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

June 28, 2019

Mr. Jayesh Shukla,Director
University Of Vt Medical Center Dialysis Berlin
Po Box 547
Barre, VT 05641

Dear Mr. Shukla:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 12, 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,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	473500	A. BUILDING _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF VT MEDICAL CENTER DIALYSIS BERLIN	PO BOX 547 BARRE, VT 05641

(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
E 000	Initial Comments An unannounced onsite survey was conducted of the University of Vermont Medical Center Dialysis Berlin End Stage Renal Dialysis (ESRD) re: requirement for Emergency Preparedness on 6/10/19. As a result of the Emergency Preparedness Survey, the following regulatory violations were identified.	E 000		
E 031	Emergency Officials Contact Information CFR(s): 494.62(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency.	E 031	E031 Plan of Correction (POC) accepted 6/27/19 J. Cummings RN MS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joseph Shukla		6/24/19

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 031	Continued From page 1 (iv) The State Protection and Advocacy Agency. This STANDARD is not met as evidenced by: Based upon record review and staff interview, the facility failed to maintain the emergency preparedness communication plan that complies with Federal, State, and Local laws and must be updated annually. Findings include: 1. Per record review of the facility's Emergency Preparedness Plan and staff interview on 6/10/19 3:30 PM the Nurse Manager confirmed that the "Community, Emergency Contact Information, Appendix C" was last updated 10/5/17 and should have been updated annually. 2. Per record review of the Emergency Preparedness Box, which is to be deployed in case of patient evacuation during a disaster, and staff interview on 6/10/19 3:30 PM the Nurse Manager confirmed that the "Community, Emergency Contact Information, Appendix C" was last updated 10/5/17 and should have been updated annually.	E 031	E031 POC accepted 6/27/19 J. Cummings RVMS See POC	
E 033	Methods for Sharing Information CFR(s): 494.62(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.	E 033	E 033 POC accepted 6/27/19 J. Cummings RVMS.	

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E 033	Continued From page 2	E 033		

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).]

(6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).

*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.

*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).

This STANDARD is not met as evidenced by:
Based upon record review and staff interview, the facility failed to ensure that patient dialysis treatment orders were current in the Emergency Preparedness Box, which is to be deployed in the case of a patient evacuation during a disaster and provides patient care information to be used by the receiving facility. (100% of patient's receiving dialysis in May 2019). Finding includes:

1) Per record review of the Emergency Preparedness Box and staff interview on 6/10/19 3:30 PM the Nurse Manager confirmed the last date all (100%) patient dialysis treatment orders

E033
POC accepted
6/27/19
J Cummings RNMS.

See POC

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E 033	Continued From page 3 were updated was on April 16, 2019.	E 033		
V 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted on 6/10/19 - 6/12/19 by the Division of Licensing and protectiotion re: conditions of compliance with 42 Code of Federal Regulations (CFR), Part 405, Subpart U, End Stage Renal Disease (ESRD) Services. The following regulatory deficiencies were identified.	V 000		
V 112	IC-CDC MMWR 2001 CFR(s): 494.30(a) The facility must demonstrate that it follows standard infection control precautions by implementing- (1)(i) The recommendations (with the exception of screening for hepatitis C), found in "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients," developed by the Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, volume 50, number RR05, April 27, 2001, pages 18 to 28. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html.	V 112		

E033
POC accepted
6/27/19
J. Cimmo RN MS

See POC

V 112
POC accepted
6/27/19
J. Cimmo RN MS

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V 112	Continued From page 4 The recommendation found under section header "HBV-Infected Patients", found on pages 27 and 28 of RR05 ("Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients"), concerning isolation rooms, must be complied with by February 9, 2009. This STANDARD is not met as evidenced by: Based upon observation and staff interview, the facility failed to follow standard infection control precautions concerning accessing a patient's dialysis site prior to initiation of dialysis and/or follow precautions to prevent potential cross-contamination through devices. (Patient #1). Finding includes: 1) Per observation of Patient #1 on 6/10/19, the Dialysis Tech (DT) did not clean the patient's access site with a Betadine Swab (antiseptic) for 30 seconds, as required to provide infection control, prior to the initiation of dialysis. Per staff interview on 6/10/19 12:01 PM, the DT confirmed she/he cleaned patient #1's access site for 15 seconds and not for the required 30 seconds prior to initiation of dialysis. 2) Per observations on 06/10/19 from 4:10 PM - 4:45 PM Infection control precautions specifically designed to prevent transmission of bloodborne viruses and/or pathogenic bacteria among patients was not adhered to. The nurse went from one station to another station, to listen to lungs sound on newly set-up patients, without disinfecting the common stethoscope. The nurse had put the stethoscope around his/her neck and walked to the common area near the nursing desks. During interview, at that time, the nurse	V 112	V112 POC accepted 6/27/19 J. Cummings RN MS See POC	

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V 112	Continued From page 5 stated that the stethoscope did not touch the patient's skin, ["it was on their shirts, not on a graft or fistula area"]. The nurse also stated that sometimes a gloved is used to cover the bell, but was in the process of cleaning it. Per the Facility's Policy RENL95 Infection Prevention Policy; I - Infection Prevention Precautions for All Patients: A) #5-"....Therefore, items taken to a patient's station,.....cleaned and disinfected before being returned to a common area or used for other patients." The UM confirmed on afternoon of 06/12/19 that sometimes gloves are used on the stethoscopes but should be cleaned after use. The CDC "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients" (MMWR, Vol.50/no. RR-5), pages 18-28, including the "Recommended Infection Control Practices for Hemodialysis Units at Glance," is incorporated by reference and has the authority of regulation.	V 112	V 112 POC accepted 6/27/19 J. Cummings RN MS See POC	
V 122	IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL CFR(s): 494.30(a)(4)(ii) [The facility must demonstrate that it follows standard infection control precautions by implementing- (4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the-] (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment. This STANDARD is not met as evidenced by: Based upon observation and staff interview, the	V 122	V 122 POC accepted 6/27/19 J. Cummings RN MS.	

