case Manager on 1/17/15 prior to arranging for discharge. Per interview on the afternoon of 2/25/15, the Manager of Social Services confirmed if Patient #2 had not been discharged they would have played a role in evaluating the potential for a safe discharge and also following-up with APS regarding the implications of returning Patient #2 to the same environment where an injury resulted. As evidenced by the hospital's policy Mandatory Reporting of Abuse, Neglect and Exploitation last approved 1/2012, which states the Department/Unit Leader is "...responsible for notifying the Social Work Department whenever a report is made and consulting with the Social Work Department whenever there is a question as to whether an act or omission is reportable". Although ED staff made the referral to APS, a consult was made to Social Services as per policy but because of the lack of Social Service	A 800	-continued from previous page-. Nursing can also order a Case Management and/or Social Work consult independent of the screening results if they believe the patient is in need of one. • Revised the Patient Safety Screen in the Hospital electronic medical record so that reports made to Adult Protective Services, Department for Children and Families or other external reporting agencies are recorded. This revision will ensure that the information will flow to the Social Work department, and be available to all providers and others involved in the patients care and discharge planning. • Added a new 1.0 Full Time Equivalent (1 full time position) to the existing Social Work staff. This addition will allow the Social Work department to now provide on call coverage on Saturdays and Sundays for consultation with complex patient discharge. • The Managers of Case Management and Social Work will conduct quarterly meetings between the Hospital and the local area Skilled Nursing Facilities and Home Health Providers for the purpose of reviewing the effectiveness of the Hospital patient's discharge plans. • All inpatient nurses will receive education and communication about revisions to the Discharge Planning policy including the new risk assessment screen. This education will occur through the Hospital's online learning system ("Healthstream").	Screening tool developed 3-23-15; Tool added to EMR by 4-15-2015. Screening tool developed 3-23-15; Tool added to electronic medical record by 4-13-15. Position approved and posted 3-20-15 Beginning April 2015 To be completed by 4-10-2015

4.3.15 B. Hunt
[Signature]
3/25/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/25/2015
NAME OF PROVIDER OR SUPPLIER RUTLAND REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 160 ALLEN ST RUTLAND, VT 05701	
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A 800	Continued From page 9 staff on the weekend the consult was never obtained and other interdisciplinary processes were not provided or utilized to assure Patient #2's circumstances and complexities within the home environment were effectively considered and evaluated prior to discharge.	A 800	A800 Criteria for Discharge Evaluations continued: • Additional reinforcement of this education to all inpatient nurses will be done through staff training sessions with their Department Clinical Managers. • The education is considered mandatory for inpatient nurses and completion of the education will be tracked through the Healthstream system and by sign-in sheets for the staff training sessions.	To be complete by 4-30-15
A 806	482.43(b)(1), (3), (4) DISCHARGE PLANNING NEEDS ASSESSMENT (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician. (3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. (4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital. This STANDARD is not met as evidenced by: Based on interview and record review, the discharge planning evaluation for 1 of 13 applicable patients failed to ensure the patient was evaluated for needing appropriate post-hospital services and the continuance of receiving care in the environment from where the patient had sustained an injury of unknown origin prior to being admitted to the hospital. (Patient #2) Findings include: Although the hospital has policies and procedures	A 806	• Measure of Effectiveness: The Discharge Planning policy was revised to include a new section on continuous assessment of the effectiveness of the discharge planning process. The policy assigns responsibility to the Managers of Case Management and Social Work to monitor and report the evaluation of the discharge planning process. The Managers will each review a sample of 10 discharge plans per month (20 total per month) on an ongoing basis to determine 1) the timeliness of the risk assessment screening, 2) the timeliness of the discharge plan evaluation, 3) whether the plan was responsive to the patient's needs, 4) whether the plan reflected the patient's, or their representative's preferences, and 5) whether the discharge was followed by a preventable admission. In addition, the Managers will review all hospital readmissions within 14 days to monitor the effectiveness of the discharge planning process. • Responsible party: Chief Nursing Officer, Director of Case Management & Social Work, Manager of Case Management, Manager of Social Work. <i>Account 4.3.15</i>	Completed by dates noted above Beginning April 1, 2015

