VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

September 1, 2023

Mr. Thomas Dee, Administrator
Southwestern Vermont Medical Center
100 Hospital Drive
Bennington, VT 05201

Provider ID #: 470012

Dear Mr. Dee:

The Division of Licensing and Protection completed a complaint investigation at your facility on **July 31, 2023**. The purpose of the investigation was to determine if your facility met the conditions of participation for Acute Care Hospitals found in 42 CFR Part 482.

Following the survey, your facility submitted a Plan of Corrections (POC), which was found to be acceptable on **September 1, 2023**.

Sincerely,

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
	470012	A. BUILDING _____ B. WING _____	C 07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VERMONT MEDICAL CENTER	100 HOSPITAL DRIVE BENNINGTON, VT 05201

(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
A 000	INITIAL COMMENTS An unannounced on-site complaint investigation #22054 was conducted by the Division of Licensing and Protection on 7/31/23 at Southwestern Vermont Medical Center regarding Conditions of Participation: Emergency Services and Discharge Planning. As a result of the investigation, the Condition of Participation for 42 CFR 482.55, Emergency Services, was determined to be out of compliance.	A 000	Southwestern Vermont Medical Center is committed to providing the highest quality of care, treatment and services in a safe environment to all patients, and maintaining a safe environment for it clinicians, staff and visitors. The hospital appreciates the opportunity to respond to the findings of a CMS complaint investigation conducted on July 31, 2023 and is pleased to submit the following information and plan of correction to demonstrate SVMC's compliance with the CMS Conditions of Participation. The Chief Nursing Officer /Vice President of Clinical Services will oversee implementation of the following to ensure SVMC is in compliance with all regulatory standards.	
A1100	EMERGENCY SERVICES CFR(s): 482.55 The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based upon interview and record review, the facility failed to ensure the emergency needs of patients in accordance with acceptable standards of practice were provided regarding appropriate discharge services and notification for the complaint-focus patient [Patient #1] related to transportation for the cognitively impaired patient back to a group home and guardian notification of the discharge from the Emergency Department. Findings include: Review of Patient #1's "Emergency Department [ED] Visit Chart Record" for 7/10/23 reveals Pt.#1, a resident at a therapeutic community residence [group home] for the developmentally disabled, was transported to the Emergency Department [ED] by the Bennington EMS [Emergency Medical Services] ambulance with complaints of abdominal pain and chest	A1100	Immediately following the complaint investigation, SVMC conducted a root cause analysis of the event to understand how and why this event occurred. All staff and providers involved in this patient's care were interviewed. We also did an analysis of patient volume and staffing during the time the patient was in the Emergency Department. The following plan of correction addresses the findings of both our CMS investigation and root cause analysis. **Lack of guardian notification at discharge:** The nurse who discharged the patient was unaware that the patient had a guardian. The evening nurse who initially cared for the patient and spoke to the patient's guardian had completed their shift and did a verbal handover to the night nurse who subsequently discharged the patient. The night nurse could not recall discussing the fact that the patient had a guardian during handover. The Emergency Department's census had been almost double its 16-bed capacity for the previous 10 hours, requiring a shift-to-shift handover of multiple patients. In addition, patient guardianship information resides on the admitting demographic screen and does not carry over into any other part of the medical record accessed by staff and providers. Hence, the discharging nurse was unaware that the patient had a guardian that should have been notified of the patient's discharge.	8/5/2023

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

Alexandra Heintz, CPHQ, CPPS — Director of QSV + Patient Safety Officer — 8.31.23