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V 122	Continued From page 6	V 122	V 122 DVC accepted 6/27/19 J. Cumm RN MS Sr PC	

facility failed to completely clean and disinfect dialysis machine surfaces for 3 of 9 dialysis stations observed (Stations #2, #7, #9). Findings include:

1. Per observation and confirmed with the Dialysis Techs (DT) at the time of the observations, the DT's failed to wipe down dialysis concentrate jugs and/or other tubing after the dialysis machine was cleaned with 1:100 bleach cloths and prior to next dialysis treatment as follows:

a) During the disinfection process on the late morning of 06/10/19 at Station #7 the dialysis technician (DT) did not wipe down nor change the jugs that held the concentrates, nor the Hanson area, prior to the set-up for the next patient. It was also observed during set-up that the new tubing was touching the [potentially contaminated] two jugs and the prepping of the new tubing was already in process. The DT confirmed " we just switch out the bottles prior to the new patient but we would wipe them down if they were visibly soiled". This DT also stated that the Hanson's [tubing on the side of them machine], would be checked before start up with the new patient.

b) Per observation of cleaning & set-up for Station #2 on the afternoon of 06/10/19 demonstrated no wiping of the two concentrate jugs nor the cleaning of the Hanson's tubing. The new set-up and the new patient was already in the chair. The DT at that point stated that the Hanson's were going to be cleaned next as part of the process.

c) Per observation of cleaning and set-up for Station #9, on 6/10/19 at 11:50 AM, the DT failed

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V 122	Continued From page 7 to wipe down the outside surface of the dialysis concentrate jug after the dialysis machine had been cleaned with 1:100 bleach cloth and prior to the next dialysis treatment. Per the Facility's Policy RENL000127 - Hemodialysis Treatment Termination #19 - "After the patient has left the station, obtain a fresh bleach cloth and disinfect the surface of the machine and the dialysis station area post treatment. Clean all station items, including the machine; including inside of door covering Hanson and Hanson's,....concentrate jugs...".	V 122	V 122 POC accepted 6/27/19 J. Cumm RN MS Surface	
V 146	IC-CATHETERS:GENERAL CFR(s): 494.30(c)(2) (2) The "Guidelines for the Prevention of Intravascular Catheter-Related Infections" entitled "Recommendations for Placement of Intravascular Catheters in Adults and Children" parts I - IV; and "Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients," Morbidity and Mortality Weekly Report, volume 51 number RR-10, pages 16 through 18, August 9, 2002. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection as the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html	V 146	V 146 POC accepted 6/27/19 J. Cumm RN MS	

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V 146	Continued From page 8	V 146		

This STANDARD is not met as evidenced by:
Based on observation and interview, dialysis staff failed to adhere to facility policy during the provision of central venous catheter (CVC) care for 1 of 2 applicable CVC patients . (Patient #8)

Per the Facility's policy ' The University of Vermont Medical Center RENL009 : Hemodialysis Vascular Access Central Venous Catheter Care and Maintenance. The procedure for care of the CVC denotes to gather supplies and (per the 6th bullet point) , "If the exit site is left open (if dressing is not applied immediately...sterile 4x3 gauze should be placed loosely over the site, until dressing material is replaced. The exception to this requirement would be the patient who routinely is dressing-free...".

1. Per observation of Patient #8's CVC exit care site and dressing change on 06/10/19 in the afternoon, the dressing supplies where not available and the exit care site was left exposed. The nurse had attached the blood lines as indicated and removed the old dressing. The nurse removed the gloves, hand hygiene was done and left the dialysis area to obtain the new dressing materials, leaving the exit site exposed for a period of time. The nurse returned several minutes later and proceeded to provide exit site care and apply a new dressing. The nurse acknowledged at that time, all needed supplies where not gathered prior the procedure to ensure a smooth workflow, this patient was not routinely dressing-free and the exit site was not covered.

V 146
POC accepted 6/27/19
J. Cummings RN BS

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V 456	Continued From page 9 PR-PARTICIPATE IN CARE;DISC/REFUSE TX CFR(s): 494.70(a)(5)	V 456	V 456 V456 POC accepted 6/27/19 J. Cummings RN MS See POC	

The patient has the right to-

(5) Be informed about and participate, if desired, in all aspects of his or her care, and be informed of the right to refuse treatment, to discontinue treatment, and to refuse to participate in experimental research;

This STANDARD is not met as evidenced by:
Based on interview and record review the facility failed to ensure patients were informed of their plan of care; and failed to ensure patients were either invited and/or had the opportunity to decline to attend the plan of care conference for 3 of 6 applicable patients (Patient #6, Patient #10, and Patient #11). Findings include:

1. As part of the interview process, Patient #11 indicated that they were not invited and stated "well I guess they keep an eye on me or they'll let me know if something changes or I can call my [primary physician] doc". Per the review of the electronic record there was no indication if the patient was asked or if the patient refused.
Per interview on 06/11/19 at 4:20 PM the Nurse Manager (NM) stated that there is a 'radio button' in the section of the IDT meeting progress notes that demonstrates the the patient was asked and/or refused and then there is in the nursing section of IDT notes that states "Patient refused because, ..."The NM said the radio button should be checked to which had happened. If the patient refused, the nurse must write the reason behind the refusal. The UM confirmed there is no documentation that the the patient was asked or

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V 456 Continued From page 10

refused participation in the care plan meeting.

2. Per interview on 6/10/19 at 2:30 PM with Patient #6, s/he stated that the staff did not discuss his/her plan of care and/or changes to the plan of care with him/her; and per interview on 6/11/19 at 1:00 PM with Patient #10, s/he also stated that changes to his/her treatments and/or plan of care was not discussed with him/her.

Per review of Patient #6's care plan dated 4/12/19 and Patient #10's care plan dated 8/22/19 there was no evidence that Patient #6 and Patient #10 had been informed and/or participated in their plans of care. Per interview with the Nurse Manager on 6/12/19 at 10:25 AM, s/he stated that documentation in the patients' record should reflect whether the patient participated and/or did not want to participate in their plan of care. S/he confirmed that for Patient #6 and Patient #10 there was no evidence that this was done.

