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
State Survey Agency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	473504	A. BUILDING _____ B. WING _____	09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH COUNTRY DIALYSIS UNIT	189 PROUTY DRIVE NEWPORT, VT 05855

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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 000		
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 develop establish 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.	E 004	See POC Carol Murray 10/17/19 tag E004 POC accepted DWTSS 11/4/19	

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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E 004	Continued From page 1 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.	E 004		
E 018	Procedures for Tracking of Staff and Patients CFR(s): 494.62(b)(1) [(b) Policies and procedures. The [facilities] must develop and implement emergency 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:]	E 018	See POC Cond report 10/17/19 tag E018 POC accepted DWLSS 11/4/19	

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E 018	Continued From page 2 (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	E 018	See POC Carol M 10/22/19	

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E 018 Continued From page 3

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.
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.

E 018

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

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness

E 023

tag E023 PoC accepted 11/4/19 DLD/SS

See POC 10/17/19 Carol M

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E 023	Continued From page 4	E 023		

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 and maintains availability of records.

*[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following:
(i) Preserves patient information.
(ii) Protects confidentiality of patient information.
(iii) 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

See POC
10/1/19
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E 023	Continued From page 5 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.	E 023		
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 000		
V 142	IC-O-SIGHT-MONITOR ACTIVITY/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	V 142		

V142 POC accepted 11/14/19 BWSS

See POC 10/17/19 CMC mp

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V 142	Continued From page 6 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 #7's 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. 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	V 142		

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10/7/19
Cand N

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V 142	Continued From page 7 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".	V 142		
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 Renal Nurse	V 401		

See POC 10/23/19 CenC MP

V 401 POC accepted 11/4/19 DW/SS

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V 401	Continued From page 8 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.	V 401		

See POC
14/2/19
Cwd

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 develop establish 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 accepted 10.31.19
DW/SS

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 develop and implement emergency 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.

POC accepted
10.31.19
DW/SL

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 RNHCIs 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 accepted
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.

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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

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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.

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THE
University of Vermont
MEDICAL CENTER

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,

Carol Muzzy

Carol Muzzy, Director
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