

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING 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

November 21, 2018

Fred Kniffin, Administrator Porter Hospital, Inc 115 Porter Drive Middlebury, VT 05753-8423

Dear Mr. Kniffin:

The Division of Licensing and Protection completed a survey at your facility on **October 31, 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 November 19, 2018.

Sincerely,

Suzanne Leavitt, RN, MS

State Survey Agency Director

Segune E. Louth Ru, ms

Assistant Director, Division of Licensing & Protection

Enclosure

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/08/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** A BUILDING COMPLETED 471307 B. WING 10/31/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 115 PORTER DRIVE PORTER HOSPITAL, INC MIDDLEBURY, VT 05753 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX IEACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) 12.18.18 coop See attached C 000 INITIAL COMMENTS Plan of correction An unannounced on-site complaint survey was completed on 10/30/18 & 10/31/18 by the Vermont Division of Licensing and Protection. The investigation of 1 complaint, # 17083. concluded that there were regulatory violations for the issues investigated related to the Medicare Conditions of Participation for CAH found at 42 CFR Part 485, Subpart F. Based on information gathered it was determined the facility was not to be in compliance with the Federal Condition of Participation for Critical Access Hospitals: Provision of Services. Refer to Tags: C - 0271 & C - 0283 0270 See attached Plan of C 270 PROVISION OF SERVICES 12.18.18 CFR(s): 485.635 correction Provision of Services This CONDITION is not met as evidenced by: Based on information gathered at the time of survey, the Critical Access Hospital (CAH) was determined not to be in compliance with the Condition of Participation: Provision of Services.

C - 0271 The CAH failed to assure that care and services were provided in accordance with currently established written policies and procedures regarding the provision of care provided by the Radiology Department.

The following regulatory violations included:

C - 0283 The CAH failed to ensure Radiology services were provided in accordance with acceptable standards of practice during the provision of diagnostic imagery.

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

C 271 PATIENT CARE POLICIES

C271 See attached plan of 12:18:18

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

(X5) DATE

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 11/08/2018 FORM APPROVED OMB NO. 0938-0391

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accordance with ap are consistent with a This STANDARD is Based on observat review the CAH faile services were provided by the Radiapplicable patients.  Per review of Depar Patient Assessment 6/20/2018) "Policy: Fwith the interdiscipling physician, Nursing a provide the most relet the optimum radiology Procedure: Assessm Radiology Department following manner whis required for all radiaperformed in the radial Despite the CAH's puradiological technological techn	are services are furnished in propriate written policies that applicable State law. In a source of the propriate written policies that applicable State law. In a source of the source of the end of the provision of care diology Department for 1 of 10 (Patient #1) Findings include: It the provision of care diology Department for 1 of 10 (Patient #1) Findings include: It the provision of the source of the end of the e						

patient had sustained a fall from his/her bed, the

radiology technologist failed to follow the

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICE

PRINTED: 11/08/2018 FORM APPROVED

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	4:20 PM the radiolo Patient #1 arrived in the patient complain arm pain. Further di radiology technolog x-rays, it was decid provider's order to plustead, x-rays of performed. It was functional for a racollaborate with ED Assistants regarding when it appears applied to change or disregatesting without prior policy. The radiology an assessment of the consult with the order PATIENT SERVICE: CFR(s): 485.635(b)(). Radiology services. By the CAH are provunder State law, and or personnel to radia This STANDARD is Based on observaties.	er interview on 10/31/18 at gy technologist stated when in the Radiology Department ned of left arm pain, not right secusion with another ist who was assisting with the ed to disregard the ED perform right humerus x-rays. Patient #1's left humerus were urther confirmed, although it is diology technologist to physicians and/or Physician gadding an additional x-ray propriate, it is not acceptable and orders for any radiology authorization, as per CAH y technologist confirmed after the patient, s/he failed to be provider.  Shadiology services furnished ided by personnel qualified id on not expose CAH patients atton hazards.  The Radiology serviced by the patients are patient, interview and record		3 See attached of correction	Dan	19-18-18
	services were provid acceptable standard provision of diagnost patient. (Patient #1) Per review of ED doo brought to the ED on out of bed at a Long	ed to ensure Radiology ed in accordance with s of practice during the ic imagery for 1 applicable Findings include:  cumentation, Patient #1 was 9/30/18 at 09:30 after rolling Term Care (LTC) facility ides. The examination by				e e