V 456

V 456
POC accepted 6/27/19
J. Cumm RN MS

See POC

V 556 POC-COMPLETED/SIGNED BY IDT & PT
CFR(s): 494.90(b)(1)

V 556

V 556
POC accepted 6/27/19
J. Cumm RN MS

The patient's plan of care must-
(i) Be completed by the interdisciplinary team, including the patient if the patient desires; and
(ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided.

This STANDARD is not met as evidenced by:
Based upon staff interview and record review, the facility's Interdisciplinary Team (IDT)

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V 556	Continued From page 11 consisting of a physician, registered nurse, dietitian and social worker failed to complete the patient's plan of care and/or have the patient and/or his/her representative sign the plan of care for 5/6 patients in the applicable sample (Patient #4, Patient #6, Patient #9, Patient #10 and Patient #11). Findings include: 1. Per record review of Patient # 11's electronic record there is no indication, as evident by documentation, that the patient or the patient's designee, signed or chose not to sign the plan of care. The patient has had two care plan meetings over the past year and half, however, no documentation was found whether through the electronic record nor a hard copy, that the plan of care was provided to the patient. (ALSO SEE V-456) 2. Per record review, Patient # 9 was newly admitted in February 2019. In April 2019 the IDT completed the care plan. However, there is no indication in the electronic record the patient did or did not signed the plan of care to acknowledge the information in the plan. The Nurse Manager, during interview on 06/12/19, stated that there was a binder that demonstrates a copy was signed by the patients. However, the prior manager's binder was not found. 3. Per record review of the IDT care plan for Patient #4 and confirmed with the Nurse Manager on 6/12/19 at 10:30 AM, the IDT failed to complete the plan of care. 4. Per review of the IDT care plan for Patient #6 initiated on 4/12/19, there was no evidence that nursing had participated and/or contributed to the patient's plan of care. There was also no	V 556	V 556 POC accepted 6/27/19 See POC J. Cummings RNMS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	473500	A. BUILDING _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF VT MEDICAL CENTER DIALYSIS BERLIN	PO BOX 547 BARRE, VT 05641

(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
V 556	Continued From page 12 evidence that the patient had signed and/or chose not to sign his/her plan of care. 5. Per review of the IDT care plan for Patient #10 initiated on 8/22/19, there was no evidence that the patient had signed and/or chose not to sign his/her plan of care. Per interview on 6/12/19 at 10:25 AM with the Nurse Manager, s/he confirmed the above information for Patient #6 and Patient #10.	V 556	V 556 POC accepted 6/27/19 J. Cummings RN for PC	
V 557	POC-INITIAL IMPLEMENTED-30 DAYS/13 TX CFR(s): 494.90(b)(2) Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. This STANDARD is not met as evidenced by: Based upon record review and staff interview, the facility failed to implement the initial plan of care within 30 calendar days for 1 of 6 patients in the sample (Patient #9). Finding includes: Per record review, Patient #9 was admitted the second to the last week of February 2019, with first treatment on 02/20/19. At that time, per record review the nurse did the required treatment assessment. Several days later, the dietician did evaluation and education with the patient. The first week of March there is a Nurse Practitioner's review denoting patient's wish to return to work at some point. It is not until April 18, 2019 nearly two months later that the full Interdisciplinary Team (IDT) evaluated and	V 557	V 557 POC accepted 6/27/19 J. Cummings RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	473500	A. BUILDING _____ B. WING _____	06/12/2019

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V 557	Continued From page 13 discussed the treatment plan. Per interview on 06/11/19 at 3:10 PM the staff nurse stated "we follow the treatment orders and do our baseline assessments". The Nurse Manager confirmed that the completion of the initial comprehensive care plan was greater than 30 days and/or 13 sessions from the date of admission.	V 557	V 557 POC accepted 6/27/19 J. Cumm RNMS	
V 558	POC-IMPLEMENT UPDATE-15 DAYS P PT ASSESS CFR(s): 494.90(b)(2) Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the completion of the additional patient assessments specified in §494.80(d). This STANDARD is not met as evidenced by: Based upon record review and staff interview, the facility delayed in updating the annual plan of care for 1 of 6 patients in the applicable sample. (Patient#11). Finding includes: The annual care plan updates was not performed within 15 days of additional assessments. Patient # 11 was admitted in December 2017. Although the initial care plan was dated 02/20/18, the next annual care plan, as evident by charting in the electronic medical record, indicates it was done on 04/11/19. The Unit Manager confirmed the IDT updates were not completed within the 15 days time frame.	V 558	V 558 POC accepted 6/27/19 J. Cumm RNMS	
V 726	MR-COMPLETE, ACCURATE, ACCESSIBLE CFR(s): 494.170 The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive	V 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	473500	A. BUILDING _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 726	Continued From page 14 dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility. This STANDARD is not met as evidenced by: Based upon observation and staff interview, the facility failed to maintain complete and accurate medical records for 5/6 patients in the applicable sample (Patient's #4,#6 #9,#10 #11), and provide timely access to patient medical records and facility reports for surveyors to review. Findings include: 1) Patient #4,#6, #9, #10, and #11 did not have completed medical records. Their records did not have the required signature of the patients' acknowledgement of their care plans, information to demonstrate they were invited to the IDT meetings, and/or required assessment or progress notes of the IDT meetings (ALSO SEE; V-456, V-556 and V-557). Per interview on 6/12/19 at 10:30 AM with the Nurse Manager, s/he confirmed the above information. 2) Per record review and staff interview, the Nurse Manager confirmed on 6/12/19 at 11:00 AM that surveyors did not have access to the patient electronic records until the afternoon of 6/11/19 and did not have timely access to all requested reports until 6/11/19.	V 726	Su POC V 726 POC accepted 6/27/19 J. Cemo RNMS	

E 000 Initial Comments:
An unannounced onsite survey was conducted of the University of Vermont Medical Center Dialysis End Stage Renal Dialysis requirement for Emergency Preparedness on 6/10/19. As a result of the Emergency Preparedness Survey, the following regulatory violation were identified

E 031 Emergency Officials Contact Information and in emergency preparedness box CFR(s): 494.62(c)(2)
The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following.
Contact information for the following: Federal, State, tribal, regional, and local emergency preparedness staff.
Other sources of assistance.

