VERMONT

AGENCY OF HUMAN SERVICES

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

September 25, 2018

Dan Bennett, Administrator
Gifford Medical Center
44 South Main Street
Randolph, VT 05060

Dear Mr. Bennett:

The Division of Licensing and Protection completed a survey at your facility on **August 22, 2018**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **September 25, 2018.**

Sincerely,

Suzanne E. Leavitt RN, MS

Suzanne Leavitt, RN, MS
State Survey Agency Director
Assistant Director, Division of Licensing & Protection

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471301	A. BUILDING _____ B. WING _____	08/22/2018

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GIFFORD MEDICAL CENTER	44 SOUTH MAIN STREET RANDOLPH, VT 05060

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C 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite recertification survey from 8/20/2018 through 8/22/2018 to determine compliance with the Conditions of Participation for Critical Access Hospitals at 42 CFR Part 485 Subpart F. Based on the information gathered at the time of the survey, the Critical Access Hospital was determined not to be in compliance with the Federal Condition of Participation for Surgical Services at 485.639. The following regulatory deficiencies were identified during the recertification survey.	C 000	See attached	
C 222	MAINTENANCE CFR(s): 485.623(b)(1) The CAH has housekeeping and preventive maintenance programs to ensure that-- all essential mechanical, electrical, and patient care equipment is maintained in safe operating condition; This STANDARD is not met as evidenced by: Based upon observation, interview and record review, the Critical Access Hospital (CAH) failed to ensure that two pharmacy refrigerators, one pharmacy freezer, and a refrigerator in the Birthing Center (BC) was appropriately labeled and maintained in safe operating condition; and a soiled utility closet containing housekeeping chemicals was secured in the Emergency Department (ED). Findings include: Per observation on 8/20/18 at approximately 12:30 PM of the BC soiled utility room, a refrigerator that was used to hold medical waste	C 222	tag C 222 accepted 9/25/18 SB	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] President and CEO 9/17/18

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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C 222	Continued From page 1 (placentas-the afterbirth from labor) did not contain a biohazard label; and the temperature of the refrigerator was not being monitored. Per interview with the BC Nurse Manager at that time, s/he stated that the Environmental Services staff monitored the refrigerator temperature. Per interview on 8/21/18 at 8:58 AM with the Vice President of Support Services, s/he confirmed that there was no biohazzard label on the refrigerator; and that no one in the facility was monitoring the refrigerator temperature. During a tour of the ED on 8/21/18 at 9:08 AM, the soiled utility room was observed to be unsecured. This room was located in the main hallway of the ED and was easily accessible to unauthorized individuals. The room contained a 1 quart bottle of Clorox bleach, 2, 10 ounce bottles of Neutra-Air aerosol, an 18.9 liter bottle of Sparkle glass cleaner, and a bucket of recyclable instruments. Per interview with the ED Nurse Manager at that time, s/he stated that the door had never been locked; and s/he was unsure if the door should be locked. Per interview on 8/22/18 at 2:30 PM with the Director of Quality Management, s/he confirmed that the door to the soiled utility room in the ED was not locked and should be. Per observation of the Pharmacy and staff interview, the VP of Ancillary Services and Pharmacy Manager confirmed on 8/20/18 at 11:30 AM that two pharmacy refrigerators and one pharmacy freezer, that contain patient chemotherapy and patient medication, have audible alarms that sound in the event of an equipment failure however are not monitored when the pharmacy is closed. These alarms are only monitored by pharmacy staff during working	C 222		