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

PRINTED: 11/08/2018 FORM APPROVED OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  471307		(X2) MULT A. BUILDIN B. WING _	PLE CONSTRUCTION  IG	(X3) DATE SU COMPLE C 10/31/2	TED	
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#### C 283 Continued From page 3

the ED provider, a Physician Assistant (PA), noted Patient #1 was experiencing moderate pain, with a decreased range of motion and bruising of the right arm. An x-ray of Patient #1's right humerus (long bone in upper arm) was ordered by the ED provider. Patient #1 was brought to the Radiology Department and at 12:50 2 views were taken not of the patient's right humerus, but x-rays were taken of the left humerus. Subsequently, the ED provider viewed the x-rays, did not identify the discrepancy in what was ordered, visualized the x-rays as if they were of the patient's right humerus. The ED provider determined the x-rays demonstrated a deformity of Patient #1's humerus, however was diagnosing from views of the left humerus, not the right humerus. As a result, Patient #1's right arm was placed in a sling and the patient was returned to the LTC facility. In addition, it was further noted on 9/30/18 at 13:18 the ED physician also visualized the x-ray, failed to note it was the wrong extremity and agreed with the PA's interpretation that Patient #1 had a"...proximal humerus fracture". Both were unaware what they were visualizing was an old fracture and the wrong extremity.

On 10/2/18, after experiencing increased pain in the right arm with shortness of breath upon inspiration with associated chest pain, the LTC facility again sent Patient #1 to the ED for further evaluation and to rule out potential cardiac symptoms. Examination noted Patient #1's specific symptoms involved the anterior chest wall and anterior aspect of the right upper chest. What had been identified was Patient #1's x-rays taken on 9/30/18 were not of the patient's right humerus, as ordered, but of the left humerus. And it was further identified by the Radiologist,

c 283 See attached Plan of 12-18-18 Correction

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/08/2018 FORM APPROVED OMB NO. 0938-0391

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C 283	the left humerus, whad also visualized assumed the x-ray humerus as previous. As a result, further ribs and chest were Cardiac and pulmo however x-rays der fractures of the right lateral right clavicle was provided, and utilize the right sling.	ence of a previous fracture of hich is what the ED provider on 9/30/18, however it was was actually of the right	C	283 See attached Correction	Plan	of	13.18.18
	Director of Radiolowrong x-rays were technologist on 9/3 the ED Provider has #1's right humerus, failed to follow the on 10/31/18 at 4:20 stated when Patien Department s/he coarm not the right arwith another radiologisting, a decision ED provider's order x-rays and instead Patient #1's left hur confirmed, although radiology technologisticans and/or Face in the provider in the pro	d/30/18 at 2:15 PM, the gy - Imaging confirmed the taken by a radiology 0/18. Reconfirming although d ordered 2 views of Patient the radiology technologist provider's orders. Per interview PM the radiology technologist that arrived in the Radiology emplained of pain in his/her left m. After further discussion by technologist who was now as made to disregard the roperform right humerus exercity images were taken of merus. It was further to it is not unusual for a pist to collaborate with ED PAs regarding adding an age when it appears					

appropriate, it is not acceptable to change or disregard orders for any radiology testing without