*(For LTC Facilities at §483.73(c)) (2) Contact information for the following:
Federal, State, tribal, regional, or local emergency preparedness staff.
The State Licensing and Certification Agency.
The Office of the State Long-Term Care Ombudsman.
Other sources of assistance.

*(For ICF/IIDs at §483.475(c)) (2) Contact information for the following:
Federal, State, tribal, regional, and local emergency preparedness staff.
Other sources of assistance.

The State Licensing and Certification Agency/The State Protection and Advocacy Agency.

This STANDARD is not met as evidenced by: Based upon record review and staff interview, the facility failed to maintain the emergency preparedness communication plan that complies with Federal, State, and Local laws and must be updated annually. Finding s include:

Per record review of the facility's Emergency Preparedness Plan and staff interview on 6/10/19 3:30 PM the Nurse Manager confirmed that the "Community, Emergency Contact Information, Appendix C" was last updated 10/5/17 and should have been updated annually.

Per record review of the Emergency Preparedness Box, which is to be deployed in case of patient evacuation during a disaster, and staff interview on 6/10/19 3:30 PM the Nurse Manager confirmed that the "Community, Emergency Contact Information, Appendix C" was last updated 10/5/17 and should have been updated annually.

ACTION PLAN

- All documents have been updated in accordance with CFR 494.62. Specifically, the Community Emergency Contact information updated annually, the dialysis orders updated monthly and all contained in the Emergency Box. Under the direction of the Nurse Manager, Primary and backup employee(s) have been identified to ensure that the orders are printed every month and placed in the emergency preparedness box. The designee (dialysis tech) and back up employee (dialysis tech) have been educated by the Nurse Manager to assure that the information lists about is updated in accordance with CFR 494.62 requirements. This education will be documented.
- 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 dialysis orders and that expiration date for emergency supplies are checked monthly and that community partners' phone numbers are updated annually.
- Ongoing surveillance for emergency preparedness will be monitored through a combination of Nurse Manager or RN designee monthly observed audits and Regulatory Readiness Rounds. Performance feedback will be reported out in the monthly dialysis QAPI meeting as well as reported at the aggregate level to leadership via the Standards of Operations Committee.
- All actions will be completed by July 14th, 2019

E 033 Methods for Sharing Information CFR(s): 494.62(c)(4)(6)
(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

(4)A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care

A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).]

((4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).

*(For RNHCIs at §403.748(c) (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.

*(For RHCs/FQHCs at §491.12(c) (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).

This STANDARD is not met as evidenced by: Based upon record review and staff interview, the facility failed to ensure that patient dialysis treatment orders were current in the Emergency Preparedness Box, which is to be deployed in the case of a patient evacuation during a disaster and provides patient care information to be used by the receiving facility. (100% of patient's receiving dialysis in May 2019). Finding includes:

Per record review of the Emergency Preparedness Box and staff interview on 6/10/19 3:30 PM the Nurse Manager confirmed the last date all (100%) patient dialysis treatment orders were updated was on April 16, 2019

ACTION PLAN

- All documents have been updated in accordance with CFR 494.62. Specifically, the Community Emergency Contact information updated annually, the dialysis orders updated monthly and all contained in the Emergency Box. Under the direction of the Nurse Manager, Primary and backup employee(s) have been identified to ensure that the orders are printed every month and placed in the emergency preparedness box. The designee (dialysis tech) and back up employee (dialysis tech) have been educated by the Nurse Manager to assure that the information lists about is updated in accordance with CFR 494.62 requirements. This education will be documented.
- 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 dialysis orders and that expiration date for emergency supplies are checked monthly and that community partners' phone numbers are updated annually.
- Ongoing surveillance for emergency preparedness will be monitored through a combination of Nurse Manager or RN designee monthly observed audits and Regulatory Readiness Rounds. Performance feedback will be reported out in the monthly dialysis QAPI meeting as well as reported at the aggregate level to leadership via the Standards of Operations Committee.
- All actions will be completed by July 14th, 2019

V 000 INITIAL COMMENTS
An unannounced onsite recertification survey was conducted on 6/10/19 - 6/12/19 by the Division of Licensing and protection re: conditions of compliance with 42 Code of Federal Regulations (CFR), Part 405, Subpart U, End Stage Renal Disease (ESRD) Services. The following regulatory deficiencies were identified

V 112 IC-CDC MMWR 2001 CFR(s): 494.30(a)
The facility must demonstrate that it follows standard infection control precautions by implementing-(1)(i) The recommendations (with the exception of screening for hepatitis C), found in "Recommendations for Preventing Transmissionof Infections Among Chronic Hemodialysis Patients," developed by the Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, volume 50, number RR05, April 27, 2001, pages 18 to 28. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Central Building, Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to:
http://www.archives.gov/federal_register/code_of_regulations/ibr_location.shtml

The recommendation found under section header "HBV-Infected Patients", found on pages 27 and 28 of RR05 ("Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients"), concerning isolation rooms, must be complied with by February 9, 2009.

This STANDARD is not met as evidenced by: Based upon observation and staff interview, the facility failed to follow standard infection control precautions concerning accessing a patient's dialysis site prior to initiation of dialysis and/or follow precautions to prevent potential cross-contamination through devices. (Patient #1). Finding includes:

Per observation of Patient #1 on 6/10/19, the Dialysis Tech (OT) did not clean the patient's access site with a Betadine Swab (antiseptic) for 30 seconds, as required to provide infection control, prior to the initiation of dialysis. Per staff interview on 6/10/19 12:01 PM, the OT confirmed she/he cleaned patient #1's access site for 15 seconds and not for the required 30 seconds prior to initiation of dialysis.

