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

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 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
	471307	A. BUILDING _____ B. WING _____	C 10/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTER HOSPITAL, INC	115 PORTER DRIVE MIDDLEBURY, VT 05753

(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 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	C 000	See attached Plan of Correction	12.18.18
C 270	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: 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.	C 270	See attached plan of correction	12.18.18
C 271	PATIENT CARE POLICIES	C 271	See attached plan of correction Accepted 11/19/18 pm/st	12.18.18

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

TITLE: President | CEO

(X6) DATE: 11/15/18

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 271	Continued From page 1 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 place 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 confirmed 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	C 271	See attached plan of correction	12.18.18

PAC cmpt 11.19.18 DM/SL

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C 271	Continued From page 2 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 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 to change or disregard orders for any radiology testing without prior authorization, as per CAH policy. The radiology technologist confirmed after an assessment of the patient, s/he failed to consult with the ordering provider.	C 271	See attached Plan of Correction	12.18.18
C 283	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	C 283	See attached Plan of correction	12.18.18

POC amnt 12.19.18 fm/bl

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C 283	Continued From page 3	C 283	See attached Plan of Correction 12-18-18	

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,

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C 283	Continued From page 4	C 283	See attached plan of Correction	12-18-18

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

POC amt 11.19.18 BM/BL

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C 283	Continued From page 5 prior authorization.	C 283	See attached plan of correction	12.18.18
C 302	RECORDS 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 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 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.	C 302	See attached plan of correction	12.18.18

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C 302	Continued From page 6	C 302	See attached plan of correction	12-18-18

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 protocol, radiological 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".

PC ant 11.19.18 pm/81

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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	C 336	See attached plan of correction	12.18.18

POC sent 11.19.18 Em JSL

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C 336	Continued From page 8	C 336	See attached plan of correction	12-18-18

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-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

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C 336	Continued From page 9 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.	C 336	See attached plan of correction	12.18.18

POC entered 11.19.18 Em JH

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

poc amt 12.19.18 AMM

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 :
    - 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.
- 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 :
    - 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

- 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:
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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.
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- 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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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-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

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- 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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THE University of Vermont HEALTH NETWORK

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