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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C 302	prior authorization. RECORDS SYSTE CFR(s): 485.638(a	EMS	C	302	see attached p		13-18-18
	The records are leg documented, readi systematically orga						3
	Based on staff into performed, and rec by ED providers ar identify the correct	is not met as evidenced by: erview, observations of x-rays cord review, there was a failure and Radiologist to accurately x-ray views associated with 1 stients. (Patient #1) Findings					
	brought to the ED out of bed at a LTC resides. The exam noted Patient #1 w pain, with a decrea bruising of the right right humerus was Patient #1 was bro Department and at of the patient's right taken of the left hu Subsequently, the did not identify the ordered, visualized the patient's right had not right h	locumentation, Patient #1 was on 9/30/18 at 09:30 after rolling consisted facility where the patient ination by the ED provider as experiencing moderate used range of motion and to arm. An x-ray of Patient #1's ordered by the ED provider, ught to the Radiology 12:50 2 views were taken not the thumerus, but x-rays were merus by radiology staff. ED provider viewed the x-rays, discrepancy in what was the x-rays as if they were of numerus. The ED provider ay showed a deformity of					
	Patient #1's humer from views of the le humerus. As a res	rus, however was diagnosing eft humerus, not the right ult, Patient #1's right arm was not the patient was returned to			\$ S		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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C 302	taken on 9/30/18 w letter "L" indicating left humerus, not of humerus. Per intenthe ED PA, confirm "L" on the x-ray and been ordered as coviewed. Per record 9/30/18 at 13:18 the the x-rays, failed to wrong extremity an interpretation that Fhumerus fracture". were visualizing was wrong extremity.  In addition, as per of protocol, radiologicare also reviewed for Radiologists. On 9/1/18 was dictated by a Fidentifies the x-rays humerus, notes a confracture. However, recognize within the "Body Part: R Hum Humerus; right 2 videnthe intended on 10/31/18 at 1:50 "it was my mistal recognize the discrorder and the films Radiologist comple 10/4/18 which state request was for a recognize the discrorder and the state request was for a recognize the discrorder and the state request was for a recognize the discrorder and the state request was for a recognize the discrepance of the state request was for a recognize the discrepance of the state request was for a recognize the discrepance of the state request was for a recognize the discrepance of the state request was for a recognize the discrepance of the state request was for a recognize the discrepance of the state request was for a recognize the discrepance of the state request was for a recognized the st	ge 6  y on 10/30/18 of the x-ray films hat was clearly noted was the the x-rays taken were of the the Patient #1's right yiew on 10/31/18 at 10:00 AM ed s/he failed to identify the discrepancy of what had impared to what was actually review it was further noted on a ED physician also visualized note the films were of the diagreed with the PA's Patient #1 had a "proximal Both were unaware what they is an old fracture and the CAH Radiology Department at tests read by other providers or accuracy by CAH's 30/18 at 15:45 a "Final Report" radiologist who correctly is viewed to be of the left deformity consistent with an old the Radiologist failed to a "Exam Information" that the erus" and "Description: ews" was supposed to have carays images. Per interview of PM the Radiologist confirmed ke" regarding the failure to epancy between the x-ray reviewed. Of note, the ted an Addendum dated at "It should be noted that the 19th humeral series and the left ed instead. There will be no		of See	attached	pan	13-18.18

charge for the left humeral series".

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

PRINTED: 11/08/2018 FORM APPROVED OMB NO. 0938-0301

STATEMENT OF	DEFICIENCIES	ZVI PROMODERALISME	T.		OWR VC	<u>). 0938-039</u>
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C 336 QUALITY ASSURANCE CFR(s): 485.641(b)

The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that —

This STANDARD is not met as evidenced by:
Based on observation, interview and record
review, the Quality Assurance program failed to
fully assess and evaluate concerns associated
with incorrect x-rays images performed; failure of
ED providers and Radiologist to identify the
inaccuracy of x-rays images compared to
provider's orders; the failure to assess the event
for potential harm to a patient; and the failure to
implement, in a timely manner, appropriate
corrective actions to prevent further radiological
adverse events. Findings include:

Per review of ED documentation, Patient #1 was brought to the ED on 9/30/18 at 09:30 after rolling out of bed at a LTC facility where the patient resides. The examination by the ED provider noted Patient #1 was experiencing moderate pain, with a decreased range of motion and bruising of the right arm. An x-ray of Patient #1's right humerus was ordered by the ED provider. Patient #1 was brought to the Radiology Department and at 12:50 2 views were taken not of the patient's right humerus, but x-rays were taken of the left humerus Subsequently, the ED provider viewed the x-rays, did not identify the discrepancy in what was ordered, visualized the x-rays as if they were of the patient's right humerus. The ED provider determined the x-ray