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C 222	Continued From page 2 hours from 7:30 AM - 5:30 PM Monday thru Friday and 7:30 AM - 4:00 PM Saturday and Sunday. Refrigerator and freezer alarms are not monitored by maintenance when the pharmacy is closed. The alarms would continue to sound until staff return the next day. Per ASHP (American Society of Health-System Pharmacists) Practice Setting Guideline: Copyright 2013, page 551: " Medication Storage and Preparation Areas: there shall be suitable facilities to enable the receipt, storage, and preparation of medications under proper conditions of sanitation, temperature ...to ensure medication integrity ..." Refer to C-0276.	C 222	See attached	
C 271	PATIENT CARE POLICIES CFR(s): 485.635(a)(1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based upon observation, record and policy review, and staff interview, the CAH failed to ensure health care services were furnished in accordance with appropriate written policies; the storage of Nitrogen Gas is in compliance with applicable State law; and failed to develop policies/procedures applicable to the reprocessing of cystoscopes. Findings include: 1. Per observation of the Medical Gas Storage area and confirmed with the VP of Ancillary Services on 8/20/18 at 11:37 AM, a cylinder of Nitrogen Gas was free standing in the storage room and was not secured to the wall to prevent falling or being knocked over. Per record review	C 271	tag C271 accepted BS 9/25/18	

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C 271	Continued From page 3 of the "Safety Data Sheet", Nitrogen Gas is considered hazardous by the Occupational Safety and Health (OSHA) Hazard Communication Standard (29 CFR 1910.1200). Conditions for safe storage include: Cylinders should be stored upright with valve protection cap in place and firmly secured to prevent falling or being knocked over. Per policy review and confirmed with the Quality Manager on 8/22/18 at 11:45 AM, there is no CAH policy concerning the handling and storage of medical gases. 2. During a tour of the Specialty Clinic on 8/21/18 at approximately 12:30 PM, one of the two exam rooms, which were used primarily for Urology services (study of the functions and disorders of the urinary system), contained two cystoscopes (instruments used to examine the bladder) hanging separately in solutions, in vacuum sealed compartments. Per interview with the Specialty Clinic Manager at that time, s/he stated that the clinic staff reprocesses the cystoscopes in the clinic after each cystoscopy procedure. S/he further stated that the reference used for the cystoscope reprocessing was a "Joint AUA/SUNA (American Urological Association/Society of Urologic Nurses and Associates) White Paper on Reprocessing of Flexible Cystoscopes; published in 2009, updated in 2013". S/he stated that the staff was trained to reprocess the cystoscopes in the clinic; and that the expectation was that each staff member would perform a return demonstration of the procedure prior to performing the procedure independently. Per review of the clinic policies and procedures, there was no evidence of a policy for reprocessing of cystoscopes. Per interview on 8/22/18 at 10:35 AM with the Director of Quality, Vice President of Operations, Nurse Manager and Interim Nurse	C 271		

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C 271	Continued From page 4 Manager of the Operating Room, Specialty Clinic Manager, Infection Control Nurse and VP of Support Services; they all confirmed that a policy had not been developed for the reprocessing of cystoscopes in the Speciality Clinic. 3. Per observations of the hospital's kitchen and food storage areas during the initial tour of the Nutrition and Food Service areas on 8/20/18 at 10:10 AM, the following perishable foods were not stored in accordance with the Food Services policies/procedures for safe food handling practices. The walk-in refrigerator had 2 containers of prepared muffin batter (lemon poppy and apple cinnamon flavored) that had been opened and staff failed to write the date opened for use on each container. In a reach in refrigerator near the food service line area, 4 containers identified as holding various broths (2 chicken, 1 beef and 1 vegetable) were dated 7/17/18. When questioned about the dates, the Director of Hospitality and Food Services confirmed that the broths had been pulled from the freezer for use; however they were not labeled with the date the broths were removed from the freezer, and no new expiration date was recorded on each container. The hospital policy # NFS-310, titled "Infection Prevention for Nutrition and Food Services", under "II. Food Service, C. Food Handling, 1. Refrigerate or freeze foods in appropriate containers, cover and date with expiratory dates for Potentially Hazardous foods", and under 6. " "Date foods stored in unit refrigerators." During interview at the time of the observation, the Director confirmed that dietary staff should have dated the muffin batter when opened for use and relabeled the foods pulled from the freezer with	C 271		

