

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 4, 2019

Mr. Jayesh Shukla, Director North Country Dialysis Unit 189 Prouty Drive Newport, VT 05855

Dear Mr. Shukla:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 25, 2019.** 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,

Suzanne Leavitt, RN, MS Assistant Division Director

Shanne Eherth

State Survey Agency

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

PRINTED: 10/07/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		473504	B. WING		09/25/2019	
	PROVIDER OR SUPPLIER	UNIT	189	ET ADDRESS, CITY, STATE, ZIP CODE PROUTY DRIVE VPORT, VT 05855		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
E 000	Initial Comments		E 000			
E 004	of North Country D Emergency Prepar result of the Emerg the following regula	on site survey was conducted ialysis re: requirements for edness on 9/24/19. As a pency Preparedness Survey, atory violations were identified. Review and Update Annually	E 004	*		
	[The [facility] must Federal, State and preparedness requ develop establish a	irements. The [facility] must and maintain a comprehensive edness program that meets the				
	§485.625(a):] The with all applicable I emergency prepare [hospital or CAH] n comprehensive emprogram that meet	§482.15 and CAHs at [hospital or CAH] must comply Federal, State, and local edness requirements. The hust develop and maintain a hergency preparedness is the requirements of this hall-hazards approach.				
	include, but not be elements:] (a) Emergency Pla and maintain an er	eparedness program must limited to, the following n. The [facility] must develop mergency preparedness plan wed], and updated at least		oc	tax acce	
	Plan. The ESRD fa maintain an emerg	ties at §494.62(a):] Emergency acility must develop and ency preparedness plan that d], and updated at least		See my	1011719	

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/07/2019

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E 004	Continued From pa	ge 1	Ε(004			
	This STANDARD is Based on interview	s not met as evidenced by: and record review the facility comprehensive Emergency					
E 018	Country Dialysis it s will keep on file all r preparedness meet attended by the Ret or designee". Per Preparedness Com 11/28/18, 1/23/19, 4 the RNS was marke minutes for each of for this meeting was response, collabora emergency respons in a sustained effort the system back to interview, the RNS PM that there was r s/he and/or a design from 11/28/18 to 8/2 Procedures for Trac CFR(s): 494.62(b)(1	cking of Staff and Patients (i) (i) (c) (c) (c) (c) (d) (d) (d) (d	ΕC)18	por t	ix (018 de
	develop and implem policies and proced plan set forth in para assessment at para and the communica this section. The po reviewed and updat	nent emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of licies and procedures must be ed at least annually.] At a es and procedures must			Sur par to	100	occession of the second

address the following:]

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

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				(OMB NO	. 0938-0391
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		473504	B. WING			<u></u>	09	/25/2019
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E 018	Continued From pa	ige 2	Е	018		6		25/
	and sheltered paties an emergency. If of patients are relocal [facility] must document	ck the location of on-duty staff ints in the [facility's] care during on-duty staff and sheltered ted during the emergency, the ment the specific name and iving facility or other location.			a _n			
	ICF/IIDs at §483.4: Policies and proced location of on-duty the [PRTF's, LTC, I and after an emerg sheltered residents emergency, the [PI	A1.184(b), LTC at §483.73(b), 75(b), PACE at §460.84(b):] dures. (2) A system to track the staff and sheltered residents in ICF/IID or PACE] care during tency. If on-duty staff and are relocated during the RTF's, LTC, ICF/IID or PACE] a specific name and location of y or other location.		The same state of		8 ⁰⁴ 8	¥ ×	
	Policies and proced (ii) Safe evacuation includes considera needs of evacuees transportation; ider location(s) and princommunication with assistance. (v) A system to tracemployees' on-duty hospice's care during on-duty employees relocated during the must document the the receiving facility.	a from the hospice, which tion of care and treatment is; staff responsibilities; ntification of evacuation mary and alternate means of the external sources of the kitch location of hospice of and sheltered patients in the ing an emergency. If the is or sheltered patients are the emergency, the hospice is specific name and location of the or other location.				Sel por pr	Mel	
	*[For CMHCs at §4 procedures. (2) Sa	85.920(b):) Policies and fe evacuation from the CMHC,						