Per observations on 06/10/19 from 4:10 PM - 4:45 PM Infection control precautions specifically designed to prevent transmission of blood borne viruses and/or pathogenic bacteria among patients was not adhered to. The nurse went from one station to another station, to listen to lungs sound on newly set-up patients, without disinfecting the common stethoscope. The nurse had put the stethoscope around his/her neck and walked to the common area near the nursing desks. During interview, at that time, the nurse stated that the stethoscope did not touch the patient's skin, ["it was on their shirts, not on a graft or fistula area"]. The nurse also stated that sometimes a gloved is used to cover the bell, but was in the process of cleaning it. Per the Facility's Policy RENL95 Infection Prevention Policy: Infection Prevention Precautions for All Patients: #5".Therefore, items taken to a patient's station, cleaned and disinfected before being returned to a common area or used for other patients. "The UM confirmed on afternoon of 06/12/19 that sometimes gloves are used on the stethoscopes but should be cleaned after use.

The CDC "Recommendations for Preventing Transmission of Infections Among Chronic Hemodialysis Patients" (MMW R, Vol.50/no. RR-5), pages 18-28, including the "Recommended Infection Control Practices for Hemodialysis Units at Glance," is incorporated by reference and has the authority of regulation

ACTION PLAN

- Under the direction of the Nurse Manager of Dialysis, all direct patient care staff will be reeducated for the purpose of reinforcement of compliance of the facility's Infection Control Policy RENL95 and Vascular Access: Needle Placement and Removal Policy RENL00047. Education will occur through in-person and e mail communication. Staff members required to attend training by July 14th, 2019.
- The in-service will include but not be limited to: scrubbing each site using a spiral motion for 30 seconds and then allowing to dry completely, and that any item taken to a patient's dialysis station including stethoscopes, will be cleaned and disinfected before being returned to a common clean area or used for other patients.
- Ongoing surveillance that staff follow infection control polices will be monitored through a combination of Nurse Manager or RN designee weekly observed audits and Regulatory Readiness Rounds.

ACTION PLAN (continued)

- Performance feedback will be reported out in the monthly dialysis QAPI meeting as well as reported at the aggregate level to leadership via the Standards of Operations Committee.
- The educational agenda and attendance sheet document the training, and staff participation, and will be available for review at the facility. Documentation of the education will be on file at the facility.
- Actions will be completed by July 14th, 2019.

V 122 IC-DISINFECT SURFACES/EQUIP/WRITTEN PROTOCOL CFR(s): 494.30(a)(4)((i)
The facility must demonstrate that it follows standard infection control precautions by implementing-
(4) And maintaining procedures, in accordance with applicable State and local laws and accepted public health procedures, for the (ii) Cleaning and disinfection of contaminated surfaces, medical devices, and equipment.

This STANDARD is not met as evidenced by: Based upon observation and staff interview, the facility failed to completely clean and disinfect dialysis machine surfaces for 3 of 9 dialysis stations observed (Stations #2, #7, #9). Findings include:

Per observation and confirmed with the Dialysis Techs (DT) at the time of the observations, the DT's failed to wipe down dialysis concentrate jugs and/or other tubing after the dialysis machine was cleaned with 1:100 bleach cloths and prior to next dialysis treatment as follows: a) During the disinfection process on the late morning of 06/10/19 at Station #7 the dialysis technician (OT) did not wipe down nor change the jugs that held the concentrates, nor the Hanson area, prior to the set-up for the next patient. It was also observed during set-up that the new tubing was touching the [potentially contaminated] two jugs and the prepping of the new tubing was already in process. The OT confirmed "we just switch out the bottles prior to the new patient but we would wipe them down if they were visibly soiled". This DT also stated that the Hanson's [tubing on the side of them machine], would be checked before start up with the new patient.

Per observation of cleaning & set-up for Station #2 on the afternoon of 06/10/19 demonstrated no wiping of the two concentrate jugs nor the cleaning of the Hanson's tubing. The new set-up and the new patient was already in the chair. The OT at that point stated that the Hanson's were going to be cleaned next as part of the process.

Per observation of cleaning and set-up for Station #9, on 6/10/19 at 11 50 AM, the OT failed to wipe down the outside surface of the dialysis concentrate jug after the dialysis machine had been cleaned with 1:100 bleach cloth and prior to the next dialysis treatment

Per the Facility's Policy RENL000127 - Hemodialysis Treatment Termination #19 - "After the patient has left the station, obtain a fresh bleach cloth and disinfect the surface of the machine and the dialysis station area post treatment Clean all station items, including the machine; including inside of door covering Hanson and Hanson's,...concentrate jugs.."

ACTION PLAN

- Under the direction of the Nurse Manager of Dialysis, all direct patient care staff will be reeducated for the purpose of reinforcement of compliance of the facility's Hemodialysis Treatment Termination Policy, RENL000127.
- Under the direction of the Nurse Manager of Dialysis, education will occur through in-person and electronic communication. Staff members are required to attend training by July 14th, 2019.
- The in-service will include but not be limited to: that after the patient has left the station, the staff member obtains a fresh bleach cloth and disinfects the surface of the machine and the dialysis station area post treatment. All station items must be cleaned including, machine, inside of door covering hansons and hansons, chair or bed, tables, TV, call bell, concentrate jugs, sharp containers and anything that may have been touched during the treatment.

ACTION PLAN (continued)

- Ongoing surveillance that staff follow infection control policies will be monitored through a combination of Nurse Manager or RN designee weekly observed audits and Regulatory Readiness Rounds.
- Performance feedback will be reported out in the monthly dialysis QAPI meeting as well as reported at the aggregate level to leadership via the Standards of Operations Committee.
- The educational agenda and attendance sheet document the training, and staff participation, and will be available for review at the facility. Documentation of the education will be kept on file at the facility.
- All actions will be completed July 14th, 2019.