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A1100	Continued From page 1 discomfort. Pt.#1's "ED Visit Chart Record" reveals under "General Appearance" the patient is listed under "Assessed Disability" as "Developmentally Delayed". Pt.#1's primary medical history lists the patient as diagnosed with Schizophrenia, and review of ED Physician Notes record Patient #1 assessed as "cognitively impaired". The ED record lists the complainant as the next of kin and records the relationship as "guardian" along with a contact phone number. The ED event history records the patient as having been received at the ED at 6:52 PM on 7/10/23, triaged, signed out by the ED Physician, ready for discharge, then removed from the ED tracker at 12:50 AM on 7/11/23. Pt.#1's "Disposition Assessment" dated 7/11/23 at 12:49 AM records the cognitively impaired group home patient as "able to safely manage at home". Additionally, Nursing Notes include "Discharge instructions covered with patient, who expresses understanding and raises no questions." Review of the facility's "Discharge Process Emergency Department-policy 2416 [revised 3/5/2020, approved 4/13/2021]" includes "Patients are assessed to determine from a cognitive and or functional status if it is safe for him/her to leave unaccompanied." The "Discharge Process Emergency Department" policy also includes "If the patient is a resident of a nursing home or community care home discharge instructions will be reviewed with the staff receiving the patient." Review of the facility's "Documentation Guidelines Emergency Department- policy 2418 [revised 11/9/2022, approved 1/20/2020]", states "Documentation is a critical component in high	A1100	**Corrective Action:** We implemented several system changes to ensure that the nursing staff is aware of every patient with a guardian on file. Once Medical Records receives guardianship paperwork and scans it into the patient's record, notification of guardianship will automatically populate next to the patient's name every time the patient comes into the Emergency Department. An additional visual cue to alert staff of guardianship was added to the visual smart board located inside the Emergency Department. Further, to ensure nurses contact the patient's guardian upon discharge, guardianship information entered on a patient's demographic screen upon admission will automatically reflex over to their discharge summary screen. A query was added to the discharge screen that asks, "Is the patient from a skilled nursing facility, group home or under guardianship?" If the response is YES, the nurse must enter in the name of the individual or guardian contacted as part of their required discharge documentation. The Assistant Nursing Director is providing education on the new process to the Emergency Department clinical staff during the week of 8/26/23. Staff not working that week will be required to read and sign off that they understand the new process before the end of their first shift worked. **Audit:** The Emergency Department nursing director or her designee will audit charts of 100% of Emergency Department patients who have a guardian on file to ensure information regarding guardianship is populating onto the discharge screen. They will also check that staff are contacting the guardian and documenting the name of the individual contacted. The Director or designee will follow-up with the individual involved on any issues of non-compliance. The audit will continue for four (4) months with an expected compliance rate of 100%. After four consecutive months of 100% compliance, the nursing director or designee will spot audit 10 charts per month to ensure ongoing compliance. Monitoring data will be reported monthly to the hospital's Quality, Safety and Value Committee and on to the Board Safety Quality Committee. The Chief Nursing Officer is responsible for this plan of correction.	8/22/23 9/3/23