which includes consideration of care and

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	treatment needs of		192	, 0				
		rsportation; identification of						
		(s); and primary and alternate cation with external sources of					8	
,	assistance,							
	procedures. (2) A s documentation that donor information, potential and actua	6.360(b):] Policies and ystem of medical preserves potential and actual protects confidentiality of I donor information, and ains the availability of records.	i					
	procedures. (2) Sat facility, which include needs of the patien					*		(Secure of the Control of the Contro
	Based on record re facility failed to dev to track the location patients who are re to include documer	s not met as evidenced by: eview and staff interview the elop and implement a system n of on-duty staff and dialysis elocated during an emergency, ntation concerning the specific of the receiving facility.					er v	STRANCIA
	Nurse Supervisor (10:21 AM that in th evacuation from the policy or procedure	and staff interview, the Renal RNS) confirmed on 9/24/19 at e event of an emergency e facility, there was no written for tracking on-duty staff, patients, name and location of y or other location.				Set with 19 could be could be	fass f	30/3e1
E 023		s for Medical Documentation	E 0	23		Serville	M	
		ocedures. The [facilities] must ment emergency preparedness				Cara		

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

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		lures, based on the emergency	۷.	323			
		ragraph (a) of this section, risk					
	assessment at para	agraph (a)(1) of this section,			*		
		ation plan at paragraph (c) of					
		olicies and procedures must be ted at least annually. At a					
		ies and procedures must					
	address the following				on _{get}		
	18990		3				
		dical documentation that					
		nformation, protects attent information, and secures					
		lability of records. [(5) or					
		n of medical documentation					
		ent information, protects					Same and the same
	and maintains avai	atient information, and secures lability of records.					Į s
	*IFor RNHCIs at 84	103.748(b):] Policies and					
		system of care documentation	,				
	that does the follow	ving:					
	(i) Preserves patier						
		entiality of patient information. aintains the availability of	•				
	records.	antains the availability of					
	*[For OPOs at §48	6.360(b):] Policies and			*		
	procedures. (2) A s	system of medical t preserves potential and actual					
		protects confidentiality of					
		I donor information, and					
	secures and mainta	ains the availability of records.					
		s not met as evidenced by:					
		eview and staff interview the intain copies of 17 of 17			ne		*
		dvanced Directives (A written		·	SU NA	_	
	statement of a pers	son's wishes regarding medical			2017/6	. W	
	treatment, including	g a living will, made to ensure			Sue poc 101719	7 "	
	those wishes are c	arried out should the person					

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

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		& INIEDICAID SERVICES		······································		MB NO. 0938-039	
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		473504	B. WING		-Nondition	09/25/2019	
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E 023	Continued From pa	ge 5	E 02	23		ä	
		unicate them to a doctor.) to of emergency evacuation addings include:					
e	confirmed on 9/24/1 emergency "Grab a cases of emergency	nd staff interview, the RNS 19 at 9:01 AM that the nd Go Bag" used by staff in y evacuation from the facility, f 17 dialysis patients'					
V 000	INITIAL COMMENT		V 00	00			
V 142	was conducted by the Protection from 9/23 compliance with 42 Part 405 Subpart Upend Stage Renal Difollowing regulatory	n-site re-certification survey the Division of Licensing and 3/19 to 9/24/19 to determine Code of Federal Regulations Condition of Participation: sease Services. The violations were identified.	V 14	12		A constitution of the cons	
	P&P CFR(s): 494.30(b)(1)		×			
		lement biohazard and cies and activities within the		f			
	Based on observati review staff failed to procedures to ensur were rigorously follo	not met as evidenced by: on, interview and policy implement policies and re infection control practices wed for 2 of 7 applicable and Patient #7). Findings			Sor policy of	Maria	