V 146 IC-CATHETERS: GENERAL CFR(s): 494.30(c) (2)

(2) The "Guidelines for the Prevention of Intravascular Catheter-Related Infections" entitled "Recommendations for Placement of Intravascular Catheters in Adults and Children" parts I - IV; and "Central Venous Catheters, Including PICCs, Hemodialysis, and Pulmonary Artery Catheters in Adult and Pediatric Patients." Morbidity and Mortality Weekly Report, volume 51 number RR-10, pages 16 through 18. August 9, 2002. The Director of the Federal Register approves this incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. This publication is available for inspection as the CMS Information Resource Center, 7500 Security Boulevard, Central Building, and Baltimore, MD or at the National Archives and Records Administration (NARA). Copies may be obtained at the CMS Information Resource Center. For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_regulations/ibr_locations.html

This STANDARD is not met as evidenced by: Based on observation and interview, dialysis staff failed to adhere to facility policy during the provision of central venous catheter (CVC) care for 1 of 2 applicable eve patients. (Patient #8)

Per the Facility's policy The University of Vermont Medical Center RENL009 Hemodialysis Vascular Access Central Venous Catheter Care and Maintenance. The procedure for care of the CVC denotes to gather supplies and (per the 6th bullet point), "If the exit site is left open (if dressing is not applied immediately...sterile 4x3 gauze should be placed loosely over the site, until dressing material is replaced. The exception to this requirement would be the patient who routinely is dressing-free..."

Per observation of Patient #8's CVC exit care site and the dressing supplies were not available and the exit care site was left exposed. The nurse had attached the blood lines as indicated and removed the old dressing. The nurse removed the gloves, hand hygiene was done and left the dialysis area to obtain the new dressing materials, leaving the exit site exposed for a period of time. The nurse returned several minutes later and proceeded to provide exit site care and apply a new dressing. The nurse acknowledged at that time, all needed supplies where not gathered prior the procedure to ensure a smooth workflow, this patient was not routinely dressing-free and the exit site was not covered.

ACTION PLAN

- Under the direction of the Nurse Manager of Dialysis, all registered nursing staff will be reeducated for the purpose of reinforcement of compliance of the facility's Hemodialysis Vascular Access: Central Venous Catheter (CVC) care and Maintenance Policy, RENL009.
- Education will occur through in-person and electronic communication. Staff members are required to attend training by July 14th, 2019.
- The in-service will include but not be limited to: If the exit site is left open to air (if dressing is not applied immediately after it has air dried) sterile 4x3 gauze should be placed loosely over the site, until the dressing material is replaced
- Ongoing surveillance of nursing staffs care of central venous catheter will be monitored through a combination of Nurse Manager or RN designee weekly observed audits and Regulatory Readiness Rounds.
- Performance feedback will be reported out in the monthly dialysis QAPI meeting as well as reported at the aggregate level to leadership via the Standards of Operations Committee.

ACTION PLAN (continued)

- The educational agenda and attendance sheet document the training, and staff participation, and is available for review at the facility. Documentation of the education is on file at the facility.
- All actions will be completed by July 14th, 2019.

V 456 PR-PARTICIPATE IN CARE: DISC/REFUSE TX CFR(s): 494.70(a)(5)

The patient has the right to be informed about and participate, if desired, in all aspects of his or her care, and be informed of the right to refuse treatment, to discontinue treatment, and to refuse to participate in experimental research;

This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure patients were informed of their plan of care; and failed to ensure patients were either invited and/or had the opportunity to decline to attend the plan of care conference for 3 of 6 applicable patients (Patient #6, Patient #10, and Patient #11). Findings include:

As part of the interview process, Patient #11 indicated that they were not invited and stated "well I guess they keep an eye on me or they'll let me know if something changes or I can call my [primary physician] doc". Per the review of the electronic record there was no indication if the patient was asked or if the patient refused.
Per interview on 06/11/19 at 4:20 PM the Nurse Manager (NM) stated that there is a 'radio button' in the section of the IDT meeting progress notes that demonstrates the patient was asked and/or refused and then there is in the nursing section of IDT notes that states "Patient refused because, ..."The NM said the radio button should be checked to which had happened. If the patient refused, the nurse must write the reason behind the refusal. The UM confirmed there is no documentation that the patient was asked or refused participation in the care plan meeting

2. Per interview on 6/10/19 at 2:30 PM with Patient #6, s/he stated that the staff did not discuss his/her plan of care and/or changes to the plan of care with him/her; and per interview on 6/11/19 at 1:00 PM with Patient #10, s/he also stated that changes to his/her treatments and/or plan of care was not discussed with him/her.
Per review of Patient #6's care plan dated 4/12/19 and Patient #10's care plan dated 8/22/19 there was no evidence that Patient #6 and Patient #10 had been informed and/or participated in their plans of care. Per interview with the Nurse Manager on 6/12/19 at 10:25 AM, s/he stated that documentation in the patient's record should reflect whether the patient participated and/or did not want to participate in their plan of care. S/he confirmed that for Patient #6 and Patient #10 there was no evidence that this was done.

ACTION PLAN

- Under the direction of the Nurse Manager/designee documented training for all registered nursing staff will be provided on correct documentation for inviting patient attend or decline plan of care meetings.
- Education will occur through in-person and electronic communication. Staff members are required to attend training by July 14th, 2019.
- The in-service will include but not be limited to: The RN will check either accept, or decline radio button on the signature page of the plan of care (POC) with expectation for documentation to include: If the patient declines meeting with the interdisciplinary team, the RN will document the reason for declination in the nursing section of the POC. The patient will be provided the option to sign their POC. If the patient declines to sign their POC, the RN will document this in nursing section of the POC. If the patient attends the POC, the POC document will be printed and the patient will sign the signature page as well as patient or patient's designee(s) input into the plan of care will be documented by the RN staff and reflected in the care plan. If the patient accepts the POC but does not wish to attend a meeting with the interdisciplinary team, the POC document will be printed and the patient will sign the signature page.
- The nurse will document the reason for declination in the nursing section of the plan of care. The signed signature pages will be located locally for review.

ACTION PLAN (continued)

- Ongoing surveillance for UVMMC patient declined or accepted involvement in their plan of care will be monitored through a combination of Nurse Manager or RN designee monthly observed audits and Regulatory Readiness Rounds.
- The number of POC's due and completed for month will be reviewed in monthly QAPI committee meetings.
- Performance feedback will be reported out in the monthly dialysis QAPI meeting as well as reported at the aggregate level to leadership via the Standards of Operations Committee.
- The educational agenda and attendance sheet document the training, and staff participation, and is available for review at the facility. Documentation of the education is on file at the facility.
- All actions will be completed by July 14th, 2019.