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C 271	Continued From page 5 the date pulled and a new expiration date.	C 271		
C 272	PATIENT CARE POLICIES CFR(s): 485.635(a)(2), (a)(4) §485.635(a)(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1). §485.635(a)(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH. This STANDARD is not met as evidenced by: Based on staff interview and record review, the CAH failed to ensure that all policies were reviewed at least annually by members of professional and clinical personnel as required. Per review of the CAH policies, multiple departments had not reviewed policies in the past twelve months in the following areas: 1. Per review of the Emergency Department polices, "Domestic Abuse and Violence" approved 5/11/17, "Child Abuse and Neglect Reporting" approved 5/11/17, and "Emergency Department Staffing Plan" approved 5/11/17, there was no indication that these policies had been reviewed on an annual basis. Per interview on 8/22/18 at 3:00 PM with a Quality Management Specialist, s/he confirmed that these policies had not been updated annually and should have been. 2. Per review of the Birthing Center policies,	C 272	See attached tag C 272 accepted 12/20/18 LS	

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C 272	Continued From page 6 "Assignment for Patient Care-Birthing Center" approved 10/20/15, "Guidelines for Consultation, and Notification of Pediatricians" approved 8/12/16, and "Adoption" approved 10/21/15, there was no indication that these policies had been reviewed on an annual basis. Per interview on 8/22/18 at 3:00 PM with a Quality Management Specialist, s/he confirmed that these policies had not been updated annually and should have been. 3. Per policy review and staff interview, the Lab Manager confirmed on 9/21/18 at 9:12 AM, the Lab Policy titled "Communication and Documentation of Critical Laboratory Values, LAB - 202", with effective date of 3/13/13 was last approved on 8/5/16. In addition, the Lab Manager acknowledged this policy was on a 3 year cycle for review as opposed to a 1 year review per organizational policy. 4. Per review of policy "Cleaning and Disinfecting" with effective date of 01/13/2016 has not been reviewed since the effective date. Per interview on 8/22/18 at 10:05 AM the Director of Quality Management confirmed although it is the CAH policy to review all organizational policies on a one year cycle, s/he is aware not every policy has been reviewed as per policy and as required. In addition, the Director acknowledged Administrative policies are presently on a 3 year cycle for review as opposed to the 1 year review. 5. The CAH policy, "Advanced Directives and Vermont Advanced Directives Registry" with an effective date of 10/18/2011, was last approved on July 7, 2016. The Director of Quality confirmed this policy had not been reviewed in the last 12 months at 9:00 AM on 8/22/2018.	C 272		

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C 272	Continued From page 7 6. Per review on 8/12/18, the pharmacy policy entitled " Drug Dispensing and Procurement in Event of all other Emergencies not including Evacuation" was last reviewed/revised on 8/12/16. During interview on the afternoon of 8/12/18, the Director of Quality confirmed that the policy had not been reviewed annually as required for CAH Conditions for Participation.	C 272	See attached	
C 276	PATIENT CARE POLICIES CFR(s): 485.635(a)(3)(iv) [The policies include the following:] Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use. This STANDARD is not met as evidenced by: Based upon observation, interview and record review, the CAH failed to ensure the safe storage and disposal of unusable drugs in two refrigerators and one freezer located in the pharmacy that contain patient chemotherapy and patient medication. Finding includes: Per observation of the Pharmacy and staff interview, the VP of Ancillary Services and Pharmacy Manager confirmed on 8/20/18 at 11:30.AM that two pharmacy refrigerators and one pharmacy freezer, that contain patient chemotherapy and patient medication, have audible alarms that sound in the event of an	C 276	tag C 276 accepted 9/25/18 SB	