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3/25/15

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

PRINTED: 03/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/25/2015
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A 806	Continued From page 11 care. Patient #2 was admitted on 1/16/15 to the hospital for treatment for closed fractures of the sacrum and coccyx, acute posthemorrhagic anemia, hip contusion and a urinary tract infection. Hospitalist #1 ordered a Social Work consultation on 1/16/15 at 20:00 with "Reason for Consult: Abuse/Neglect" and a consult for Palliative Care to assist with the management of medical decisions. On 1/17/15 at 05:29 the Orthopedic Specialist ordered a wound assessment and management for a pressure ulcer to Patient #2's left heel. The hospital policy Patient Discharge Preparation last reviewed on 03/2011 states "Effective patient discharge preparation assures that the patient is properly placed at the appropriate level of care for his/her continuing needs. Patient Discharge preparation is the joint responsibility of and results from, the collaborative efforts of physicians, nurses, case manager, social workers and members of the Patient Care Team." Per interview on 2/23/15 at 2:30 PM the Director of Case Management/ Utilization Review/Social Services confirmed 5 days per week there is a daily process for evaluating patients for discharge planning, noting Case Managers play an important role in developing individual discharge plans. Also noting the hospital is in the development of a unit based model, Case Managers partake in daily rounds at which time each patient is discussed, evaluating their discharge status and preparing a discharge plan in collaboration with social workers, physicians, nursing and patient and/or family. It was also confirmed by the Director weekend coverage is limited to 1 Case Manager for the entire hospital	A 806	A806 Discharge Planning Needs Assessment continued: • The Discharge Planning policy was revised to ensure that there is an effective discharge planning process in place that addresses all patients' needs for post-hospital services. This includes an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital. •Measure of Effectiveness: The Discharge Planning policy was revised to include a new section on continuous assessment of the effectiveness of the discharge planning process. The policy assigns responsibility to the Managers of Case Management and Social Work to monitor and report the evaluation of the discharge planning process. The Managers will each review a sample of 10 discharge plans per month (20 total per month) on an ongoing basis to determine 1) the timeliness of the risk assessment screening, 2) the timeliness of the discharge plan evaluation, 3) whether the plan was responsive to the patient's needs, 4) whether the plan reflected the patient's, or their representative's preferences, and 5) whether the discharge was followed by a preventable admission. In addition, the Managers will review all hospital readmissions within 14 days to monitor the effectiveness of the discharge planning process. • Responsible party: Chief Nursing Officer, Director of Case Management & Social Work, Manager of Case Management, Manager of Social Work.	Completed 3-23-15 Beginning April 1, 2015

Bi-urgent
4-3-15
3/25/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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A 806	<p>Continued From page 12</p> <p>limiting the availability to evaluate all patients who maybe considered for discharge. However, upon request by Nursing or a Physician the Case Manager can provide an assessment of potential discharge plans and assist both nursing and patient and/or family to assure a discharge plan is safe and appropriate.</p> <p>On 1/17/15, family requested Patient #2 be discharged. Per interview on 2/24/15 at 10:50 AM Nurse #1, assigned to Patient #2 on 1/17/15, stated the Orthopedic Specialist had provided a verbal order for Patient #2 to be discharged. Nurse #2 confirmed although information was available regarding the APS referral, the significant injuries Patient #2 sustained, the consults for both Social Services and Wound Care Specialist, s/he failed to consider contacting the Case Manager regarding these significant factors prior to discharging Patient #2. In addition, a referral to the Home Health Agency was not made by Nurse #1 nor was there any assurance the necessary equipment was in place at home prior to discharge and whether staff were proficient and/or appropriate to continue to provide care to this vulnerable individual. Per interview on 2/24/15 at 3:10 PM, the Clinical Manager for Utilization Review and also a Case Manager stated "...typically I don't see the physician as qualified for forming a discharge plan, I see them as part of the discharge plan". The Clinical Manager further stated given the injuries sustained at home, a pending referral to APS for possible abuse and/or neglect, it would have been beneficial for nursing to have consulted with the available Case Manager on 1/17/15 prior to arranging for discharge. Per interview on the afternoon of 2/25/15, the Manager of Social Services confirmed if Patient</p>	A 806	END	
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A 806	Continued From page 13 #2 was not discharged they would have played a role in evaluating the potential for a safe discharge and also following-up with APS regarding the implications of returning Patient #2 to the same environment where an injury resulted.	A 806			

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3/25/15