V 556 POC-COMPLETED/SIGNED BY IDT & PT CFR(s): 494.90(b)(1)
The patient's plan of care must-Be completed by the interdisciplinary team, including the patient if the patient desires; and (ii) Be signed by the team members, including the patient or the patient's designee; or, if the patient chooses not to sign the plan of care, this choice must be documented on the plan of care, along with the reason the signature was not provided.

This STANDARD is not met as evidenced by: Based upon staff interview and record review, the facility's Interdisciplinary Team (IDT) consisting of a physician, registered nurse, dietitian and social worker failed to complete the patient's plan of care and/or have the patient and/or his/her representative sign the plan of care for 5/6 patients in the applicable sample (Patient#4, Patient #6, Patient #9, Patient #10 and Patient #11). Findings include:

Per record review of Patient# 11's electronic record there is no indication, as evident by documentation, that the patient or the patient's designee; signed or chose not to sign the plan of care. The patient has had two care plan meetings over the past year and half, however, no documentation was found whether through the electronic record nor a hard copy, that the plan of care was provided to the patient. (ALSO SEE V-456)

Per record review, Patient # 9 was newly admitted in February 2019. In April 2019 the IDT completed the care plan. However, there is no indication in the electronic record the patient did or did not signed the planof care to acknowledge the information in the plan. The Nurse Manager, during interview on 06/12/19, stated that there was a binder that demonstrates a copy was signed by the patients. However, the prior manager's binder was not found.

Per record review of the IDT care plan for Patient #4 and confirmed with the Nurse Manager on 6/12/19 at 10:30 AM, the IDT failed to complete the plan of care.

Per review of the IDT care plan for Patient #6 initiated on 4/12/19, there was no evidence that nursing had participated and/or contributed to the patient's plan of care. There was also no evidence that the patient had signed and/or chose not to sign his/her plan of care.

5. Per review of the IOT care plan for Patient #10 initiated on 8/22/19, there was no evidence that the patient had signed and/or chose not to sign his/her plan of care.

Per interview on 6/12/19 at 10:25 AM with the Nurse Manager, s/he confirmed the above information for Patient #6 and Patient #10

ACTION PLAN

- Under the direction of the Nurse Manager/designee, documented training for all registered nursing staff will be provided on correct documentation for plan of care creation and meetings.
- All registered nursing staff, the facility social worker and registered dietitian will be educated on the expectations outlined in Initial Assessment and Plan of Care for New Dialysis Patients Policy RENL 301.

ACTION PLAN (continued)

- Education will occur through in-person and electronic communication. Staff members are required to attend training by July 14th, 2019.
- The education will include but not limited to: All 16 parameters in the initial Plan of Care will be addressed and used to produce a Plan of Care that specifies the services necessary to address the patient's needs. This will be developed in conjunction with the patient. This will be documented in the patient's record and a written copy will be provided to the patient. The initial Plan of Care must be completed and all components addressed each time at the following intervals: within the first 30 days or 13 treatments for new patients; monthly for unstable patients; 3 months after the start of dialysis; and annually from the date of the last initial Care Plan completed.
- The in-service will include: The RN will check either accept, or decline radio button on the signature page of the plan of care (POC) with expectation for documentation to include: If the patient declines meeting with the interdisciplinary team, the RN will document the reason for declination in the nursing section of the POC. The patient will be provided the option to sign their POC. If the patient declines to sign their POC, the RN will document this in nursing section of the POC. If the patient attends the POC, the POC document will be printed and the patient will sign the signature page as well as patient or patient's designee(s) input into the plan of care will be documented by the RN staff and reflected in the care plan. If the patient accepts the POC but does not wish to attend a meeting with the interdisciplinary team, the POC document will be printed and the patient will sign the signature page.
- The nurse will document the reason for declination in the nursing section of the plan of care. The signed signature pages will be located locally for review
- Ongoing surveillance for UVMMC patient or representative sign plan of care will be monitored through a combination of Nurse Manager or RN designee monthly observed audits and Regulatory Readiness Rounds.
- Performance feedback will be reported out in the monthly dialysis QAPI meeting as well as reported at the aggregate level to leadership via the Standards of Operations Committee.
- The educational agenda and attendance sheet document the training, and staff participation, and is available for review at the facility. Documentation of the education will be on file at the facility.
- All actions will be completed by July 14th, 2019

V 557 POC-INITIAL IMPLEMENTED-30 DAYS/13 TX CFR(s): 494.90(b)(2)
Implementation of the initial plan of care must begin within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session

This STANDARD is not met as evidence by: Based upon record review and staff interview, the facility failed to implement the initial plan of care within 30 calendar days for 1 of 6 patients in the sample (Patient #9). Finding includes

Per record review, Patient #9 was admitted the second to the last week of February 2019, with first treatment on 02/20/19. At that time, per record review the nurse did the required treatment assessment. Several days later, the dietician did evaluation and education with the patient. The first week of March there is a Nurse Practitioner's review denoting patient's wish to return to work at some point. It is not until April 18, 2019 nearly two months later that the full Interdisciplinary Team (IDT) evaluated and discussed the treatment plan. Per interview on 06/11/19 at 3:10 PM the staff nurse stated "we follow the treatment orders and do our baseline assessments". The Nurse Manager confirmed that the completion of the initial comprehensive care plan was greater than 30 days and/or 13 sessions from the date of admission

ACTION PLAN

- Under the direction of the Nurse Manager/designee, documented training for all registered nursing staff will be provided on correct documentation for plan of care creation and meetings.
- All registered nursing staff, the facility social worker and registered dietitian will be in-serviced on Initial Assessment and Plan of Care for New Dialysis Patients Policy RENL 301.

ACTION PLAN (continued)

- Education will occur through in-person and electronic communication. Staff members are required to attend training by July 14th, 2019.
- The education will include but not limited to: The initial plan of care must be completed and all components addressed each time at the following intervals: Within the first 30 days or 13 treatments for new patients. Monthly for unstable patients. 3 months after the start of dialysis. Annually from the date of the last initial care plan completed.
- A tracking tool was developed to support the required time frames by the Nurse Manager.
- Ongoing surveillance for UVMMC patient to have plan of care completed as per policy plan will be monitored through a combination of Nurse Manager or RN designee monthly observed audits and Regulatory Readiness Rounds.
- The educational agenda and attendance sheet document the training, and staff participation, and is available for review at the facility. Documentation of the education is on file at the facility.
- Performance feedback will be reported out in the monthly dialysis QAPI meeting as well as reported at the aggregate level to leadership via the Standards of Operations Committee.
- All actions will be completed by July 14th, 2019.