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C 276	Continued From page 8 equipment failure and are not monitored when the pharmacy is closed. These alarms are only monitored by pharmacy staff during working hours from 7:30 AM - 5:30 PM Monday thru Friday and 7:30 AM - 4:00 PM Saturday and Sunday. Refrigerator and freezer alarms are not monitored by maintenance when the pharmacy is closed. The alarms would continue to sound until staff return the next day. Per ASHP (American Society of Health-System Pharmacists) Practice Setting Guideline: Copyright 2013, page 551: Medication Storage and Preparation Areas: "there shall be suitable facilities to enable the receipt, storage, and preparation of medications under proper conditions of sanitation, temperature, ...to ensure medication integrity ..." Per staff interview on 8/20/18 at 3:40 PM, the Pharmacy Manager confirmed that the pharmacy policy titled "Storage of Medication PH-136" effective date 11/13/2017 does not address what actions staff should take in the event of an equipment failure of the two pharmacy refrigerators and pharmacy freezer which store patient chemotherapy and patient medications that require specific refrigeration/freezer temperatures for maintaining stability. In addition, the policy does not address what actions staff should take if the patient chemotherapy or patient medications were determined to be unusable for patient administration following an equipment failure and replacements were not immediately available if needed. Also refer to C- 0222.	C 276	See attached	
C 280	PATIENT CARE POLICIES CFR(s): 485.635(b)(1)(i)	C 280	tag C280 accepted 9/25/18 KS	

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C 280	Continued From page 9 (1) General (i) The CAH provides those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These CAH services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the CAH failed to maintain evidence of staff training and competency for reprocessing of cystoscopes for the Urology service of the Specialty Clinic. Findings include: During a tour of the Specialty Clinic on 8/21/18 at approximately 12:30 PM, one of the two exam rooms, which were used primarily for Urology services, had two cystoscopes hanging separately in solutions, in vacuum sealed compartments. Per interview with the Clinic Manager at that time, s/he stated that the clinic staff reprocesses the cystoscopes in the clinic after each cystoscopy procedure. S/he stated that the reference used for the cystoscope reprocessing was a "Joint AUA/SUNA (American Urological Association/Society of Urologic Nurses and Associates) White Paper on Reprocessing of Flexible Cystoscopes; published in 2009, updated in 2013". S/he stated that the staff was trained to reprocess the cystoscopes in the clinic; and that the expectation was that each staff member would perform a return demonstration of the procedure prior to performing the procedure independently. Per review on 8/22/18 at	C 280		

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C 280	Continued From page 10 approximately 9:00 AM of the Specialty Clinic Manager's personnel file, there was no evidence of training and/or documented competency for cystoscope reprocessing. Per interview on 8/22/18 at approximately 11:00 AM with the Director of Quality and Vice President of Operations, they each confirmed that there was no evidence of training and/or documented competency for the Specialty Clinic Manager and the other staff who reprocess cystoscopes for the Urology service of the Specialty Clinic.	C 280	See attached	
C 320	SURGICAL SERVICES CFR(s): 485.639 If a CAH provides surgical services, surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body, or responsible individual, of the CAH in accordance with the designation requirements under paragraph (a) of this section. This CONDITION is not met as evidenced by: Based on observation and interview the Condition of Participation for Surgical Services was not met as evidenced by the failure of the CAH to ensure a designated space was delineated in the Decontamination room for individuals who enter this restricted area without proper protective attire; failure to ensure proper storage of endoscopes; failure to ensure ventilation hoods in Central Sterile remained free of dust/debris; and staff failure to recognize outdated test strips were being used during reprocessing of endoscopes. Findings include: During a tour on 8/20/18 at 11:30 AM and from 1:00 - 3:00 PM of the perioperative locations with	C 320	for C 320 accepted 9/20/18 BS	

