

Division of Licensing and Protection

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Waterbury VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

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Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

March 27, 2017


Claudio Fort, Administrator
North Country Hospital And Health Center
189 Prouty Drive
Newport, VT 05855

Dear Mr. Fort:

The Division of Licensing and Protection completed a survey at your facility on **February 15, 2017**. 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 **March 27, 2017**.

Sincerely,



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

Enclosure



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

PRINTED: 03/24/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 471304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/15/2017
NAME OF PROVIDER OR SUPPLIER NORTH COUNTRY HOSPITAL AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 189 PROUTY DRIVE NEWPORT, VT 05855		
(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 CRDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
C 000	INITIAL COMMENTS	C 000			
C 297	<p>An unannounced complaint survey was conducted on 2/14/17 - 2/15/17 by the Division of Licensing and Protection to determine compliance with Conditions of Participation for Critical Access Hospitals at 42 CFR, Part 485, Subpart F. the following regulatory violations were identified as a result of the complaint.</p> <p>485.635(d)(3) NURSING SERVICES</p> <p>All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review nursing staff failed to administer a narcotic medication in accordance with physician orders, accepted standards of practice and in accordance with CAH policies and procedures for 1 of 4 applicable patients. (Patient #1) Findings include:</p> <p>Patient #1, was admitted to the CAH in 2016. During this continued hospitalization, Patient's #1's health deteriorated. Per the patient's consent and family approval, Patient #1 was placed on Palliative Care. During the provision of end of life care, Patient #1's physician had prescribed pain medication to include: Morphine 5 mg/0.5 ML SC (subcutaneous injection) every 20 minutes for pain and respiratory distress. The Pharmacy provides Morphine in 10 mg (1 ML) predrawn syringes which are stocked and stored</p>	C 297	<p><i>POC C-297-342 acute</i> <i>3.27.17 fin-j</i></p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Director Quality / PT-Safety / RISK

03/22/2017

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 297	<p>Continued From page 1 in an Omnicell (automated dispensing system) on the Medical/Surgical unit.</p> <p>Per CAH Pharmacy Department policy titled: Controlled Substances, effective date June 4, 2015, states "Part V - Administration Waste and Disposal: Any controlled substance packaged in a dose larger than the dose being administered must be wasted immediately before or after administration. Wastage is witnessed and documentation by two individuals, one of which must be licensed. Signature of each individual involved with the wastage of a controlled substance medication is documented electronically....". Per review of the Medication Administration Record (MAR) on 12/14/16 at 1:00 AM Nurse #1 administered 5 mg (.5 ML) of Morphine SC to Patient #1. The nurse followed the required process for waste and disposal of the additional 5 mg prior to administering the prescribed dose of 5 mg. Approximately 2.5 hours later, Patient #1's family reported to Nurse #1 that Patient #1 appeared in pain. After a brief assessment of Patient #1, Nurse #1 obtained another 10 mg syringe of Morphine from the Omni cell, but failed to complete the waste and disposal process by discarding .5 ML (5 mg of Morphine) from the syringe that would be witnessed by another nurse, prior to entering the patient's room. Instead, the nurse went directly to Patient #1's room and administered the full syringe of Morphine 10 mg which was not the prescribed dose.</p> <p>Per interview on 2/15/16 at 8:20 AM Nurse #1 confirmed s/he was aware of the CAH policy and procedure for waste and disposal of controlled substances but stated it was his/her intent during</p>	C 297	<p>Policy has been revised to clarify expectations for the "wasting" of medications when needed. Policy previously stated that controlled substances must be wasted "immediately before or after medication administration". Policy now states that controlled substances must be wasted "immediately before administration, the only exception will be in specialized settings when a physician/prescriber is present."</p>	3/20	

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C 297	Continued From page 2 the administration of the SC Morphine, to only inject 5 mg/.5 ML and was going to stop when the syringe was half empty. Per CAH policy Medication Administration effective 5/1/2015 states: "Before administering a medication, the authorized individual administering the medication completes the following: Verifies that the medication is administered in the correct dose and that the route is appropriate for the medication and patient". The policy also states: "Discard unusable medications per hospital policy". The process of discard should have occurred prior to entering the patient's room, not during the administration of a SC injection. Per review of the Omnicell Transactions by Patient report noted the Morphine 10 mg/1 ML had been removed by Nurse #1 on 12/14/16 at 3:29 AM with no documentation of wasting the medication. Per interview on 4:45 PM on 2/14/17 the Pharmacy Clinical Analysis confirmed s/he had identified the irregularity and reported directly to the Pharmacy manager. Per interview at 9:00 AM on 2/15/17 the Director of Pharmacy also confirmed ".....this was a breach in protocol". Per interview on 2/14/17 at 3:30 PM, the CNO (Chief Nursing Officer) stated s/he had not been informed of the breach in protocol and/or the reported medication administration error. In addition, Nurse #1 stated s/he had not received counseling or involved in a discussion regarding opportunities for improving his/her S.C. medication administration process especially when involving the waste/disposal of a controlled substance (Morphine).	C 297	Medication Safety meeting was held on 3/14 with Nursing Leadership. Pharmacy 3/20 Director reviewed the Controlled Substance policy with changes on how medications are wasted. This policy was updated on 3/10, added to policy manager on 3/20. Policy changes have been assigned to employees to review through the iAttest feature on Policy Manager 3/20 with a due date of 4/21. On 4/10 PI Coach/ Project Leader will send an update to nursing directors on who has completed the attestation. Omnicell safety reports will continue to be monitored on a weekly basis as in the past, or on demand if needed more frequently, for timing of medication wasting. Safety reports are reviewed by Pharmacy tech Clinical Informaticist and any concerns are forwarded to Quality and Nursing leadership for review and investigation.	3/20	4/21
C 342	485.641(b)(5)(ii) QUALITY ASSURANCE [The program requires that--]	C 342	Nurse had discussion with nursing supervisor at the time of the error and was fully aware that she had failed to follow protocol and had self-reported the error. When similar errors occur in the future, a follow up discussion with involved parties focused on quality improvement will take place and be documented within the event reporting system.	3/10	3/10

