

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

April 10, 2017

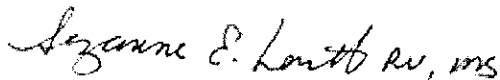
Eileen Whalen, Administrator
University Of Vermont Medical Center
111 Colchester Ave
Burlington, VT 05401

Dear Ms. Whalen:

The Division of Licensing and Protection completed a survey at your facility on **February 22, 2017**. 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 **April 10, 2017**.

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

MAR 27 2017 PRINTED: 03/06/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/22/2017
NAME OF PROVIDER OR SUPPLIER UNIVERSITY OF VERMONT MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401		
(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		A 000		
A 130	<p>An unannounced on-site survey was conducted from 2/21/17 - 2/22/17 by staff from the Vermont Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The purpose of the survey was to investigate complaint #15237. The following regulatory violations were identified.</p> <p>482.13(b)(1) PATIENT RIGHTS: PARTICIPATION IN CARE PLANNING</p> <p>The patient has the right to participate in the development and implementation of his or her plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to include the patient's representative in the development and implementation of the discharge plan for 1 of 10 applicable patients in the sample. (Patient #1). Findings include:</p> <p>Per record review, Patient #1 has Alzheimer's dementia (type of chronic or persistent disorder of mental processes affecting memory, personality, and/or behavior) heart, kidney, and other nervous system conditions. S/he was admitted to the hospital on 12/16/16 from a residential care home with pneumonia and a pleural effusion (excess fluid in the lung). Per interview with Patient #1's legal guardian, Patient #1 was discharged two days later on a very cold day, dressed only in a hospital gown covered with blankets; and was sent back to the care home, alone in a cab.</p> <p>Per review of the provider admission and discharge notes, Patient #1 refused to take</p>		A 130	<p>SEE ATTACHED Plan of Correction C. Huggins</p> <p>POC A130 - A812 accepted 4.10.17 DW/SM</p>	3/31/17

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

TITLE

(X6) DATE

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 130	Continued From page 1 antibiotics at the care home, became increasingly agitated, was up all night crying out in pain, and was very irritable with the staff at the care home. Patient #1 was sent to the Emergency Department via ambulance and was admitted for IV (in the vein) antibiotics and mood management. Patient #1's legal guardian had been at the hospital the day prior to discharge and had discussed with the provider the specific discharge requirements for a safe discharge for Patient #1. Per review of the nursing progress notes on 12/18/16 at 11:00 AM, the patient had written discharge orders to go back to the residential care home. Report was called to the residential care home; and Patient #1 verbalized understanding of discharge instructions and denied further questions. Per record review Patient #1 was discharged on the weekend and the Case Manager who developed the discharge plan failed to consult with Patient #1's legal guardian regarding Patient #1's functional status, and specific discharge needs. Per interview on 2/21/17 at 2:35 PM with the Manager and Supervisor of Case Management and Social Work, each confirmed that Patient #1's legal guardian was not consulted nor given the opportunity to participate in plans regarding Patient #1's discharge needs.	A 130			
A 800	482.43(a) CRITERIA FOR DISCHARGE EVALUATIONS The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. This STANDARD is not met as evidenced by: Based on staff interview and record review, the	A 800			