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C 320	Continued From page 11 the interim nurse manager for Surgical Services the following observations were made: 1. An outdated and opened test strip container was observed sitting on top of the Steris/Reliance endoscope processing machine. The "Verify - Process Indicator for Reliance EPS Endoscope Processing System" test strips had an expiration date of 1/4/18. The test strips are to be used by staff when reprocessing endoscopes (an instrument that can be introduced into the body to give a view of its internal parts/digestive system which physicians use to diagnose and treat). The test strips validate that an effective dose of Paracetic Acid (a high level disinfectant) was utilized when reprocessing endoscopes, ensuring disinfection was effective prior to reuse and eliminating possibility of microbial contamination within the endoscope. The interim nurse manager confirmed staff failed to follow endoscope cleaning process by using outdated test strips. 2. Within Central Sterile Processing (where surgical instruments are prepared, packed and sterilized for patient use) dust was observed on 2 exhaust hoods located above the 2 autoclaves (large pressure chambers used for sterilization of surgical instruments). A third exhaust hood located above the instrument washer also had dust adhering to the hood. Each of the three hoods are connected to individual duct systems. Dust was also noted to be adhering to the round duct ventilation system extending approximately 3-4 feet above the room ceiling. On 8/22/18 at 8:20 AM the Facility Manager confirmed housekeeping would be responsible for the daily cleaning of the hoods and Facility/Maintenance staff would be responsible for the cleaning of the duct system, however s/he was unsure when the	C 320		

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C 320	Continued From page 12 ducts were last cleaned and what the time frame would be for periodic scheduling to ensure Central Sterile Processing remained free of dust exposure. 3. Within the Decontamination room (a receiving area for cleaning soiled, contaminated instruments/equipment) and where blood borne pathogen precautions must be maintained there was a failure to provide a line of demarcation to alert staff who enter without required PPE (Personal Protective Equipment) not to travel beyond a certain point within the semi-restricted area. Central Sterile Processing staff confirmed on the morning of 8/20/18 staff occasionally will enter the Decontamination room to drop off soiled instruments from physician offices/clinics without donning protective covering as required. Per 2016 AORN (Association of periOperative Registered Nurses): Patient and Workers Safety Environment of Care Part 2, page 267 states: "The designated areas should be separated by signage indicating the attire required for entering the area and who may access... the doors separating the restricted area from the semi-restricted area;" and "Doors, signage or a line of demarcation to identify the separation between the unrestricted and semi-restricted areas. Signs provide a visual cue that alerts persons to the restrictions required for entry into each area." 4. On 3 separate occasions between 8/20/18 -8/22/18 and confirmed with the interim nurse manager for Surgical Services, the door to the endoscope storage cabinet was observed to be left opened. The cabinet is located within the reprocessing room and after endoscopes are	C 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	471301	A. BUILDING _____ B. WING _____	08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIFFORD MEDICAL CENTER	44 SOUTH MAIN STREET RANDOLPH, VT 05060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 320	Continued From page 13 reprocessed they are placed in the scope cabinet. Keeping the rolltop cabinet door closed promotes drying, protects the endoscopes from damage and prevents recontamination. However, repeatedly the door was left open which lessened the benefits of the air drying system within the cabinet and limited the protection of the endoscopes when the door remained open for extended periods. Per Disinfection, Sterilization and Antisepsis Principles, Practices, Current Issues, and New Research edited by William A. Rutala, PhD., MPH states: "5. Store the endoscopes in a way that prevents recontamination and promotes drying". 5. When requested evidence of competency of staff identified responsible for the cleaning of endoscopes, the only evidence of competency was provided for 1 individual who works both in the operating room and endoscopy. A second individual, classified as a contracted traveler, was identified on the morning of 8/22/18 by the interim nurse manager for surgical services as a second person responsible for endoscope reprocessing. However, there was no evidence of this individuals competency in accordance with CAH policies and procedures for the cleaning of endoscopes, although s/he has been performing this process for several months since accepting assignment at the CAH. Per CDC (Centers for Disease Control) and HICPAC (Healthcare Infection Control Practice Advisory Committee) stated in January 25, 2017 within the published Essential Elements of a Reprocessing Program for Flexible Endoscopes - Recommendations of the Healthcare Infection Control Advisory Committee: " Management should ensure that: F. All personnel involved in the reprocessing of endoscopes, including supervisors and managers	C 320		

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	471301	A. BUILDING _____ B. WING _____	08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIFFORD MEDICAL CENTER	44 SOUTH MAIN STREET RANDOLPH, VT 05060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 320	Continued From page 14 of reprocessing, receive ongoing education, training and assessment of competency...".	C 320		
E 000	Initial Comments The Division of Licensing and Protection conducted an Emergency Preparedness survey during the Critical Access Hospital recertification survey from 8/20/2018 through 8/22/2018. The Critical Access Hospital was found to be in Substantial Compliance with the required regulations related to Emergency Preparedness.	E 000		