V 558 POC-IMPLEMENT UPDATE-15 DAYS P PT ASSESS CFR(s): 494.90(b)(2)
Implementation of monthly or annual updates of the plan of care must be performed within 15 days of the completion of the additional patient assessments specified in §494.80(d).

This STANDARD is not met as evidenced by: Based upon record review and staff interview, the facility delayed in updating the annual plan of care for 1 of 6 patients in the applicable sample. (Patient#11). Finding includes:

The annual care plan updates was not performed within 15 days of additional assessments. Patient # 11 was admitted in December 2017. Although the initial care plan was dated 02/20/18, the next annual care plan, as evident by charting in the electronic medical record, indicates it was done on 04/11/19. The Unit Manager confirmed the IDT updates were not completed within the 15 days' time frame.

ACTION PLAN

- Under the direction of the Nurse Manager/designee, documented training for all registered nursing staff will be provided on correct documentation for plan of care creation and meetings.
- All registered nursing staff, the facility social worker and registered dietitian will be in-serviced on Initial Assessment and Plan of Care for New Dialysis Patients Policy RENL 301.
- Education will occur through in-person and electronic communication. Staff members are required to attend training by July 14th, 2019.
- The education will include but not limited to: The initial plan of care must be completed and all components addressed each time at the following intervals: Within the first 30 days or 13 treatments for new patients. Monthly for unstable patients. 3 months after the start of dialysis. Annually from the date of the last initial care plan completed.
- The education will include but not limited to: The initial plan of care must be completed and all components addressed each time at the following intervals: Within the first 30 days or 13 treatments for new patients. Monthly for unstable patients. 3 months after the start of dialysis. Annually from the date of the last initial care plan completed
- A tracking tool was developed to support the required time frames by the Nurse Manager.
- Ongoing surveillance for UVMMC patient to have plan of care completed as per policy plan will be monitored through a combination of Nurse Manager or RN designee weekly observed audits and Regulatory Readiness Rounds.
- The educational agenda and attendance sheet document the training, and staff participation, and is available for review at the facility. Documentation of the education is on file at the facility.

ACTION PLAN (continued)

- Performance feedback will be reported out in the monthly dialysis QAPI meeting as well as reported at the aggregate level to leadership via the Standards of Operations Committee.
- All actions will be completed by July 12, 2019.

V 726 MR-COMPLETE, ACCURATE, ACCESSIBLE CFR(s): 494.170
The dialysis facility must maintain complete, accurate, and accessible records on all patients, including home patients who elect to receive dialysis supplies and equipment from a supplier that is not a provider of ESRD services and all other home dialysis patients whose care is under the supervision of the facility.

This STANDARD is not met as evidenced by: Based upon observation and staff interview, the facility failed to maintain complete and accurate medical records for 5/6 patients in the applicable sample (Patient's #4,#6 #9,#10 #11), and provide timely access to patient medical records and facility reports for surveyors to review. Findings include:

Patient #4, #6, #9, #10, and #11 did not have completed medical records. Their records did not have the required signature of the patients' acknowledgement of their care plans, information to demonstrate they were invited to the IDT meetings, and/or required assessment or progress notes of the IDT meetings (ALSO SEE: V-456, V-556 and V-557). Per interview on 6/12/19 at 10:30 AM with the Nurse Manager, s/he confirmed the above information.

Per record review and staff interview, the Nurse Manager confirmed on 6/12/19 at 11:00 AM that surveyors did not have access to the patient electronic records until the afternoon of 6/11/19 and did not have timely access to all requested reports until 6/11/19.

ACTION PLAN

- See action plans under V tags V456, V 556 and V 557 related to: Patient #4, #6, #9, #10, and #11 did not have completed medical records. Their records did not have the required signature of the patients' acknowledgement of their care plans, information to demonstrate they were invited to the IDT meetings, and/or required assessment or progress notes of the IDT meetings (ALSO SEE: V-456, V-556 and V-557). Per interview on 6/12/19 at 10:30 AM with the Nurse Manager, s/he confirmed the above information.
- The policy INFORPO10 was reviewed by the Director of Accreditation and Regulatory Affairs, IS Support Services Manager, IS Support Center Supervisor and Manager of IT Service Delivery. Based on the review, a phone system redundancy was implemented.
- Policy INFOPROC10 "Releasing Records for Unannounced Surveyors- Account Requested Procedures" will be reviewed with IT Support Team and the Accreditation ad Regulatory Affairs in staff meetings held by the Directors.
- This review and accompanying documentation will be completed by July 14th, 2019.
- Testing the performance of the survey notification system will occur under the direction of the Director of Accreditation and Regulatory Affairs as part of routine readiness rounds effective July 14th, 2019. Performance feedback will be shared with the leaders as appropriate.
- All actions completed by July 14th, 2019.
- Under the direction of the Nurse Manager/designee, the Renal Nurse Supervisor/designee will be trained in surveyor readiness and system reports to be provided to surveyor.
- Training will be provided in person Nurse Manager/designee.
- All actions completed by July 14th, 2019.

The University of Vermont MEDICAL CENTER

June 24, 2019

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

Re: CMS Certification Number (CCN): 473500
Survey date: June 12, 2019

Dear Suzanne Leavitt,

Please find attached CMS-2567 form and the attached Plan of Correction in response to the Statement of Deficiencies from the survey completed by the Division on June 12, 2019.

The University of Vermont Medical Center is committed to continuously improving the quality of services we provided to our patients. As part of our ongoing performance improvement program, we would like to take this opportunity to response to the regulatory deficiencies that were cited.

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

Sincerely,

Carol Muzzy, Director
Accreditation & Regulatory Affairs
University of Vermont Medical Center
1 South Prospect Street
Burlington, VT 05401
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