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

May 29, 2018

Mr. Jayesh Shukla, Director
University Of Vt Medical Center Dialysis St Albans
7 Crest Rd Ste 78
Saint Albans, VT 05478

Dear Mr. Shukla:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 2, 2018**. 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	473502	A. BUILDING ______ B. WING ______	05/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF VT MEDICAL CENTER DIALYSIS ST ALBANS	**7 CREST RD STE 78 SAINT ALBANS, VT 05478**

(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 At the time of the University of Vermont Medical Center St. Albans End Stage Renal Dialysis (ESRD) unit recertification survey conducted on 4/30/18 - 5/2/18 by the Division of Licensing and Protection, the Emergency Preparedness survey was also conducted. As a result of the Emergency Preparedness survey the following regulatory violation was identified: .	E 000		
E 038	ESRD EP Training Program CFR(s): 494.62(d)(1) (d)(1) Training program. The dialysis facility must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. Staff training must: (iii) Demonstrate staff knowledge of emergency procedures, including informing patients of- (A) What to do; (B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated; (C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and	E 038	E038 Plan of correction accepted 5/24/18 Patrick Cummings RN, MS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Director (X6) DATE: 5/18/18

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 038	Continued From page 1 (D) How to disconnect themselves from the dialysis machine if an emergency occurs. (iv) Demonstrate that, at a minimum, its patient care staff maintains current CPR certification; and (v) Properly train its nursing staff in the use of emergency equipment and emergency drugs. (vi) Maintain documentation of the training. This STANDARD is not met as evidenced by: Based on staff interview and review of the ESRD unit staff training and Emergency Preparedness policies and procedures, there was a failure to assure staff have been provided sufficient initial training with the processes associated with emergency procedures and actions necessary during the time of a disaster or state or local emergency. Although the ESRD unit, in collaboration with the University of Vermont Medical Center, has developed an Emergency plan, the present formalized training for staff has not included all the necessary components necessary to assure staff are prepared, competent and able to comply with designated responsibilities at the time of an emergency situation. The present Emergency Management exam for 2017 is included with other yearly mandatory testing for ESRD staff, however the content is limited and focused on violence in the workplace and refers staff to safety manuals and handbooks. The present exam for staff does not address the additional training necessary to evaluate staff competence and awareness of their responsibilities if a state or local disasters occurs or significant weather event or all hazard approach which would impact the safety of both patients and employees.	E 038	SEE ATTACHED PLAN OF CORRECTION E 038 Plan of correction accepted 5/24/18 Patrice Cummings RN MS	5/31/18

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E 038	Continued From page 2 Per interview on 05/01/18 @ 8:30 AM a staff person was unable to clearly explain, for example, the emergency protocol for an intruder, but stated "I think we're going to get locks, but that hasn't happened yet". The basic safety drills [Fire] had been conducted. Per interview on the afternoon of 5/1/18, the Renal Nurse Supervisor confirmed present training/testing of staff is limited to the integrated program provided by University of Vermont Medical Center and the training/testing of ESRD staff is only preformed once per year, specifically each October. As a result, the present unified training and testing program is limited and fails to address all the necessary hazard assessment components associated with each specific community based ESRD unit.	E 038	E038 Plan of correction accepted 5/24/18 Patricia Cummings RN MO SEE ATTACHED PLAN OF CORRECTION	5/31/18
V 000	INITIAL COMMENTS An unannounced on site recertification survey was conducted by the Division of Licensing and Protection from 4/30/18 to 5/2/18 to determine compliance with 42 Code of Federal Regulations Part 405, Subpart U, Condition of Participation of End Stage Renal Disease Services. The following regulatory violations were identified:	V 000		
V 556	POC-COMPLETED/SIGNED BY IDT & PT CFR(s): 494.90(b)(1) 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	V 556	V556 Plan of correction accepted 5/24/18 Patricia Cummings RN MO	

