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,

Shame Eherth

Suzanne Leavitt, RN, MS State Survey Agency Director

Assistant Director, Division of Licensing & Protection

Enclosure

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

PRINTED: 08/21/2023 FORM APPROVED OMB NO. 0938-0391

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STREET ADDRESS, CITY, STATE, ZIP CODE			470012							
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LABORATORY DIRECTOR'S OR PROJUDENSOPPLIER REPRESENTATIVE'S SIGNATURE

Mosanda Heintz CPHQ CPPS Director of QSV + Parkent Safety officer 8.3.23

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.

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

PRINTED: 08/21/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUILDING		С				
		470012	B. WING			07/31/2023			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
		_		100 HOSPITAL DRIVE					
SOUTHW	ESTERN VERMONT MED	DICAL CENTER		BENNINGTON, VT 05201					
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			COMPLETION DATE		
					Corrective Action:		9/22/22		
A1100	Continued From page	:1	A1	100	We implemented several system changes to	ensure	8/22/23		
	discomfort.				that the nursing staff is aware of every patienguardian on file. Once Medical Records rece				
		rt Record" reveals under			guardianship paperwork and scans it into the				
		e" the patient is listed under			record, notification of guardianship will auto				
	"Assessed Disability"	•			populate next to the patient's name every time				
		nary medical history lists the			patient comes into the Emergency Department				
	T	with Schizophrenia, and			additional visual cue to alert staff of guardian				
V		an Notes record Patient #1			added to the visual smart board located insid	e the			
	•	vely impaired". The ED			Emergency Department. Further, to ensure n				
		ainant as the next of kin and			contact the patient's guardian upon discharge				
	•	nip as "guardian" along with			guardianship information entered on a patien	t's			
ľ	a contact phone num			demographic screen upon admission will					
	records the patient as having been received at				automatically reflex over to their discharge s				
the ED at 6:52 PM on 7/10/23, triaged, significant		_			screen. A query was added to the discharge s that asks, "Is the patient from a skilled nursing				
	by the ED Physician, ready for discharge, then				facility, group home or under guardianship?"				
		•			response is YES, the nurse must enter in the		2		
	removed from the ED tracker at 12:50 AM on 7/11/23. Pt.#1's "Disposition Assessment" da				the individual or guardian contacted as part of				
		ecords the cognitively	required discharge documentation.						
		patient as "able to safely							
		Iditionally, Nursing Notes			The Assistant Nursing Director is providing		9/3/23		
					education on the new process to the Emerger				
	include "Discharge instructions covered wit patient, who expresses understanding and		Department clinical staff during the week of						
	no questions."	23 understanding and raises			Staff not working that week will be required				
	no questions.				and sign off that they understand the new probefore the end of their first shift worked.	cess			
	Review of the facility's	s "Discharge Process			Audit:				
		ent-policy 2416 [revised			The Emergency Department nursing director	or her			
3/5/2020, approved 4/13/ "Patients are assessed to cognitive and or functional him/her to leave unaccort					designee will audit charts of 100% of Emergi				
					Department patients who have a guardian on)			
					ensure information regarding guardianship is				
					populating onto the discharge screen. They v				
		•			check that staff are contacting the guardian a				
	The "Discharge Process Emergency Department" policy also includes "If the patient is a resident of				documenting the name of the individual cont				
	•	•			The Director or designee will follow-up with				
	a nursing home or con				individual involved on any issues of non-con				
	discharge instructions will be reviewed with the staff receiving the patient." Review of the facility's "Documentation				The audit will continue for four (4) months vexpected compliance rate of 100%. After four				
					consecutive months of 100% compliance, the				
					director or designee will spot audit 10 charts				
					month to ensure ongoing compliance. Monit	• 1			
	_	by Department- policy 2418			data will be reported monthly to the hospital'				
[revised 11/9/2022, approved 1/20/2020]", sta "Documentation is a critical component in high					Quality, Safety and Value Committee and on				
		critical component in high	Board Safety Quality Committee. The Chief						
ORM CMS-256	7(02-99) Previous Versions Obso	lete Event ID:9X9F11		Fa	Afficerioresponsible for this plan of correct		et Page 2 of 4		