Gifford Medical Center

Provider ID: 471301
Plan of correction for deficiencies noted August 20-22, 2018
Date: September 21, 2018 (amended from September 18, 2018 submission)

Tag ID	Program Criteria	Deficiency	Resolution & Monitoring	Status
C-222	Maintenance	Failure to ensure system notification for 2 refrigerators & 1 freezer in Pharmacy	Refrigerators and freezer will be wired to the MEGA3 NFPA Medical Gas Notification System in patient registration and on clinical units where an audible alert of system failure will occur.	Anticipated completion – 9/30 Assigned to: VP Support Svcs
		Label and temperature log for a refrigerator in Birthing Center	The refrigerator has been removed from service as of 9/17.	Complete – 9/17 Assigned to: BC Nurse Mgr
		ED soiled utility room was not locked	New lockset installed; room secure	Complete – 8/22 Monitoring: ED Nurse Mgr will ensure door remains locked.
C-271	Patient care policies	No policy for safe storage of medical gases Tank in medical gas storage unsecured	Policy created Unsecured tank was immediately secured during inspection. Check of tanks weekly x 8 weeks	Complete – 8/22 Tank secured 8/20 Monitoring: Weekly check by QM through Oct 19th 100% of tanks will be securely stored
		No policy for cleaning of cystoscopes	Discussed draft policy with surveyors during inspection. Policy now in place	Complete – 8/27 Assigned to: VP Operations
		Failed to follow policy on dating of food	Staff re-educated to policy and signage placed as reminder Random bi-weekly audit of dating x 2 months	Complete – 8/22 Assigned to: Dir. Hospitality Monitoring: Dir. Hospitality bi-weekly check through Oct 26th 100% of food will be

				dated appropriately
C-272	Patient care policies	The following policies had not been reviewed in the past 12 months: NUR-667 Domestic Abuse and Violence	Policy reviewed and confirmed 1-year review cycle	QM check of policy review cycle - complete 9/17. Weekly through October, QM will monitor "policies with expired processes" report and provide feedback to department managers. Anticipated completion – 9/30 by ED Nurse Mgr
		NUR-665 Child Abuse and Neglect Reporting	Policy reviewed and confirmed 1-year review cycle	Anticipated completion – 9/30 by ED Nurse Mgr
		NUR-679 Emergency Department Staffing Plan	Policy reviewed and confirmed 1-year review cycle	Anticipated completion – 9/30 by ED Nurse Mgr
		NUR-303 Assignment for Patient Care-Birthing Center	Policy reviewed and confirmed 1-year review cycle	Anticipated completion – 9/30 by BC Nurse Mgr
		NUR-355 Guidelines for Consultation and Notification of Pediatricians	Policy reviewed and confirmed 1-year review cycle	Anticipated completion – 9/30 by BC Nurse Mgr
		NUR-301 Adoption	Policy reviewed and confirmed 1-year review cycle	Anticipated completion – 9/30 by BC Nurse Mgr
		LAB-202 Communication and Documentation of Critical Laboratory Values	Policy reviewed and confirmed 1-year review cycle	Complete – 9/6 Assigned to: Lab Mgr
		ENV-101 Cleaning and Disinfecting	Policy reviewed and confirmed 1-year review cycle	Complete – 9/17 Assigned to: ES Mgr
		CM-101 Advanced Directives & VT Advance Directive Registry	Policy reviewed and confirmed 1-year review cycle	Complete - 8/22 Assigned to: Dir Pt Financial Svcs
		PH-113 Drug Dispensing & Procurement in Event of all other Emergencies not including Evacuation	Policy review cycle confirmed to be 1-year. Policy revision in progress following completion of connecting the refrigerators and freezer to	Review completed 9/7 however further revision needed by Pharmacy Mgr pending connection to medical gas notification system