During the afternoon changeover session on

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Particular descriptions of		9950 V 500000		189 PROUTY DRIVE		
NORTH	COUNTRY DIALYSIS	JNIT		NEWPORT, VT 05855		
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V 142	Continued From pa		V 143	2		
	09/23/19, it was ob	served that a Renal Technician				
		adequately disinfect the skin				
		ents' prior to cannulating their				
	vascular accesses.	Per observation of Patient				
	#7's vascular acces	ss skin preparation, RT#1 used			10	
*	a Chlorhexidine pre	ep sponge for the upper area				
	(venous portion) of	the vascular access site for				
	15 seconds and an	other Chlorhexidine prep	NI.			
	sponge for the lowe	er area (arterial portion) of the				
	vascular access sit	e for 15 seconds. During a				
	second observation	n, RT#1 proceeded to prep				
	Patient #5's vascula	ar access site in the same				
		prep sponges, one for 15				
	seconds on the up	per area and one on the lower				
	area of the vascula	r access.				
	Technician #2 (RT# disinfecting patient: RT#2 stated, "We in	r interviewed a second Renal #2) regarding the process for s' vascular access sites. The use two sponges, one for the r the arterial insertion sites for ds".				
	Renal Nurse Super acknowledged that using two prep spote be used on the low vascular access for be used on the upprocessed making a disinfection. S/he (arterial and venous	o/24/19 at 9:30 AM with the rivisor (RNS), s/he staff may be confused by inges thinking that one was to rer (arterial) portion of the r 15 seconds and one was to per portion of the access for 15 total of 30 seconds of confirmed that each area is portion) of the vascular disinfected for 30 seconds, per		S. S	ory h	

Per review of the policy RENL 000047 VASCULAR ACCESS (effective 5/10/18) it read, "Step #5 - Disinfect Skin a) Chlorhexidine is the

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		473504	B. WING			09/25	/2019
	PROVIDER OR SUPPLIER	UNIT			REET ADDRESS, CITY, STATE, ZIP CODE PROUTY DRIVE	-A	
NORTH	COUNTRY DIALYSIS	UNII		NE	WPORT, VT 05855		
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V 142	Continued From pa	age 7	V	142	¥		
		tant: scrub each site, arterial	y	142			
	and venous individu	ually with a new Chloraprep					
		0 seconds and then allow to nimum 30 seconds). Repeat			a		
		palpation of site is done again".				8 0	
V 401	PE-SAFE/FUNCTION	ONAL/COMFORTABLE	V	401			
	ENVIRONMENT						
	CFR(s): 494.60						
		must be designed,					
		ped, and maintained to provide aff, and the public a safe,					
	functional, and com						
	environment.					•	
	This STANDARD i	s not met as evidenced by:			*		
	Based on observa	tion and interview, the facility					
		afe treatment environment for the public as evidenced by a					
	supply room door b	eing left open potentially				8	
		ed access to medical and sharp tools. Findings					
	include:	and sharp tools. Fillulings			⊕ <u>J</u>		
	During the initial ter	ur on the morning of 09/23/19,					`
4		were observed within				146	1 od
	proximity of the uns	secured supply room door.				Vac	, at a
		oor was situated inside the pefore the patient waiting		34		1,1	MM
	room; and was not	visible from the nursing			No.	1/	, Kin,
792		solutions, syringes, and other			Sel 119	1	V
		On 9/23/19 at 1:20 PM, the served to be propped open			OM W.		
	(for approximately 2	20 minutes). The box cutters			See Par Mis		
		of a cart within five feet of the			- JON		
	opened door and o	n ton of hoves several feet			1 18/2		

away. The observation was brought to the staff's

attention at that time. The Renal Nurse

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERV	ICES			UN	<u>MB NO. 0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED			
		473504		B. WING			09/25/2019
NAME OF F	PROVIDER OR SUPPLIER	1		STRE	ET ADDRESS, CITY, STA	TE, ZIP CODE	03/23/2013
NORTH (COUNTRY DIALYSIS	UNIT		1	PROUTY DRIVE PORT, VT 05855		
/VA) ID	SIMMADV STO	ATEMENT OF DEFICIENCIES	9	ID NEV	NACIONALE INVESTIGATION CONTRACTOR CONTRACTO	N OF CORRECTION	l (VE)
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V 401	Continued From pa	age 8		V 401			
		age o acknowledged that th	e box	V 401			
	cutters should not l	be able to be accesse	ed by				
		and that the door sh	ould not				
	be propped open.		22				
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E 000 INITIAL COMMENTS:

An unannounced on site survey was conducted of North Country Dialysis re: requirements for Emergency Preparedness on 9/24/19. As a result of the Emergency Preparedness Survey, the following regulatory violations were identified

E 004 Develop EP Plan, Review and Update Annually, CFR(s): 494.62(a)

The facility must comply with all applicable Federal, State and local emergency preparedness requirements. The (facility) must develope stablish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.

For hospitals at §482.15 and CAHs at §485.625(a): The hospital or CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital or CAH must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.

The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.

For ESRD Facilities at §494.62(a): Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be evaluated, and updated at least annually.

This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to maintain a comprehensive Emergency Preparedness Plan. Findings include:

Per review of the Emergency Plan for the North Country Dialysis it states, "Newport dialysis facility will keep on file all minutes of emergency preparedness meetings at North Country Hospital attended by the Renal Nurse Supervisor (RNS), or designee". Per review of the Emergency Preparedness Committee Meeting Minutes dated 11/28/18, 1/23/19, 4/23/19, 6/26/19, and 8/28/19, the RNS was marked absent on the meeting minutes for each of these dates. The stated goal for this meeting was: "Enhance surge capacity response, collaborate with and integrate plans of emergency response partners, maintain services in a sustained effort and have the ability to bring the system back to normal operation". Per interview, the RNS confirmed on 9/24/19 at 1:45 PM that there was no written documentation that s/he and/or a designee attended this meeting from 11/28/18 to 8/28/19.

ACTION PLAN

- The North Country Dialysis Emergency Plan was reviewed by the Renal Site Supervisor as well as the
 University of Vermont Medical Center Emergency Management Coordinator for compliance in
 accordance with EO18 494.62(a). The plan includes a facility-based and community-based risk
 assessment and plans for response in an emergency situation.
- The Emergency Plan has been revised and annual communication around emergency preparedness
 related to the dialysis facility needs is now articulated in plan by a combination of ad hoc meeting
 participation with North Country emergency planning meetings with meeting minutes in emergency
 binder and attendance at annual planning with other community agencies.
- As part of the monitoring process, an emergency management section will be added to the template
 of the monthly QAPI meeting. This prompt will allow leadership to check that there is documentation
 of collaboration with emergency response partners that fulfils the mission to maintain services and

Poc acentr 10.31.19

have the ability to bring the system back to normal operation. The documentation will include, at a minimum, annual community partner meeting minutes. Ongoing surveillance will be monitored through RN supervisor review of QAPI minutes and Regulatory Readiness Rounds.

All actions will be completed by October 17th, 2019.

E 018 Procedures for Tracking of Staff and Patients CFR(s): 494.62(b)(1)

- (b) Policies and procedures. The [facilities] must developed implementemergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:
- (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b): Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

For Inpatient Hospice at §418.113(b)(6): Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; *staff* responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.

(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

For CMHCs at §485.920(b): Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

For OPOs at§ 486.360(b): Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

For ESRD at§ 494.62(b): Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.

This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to develop and implement a system to track the location of on-duty staff and dialysis patients who are relocated during an emergency, to include documentation concerning the specific name and location of the receiving facility.