SEE ATTACHED
Plan of
Correction
C. M. May

3/31/17

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A 800	Continued From page 2 hospital failed to identify discharge planning needs for 2 of 10 applicable patients in the sample. (Patient #1 and Patient #8). Findings include: 1. Per record review, Patient #1 has Alzheimer's dementia, heart, kidney, and other nervous system conditions. On 12/16/16, Patient #1 was admitted to the hospital and was newly diagnosed with pneumonia and a pleural effusion. Per interview with Patient #1's legal guardian, Patient #1 needed help getting dressed and had trouble getting in and out of vehicles; and upon discharge would need a wheelchair van and/or ambulance for transportation back to the residential care home where s/he resided. Patient #1 was discharged two days later, dressed only in a hospital gown, covered with blankets, and sent back to the home, alone in a cab. Per record review there was no evidence of an admission assessment/evaluation for his/her initial discharge needs. Per review of the policy "Discharge Planning and Patient Discharge" (revised/reviewed 2/3/17) under procedure it states, "2. All patients will be assessed within 24 hours of admission for initial discharge needs." Per interview on 2/21/17 at 2:35 PM with the Manager and Supervisor of Case Management and Social Work, each stated that it was the responsibility of the Case Manager to complete an initial discharge planning assessment/evaluation within 24 hours of admission. They each confirmed that the Case Manager failed to complete an assessment/evaluation of the initial discharge needs for Patient #1, per hospital policy/procedure. 2. Per record review, Patient #8 was admitted to	A 800	SEE ATTACHED PLAN OF CORRECTION C H Wray		3/31/17

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A 800	Continued From page 3 the hospital on 1/30/17 with pneumonia and discharged home five days later. S/he has a history of asthma (chronic lung disease that inflames and narrows the airways), diabetes (metabolic disorder characterized by high blood sugar, insulin resistance and lack of insulin), some cognitive and memory deficits, and multiple hospital admissions for recurrent pneumonia. Upon further record review, there was no evidence of an admission assessment/evaluation for his/her initial discharge needs. Per review of the policy "Discharge Planning and Patient Discharge" (revised/reviewed 2/3/17) under procedure it states, "2. All patients will be assessed within 24 hours of admission for initial discharge needs." Per interview on 2/22/17 at 1:58 PM with the Director of Clinical Operations and Manager of Case Management and Social Work, each stated that it was the responsibility of the Case Manager to complete an initial discharge planning assessment/evaluation within 24 hours of admission. They each confirmed that the Case Manager failed to complete an assessment/evaluation of the initial discharge needs for Patient #8, per hospital policy/procedure.	A 800	SEE ATTACHED Plan of Correction	3/31/17	
A 812	482.43(b)(6) DOCUMENTATION OF EVALUATION [The hospital must] include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan This STANDARD is not met as evidenced by: Based on staff interview and record review the hospital failed to include the discharge planning evaluation in the medical record for 2 of 10 applicable patients in the sample (Patient #1,	A 812			

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A 812	Continued From page 4 Patient #8). Findings include: 1. Per record review, Patient #1 has Alzheimer's dementia, heart, kidney, and other nervous system conditions. On 12/16/16, Patient #1 was admitted to the hospital and was newly diagnosed with pneumonia and a pleural effusion. Per interview with Patient #1's legal guardian, Patient #1 needed help getting dressed and had trouble getting in and out of vehicles; and upon discharge would need a wheelchair van and/or ambulance for transportation back to the residential care home where s/he resided. Patient #1 was discharged two days later, dressed only in a hospital gown, covered with blankets, and sent back to the home, alone in a cab. Per record review there was no evidence of an admission assessment/evaluation for his/her initial discharge needs in the medical record. Per review of the policy "Discharge Planning and Patient Discharge" (revised/reviewed 2/3/17) under procedure it states, "2. All patients will be assessed within 24 hours of admission for initial discharge needs." Per interview on 2/21/17 at 2:35 PM with the Manager and Supervisor of Case Management and Social Work, each stated that it was the responsibility of the Case Manager to complete an initial discharge planning assessment/evaluation within 24 hours of admission. They each confirmed that the Case Manager failed to complete and document in the medical record, an assessment/evaluation of the initial discharge needs for Patient #1, per hospital policy/procedure. 2. Per record review, Patient #8 was admitted to the hospital on 1/30/17 with pneumonia and discharged home five days later. S/he has a history of asthma (chronic lung disease that		A 812	SEE ATTACHED PLAN OF CORRECTION C. H. M. [Signature]	3/31/17