			the MEGA3 NFPA Medical Gas Notification System see also response C-222	Anticipated completion – 9/30 Assigned to: VP Support Svcs
C-276	Patient Care policies	PH-113 Drug Dispensing & Procurement in Event of all other Emergencies not including Evacuation did not adequately address actions following an equipment failure event.	Policy revision in progress following completion of connecting the refrigerators and freezer to the MEGA3 NFPA Medical Gas Notification System see also response C-222 and C-272 above	Anticipated completion – 9/30 by Pharmacy Mgr
C-280	Patient care policies	Staff training and competency for reprocessing of cystoscopes	Documentation for competency developed and completed for staff who process cystoscopes	Training & Competency complete – 9/18 by OR Nurse Mgr All appropriate staff with documented competency by 9/30 Assigned to: Specialty Clinic Mgr
C-320	Surgical Services	Failure to ensure proper storage of endoscopes	Staff educated on the requirement to close the endoscope storage cabinet. Daily check by manager x 2 months	Education complete – 9/5 by OR Nurse Mgr Monitoring through Oct 26th 100% compliance on closing the storage cabinet Assigned to: OR Nurse Mgr
		Staff training and competency for reprocessing of endoscopes	Documentation for competency developed and completed for staff who process endoscopes	Training & Competency complete - 9/18 by OR Nurse Mgr. All appropriate staff with documented competency by 9/30 Assigned to: OR Nurse Mgr
		An outdated supply was found in the endoscopy suite	Staff are assigned a weekly check for outdated supplies	Anticipated Completion – 9/30 by OR Nurse Mgr
		Dust found in and around 3 exhaust hoods and connecting ducts in	Cleaning of exhaust hoods and ducts has been added to the weekly cleaning	Completed – 8/27 by ES Mgr/OR Mgr/VP Support Svs

		Central Sterile	schedule of Env. Svs. Daily check of hoods x 2 months to ensure weekly cleaning is adequate. Monitoring will be quarterly per EOC rounding schedule thereafter.	Daily monitoring through Oct 26th to ensure area is dust free by OR Nurse Mgr. Quarterly monitoring after November 1 by EOC rounds team.
		Failure to provide an adequate demarcation line/signage alerting staff of the requirement to wear PPE in the decontamination room	Closed stainless steel cart ordered to be the designated place for drop off of instruments from clinics "Authorized personnel only – PPE required" sign placed at entry of the decontamination room in central sterile	Anticipated completion – 9/30 by OR Nurse Mgr Complete - 9/21 by OR Nurse Mgr

Director of Quality Management will provide oversight and monitor completion of this corrective action plan through weekly check-in with each responsible party above and monitor progress on policy review.

POC accepted
SB 9/25/18

VERMONT

AGENCY OF HUMAN SERVICES

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

September 5, 2018

Mr. Joseph Woodin, Administrator
Gifford Memorial Hospital--Swing Bed Unit
44 South Main Street
Randolph, VT 05060

Dear Mr. Woodin:

The Division of Licensing and Protection completed a survey at your facility on **August 22, 2018**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485, Subpart F including the special requirements for swing bed providers. This survey found that your facility was in substantial compliance with the participation requirements.

Please **sign the enclosed CMS-2567 and return** to this office by **September 15, 2018**.

Sincerely,

Suzanne Leavitt, RN, MS
State Survey Agency Director
Assistant Director, Division of Licensing & Protection

Enc.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	47Z301	A. BUILDING _____ B. WING _____	08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIFFORD MEMORIAL HOSPITAL--SWING BED UNIT	44 SOUTH MAIN STREET RANDOLPH, VT 05060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS An unannounced on-site survey was conducted by the Division of Licensing and Protection of the Gifford Medical Center Critical Access Hospital Swing Bed Unit on 8/20/18 - 8/21/18. The Swing Bed Unit was found to be in Substantial Compliance under 42 CFR 412.20 Sub Part B Appendix T.	C 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.