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V 556	Continued From page 3 provided. This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to include the patient and/or patient's designee's signature on the plan of care; and/or document reasons for refusal of signing the plan of care for 4 of 4 applicable patients (Patient #1, Patient #2, Patient #4, and Patient #9). Findings include: Per review of the current Interdisciplinary (team consisting of physician, nurse, social worker, and dietitian) Plans of Care for Patients #1, #2, #4, and #9, there was no evidence that the patients and/or patient's designees had signed the plan of care to acknowledge that they had received the information in the plan of care. There was also no evidence that if the patients did not choose to sign their plan of care, that their reason for refusal was documented in the medical record. Per interview on 5/1/18 at 3:42 PM with the Site Supervisor and Nurse Manager, they each confirmed that the patient and/or the patient's designee have not been signing the plans of care. They also confirmed that there was no documentation in the medical record for Patients #1, #2, #4, and #9 that explained the reasons, if the patient chose to refuse to sign their plans of care. Per review of the policy, Initial Assessment and Plan of Care for New Dialysis Patients, date effective 3/21/17,, "All 16 parameters in the initial Plan of Care will be addressed and used to produce a Plan of Care that specifies the	V 556	SEE ATTACHED PLAN OF CORRECTION V556 Plan of correction accepted 5/24/18 Patricia Cummings RN MS	5/30/18

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V 556	Continued From page 4 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."	V 556	V556 Plan of correction accepted 5/24/18 Patrick Cummings RN MS	
V 715	MD RESP-ENSURE ALL ADHERE TO P&P CFR(s): 494.150(c)(2)(i) The medical director must- (2) Ensure that- (i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysician providers; This STANDARD is not met as evidenced by: Based upon record review and staff interview, the Medical Director failed to ensure that a policy and procedure was developed that included the Standard of Care used by nursing staff to assess, intervene, and cannulate (needle placement) a new arteriovenous fistula (dialysis access site) to prevent an infiltration of blood into the surrounding area. Per staff interview and document review, the Dialysis Nurse Manager confirmed on 5/1/18 at 9:35 AM, that nursing staff follow the Standard of Care identified by the Dialysis Unit for new arteriovenous fistulas (AVF) titled, "Fistula First:	V 715	SEE ATTACHED PLAN OF CORRECTION V715 Plan of correction accepted 5/24/18 Patrick Cummings RN MS	5/31/18

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V 726	Continued From page 6 #2 presented with both a CVC and AVF access site. At that time the nurse stated that patient's access was a 1:1. This was meant that the access for dialysis was to incorporate one of the (tubing) lines into the CVC port and one line and needle into AVF site, until the AFV site was 'mature', which could take weeks to months. Per review of the guidelines that the Dialysis Unit identified as the Standard of Practice used for this protocol, "Fistula First: New AV Fistula Management" stated that needle placement,[incremental] gauge of needle size, monitoring and other considerations were to take place. Per record review for Patient #2 on 04/30/18 in the afternoon, demonstrated missing information. The nursing progress note of 04/09/18 stated "One-17gage needle attempt today, unsuccessful and fistula was infiltrated...ice applied will rest (fistula) for 1 week as per protocol...". Two days latter, the nursing progress demonstrated that the nurse used the fistula, however, there was no clear assessment other than as noted "no issues with cannulation (needle placement)". The progress note of 04/13/18 states " first needle unsuccessful, second attempt, 1 needle - 1 cath, some old bruising noted around the fistula". There are no needle gauge sizes noted in the progress note of 04/18/18 & 04/20/18. Per interview on 05/01/18 at 9:30 AM the Dialysis Unit Supervisor confirmed documentation in the record was not clear and/or incomplete.	V 726	SEE ATTACHED PLAN OF CORRECTION V 726 plan of correction accepted 5/24/18 Patsy Cummings RN	5/31/18

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V 715	Continued From page 5 New AV Fistula Management", when providing care to a patient with a new AVF. Per document review, the Standard of Care includes treating blood infiltrations per facility policy and physician orders, and provides instructions for staff concerning an infiltration of a new AVF. Also this Standard of Care states all polices and procedures should be reviewed and approved by the Medical Director and Governing Body. Per staff interview and policy review, the Nurse Manager confirmed on 5/1/18 at 9:35 AM that the facility policy titled: "Vascular Access: Needle Placement and Removal" effective date 12/14/17 does does not include the "Fistula First: New AV Fistula Management" standard of care used by nursing staff to provided care for patients with new AV fistulas.	V 715	V715 plan of correction accepted 5/24/18 Patricia Cummings RN [illegible] SEE ATTACHED PLAN OF CORRECTION	5/31/18
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, record review and interviews, the facility failed to have an accurate and/or complete record for 1 applicable patient [Patient #2] in the sample, with a concurrent CVC (Central Venous Catheter) and AVF (Arterial Venous Fistula) dialysis access sites. Finding include: Per observation on 04/30/18 at 11:35 AM Patient	V 726	V 726 plan of correction accepted 5/24/18 Patricia Cummings RN [illegible]	