0336 See attached pan

12.18.18

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: LU7G11

Facility ID. 471307 11.19, 18

If continuation sheel Page 8 of 10

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		of Patient #1's humerus, osing from views of the left			UT	·	N VECN (				
		ght humerus. As a result,									
		m was placed in a sling and									
	the patient was retu	irned to the LTC facility.									
	taken on 9/30/18 w letter "L" indicating left humerus, not of humerus. Per intendice the ED PA confirme on the x-rays and the been ordered as coviewed. Per record 9/30/18 at 13:18 the the x-rays, failed to wrong extremity an interpretation that Fhumerus fracture".	on 10/30/18 of the x-ray films hat was clearly noted was the the x-rays taken were of the fithe Patient #1's right view on 10/31/18 at 10:00 AM and she failed to identify the "L" ne discrepancy of what had empared to what was actually review it was further noted on a ED physician also visualized note the images were of the diagreed with the PA's Patient #1 had "proximal Both were unaware what they is an old fracture and the									170
	reporting system) ir Patient #1 had expe and required a seco internal review faile of the issues assoc	within the SQSS (event nternal review to identify erienced increased pain issues and ED visit on 10/2/18. The d to recognize the significance lated with the wrong x-rays retations by providers and the l by the patient.									
	ensure the Radiolog consistently being for technologists. Ensu	as a lack of follow-up to gy policies and procedures are ollowed by all radiological ring an interdisciplinary		,			(8)			8	

interview on 10/31/18 at 2:55 the Director for Quality Assurance agreed, the present internal

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

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STATEMENT AND PLAN (	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LE CONSTRI		*	(X3) DAT	E SURVEY MPLETED
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C 336	assure the events a x-rays and interpret	ge 9 lan was not sufficient to associated with the wrong ations were appropriately rrective actions initiated.	C 336	See	outha COVV	ched ecti	plan	12.18.18
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#### C 000 INITIAL COMMENTS:

An unannounced on-site complaint survey was completed on 10/30/18 & 10/31/18 by the Vermont Division of Licensing and Protection. The investigation of 1 complaint, # 17083, concluded that there were regulatory violations for the issues investigated related to the Medicare Conditions of Participation for CAH found at 42

CFR Part 485, Subpart F.

Based on information gathered it was determined the facility was not to be in compliance with the Federal Condition of Participation for Critical Access Hospitals: Provision of Services. Refer to Tags: C-0271 & C-0283

### C270 PROVISION OF SERVICES CFR(s): 485.635

Provision of Services

This CONDITION is not met as evidenced by: Based on information gathered at the time of survey, the Critical Access Hospital (CAH) was determined not to be in compliance with the Condition of Participation: Provision of Services. The following regulatory violations included:

# We are responding to this condition-level deficiency through the Plans of Action below. Our Plans of Action are incorporated here by reference to the standard level deficiencies

C - 0271 The CAH failed to assure that care and services were provided in accordance with currently established written policies and procedures regarding the provision of care provided by the Radiology Department.

C - 0283 The CAH failed to ensure Radiology services were provided in accordance with acceptable standards of practice during the provision of diagnostic imagery

### C271 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 on observations, interviews and record review the CAH failed to ensure that care and services were provided in accordance with currently established written policies and procedures regarding the provision of care provided by the Radiology Department for 1 of 10 applicable patients. (Patient #1) Findings include:

Per review of Department of Radiology policy Patient Assessment (last reviewed/revised: 6/20/2018) "Policy: Patient assessment is made with the interdisciplinary approach of the physician, Nursing and Imaging Services to provide the most relevant information to allow for the optimum radiological exam and results. Procedure: Assessment of patients in the Radiology Department shall take placed in the following manner whenever possible. 1. An order is required for all radiological procedures performed in the radiology department" Despite the CAH's present policy & procedure, radiological, technologists failed on 9/30/18 to take an interdisciplinary approach by consulting with the Emergency Department (ED) provider prior to changing an x-ray procedure. Per interview on 10/30/18 at 2:15 PM, the Director of Radiology - Imaging confirm ED the wrong x-rays were taken by a radiology technologist on 9/30/18. Although the ED Provider had ordered 2 views of Patient #1's right humerus after the patient had sustained a fall from his/her bed, the radiology technologist failed to follow the provider's orders. Per interview on 10/31/18 at 4:20 PM the radiology technologist stated when Patient #1 arrived in the Radiology Department the patient complained of left arm pain, not right arm pain. Further discussion with