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C 342	<p>Continued From page 3</p> <p>the CAH also takes appropriate remedial action to address deficiencies found through the quality assurance program.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the CAH failed to take appropriate action to address an identified deficient practice after receiving a report of a medication error and breach in policy and medication administration protocol. The QA/PI (Quality Assurance/Performance Improvement) program failed to clearly determine the proper remedial action and interventions to ensure the error and nursing practice were analyzed and corrective action initiated to ensure patient safety. Findings include:</p> <p>Per CAH Pharmacy Department policy titled: Controlled Substances, effective date June 4, 2015, states "Part V - Administration Waste and Disposal: Any controlled substance packaged in a dose larger than the dose being administered must be wasted immediately before or after administration. Wastage is witnessed and documentation by two individuals, one of which must be licensed. Signature of each individual involved with the wastage of a controlled substance medication is documented electronically....". Per review of the Medication Administration Record (MAR) on 12/14/16 at 1:00 AM Nurse #1 administered 5 mg (.5 ML) of Morphine SC to Patient #1. The nurse followed the required process for waste and disposal of the additional 5 mgs of Morphine prior to administering the prescribed dose of 5 mg.</p>	C 342	<p>The SQSS event reporting system has features for event follow up, QI, and RCA which have not been utilized. Those features have been implemented and will be utilized in the future when significant events or breaches of protocol occur. Events are monitored by the Quality Director.</p> <p>Significant events are reported monthly to Quality Improvement Committee by Quality Director for discussion and further analysis/action if indicated.</p>	3/21	

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C 342	<p>Continued From page 4</p> <p>Approximately 2.5 hours later, Patient #1's family reported to Nurse #1 that Patient #1 appeared in pain. After a brief assessment of Patient #1, Nurse #1 obtained another 10 mg syringe of Morphine from the Omnicell, but failed to complete the waste and disposal process by discarding .5 ML from the syringe that would be witnessed by another nurse, prior to entering the patient's room. Instead, the nurse went directly to Patient #1's room and administered the full syringe of Morphine 10 mg which was not the prescribed dose.</p> <p>After Nurse #1 reported the medication error and breach of procedure on 12/14/16, the Occurrence Report was reviewed by the Director of QA/PI and Patient Safety who had also been alerted by the Pharmacy Clinical Analyst of the of the noted event via the Omnicell report. On 12/14/16 at 10:12 AM the Director of QA/PI and Patient Safety reviewed the Occurrence Report with 2 members of nursing services. The error was categorized as an error that reached the patient and monitoring was required to confirm there was no harm to the patient and/or required intervention to preclude harm. From the meeting it was determined Patient #1 did not experience significant harm. It was also noted Morphine was provided in 2 mg, 4 mg and 10 mg dose/syringes and a discussion would be planned with the hospitalist to review Morphine dose orders. The Director for QA/PI and Patient Safety confirmed on 2/14/17 at 4:45 PM s/he failed to discuss the error with the Pharmacist to investigate if there were options in supplying Morphine in alternative predrawn syringes that would not require a nurse to waste half of the dose or administer a full dose in error.</p>	C 342	<p>Medication errors are reviewed monthly at nursing leadership meeting with Pharmacy and Quality. Effective April 2017, that discussion will focus on in depth review of identified high risk medications, as well as review of reversal agent usage.</p>	4/2017	

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C 342	Continued From page 5 Per interview on 2/15/17 at 9:00 AM, the Director of Pharmacy confirmed Nurse #1 had breached protocol regarding the wasting of .5 cc of Morphine. The Pharmacist further confirmed as of 2/14/17, since the occurrence was brought to his/her attention by the surveyors, the Omnicell will now be stocked with Morphine 5 mg. predrawn syringes. This availability will help eliminate the wasting of medication and will further assure patient safety is being maintained.	C 342	10 mg syringes of morphine have been removed from the Omnicells. Pharmacy Director has discussed with Hospitalist and Anesthesia physicians who are in agreement that dosages of 2 mg, 4 mg, and 5 mg will meet their prescribing needs and minimize wasting and enhance patient safety.	3/14	