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Initial Comments
At the time of the University of Vermont Medical Center St. Albans End Stage Renal Dialysis (ESRD) unit recertification survey conducted on 4/30/18 - 5/2/18 by the Division of Licensing and Protection, the Emergency Preparedness survey was also conducted. As a result of the Emergency Preparedness survey the following regulatory violation was identified

E 038 ESRD EP Training Program, CFR(s): 494.62(d)(1)
(d)(1) Training program. The dialysis facility must do all of the following:

(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually. Staff training must:
(iii) Demonstrate staff knowledge of emergency procedures, including informing patients of-
- *(A) What to do;*
- *(B) Where to go, including instructions for occasions when the geographic area of the dialysis facility must be evacuated;*
- *(C) Whom to contact if an emergency occurs while the patient is not in the dialysis facility. This contact information must include an alternate emergency phone number for the facility for instances when the dialysis facility is unable to receive phone calls due to an emergency situation (unless the facility has the ability to forward calls to a working phone number under such emergency conditions); and*
- *(D) How to disconnect themselves from the dialysis machine if an emergency occurs.*
  - *(iv) Demonstrate that, at a minimum, its patient care staff maintains current CPR certification; and*
  - *(v) Properly train its nursing staff in the use of emergency equipment and emergency drugs.*
  - *(vi) Maintain documentation of the training.*

This STANDARD is not met as evidenced by: Based on staff interview and review of the ESRD unit staff training and Emergency Preparedness policies and procedures, there was a failure to assure staff have been provided sufficient initial training with the processes associated with emergency procedures and actions necessary during the time of a disaster or state or local emergency.

Although the ESRD unit, in collaboration with the University of Vermont Medical Center, has developed an Emergency plan, the present formalized training for staff has not included all the necessary components necessary to assure staff are prepared, competent and able to comply with designated responsibilities at the time of an emergency situation. The present Emergency Management exam for 2017 is included with other yearly mandatory testing for ESRD staff, however the content is limited and focused on violence in the workplace and refers staff to safety manuals and handbooks. The present exam for staff does not address the additional training necessary to evaluate staff competence and awareness of their responsibilities if a state or local disasters occurs or significant weather event or all hazard approach which would impact the safety of both patients and employees

Per interview on 05/01/18 @ 8:30 AM a staff person was unable to clearly explain, for example, the emergency protocol for an intruder, but stated "I think we're going to get locks, but that hasn't happened yet". The basic safety drills [Fire] had been conducted.

Per interview on the afternoon of 5/1/18, the Renal Nurse Supervisor confirmed present training/testing of staff is limited to the integrated program provided by University of Vermont Medical Center and the training/testing of ESRD staff is only preformed once per year, specifically each October. As a result, the present unified training and testing program is limited and fails to address all the necessary hazard assessment components associated with each specific community based ESRD unit

E 038
Plan of correction accepted 5/24/18
Patrice Cummings RN MS

ACTION PLAN

- The Emergency Preparedness Plan Policies and Procedures were reviewed and revised to include the required emergency planning elements as outlined in E 038 ESRD EP Training Program, CFR(s): 494.62(d)(1). The Director of Dialysis, Nurse Manager, Nurse Educator and Renal Nurse Supervisor (RNS) finalized the review and revisions on May 15, 2018.

- Documented mandatory emergency planning staff training under the Direction of the Nurse Manager will be completed through a combination of scheduled staff meetings and/or one on one training sessions by May 31, 2018. Going forward, in addition to annual education, the training will be added to new employee orientation, and be a standing agenda item on staff meetings.

- Emergency Preparedness training, as identified above, will be monitored through a combination of Renal Nurse Supervisor or RN designee monthly-unannounced staff interviews specific to staff awareness of the emergency plan. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operations Committee.