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A 812	Continued From page 5 inflames and narrows the airways), diabetes (metabolic disorder characterized by high blood sugar, insulin resistance and lack of insulin), some cognitive and memory deficits, and multiple hospital admissions for recurrent pneumonia. Upon further record review, there was no evidence of an admission assessment/evaluation for his/her initial discharge needs in the medical record. Per review of the policy "Discharge Planning and Patient Discharge" (revised/reviewed 2/3/17) under procedure it states, "2. All patients will be assessed within 24 hours of admission for initial discharge needs." Per interview on 2/22/17 at 1:58 PM with the Director of Clinical Operations and Manager of Case Management and Social Work, each stated that it was the responsibility of the Case Manager to complete an initial discharge planning assessment/evaluation within 24 hours of admission. They each confirmed that the Case Manager failed to complete and document in the medical record, an assessment/evaluation of the initial discharge needs for Patient #8, per hospital policy/procedure.	A 812	SEE ATTACHED PLAN of CORRECTION C.M. 3/13/17

A 000, INITIAL COMMENTS:

An unannounced on-site survey was conducted from 2/21/17 - 2/22/17 by staff from the Vermont Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The purpose of the survey was to investigate complaint #15237. The following regulatory violations were identified

A 130 482.13 (b)(1) PATIENT RIGHTS: PARTICIPATION IN CARE PLANNING

The patient has the right to participate in the development and implementation of his or her plan of care.

This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to include the patient's representative in the development and implementation of the discharge plan for 1 of 10 applicable patients in the sample. (Patient #1). Findings include:

Per record review, Patient #1 has Alzheimer's dementia (type of chronic or persistent disorder of mental processes affecting memory, personality, and/or behavior) heart, kidney, and other nervous system conditions. S/he was admitted to the hospital on 12/16/16 from a residential care home with pneumonia and a pleural effusion (excess fluid in the lung). Per interview with Patient #1's legal guardian, Patient #1 was discharged two days later on a very cold day, dressed only in a hospital gown covered with blankets; and was sent back to the care home, alone in a cab.

Per review of the provider admission and discharge notes, Patient #1 refused to take antibiotics at the care home, became increasingly agitated, was up all night crying out in pain, and was very irritable with the staff at the care home.

Patient #1 was sent to the Emergency Department via ambulance and was admitted for IV (in the vein) antibiotics and mood management. Patient #1's legal guardian had been at the hospital the day prior to discharge and had discussed with the provider the specific discharge requirements for a safe discharge for

Patient #1 Per review of the nursing progress notes on 12/18/16 at 11:00 AM, the patient had written discharge orders to go back to the residential care home. Report was called to the residential care home; and Patient #1 verbalized understanding of discharge instructions and denied further questions.

Per record review Patient #1 was discharged on the weekend and the Case Manager who developed the discharge plan failed to consult with Patient #1's legal guardian regarding

Patient #1's functional status, and specific discharge needs. Per interview on 2/21/17 at 2:35 PM with the Manager and Supervisor of Case Management and Social Work, each confirmed that Patient #1's legal guardian was not consulted nor given the opportunity to participate in plans regarding Patient #1's discharge needs.

ACTION PLAN

- A quality review was performed in January 2017 by a multidisciplinary team including physician, case management & social work and nursing representatives. Opportunities were identified to better clarify roles and accompanying responsibilities.
- The UVMHC policy Transitions to Sub Acute and Post-Acute Care Rehabilitation Facilities has been reviewed and updated under the direction of the Manager of Case Management and Social Work. The updated referenced policy specifically states discharge planning will be facilitated by Case Management/Social Work, who will assess the patient/family needs through communication with providers, the patient and family members/surrogate as well as from direct observation of the patient. Case Management and Social work were educated by the Manager on the policy changes through a combination of electronic communications and staff meetings during the month of March.

