VERMONT

AGENCY OF HUMAN SERVICES
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

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October 28, 2022

Mr. Shawn Tester
Northeastern Vermont Regional Hospital
1315 Hospital Drive
Saint Johnsbury, VT 05819-9758

Dear Mr.. Tester:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on October 12, 2022. 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
	471303	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHEASTERN VERMONT REGIONAL HOSPITAL	1315 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

(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
C 000	INITIAL COMMENTS An unannounced on-site investigation of complaint #21184 was conducted on 10/10/22 through 10/12/22 by the Division of Licensing and Protection to determine compliance with the Conditions of Participation for Critical Access Hospitals (CAHs) at 42 CFR. Part 485, Subpart F. The following regulatory violations were identified.	C 000	The Director of Quality/Infection Preventionist, and the Risk and Compliance Officer, confirmed that the Patient Rights brochure did not contain wording specific to non-end-of-life visitation. While they did not review all 10 records with the reviewer, they were able to identify that there was not a written protocol for how a patient received information about their Rights and Responsibilities.	
C1056	PATIENT VISITATION RIGHTS CFR(s): 482.635(f)(1), 482.635(f)(2) §485.635(f) Standard: Patient visitation rights. A CAH must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation. A CAH must meet the following requirements: (1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, in advance of furnishing patient care whenever possible. (2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. This STANDARD is not met as evidenced by: Based on interview and record review the CAH	C1056	**Corrective Action:** ✓ The Patient Rights and Responsibilities document is being modified to include wording that outlines the right of each patient to visitation. ✓ A policy that outlines the protocol for how the *Patient Rights and Responsibilities* will be given to each patient has been created and will be uploaded into our Policy Management system (title: *Patient Rights and Responsibilities*). ✓ Our informatics team has worked with registration staff to create a mechanism to document that each patient has received the *Patient Rights and Responsibilities Brochure* Tag C1056 POC Accepted on 10/28/2022 by D.Wideawake/S.Leavitt	11.16.2022 10.25.2022 11.16.2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia A. Lamont, RN, CPHQ, CIC — TITLE: Director of Quality/Infection Preventionist — (X6) DATE: 10.26.2022

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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C1056	Continued From page 1 (Community Access Hospital) failed to assure that patients and/or their support persons were informed of their visitation rights for 10 of 10 records reviewed (Patient's #1-10). Findings include: During record review on 10/10/22, 10/11/22, and 10/12/22 for Patient's #1-10, there was no evidence that the patients and/or their support persons were informed of their visitation rights. This was confirmed during an interview on 10/12/22 at 4:53 PM with the Director of Risk Management and the Director of Quality.	C1056	The Assistant Director Information Services/Clinical Informatics, along with the Director of Quality/Infection Preventionist and the Risk and Compliance Officer confirmed that two records had a discharge condition listed as "serious" with information in the remaining notes that did not appear to align with this. Subsequent review of these patient records identified that patient's admitted from the Emergency Department are given a discharge disposition and condition. Upon admission to, and discharge from inpatient units, this disposition and condition follows through on the patient chart because of the Universal Discharge tool that is part of our EHR.. Providers are not alerted of this required field because criteria has already been met and carried forward. Records for patient #5 and #10 were reviewed with discharging providers, and they confirmed a system issue. **Corrective Action:** ✓ The informatics team is actively working with our EHR vendor (Meditech) to see what system changes can be done to prevent the carry-over of the discharge condition between units and/or to create a custom pop-up alert to bring attention to the field.	11.16.2022
C1104	RECORDS SYSTEM CFR(s): 485.638(a)(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on interview and record review the CAH failed to ensure medical records were accurately documented for 2 of 10 records reviewed (Patient #5 and Patient #10). Findings include: 1. Per record review, Patient #5 was admitted on 10/8/22 with nausea, vomiting, and abdominal pain. The patient was discharged on 10/9/22 with the following instructions: "Rx (prescription) for levsin for bowel spasms, f/u (follow-up) in clinic for cultures results, push fluids, rest for the next 24 hrs, F/u PCP (primary care physician) this week, Radiology will call to schedule US (ultrasound) on Monday, F/u with Surgical Assoc this week". Per Patient #5's discharge summary, his/her disposition was "Home" and his/her condition was "Serious". The patient's "Status at Discharge", states, "independent ambulation ...	C1104	✓ Provider education has been implemented to alert staff of this issue. Education includes screen shots of what the issue is, along with a mechanisms for providers to go in and change the discharge condition. ✓ Once the EHR changes have occurred, the informatics team, along with quality management, will conduct random checks for several months to ensure that the changes are supporting process improvement.	10.24.2022 11.30.2022

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C1104	Continued From page 2 patient is back to baseline ...mental status grossly normal ...speech and movement normal ...congruent mood ...normal affect". 2. Per record review, Patient #10 was admitted on 9/7/22 with a gastrointestinal bleed, anemia (low blood count) and atrial fibrillation (fast heart rate). The patient was discharged on 9/8/22. Per Patient #10's discharge summary, his/her disposition was "Home" and his/her condition was "Serious". Patient #10's hospital course revealed the patient was "resuscitated with PRBC's (packed red blood cells) ...physiologically improved and endoscopy ("A procedure in which an instrument is introduced into the body to give a view of its internal parts.") showed diffuse gastritis (inflammation of stomach lining) ...Hgb ("Protein in red blood cells that carries oxygen throughout the body.") was improved the afternoon of 9/8 and ...(Patient #10) was discharged home in good condition". Per interview on 10/12/22 at 3:00 PM with the Manager of Clinical Informatics, S/He confirmed that the discharge summaries for Patient's #5 and #10 exhibited contradicting information and were not accurate. This was further confirmed by the Director of Risk Management and the Director of Quality at 4:53 PM. Per review of the policy "Medical Staff Medical Records"-approved on 8/13/2020, it states "An accurate and complete medical record is essential for the proper care of patients ...It provides documentation of the patient's prior medical history, current condition and is invaluable for his/her future health care ...3. Discharge Summaries a. Must contain the reason	C1104		

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C1104	Continued From page 3 for hospitalization, significant findings, procedures performed (if any), consultations done (if any), treatment rendered, the patient's condition at discharge and instructions to the patient and family and/or caregiver(s).".	C1104	Tag C1104 POC accepted on 10/28/2022 by D.Wideawake/ S.Leavitt	