E038
Plan of correction accepted 5/24/18
[illegible] RN MS

V 000 INITIAL COMMENTS
An unannounced on site recertification survey was conducted by the Division of Licensing and Protection from 4/30/18 to 5/2/18 to determine compliance with 42 Code of Federal Regulations Part 405, Subpart U, Condition of Participation of End Stage Renal Disease Services. The following regulatory violations were identified:

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

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

This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to include the patient and/or patient's designee's signature on the plan of care; and/or document reasons for refusal of signing the plan of care for 4 of 4 applicable patients (Patient #1, Patient #2, Patient #4, and Patient #9). Findings include:

Per review of the current Interdisciplinary (team consisting of physician, nurse, social worker, and dietitian) Plans of Care for Patients #1, #2, #4, and #9, there was no evidence that the patients and/or patient's designees had signed the plan of care to acknowledge that they had received the information in the plan of care. There was also no evidence that if the patients did not choose to sign their plan of care, that their reason for refusal was documented in the medical record.

Per interview on 5/1/18 at 3:42 PM with the Site Supervisor and Nurse Manager, they each confirmed that the patient and/or the patient's designee have not been signing the plans of care. They also confirmed that there was no documentation in the medical record for Patients #1, #2, #4, and #9 that explained the reasons, if the patient chose to refuse to sign their plans of care.

Per review of the policy, Initial Assessment and Plan of Care for New Dialysis Patients, date effective 3/21/17, "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."

ACTION PLAN

- Under the direction of the Director of Dialysis and Nurse Manager, the current care plan documentation was reviewed for performance opportunities. The electronic health record was modified on May 15, 2018 to include documentation prompts for patient's care plan attendance and or reason for declination.

- Under the direction of the Nurse Manager/or designee documented mandatory staff training applicable to their role will be completed through a combination of scheduled staff meetings and/or one on one training by May 31, 2018. In addition, content will be added to the dialysis new employee orientation as appropriate to the role. The training will focus on the requirement for the patient and/or patient's designee's signature on the plan of care; and/or documented reasons for refusal of signing the plan of care.

- Ongoing surveillance for UVMMC patient declined or accepted involvement in their plan of care will be monitored through a combination of (Renal Nurse Supervisor) RNS or RN designee weekly-observed audits and Regulatory Readiness Rounds. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operations Committee.

V556 Plan of Correction accepted 5/24/18
Trudi Cummings RN MS

V 715 MD RESP ENSURE ALL ADHERE TO P & P CFR(s): 494.150(c)(2)(i)

The medical director must-

(2) Ensure that-

(i) All policies and procedures relative to patient admissions, patient care, infection control, and safety are adhered to by all individuals who treat patients in the facility, including attending physicians and nonphysical providers;

This STANDARD is not met as evidenced by: Based upon record review and staff interview, the Medical Director failed to ensure that a policy and procedure was developed that included the Standard of Care used by nursing staff to assess, intervene, and cannulate (needle placement) a new arteriovenous fistula (dialysis access site) to prevent an infiltration of blood into the surrounding area.

Per staff interview and document review, the Dialysis Nurse Manager confirmed on 5/1/18 at 9:35 AM, that nursing staff follow the Standard of Care identified by the Dialysis Unit for new arteriovenous fistulas (AVF) titled, "Fistula First New AV Fistula Management", when providing care to a patient with a new AVF. Per document review, the Standard of Care includes treating blood infiltrations per facility policy and physician orders, and provides instructions for staff concerning an infiltration of a new AVF. Also this Standard of Care states all policies and procedures should be reviewed and approved by the Medical Director and Governing Body.

Per staff interview and policy review, the Nurse Manager confirmed on 5/1/18 at 9:35 AM that the facility policy titled: "Vascular Access: Needle Placement and Removal" effective date 12/14/17 does not include the "Fistula First: New AV Fistula Management" standard of care used by nursing staff to provide care for patients with new AV fistulas.

ACTION PLAN

- Under the direction of the Director of Dialysis and the Medical Director in collaboration with, Nurse Manager of Dialysis, Dialysis Nurse Educator, and the Renal Nurse Supervisor (RNS), the RENL000047 Vascular Access: Needle Placement and Removal policy was revised and approved on May 15, 2018. A section was added titled New AVF Management that includes language addressing the Standard of Care used by RN staff to assess, intervene, and cannulate a new arteriovenous fistula for prevention and treatment of blood infiltration into the surrounding area.