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

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					С		
470012		B. WING_	B. WING		31/2023		
NAME OF PROVIDER OR SUPPLIER			- '	STREET ADDRESS, CITY, STATE, ZIP CODE			
				100 HOSPITAL DRIVE			
SOUTHWI	ESTERN VERMONT MED	DICAL CENTER		BENNINGTON, VT 05201			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ON	(X5) COMPLETION	
PREFIX TAG			PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
				Assessment of the patient's ability for	afe	8/22/23	
A1100	Continued From page	2	A1100 discharge unaccompanied: While the patient of			0/22/23	
	quality patient care ar	nd safe, effective nursing		nursing's assessment of the patient both			
		ctional Discharge/Planning',		admission and prior to discharge was that			
		ess living situation to help		had decision-making capacity. The patie			
		planning needs." Under		to the Emergency Department unaccomp			
	'Discharge Summary/	/Education', the policy		Rescue Squad. Staff reported that the par			
		ment "transfer time, mode		to communicate clearly and expressed un			
	of transfer, status dur	ing transfer. Name of		of her discharge instructions. As such, th			
	individual who receive	ed the hand off		the patient was safe for discharge unacco			
	Documentation"			that she understood public transportation arranged. The patient was transported by			
				to just inside the canopy entrance and wa			
	An interview and reco	ord review were conducted		to wait in the hallway for transportation			
	with the Assistant Dire	ector of the Emergency		Corrective Action: Communication wit			
	Department [ADED] of	on 7/31/23 at 12:02 PM. The		patient's guardian prior to discharge wou			
	ADED confirmed ther	e was no documentation in		provided a mechanism for the nurse and	guardian to		
	Pt.#1's medical record	d regarding Pt.#1's		collaborate on a safe discharge plan for t			
	discharge destination			As such, the corrective action plan and a			
	transported to the [un	documented] destination,		above regarding staff awareness of guardianship and			
		n that the patient's listed		follow-up with the guardian addresses th	s finding.		
	guardian was notified			Transportation Home:			
		ansportation] from the ED.		Staff did not complete the discharge scre	n regarding		
		Nursing Notes recorded		the patient's discharge destination and ho			
		called the ED during the		be transported. This is not a required fiel			
		ing an update on the patient.		discharge summary screen and it is not c	nsistently		
	The ADED stated it was his/her expectation that			completed per policy.			
	transportation would be arranged prior to discharging the patient out of the facility, that the			Corrective Action: A system fix was im		7/31/23	
				on 7/31/23 to create a hard stop on the discreen that states: "How is the patient get			
	patient's guardian wo			Staff can no longer move forward on the			
		nd that this information		documentation screen until they complet			
		d in Pt.#1's medical record		question. Because this is a required field			
		DED stated that S/he would		compliance is expected.			
	_	scharged from the facility					
	-	ortation, at '1:00 AM in the		The Assistant Nursing Director provided		8/21/23	
	morning'.			education to the Emergency Department			
	Per review of the complainant's report dated			between 8/9/23-8/21/23. Additionally, st			
		that after being discharged		required to review an educational slide d			
		to get back to the group		off that they understood the ED's discharge proceed and documentation policy.			
	residence and ended			Audit:			
		way back to the hospital ED		The Director of the Emergency Department	nt or		
	around 3:30 AM. The hospital ED then called the			designee will audit a 100% of charts for			

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

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CENTER	3 FUR MEDICARE & I	VIEDICAID SERVICES				OIVID IV	7. 0930-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ORDECTION I IDENTIFICATION NI IMPED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		470012	B. WING				31/2023			
NAME OF P	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
				100 HOSPITAL DRIVE						
SOUTHWESTERN VERMONT MEDICAL CENTER				BENNINGTON, VT 05201						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE			
A1100	police to provide transback to his/her group the ADED, when Pt. # was not registered as there was no docume returned and that politransport the patient that interview and recovered with the Chief Nursing at 12:34 PM. The CN record documented the "Developmentally Desimpaired", and with a The CNO confirmed the instructions for staff to determine from a cogstatus if it is safe for hunaccompanied and of a nursing home or discharge instructions staff receiving the path Pt.#1's medical record documentation that the patient's back no documentation that group home staff were was being discharges "disappointed" that the	sportation to the patient home. Per interview with f1 returned to the ED, S/he is a patient and therefore entation that S/he had ice had to be contacted to to the group home. ord review were conducted g Officer [CNO] on 7/31/23 O confirmed Pt.#1's medical me patient as layed", "cognitively history if Schizophrenia. the facility's policies include to assess patients "to nitive and or functional	A1	100	have a guardian on file to ensure staff are conthe discharge screen according to documental guidelines. The audit will continue for four (months with an expected compliance rate of After four consecutive months of 100% compliance four consecutive months of 100% compliance. Monit data will be reported monthly to the hospital Quality, Safety and Value Committee and on Board Safety Quality Committee. The Chief Officer is responsible for this plan of correction of the group home: This patient resides in a group environment that does not have regular staff. As such, there was no one at the group home to contact to review the patient's discharge instructions. However, communication with patient's guardian prior to discharge would han opportunity for the nurse and guardian to collaborate on a safe discharge plan for this patient's action plan and audit listed ab relative to staff awareness of guardianship an notification upon discharge addresses this find. Tag A1100 POC accepted on 9/1/2 D. Wideawake\S. Leavitt	tion 4) 100%. pliance, per toring s to the Nursing ion. ent's home on site. for staff the ave been patient. ove d d dding.				