pre and 12.19.18 And

another radiology technologist who was assisting with the x-rays, it was decided to disregard the ED provider's order to perform right humerus x-rays. Instead, x-rays of Patient #1's left humerus were performed. It was further confirmed, although it is not unusual for a radiology technologist to collaborate with ED physicians and/or Physician Assistants regarding adding an additional x-ray when it appears appropriate, it is not acceptable j to change or disregard orders for any radiology testing without prior authorization, as per CAH policy. The radiology technologist confirmed after assessment of the patient, s/he failed to consult with the ordering provider.

#### ACTION PLAN

- The policy Identification, labeling and Quality Assurance of Radiology Studies was created in collaboration
  with the UVMMC Radiology Regional Director and the Radiology Director. The policy establishes a standard
  approach in which patients are identified and images are labeled in the Radiology Department. Specifically
  articulated:
  - O If the order does not match the patient's understanding of the area to be imaged, a phone call will be made to the ordering provider to confirm the correct examination to be performed. A new order will be requested if the examination that is needed is different than the original request.
  - O The technologist who is acquiring the images is responsible for ensuring that the patient data that is entered into the modality matches the patient that is being imaged and matches the Radiology order. This verification is a documented hard stop.
- Radiology Technologists will be educated by the Director of Radiology by a combination of staff meeting and
  via electronic learning management system. The education will be documented. The policy and the
  expectations have been added to department orientation.
- The Director of Radiology has been added as a member of the UVMMC Radiology Quality and Safety Committee effective 11/13/18.
- The accompanying deficiency report and action plans will be presented at the Medical Executive Committee on 12/12/18 and at the Quality Care Committee of the Board on 12/14/18 by the Chief Medical Officer.
- The Radiology Director or designee will perform weekly random reviews for verification that the images performed match the images ordered as outlined in the policy: "Identification, Labeling and Quality Assurance of Radiology Studies." The reviews will be comprised of reviewing the hard stop verification documentation and related images. Compliance data will be shared by the Radiology Director on an individual basis as required and presented at Porter Quality and Safety Committee as a quality metric going forward beginning January, 2019.
- All actions will be completed effective 12/18/18.

### C283 PATIENT SERVICES, CFR(s: 485.635(b)(3)

Radiology services. Radiology services furnished by the CAH are provided by personnel qualified under State law, and do not expose CAH patients or personnel to radiation hazards.

This STANDARD is not met as evidenced by: Based on observation, interview and record review, the CAH failed to ensure Radiology services were provided in accordance with acceptable standards of practice during the provision of diagnostic imagery for 1 applicable patient. (Patient #1) Findings include:

Per review of ED documentation, Patient #1 was brought to the ED on 9/30/18 at 09:30 after rolling out of bed at a Long Term Care (LTC) facility where the patient resides. The examination by the ED provider, a Physician Assistant (PA), noted Patient#1 was experiencing moderate plaint with decreased range of motion of bruising of

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the right arm. An x-ray of Patient #1's right humerus (long bone in upper arm) was ordered by the ED provider, Patient #1 was brought to the Radiology Department and at 12:50 2 views were taken not of the patient's right humerus, but x-rays were taken of the left humerus. Subsequently, the ED provider viewed the x-rays, did not identify the discrepancy in what was ordered, visualized the x-rays as if they were of the patient's right humerus. The ED provider 'determined the x-rays demonstrated a deformity of Patient #1's humerus, however was diagnosing from views of the left humerus, not the right humerus. As a result, Patient #1's right arm was placed in a sling and the patient was returned to the LTC facility. In addition, it was further noted on 9/30/18 at 13:18 the ED physician also visualized the x-ray, failed to note it was the wrong extremity and agreed with the PA's interpretation that Patient #1 had a"...proximal humerus fracture". Both were unaware what they were visualizing was an old fracture and the wrong extremity. On 10/2/18, after experiencing increased pain in the right arm with shortness of breath upon inspiration with associated chest pain, the LTC facility again sent Patient #1 to the ED for further evaluation and to rule out potential cardiac symptoms. Examination noted Patient #1's specific symptoms involved the anterior chest wall and anterior aspect of the right upper chest. What had been identified was Patient #1's x-rays taken on 9/30/18 were not of the patient's right humerus, as ordered, but of the left humerus. And it was further identified by the Radiologist, Patient #1 had evidence of a previous fracture of the left humerus, which is what the ED provider had also visualized on 9/30/18, however it was assumed the x-ray was actually of the right humerus as previously noted.