POCACCENT 10.31.19 DW 1SL Findings include:

Per record review and staff interview, the Renal Nurse Supervisor (RNS) confirmed on 9/24/19 at 10:21 AM that in the event of an emergency evacuation from the facility, there was no written policy or procedure for tracking on-duty staff, location of dialysis patients, name and location of the receiving facility or other location

ACTION PLAN

- Under the supervision of the Renal Site Supervisor a tracking form has been created to support the North Country Dialysis emergency plan policy related to tracking location of on-duty staff and patients. Under the direction of the Renal Site Supervisor, the Newport Dialysis Emergency Management Policy was revised to reference a newly created "Patient Tracking Form" that would be utilized for tracking on duty staff, location of dialysis patients, name, and location of the receiving facility or other location. The reference form will support the compliance with EO18- 494.62 (b) 01 system to track location of on-duty staff and sheltered patients in the dialysis facility care during and after an emergency.
- Staff will be educated on the updated Newport Dialysis Emergency Management policy and form by the Renal Site supervisor through in person staff meetings.
- All of the above will be completed by October 17th, 2019

E 023 Policies/Procedures for Medical Documentation CFR(s): 494.62(b)(4)

policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]

(5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. (5) or (3), (4),(6) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures land maintains availability of records.

For RNHCls at §403.748(b): Policies and procedures. (5) A system of care documentation that does the following:

Preserves patient information.

Protects confidentiality of patient information.

Secures and maintains the availability of records.

For OPOs at §486.360(b): Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to maintain copies of 17 of 17 dialysis patients' Advanced Directives (A written statement of a person's wishes regarding medical treatment, including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.) to be utilized in cases of emergency evacuation from the facility. Findings include:

Per record review and staff interview, the RNS confirmed on 9/24/19 at 9:01 AM that the emergency "Grab and Go Bag" used by staff in cases of emergency evacuation from the facility, did not include 17 of 17 dialysis patients' Advanced Directives

Poc accento 10.31.19 Dw/Sl

ACTION PLAN

- Under the direction of the Renal Site Supervisor, In accordance with E023-494.62(b).04, to secure a
 system of care documentation that preserves patient information, protects confidentiality and secures
 and maintains the availability of the records.
- Advanced directives were printed in addition to the current process of documenting code status on all
 current patients receiving dialysis at North Country site. These were placed in grab and go kit.
- The inclusion of the Advance Directive has been incorporated into the new patient admission under the oversight of the social worker who admits the patient.
- Staff will be educated on the updated work flow by the Renal Site supervisor through in person staff meetings.
- As part of the monitoring process, an emergency management section will be added to the template
 of the monthly QAPI meeting. This prompt will allow leadership to check that emergency box has been
 checked for advanced directives.
- Ongoing surveillance will be monitored through RN supervisor or designee and Regulatory Readiness Rounds.
- All actions will be completed by October 17th, 2019.

V 000 INITIAL COMMENTS

An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection from 9/23/19 to 9/24/19 to determine compliance with 42 Code of Federal Regulations Part 405 Subpart U, Condition of Participation: End Stage Renal Disease Services. The following regulatory violations were identified.

V 142 IC-O-SIGHT-MONITORACTIVITY/IMPLEMENT P&P CFR(s): 494.30(b)(1)

The facility must-(1) Monitor and implement biohazard and infection control policies and activities within the dialysis unit;

This STANDARD is not met as evidenced by: Based on observation, interview and policy review staff failed to implement policies and procedures to ensure infection control practices were rigorously followed for 2 of 7 applicable patients (Patient #5 and Patient #7). Findings include:

During the afternoon changeover session on 09/23/19, it was observed that a Renal Technician #1 (RT#1), failed to adequately disinfect the skin of two dialysis patients' prior to cannulating their vascular accesses. Per observation of Patient #Ts vascular access skin preparation, RT#1 used a Chlorhexidine prep sponge for the upper area (venous portion) of the vascular access site for 15 seconds and another Chlorhexidine prep sponge for the lower area (arterial portion) of the vascular access site for 15 seconds. During a second observation, RT#1 proceeded to prep Patient #5's vascular access site in the same manner, using two prep sponges, one for 15 seconds on the upper area and one on the lower area of the vascular access.

poc accent 10/31/19 DN & The nurse surveyor interviewed a second Renal Technician #2 (RT#2) regarding the process for disinfecting patients' vascular access sites. The RT#2 stated, "We use two sponges, one for the venous and one for the arterial insertion sites for about 15-20 seconds".

