

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

PRINTED: 07/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>470012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/11/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHWESTERN VERMONT MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 HOSPITAL DRIVE</b> <b>BENNINGTON, VT 05201</b>
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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	A 000		
A 145	<p>482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT</p> <p>The patient has the right to be free from all forms of abuse or harassment.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews the facility failed to report to the appropriate SA (State Agency) an allegation of abuse of 1 patient by care providers. (Patient #1). Findings include:</p> <p>1. Per record review Patient #1, who was admitted, on 10/31/12, alleged an incident of staff mistreatment against him/her that was not reported to the appropriate SA within the required time period of 48 hours. Per review the patient was admitted for repair of a wound dehiscence (pulling apart of wound edges) and underwent 3 surgical procedures between 11/1/12 and 11/8/12. During interview, on the morning of 4/9/13, Nurse #1, who worked in the role of Clinical Coordinator of the Medical/Surgical Unit, stated that on the evening of 11/9/12 Patient #1 had disclosed to him/her that staff who had worked during the previous night shift had hurt him/her during provision of peri care. The nurse stated that, although the patient had been groggy and sleepy at the time of the allegation, s/he had used words like molestation and rape and disclosed a history of previous molestation. Nurse</p>	A 145		

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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A 145	<p>Continued From page 1.</p> <p>#1 stated that the patient was not able to name or describe the staff members who had allegedly hurt him/her. The nurse further stated that, although Patient #1 refused to talk further about the alleged treatment by staff at that time, s/he did again, on 11/13/12, verbalize the same concern about the alleged mistreatment by staff 3 days earlier.</p> <p>Per interview, at 8:13 on 4/9/13, the Risk Manager confirmed that, although they did report to the SA, the report was not made until until 11 days following the allegation, on 11/20/12.</p>	A 145		
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