As a result, further x-rays of Patient #1's right ribs and chest were ordered by the ED provider. Cardiac and pulmonary diagnosis were ruled out, however x-rays demonstrated Patient #1 had fractures of the right third, fourth and fifth ribs and lateral right clavicle (collarbone). Pain medication was provided, and the patient was to continue to utilize the right sling, now for the treatment of the right clavicle fracture. Patient #1 was returned to the LTC facility.

Per interview on 10/30/18 at 2:15 PM, the Director of Radiology - Imaging confirmed the wrong x-rays were taken by a radiology technologist on 9/30/18. Reconfirming although the ED Provider had ordered 2 views of Patient #1's right humerus, the radiology technologist failed to follow the provider's orders. Per interview on 10/31/18 at 4:20 PM the radiology technologist stated when Patient #1 arrived in the Radiology Department s/he complained of pain in his/her left arm not the right arm. After further discussion with another radiology technologist who was assisting, a decision was made to disregard the ED provider's order to perform right humerus x-rays and instead x-ray images were taken of Patient #1's left humerus. It was further confirmed, although it is not unusual for a radiology technologist to collaborate with ED physicians and/or PAs regarding adding an additional x-ray image when it appears appropriate, it is not acceptable to change or disregard orders for any radiology testing without prior authorization.

#### ACTION PLAN

- The policy: "Identification, Labeling and Quality Assurance of Radiology Studies" was created in
  collaboration with the UVMMC Radiology Regional Director and the Radiology Director. The policy
  establishes a standard approach in which patients are identified and images are labeled in the Radiology
  Department. Specifically articulated:
  - o If the order does not match the patient's understanding of the area to be imaged, a phone call will be made to the ordering provider to confirm the correct examination to be performed. A new order will be requested if the examination that is needed is different than the original request.
  - The technologist who is acquiring the images is responsible for ensuring that the patient data that is entered into the modality matches the patient that is being imaged and matches the Radiology order. This verification is a documented hard stop.
- Radiology Technologists will be educated by the Director of Radiology by a combination of staff meeting and via electronic learning management system. The education will be documented. The policy and the expectations have been added to department orientation.

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- The Director of Radiology has been added as a member of the UVMMC Radiology Quality and Safety Committee effective 11/13/18.
- The Medical Director of the Emergency Department will use this case as an educational opportunity for the Emergency Department providers and Advanced Practice Providers (APPs) during a provider meeting.
- A licensed application called Powerscribe 360 Quality Check will be implemented. This system checks reports
  discrepancies such as laterality mismatch.
- The accompanying deficiency report and action plans will be presented at the Medical Executive Committee on 12/12/18 and at the Quality Care Committee of the Board on 12/14/18 by the Chief Medical Officer.
- The Radiology Director or designee will perform weekly random reviews for verification that the images
  performed match the images ordered as outlined in the policy: "Identification, labeling and Quality Assurance
  of Radiology Studies." The reviews will be comprised of reviewing the hard stop verification documentation
  and related images. Compliance data will be shared by the Radiology Director on an individual basis as
  required and presented at Porter Quality and Safety Committee as a quality metric going forward beginning
  January, 2019.
- All actions will be completed effective 12/18/18.

