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 4, 2024

Mr. Thomas Dee, CEO
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 survey at your facility on **August 8, 2024**. The purpose of the survey 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 4, 2024**.

Sincerely,

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

Enclosure

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

PRINTED: 08/20/2024
FORM APPROVED
OMB NO. 0938-0391

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 08/08/2024

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 for #23113 and #22736 was conducted at Southwestern Vermont Medical Center on 8/8/2024 by the Division of Licensing and Protection as authorized by the Centers for Medicare and Medicaid to determine compliance with the 42 CFR Part 482 Conditions of Participation for Hospitals: Patient Rights, Discharge Planning, Emergency Services and Medical Records. As a result of the investigation for complaint #23113 a regulatory violation was identified. Findings include:	A000		
A 438	FORM AND RETENTION OF RECORDS CFR(s): 482.24(b) The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on staff interview and record review, there was a failure to ensure the medical record for one applicable patient was accurately written describing correct interactions and medication administration. (Patient #1) Findings include: Patient #1 presented to the Emergency Department (ED) on 4/25/24 for evaluation for alcohol withdrawal, requesting to be detoxified but expressing fear of withdrawal reporting s/he has past history of seizures during the withdrawal process. Patient #1 did report some delusions	A438	Following the on-site complaint investigation, a full review of the error noted in the medical record was completed. The review noted that the error in documentation was attributed to an incorrect or incomplete handover between hospitalists. Additionally, a more thorough review of medical record documentation completed by the hospitalists provided awareness of the potential for errors in documentation to be overlooked secondary to the change from the traditional dictation system to Dragon Dictate in which the provider is responsible for dictation and review of their dictation for errors. In an effort to reduce the risk of errors, the following plan has been implemented: 1. 08.20.24: SVMC Policy # 960: Documentation and authentication policy – Medical Staff, approved 6/1/1998, revised 3/27/2023 was reviewed during the Peer Review Committee. It remains current and does not require modification.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Vice President Patient Care/Chief Nursing Officer
(X6) DATE: 08.22.24

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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A 438	Continued From page 1 regarding mind control associated with computers. However, the ED provider described Patient #1 with ". ...appropriate mood and affect, the patient is calm and cooperative. ...does not appear that s/he is responding to internal stimuli at this point. .. ". Patient #1 spoke with a member of a recovery program confirming his/her interest in a detoxification program after hospital discharge. During the course of admission, Patient #1 was managed for alcohol withdrawal utilizing a CIWA (Clinical Institute Withdrawal Assessment Alcohol Scale) to treat alcohol withdrawal. During this process the patient is assessed frequently by nursing who monitor vital signs, anxiety, sweating, tremors and nausea. Medication (benzodiazepines) are administered depending upon CIWA score. Shortly after inpatient admission to the hospital, Patient #1 began developing behaviors described as "....aggressive and violent". Staff discussed and attempts were made to have Patient #1 evaluated for a possible psychiatric hospitalization determining the patient to be an involuntary admission. During the course of the late evening multiple staff attempted to manage Patient #1's behaviors and initially was briefly seen during a "Telepsychiatric" evaluation by a psychiatrist. Patient #1 was determined to require further psychiatric intervention and s/he would be held as an "involuntary" inpatient pending psychiatric hospitalization. Per review of the medical record, a Hospitalist note dated 4/26/24 states ". .. becoming verbally aggressive, threatening violence/homicide that patient should should be chemically restrained. ".	A 438	2. 08.28.24: The CNO will attend the meeting of the Hospitalists to discuss the concern with accurate medical records and documentation. During this meeting, SVMC Policy #960: Documentation and authentication policy will be reviewed with the hospitalists. Hospitalists not able to attend the meeting will meet one on one with the CNO to review the policy. All hospitalists will receive the information and review the policy by 08/29/24. 3. 08.22.24: Audits of inpatient progress notes were initiated. The process is: on a monthly basis, 10 progress notes completed in the preceding 24 hours are reviewed for accuracy of pertinent medical information. This will be completed monthly until 100% accuracy in pertinent medical information is noted. Once 100% accuracy in pertinent medical information is noted, the frequency of audits will be modified to quarterly. Audits will be continued on a quarterly basis until 3 consecutive quarters of 100% accuracy in pertinent medical information is noted. 4. 08.30.24: All corrective actions will be completed. Auditing will continue to assure compliance with the plan of correction.	