- Each RN staff member is required to read, acknowledge and sign off on their understanding of the aforesaid policy to be completed by May 31, 2018. In addition, content will be incorporated into the dialysis new employee RN orientation.

- Ongoing surveillance of UVMMC AV Fistula Management will be monitored through a combination of RNS or RN designee weekly observed audits and Regulatory Readiness Rounds. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operations Committee.

V 715 plan of correction accepted 5/24/18
Patricia Cummings RN MS

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, record review and interviews, the facility failed to have an accurate and/or complete record for 1 applicable patient [Patient #2] in the sample, with a concurrent CVC (Central Venous Catheter) and AVF (Arterial Venous Fistula) dialysis access sites. Finding include:

Per observation on 04/30/18 at 11:35 AM Patient #2 presented with both a CVC and AVF access site. At that time the nurse stated that patient's access was a 1:1. This was meant that the access for dialysis was to incorporate one of the (tubing) lines into the CVC port and one line and needle into AVF site, until the AFV site was 'mature', which could take weeks to months.

Per review of the guidelines that the Dialysis Unit identified as the Standard of Practice used for this protocol, "Fistula First: New AV Fistula Management" stated that needle placement,[incremental] gauge of needle size, monitoring and other considerations were to take place.

Per record review for Patient #2 on 04/30/18 in the afternoon, demonstrated missing information. The nursing progress note of 04/09/18 stated "One-17gage needle attempt today, unsuccessful and fistula was infiltrated...ice applied will rest (fistula) for 1 week as per protocol...". Two days later, the nursing progress demonstrated that the nurse used the fistula, however, there was no clear assessment other than as noted "no issues with cannulation (needle placement)". The progress note of 04/13/18 states "first needle unsuccessful, second attempt, 1 needle - 1 cath, some old bruising noted around the fistula". There are no needle gauge sizes noted in the progress note of 04/18/18 & 04/20/18.

Per interview on 05/01/18 at 9:30 AM the Dialysis Unit Supervisor confirmed documentation in the record was not clear and/or incomplete.

ACTION PLAN

- Under the direction of the Director of Dialysis and in collaboration with the Nurse Manager of Dialysis, Manger Renal Systems Tech Services, Dialysis Nurse Educator and the RNS the electronic medical record was updated to support documentation for nurse assessment with use of Primary Access and Back Up Access on the day order effective May 10, 2018. The documentation includes the needle size.

- Each RN staff member will complete education to the use of the documentation fields in the electronic medical record to record use of primary and back-up to document the use of a fistula and catheter if used simultaneously to be completed by May 31, 2018. In addition, content will be added to the dialysis new employee orientation as appropriate to the role.

- Ongoing surveillance of UVMMC AV Fistula Management will be monitored through a combination of Dialysis Site Supervisor or RN designee weekly observed audits and Regulatory Readiness Rounds. Performance feedback will be given as required at the unit level, reported out in the monthly dialysis QAPI meeting and Renal Leadership meeting quarterly as well as reported at the aggregate level to leadership via the Standards of Operations Committee.

V 726 plan of correction accepted 5/24/18
Patricia Cummings RNMS

THE
University of Vermont
MEDICAL CENTER

Jeffords Institute for Quality
Accreditation and Regulatory Affairs Department
111 Colchester Avenue
Burlington, VT 05401

May 18, 2018

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury VT 05671-2060
http://www.dail.vermont.gov

Re: CMS Certification Number (CCN): 473502
Conditions of Participation for 42 CFR Part 405.2150
University of Vermont Medical Center Dialysis – St. Albans

Dear Suzanne Leavitt,

Please find attached CMS 2567 form and accompanying Plan of Correction in response to the Statement of Deficiencies from the survey completed by the Division of Licensing and Protection on 5/2/2018.

The University of Vermont is committed to continuously improving the quality of services we provide to our patients. As part of our ongoing performance improvement program, we would like this opportunity 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, Director
Accreditation & Regulatory Affairs
The University of Vermont Medical Center
111 Colchester Avenue
Burlington, VT 05401
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