Per interview on 09/24/19 at 9:30 AM with the Renal Nurse Supervisor (RNS), s/he acknowledged that staff may be confused by using two prep sponges thinking that one was to be used on the lower (arterial) portion of the vascular access for 15 seconds and one was to be used on the upper portion of the access for 15 seconds making a total of 30 seconds of disinfection. S/he confirmed that each area (arterial and venous portion) of the vascular access was to be disinfected for 30 seconds, per their policies and procedures.

Per review of the policy RENL 000047 VASCULAR ACCESS (effective 5/10/18) it read, "Step #5 - Disinfect Skin a) Chlorhexidine is the first choice disinfectant: scrub each site, arterial and venous individually with a new Chloraprep sponge gently for 30 seconds and then allow to dry completely (minimum 30 seconds). Repeat skin disinfection if palpation of site is done again

ACTION PLAN

- Under direction of the Renal Site Supervisor, all staff, applicable to their role, received education on the expectations outlined in the facility's Infection Control policy, RENL 000047 "Vascular Access: Needle Placement and Removal, Including Managing new AVF". This policy is related to V142- 494.30
 (b) on implementation of infection control practices.
- Education on this policy occurred through in-person staff meetings by Renal Site Supervisor
- The training included scrubbing each site with appropriate skin antiseptic for 30 seconds and then allowing it to dry completely.
- Compliance will be monitored through weekly return demonstration of site cleaning x 4 weeks.
 Performance monitoring will be re-evaluated by Renal Site Supervisor, Director of Renal and Director of Accreditation & Regulatory Affairs once sustained improvement is achieved
- All of the above will be completed by October 17th, 2019.

V 401 PE-SAFE/FUNCTIONAL/COMFORTABLE ENVIRONMENT CFR(s): 494.60

The dialysis facility must be designed, constructed, equipped, and maintained to provide dialysis patients, staff, and the public a safe, functional, and comfortable treatment environment.

This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe treatment environment for patients, staff, and the public as evidenced by a supply room door being left open potentially allowing unauthorized access to medical supplies, solutions, and sharp tools. Findings include:

During the initial tour on the morning of 09/23/19, several box cutters were observed within proximity of the unsecured supply room door. This supply room door was situated inside the Renal Unit's door, before the patient waiting room; and was not visible from the nursing station. It contained solutions, syringes, and other treatment supplies. On 9/23/19 at 1:20 PM, the supply door was observed to be propped open (for approximately 20 minutes). The box cutters were visible on top of a cart within five feet of the opened door and on top of boxes several feet away the observation was brought to the staff's attention at that time. The

10.31.19 DW/Sl Renal Nurse Supervisor (RNS) acknowledged that the box cutters should not be able to be accessed by unauthorized users and that the door should not be propped open.

ACTION PLAN

- A decision regarding the feasibility of replacing automatic magnetic door opening will be reviewed by Renal Site Supervisor, Director of Renal, Director of Accreditation & Regulatory Affairs
- All staff were re-educated through a combination of in person and electronic communication on the requirement to keep supply room door closed when not in use.
- Compliance will be monitored through unit-based audits and Regulatory Readiness Rounds.
- All actions will be completed by October 17th, 2019.

pc ant 10.31.19 Dr.Sl



Accreditation and Regulatory Affairs Department 111 Colchester Avenue Burlington, VT 05401

October 17, 2019

Department of Disability, Aging and Independent Living Division of Licensing and Protection HC 2 South, 280 State Drive Waterbury, VT 05671-2060

Re: CMS Certification Number (CCN): 473504

Dear Suzanne Leavitt,

Please find the attached Plan of Corrections and form CMS-2567 in response to the Statement of Deficiencies and Findings in regard to survey number 473504.

The University of Vermont Medical Center is committed to continuously improving the quality of services we provide to respond to the regulatory deficiencies that were cited.

If you have questions regarding the attached Plan of Correction or require further clarification, please do not hesitate to contact me.

Sincerely,

Caul M

Carol Muzzy, Director

Accreditation & Regulatory Affairs

The University of Vermont Medical Center

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