### C302 RECORDS OF SYSTEMS (CFR)(s) 485.638(a)(2)

The records are legible, complete, accurately documented, readily accessible, and systematically organized

This STANDARD is not met as evidenced by: Based on staff interview, observations of x-rays performed, and record review, there was a failure by ED providers and Radiologist to accurately identify the correct x-ray views associated with 1 of 10 applicable patients. (Patient #1) Findings include:

Per review of ED documentation, Patient# 1 was brought to the ED on 9/30/18 at 09:30 after rolling out of bed at LTC facility where the patient resides. The examination by the ED provider noted Patient #1 was experiencing moderate pain, with a decreased range of motion and bruising of the right arm. An x-ray of Patient #1's right humerus was ordered by the ED provider. Patient #1 was brought to the Radiology Department and at 12:50 2 views were taken not of the patient's right humerus, but x-rays were taken of the left humerus by radiology staff. Subsequently, the ED provider viewed the x-rays, did not identify the discrepancy in what was ordered, visualized the x-rays as if they were of the patient's right humerus. The ED provider determined the x-ray showed a deformity of Patient #1's humerus, however was diagnosing from views of the left humerus, not the right humerus. As a result, Patient #1's right arm was placed in a sling and the patient was returned to the LTC facility. Upon further review on 10/30/18 of the x-ray films taken on 9/30/18 what was clearly noted was the letter "L" indicating the x-rays taken were of the left humerus, not of the Patient #1's right humerus. Per interview on 10/31/18 at 10:00 AM the ED PA, confirmed s/he failed to identify the "L" on the x-ray and discrepancy of what had been ordered as compared to what was actually viewed. Per record review it was further noted on 9/30/18 at 13:18 the ED physician also visualized the x-rays, failed to note the films were of the wrong extremity and agreed with the PA's interpretation that Patient #1 had a "...proximal humerus fracture". Both were unaware what they were visualizing was an old fracture and the wrong extremity.

In addition, as per CAH Radiology Department protocolradiological tests read by other providers are also reviewed for accuracy by CAH's Radiologists. On 9/30/18 at 15:45 a "Final Report" was dictated by a Radiologist who correctly identifies the x-rays viewed to be of the left humerus, notes a deformity consistent with an old fracture. However, the Radiologist failed to recognize within the "Exam Information" that the "Body Part: R Humerus" and "Description: Humerus; right 2 views" was supposed to have been the intended x-rays images. Per interview on 10/31/18 at 1:50 PM the Radiologist confirmed "....it was my mistake" regarding the failure to recognize the discrepancy between the x-ray order and the films reviewed. Of note, the Radiologist completed an Addendum dated 10/4/18 which stated: "It should be noted that the request was for a right humeral series and the left humerus was imaged instead. There will be no charge for the left humeral series"

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#### ACTION PLAN

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  - The technologist who is acquiring the images is responsible for ensuring that the patient data that is entered into the modality matches the patient that is being imaged and matches the Radiology order. This verification is a documented hard stop.
- Radiology Technologists will be educated by the Director of Radiology by a combination of staff meeting and
  via electronic learning management system. The education will be documented. The policy and the
  expectations have been added to department orientation.
- The Director of Radiology has been added as a member of the UVMMC Radiology Quality and Safety Committee effective 11/13/18.
- The Medical Director of the Emergency Department will use this case as an educational opportunity for the Emergency Department providers and Advanced Practice Providers (APPs) during a provider meeting.
- A licensed application called Powerscribe 360 Quality Check will be implemented. This system checks reports discrepancies such as laterality mismatch.
- The accompanying deficiency report and action plans will be presented at the Medical Executive Committee on 12/12/18 and at the Quality Care Committee of the Board on 12/14/18 by the Chief Medical Officer.
- The Radiology Director or designee will perform weekly random reviews for verification that the images
  performed match the images ordered as outlined in the policy: "Identification, labeling and Quality Assurance
  of Radiology Studies." The reviews will be comprised of reviewing the hard stop verification documentation
  and related images. Compliance data will be shared by the Radiology Director on an individual basis as
  required and presented at Porter Quality and Safety Committee as a quality metric going forward beginning
  January, 2019.
- All actions will be completed effective 12/18/18.