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A1100	Continued From page 2 quality patient care and safe, effective nursing practice." Under 'Functional Discharge/Planning', the policy reads "Assess living situation to help determine discharge planning needs." Under 'Discharge Summary/Education', the policy instructs staff to document "transfer time, mode of transfer, status during transfer. Name of individual who received the hand off Documentation ..." An interview and record review were conducted with the Assistant Director of the Emergency Department [ADED] on 7/31/23 at 12:02 PM. The ADED confirmed there was no documentation in Pt.#1's medical record regarding Pt.#1 's discharge destination, how S/he would be transported to the [undocumented] destination, and no documentation that the patient's listed guardian was notified that Pt.#1 was being discharged [without transportation] from the ED. The ADED confirmed Nursing Notes recorded Pt.#1's guardian had called the ED during the patient's stay requesting an update on the patient. The ADED stated it was his/her expectation that transportation would be arranged prior to discharging the patient out of the facility, that the patient's guardian would be notified of the patient's discharge, and that this information would be documented in Pt.#1's medical record but it was not. The ADED stated that S/he would 'not feel safe' being discharged from the facility alone, without transportation, at '1:00 AM in the morning'. Per review of the complainant's report dated 7/13/23, Pt.#1 stated that after being discharged S/he was unsure how to get back to the group residence and ended up getting lost - S/he eventually found their way back to the hospital ED around 3:30 AM. The hospital ED then called the	A1100	**Assessment of the patient's ability for safe discharge unaccompanied:** While the patient was noted to have moderate cognitive impairment, nursing's assessment of the patient both at time of admission and prior to discharge was that the patient had decision-making capacity. The patient had come to the Emergency Department unaccompanied via Rescue Squad. Staff reported that the patient was able to communicate clearly and expressed understanding of her discharge instructions. As such, the nurse felt the patient was safe for discharge unaccompanied and that she understood public transportation had been arranged. The patient was transported by wheelchair to just inside the canopy entrance and was instructed to wait in the hallway for transportation to arrive. **Corrective Action:** Communication with the patient's guardian prior to discharge would have provided a mechanism for the nurse and guardian to collaborate on a safe discharge plan for this patient. As such, the corrective action plan and audit listed above regarding staff awareness of guardianship and follow-up with the guardian addresses this finding. **Transportation Home:** Staff did not complete the discharge screen regarding the patient's discharge destination and how she was to be transported. This is not a required field on the discharge summary screen and it is not consistently completed per policy. **Corrective Action:** A system fix was implemented on 7/31/23 to create a hard stop on the discharge screen that states: "How is the patient getting home?" Staff can no longer move forward on the discharge documentation screen until they complete this question. Because this is a required field, 100% compliance is expected. The Assistant Nursing Director provided 1:1 education to the Emergency Department clinical staff between 8/9/23-8/21/23. Additionally, staff were required to review an educational slide deck and sign off that they understood the ED's discharge procedure and documentation policy. **Audit:** The Director of the Emergency Department or designee will audit a 100% of charts for patients who	8/22/23 7/31/23 8/21/23

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A1100	Continued From page 3 police to provide transportation to the patient back to his/her group home. Per interview with the ADED, when Pt. #1 returned to the ED, S/he was not registered as a patient and therefore there was no documentation that S/he had returned and that police had to be contacted to transport the patient to the group home. An interview and record review were conducted with the Chief Nursing Officer [CNO] on 7/31/23 at 12:34 PM. The CNO confirmed Pt.#1's medical record documented the patient as "Developmentally Delayed", "cognitively impaired", and with a history if Schizophrenia. The CNO confirmed the facility's policies include instructions for staff to assess patients "to determine from a cognitive and or functional status if it is safe for him/her to leave unaccompanied" and "If the patient is a resident of a nursing home or community care home discharge instructions will be reviewed with the staff receiving the patient." The CNO confirmed Pt.#1's medical record listed the patient as being discharged alone at 12:50 AM on 7/11/23, with no documentation that transport was arranged to take the patient's back to their group home, and no documentation that the patient's guardian or group home staff were notified that the patient was being discharged. The CNO stated S/he was "disappointed" that the facility's process had allowed Pt. #1 "to be discharged to the streets at 1:00 AM."	A1100	have a guardian on file to ensure staff are completing the discharge screen according to documentation guidelines. The audit will continue for four (4) months with an expected compliance rate of 100%. After four consecutive months of 100% compliance, the nursing director will spot audit 10 charts per month to ensure ongoing compliance. Monitoring data will be reported monthly to the hospital's Quality, Safety and Value Committee and on to the Board Safety Quality Committee. The Chief Nursing Officer is responsible for this plan of correction. **Review of discharge instructions with patient's group home:** This patient resides in a group home environment that does not have regular staff on site. As such, there was no one at the group home for staff to contact to review the patient's discharge instructions. However, communication with the patient's guardian prior to discharge would have been an opportunity for the nurse and guardian to collaborate on a safe discharge plan for this patient. The corrective action plan and audit listed above relative to staff awareness of guardianship and notification upon discharge addresses this finding. **Tag A1100 POC accepted on 9/1/23 by D. Wideawake\S. Leavitt**	