Pam Duchene PhD, APRN

Vice President Patient Care/Chief Nursing Officer 08.22.24

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

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A 438	Continued From page 2 A second transcription by a Hospitalist states " USC" (United Counseling Services) later evaluated the patient after s/he received Haldol and felt s/he was able to make appropriate decisions.....". Further review confirmed via amended documentation, Patient #1 was never restrained nor did s/he receive emergency involuntary medications. Eventually, Patient #1 did allow a second interview with USC and was determined psychiatric hospitalization was not necessary and the patient was discharged against medical advice. Per interview on 8/8/24 at 2:30 PM the Patient Advocate confirmed errors were made in Patient #1's medical record and parts have been amended to reflect accuracy.	A 438	**Tag A 438 POC accepted on 9/4/24 by M. McIntosh/D. Wideawake**	

Pam Duchene PhD, APRN

Vice President Patient Care/Chief Nursing Officer 08.22.24

Policy Title:	Documentation and Authentication Policy - Medical Staff - SVHC	Policy ID	960
Department	*Medical Staff Office; *Standards, Regulatory		
Keywords	Not Set		

I. Purpose of Policy

To provide guidelines for documenting and completing a medical record.

II. Policy Scope

Southwestern Vermont Medical Center

III. Definitions

Not applicable

IV. Policy Statement

Medical records shall be maintained on all patients evaluated and treated at Southwestern Vermont Medical Center

A. GENERAL:

1. Documentation in the medical record shall contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medication and services.
2. Entries in the medical record shall be made only by individuals as specified in Departmental, service, or facility policy. All entries must be dated, timed and authenticated.
3. The method of correcting an entry in the medical record is to draw a single line through the incorrect information and write, "corrected entry" above, then initial and date the correction. One should be able to interpret the original entry as well as the corrected entry notation.
4. Documentation shall be legible, clear in intent, and complete without the use of Dangerous Abbreviations Policy - HIS
5. Rubber stamp signatures are unacceptable.

B. DIAGNOSES:

1. Diagnoses should be documented in the medical record at the time of discharge to ensure accurate and complete medical coding.
    a. The principal diagnosis is that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.

   b. The secondary diagnoses are those conditions that coexist at the time of admission, or develop subsequently, that affect the treatment received and/or length of stay.

C. AUTHENTICATION:

1. Electronic signature requires
   a. that only the person to whom the electronic signature identification has been assigned can access that signature;
   b. that reports are electronically signed within 5 days of document availability;
   c. that persons using electronic signatures are able to review and edit the document prior to signature;
   d. that after signature the document cannot be edited and any revisions required after signature must be made as an addendum.

D. HISTORY AND PHYSICAL:

1. A full history and physical is required on all inpatients and same day surgery patients and shall include the chief complaint or reason for admission, description of symptoms, history of present illness, current medications and allergies, review of systems, past medical/surgical history, family history, social history, physical examination, assessment, and treatment plan. For female adult patients, breast and pelvic examinations are required when clinically indicated and/or pertinent. Rectal examination is required when clinically indicated and/or pertinent. For surgical patients, indications/preop diagnosis and proposed procedure must be included. For dental surgery patients, a detailed description of the dental plan must be included.
2. For Obstetrics patients, the entire prenatal record can be utilized as the history and physical provided it is updated to reflect the patient's condition upon admission or within 24 hours of registration or inpatient admission.
3. A focused history and physical is required for non-inpatient services and procedures and shall include a pertinent, relevant history and physical, a current list of medical problems, allergies and medications, assessment and plan. Non-inpatient services and procedures include observation, pediatric monitored anesthesia care (MAC), minor surgery and invasive procedures requiring anesthesia services, IV procedural sedation, cardioversion, and endoscopic procedures.
4. Pediatric assessments shall include immunization status, psychosocial assessment, and growth and development status.
5. History and physicals must be recorded within 24 hours of the patient's date of admission, or recorded no earlier than 30 days prior to admission or date of service but prior to surgery or a procedure requiring anesthesia services.
6. The medical history and physical examination must be completed by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
7. An updated history and physical examination of the patient indicating whether or not there were any changes in the patient's condition in the interval must be documented within 24 hours after admission but prior to surgery or a procedure requiring anesthesia. The history and physical requirement does not apply for emergency surgery; however, it must be done as soon as possible after emergency surgery.