### C 336 QUALITY ASSURANCE CFR(s): 485.641(b)

The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that — This STANDARD is not met as evidenced by: Based on observation, interview and record review, the Quality Assurance program failed to fully assess and evaluate concerns associated with incorrect x-rays images performed; failure of ED providers and Radiologist to identify the inaccuracy of x-rays images compared to provider's orders; the failure to assess the event for potential harm to a patient; and the failure to implement, in a timely manner, appropriate corrective actions to prevent further radiological adverse events. Findings include: Per review of ED documentation, Patient #1 was brought to the ED on 9/30/18 at 09:30 after rolling out of bed at a LTC facility where the patient resides. The examination by the ED provider noted Patient #1 was experiencing moderate pain, with a decreased range of motion and bruising of the right arm. An x-ray of Patient #1's right humerus was ordered by the ED provider. Patient #1 was brought to the Radiology Department and at 12:50 2 views were taken not of the patient's right humerus, but x-rays were taken of the left humerus. Subsequently, the ED provider viewed the x-rays, did not identify the discrepancy in what was

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Upon further review on 10/30/18 of the x-ray films taken on 9/30/18 what was clearly noted was the letter "L" indicating the x-rays taken were of the left humerus, not of the Patient #1's right humerus. Per interview on 10/31/18 at 10:00 AM the ED PA confirmed s/he failed to identify the "L" on the x-rays and the discrepancy of what had been ordered as compared to what was actually viewed. Per record review it was further noted on 9/30/18 at 13:18 the ED physician also visualized the x-rays, failed to note the images were of the wrong extremity and agreed with the PA's interpretation that Patient #1 had "...proximal humerus fracture". Both were unaware what they were visualizing was an old fracture and the wrong extremity.

There was a failure within the SQSS (event reporting system) internal review to identify Patient #1 had experienced increased pain issues and required a second ED visit on 10/2/18. The internal review failed to recognize the significance of the issues associated with the wrong x-rays and incorrect interpretations by providers and the effects experienced by the patient.

In addition, there was a lack of follow-up to ensure the Radiology policies and procedures are consistently being followed by all radiological technologists. Ensuring an interdisciplinary approach is incorporated as needed. Per interview on 10/31/18 at 2:55 the Director for Quality Assurance agreed, the present internal review and action plan was not sufficient to assure the events associated with the wrong x-rays and interpretations were appropriately investigated and corrective actions initiated

#### ACTION PLAN

- The policy: "Identification, Labeling and Quality Assurance of Radiology Studies" was created in collaboration with the UVMMC Radiology Regional Director and the Radiology Director. The policy establishes a standard approach in which patients are identified and images are labeled in the Radiology Department. Specifically articulated:
  - Of the order does not match the patient's understanding of the area to be imaged, a phone call will be made to the ordering provider to confirm the correct examination to be performed. A new order will be requested if the examination that is needed is different than the original request.
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- The Medical Director of the Emergency Department will use this case as an educational opportunity for the Emergency Department providers and Advanced Practice Providers (APPs) during a provider meeting.
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- The accompanying deficiency report and action plans will be presented at the Medical Executive Committee on 12/12/18 and at the Quality Care Committee of the Board on 12/14/18 by the Chief Medical Officer.

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- The Radiology Director or designee will perform weekly random reviews for verification that the images
  performed match the images ordered as outlined in the policy: "Identification, Labeling and Quality Assurance
  of Radiology Studies." The reviews will be comprised of reviewing the hard stop verification documentation
  and related images. Compliance data will be shared by the Radiology Director on an individual basis as
  required and presented at Porter Quality and Safety Committee as a quality metric going forward beginning
  January, 2019.
- Effective immediately is the formalization of Safety Adjudication Committee Triage Workgroup chaired by
  the Chief Medical Officer. The purpose of this meeting is for rapid review, triage, and communication of
  information about reported occurrences at The University of Vermont Health Network Porter Medical Center.
  The goal is to improve patient care, patient safety, patient satisfaction, and quality outcomes. The meeting will
  take place weekly.
- All actions will be completed effective 12/18/18.

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Porter Medical Center

November 2018

Department of Licensing & Protection HC2 South, 280 State Drive Waterbury, VT 05671-2060

Re:

CMS Certification Number (CCN): 471307

Survey ID: 42 CFR Part 485.635

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 October 31, 2018.

Porter Medical Center 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 to take this opportunity to respond to the regulatory deficiencies that were cited.

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

Sincerely,

Fred Kniffin, MD

President/Chief Executive Officer

UVMHN/Porter Medical Center