E. ORDERS:

1. All orders shall be dated and timed, clear in intent, legible, and written without the use of Dangerous Abbreviations Policy - HIS.
2. Providers may sign orders of those providers sharing coverage.
3. Providers may fax or provide photocopies of orders.
    a. Non-medication orders must be signed and dated prior to faxing/photocopying but need not be signed again in the record.
    b. Medication orders must be signed and dated prior to faxing/photocopying and additionally signed in the record within 48 hours.
4. Verbal orders can be dictated to inhalation therapists regarding instructions for inhalation therapy, registered pharmacists, registered and licensed practical nurses, and unit secretaries. Only registered nurses and medication certified licensed practical nurses may transcribe medication orders.
5. Verbal medication orders shall be authenticated within 48 hours.
    a. DNAR verbal orders may be taken by two registered nurses simultaneously.
    b. DNAR, HINN notification, and restraint orders must be signed within 24 hours by the attending physician.
6. Discharge orders shall be issued within 24 hours prior to discharge for all patients. If the discharge is per criteria and the patients fails to meet the criteria within 24 hours of issuing the discharge order, the provider must document why the patient was not discharged and enter a new discharge order.

F. PROGRESS NOTES:
1. Progress notes shall be documented daily and shall reflect changes in condition and response to care, treatment and services provided.
2. A final progress note can be written in lieu of a discharge summary for admissions under 48 hours. The note shall include patient's general condition and diagnoses, and instructions for the patient's activity, diet, and medications as well as any follow-up appointments.

G. CONSULTATION:
1. A written order in the medical record for consultation is required.
2. Documentation shall include reason for consultation, assessment, findings, and recommendations. Dictation of the report shall be within 24 hours of the examination.
3. Refer to Pediatric Collaborative Care Policy - Medical Staff - SVHC policy for guidance on pediatric consultations.

H. OPERATIVE RECORD:
1. An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care. If the physician or other licensed practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.
2. When a full operative or other high-risk procedure report cannot be dictated or entered immediately into the patient's medical record after the operation procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name of primary surgeon and assistants, procedure performed and a

description of each finding, estimated blood loss, specimens removed, and post-operative diagnosis.
3. A post-operative progress note shall be entered in the medical record immediately after the procedure.

I. ANESTHESIA RECORD:
1. The anesthetist (AA/CRNA) or anesthesiologist is responsible for documentation of all details of the anesthetic.
2. The anesthetist (AA/CRNA) or anesthesiologist is responsible for documenting a post anesthesia evaluation within 48 hours following a procedure for all .patients for which they provided anesthesia.
3. Practitioners (non-anesthesiologists) qualified to administer anesthesia must document a post-anesthesia evaluation within 48 hours after a procedure requiring moderate or deep sedation.
4. The anesthesiologist supervising the administration of anesthesia by a AA will sign the anesthesia record and co-sign the note of post anesthesia evaluations; CRNA does not require a co-signature.

J. DISCHARGE SUMMARY:
1. A discharge summary shall be documented immediately prior to transfer or following discharge and shall include principal and secondary diagnoses, significant findings, procedures performed and treatment rendered, patient's condition at discharge and discharge instructions to include disposition of care, provisions for follow-up care, including diet, medications and activity. Discharge instructions may be documented in the discharge summary or referred to in the summary and addressed through the Discharge Instruction form, a copy of which is given to the patient. The form must be signed by the individual issuing the instructions.
2. A short stay summary or final progress note may be substituted for a dictated discharge summary when the patient is discharged within 48 hours of admission.
3. A Hollister Summary or final progress note may be substituted for a discharge summary when a patient is discharged after a normal spontaneous vaginal delivery.

K. EMERGENCY REPORT:
1. The emergency record shall be signed by the provider treating the patient.
2. The emergency report shall be dictated within 24 hours of the time of service.
3. Emergency Room practitioners qualified to administer anesthesia must document a post-anesthesia evaluation within 48 hours after a procedure requiring moderate or deep sedation.

L. SVMC Medical Practices

Medication reconciliation occurs at provider visits.

Any changes made to the medication record are immediately available to view in the patient's electronic health record chart medication list. If for any reason the list cannot be accurately reconciled at the time of visit, this will be communicated to the provider and the reconciliation updated in the soonest timeframe possible.

Changes to the patient's medication list, including additions of new medications with accompanying education, are communicated in both verbal and written format and documented in the patient's record.

V. References

1. Joint Commission Standards: RC 01.02.01; RC 02.01.01; RC 02.01.03; RC 02.04.01, MS.03.01.01, PC.03.01.07
2. CMS Conditions of Participation

Responsible Owner:	**Carl Dobson (DR)**	**Original Creation Date**	**06/01/1998**
Approved By:	**Medical Executive Committee, PolicyTech Oversight Committee, Carl Dobson (DR)**	**Last Modified**	**03/27/2023**
Approval Date:	**07/18/2023**	**Next Periodic Review**	**07/18/2026**
Related Polices & Procedures:	Dangerous Abbreviations Policy - HIS Pediatric Collaborative Care Policy - Medical Staff - SVHC		
Related Job Aids:			