AC A-130-A-812 acont
4-10-17 SLDW

- The UVMHC policy Discharge Planning and Patient Discharge has been updated to include that all patients will be assessed by nursing and/or case management within 24 hours of admission for initial discharge needs. Case manager will assess patient within 48 hours of admission unless he/she does not meet criteria determined to meet needs for discharge assistance. Case Management and Social Work were educated on the policy changes through a combination of electronic communications and staff meetings during the month of March.
- Documentation to support the Discharge Planning and Patient Discharge was added to the medical record during the month of March 2017. Specifically, an Initial Assessment Status complete/pending documentation prompt was added to the Case Management and Social Work documentation. This supports being able to discern timely completion of assessments in real time to ensure care planning is occurring
- In February 2017, the importance of a safe patient discharge plan individualized to each patient's needs was reinforced through the UVMHC Nursing Initiatives. Nursing Initiatives is an educational tool that was sent to Nurse Educators and Nursing Managers to review with all staff during the month of February 2017.
- A RN Clinical Analyst will review cases monthly for appropriate documentation of a patient specific, safe discharge plan. Performance data will be provided to the Director and Manager of Case Management for feedback as required.
- All actions will be completed effective 3/31/2017.

A 800.482.43 (a) CRITERIA FOR DISCHARGE EVALUATIONS

The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. This STANDARD is not met as evidenced by:

Based on staff interview and record review, the hospital failed to identify discharge planning needs for 2 of 10 applicable patients in the sample. (Patient #1 and Patient #8). Findings include:

1. Per record review, Patient #1 has Alzheimer's dementia, heart, kidney, and other nervous system conditions. On 12/16/16, Patient #1 was admitted to the hospital and was newly diagnosed with pneumonia and a pleural effusion. Per interview with Patient #1's legal guardian, Patient #1 needed help getting dressed and had trouble getting in and out of vehicles; and upon discharge would need a wheelchair van and/or ambulance for transportation back to the residential care home where s/he resided. Patient #1 was discharged two days later, dressed only in a hospital gown, covered with blankets, and sent back to the home, alone in a cab. Per record review there was no evidence of an admission assessment/evaluation for his/her initial discharge needs. Per review of the policy "Discharge Planning and Patient Discharge"(revised/reviewed 2/3/17) under procedure it states, "2. All patients will be assessed within 24 hours of admission for initial discharge needs. "Per interview on 2/21/17 at 2:35 PM with the Manager and Supervisor of Case Management and Social Work, each stated that it was the responsibility of the Case Manager to complete an initial discharge planning assessment/evaluation within 24 hours of admission. They each confirmed that the Case Manager failed to complete an assessment/evaluation of the initial discharge needs for Patient #1, per hospital policy/procedure

2. Per record review, Patient #8 was admitted to the hospital on 1/30/17 with pneumonia and discharged home five days later. S/he has a history of asthma (chronic lung disease that inflames and narrows the airways), diabetes (metabolic disorder characterized by high blood sugar, insulin resistance and lack of insulin), some cognitive and memory deficits, and multiple hospital admissions for recurrent pneumonia. Upon further record

review, there was no evidence of an admission assessment/evaluation for his/her initial discharge needs. Per review of the policy "Discharge Planning and Patient Discharge" (revised/reviewed 2/3/17) under procedure it states, "2. All patients will be assessed within 24 hours of admission for initial discharge needs." Per interview on 2/22/17 at 1:58 PM with the Director of Clinical Operations and Manager of Case Management and Social Work, each stated that it was the responsibility of the Case Manager to complete an initial discharge planning assessment/evaluation within 24 hours of admission. They each confirmed that the Case Manager failed to complete an assessment/evaluation of the initial discharge needs for Patient #8, per hospital policy/procedure.

ACTION PLAN

- A quality review was performed in January 2017 by a multidisciplinary team including physician, case management & social work and nursing representatives. Opportunities were identified to better clarify roles and accompanying responsibilities.
- The UVMHC policy Transitions to Sub Acute and Post-Acute Care Rehabilitation Facilities has been reviewed and updated under the direction of the Manager of Case Management and Social Work. The updated referenced policy specifically states discharge planning will be facilitated by Case Management/Social Work, who will assess the patient/family needs through communication with providers, the patient and family members/surrogate as well as from direct observation of the patient. Case Management and Social work were educated by the Manager on the policy changes through a combination of electronic communications and staff meetings during the month of March.
- The UVMHC policy Discharge Planning and Patient Discharge has been updated to include that all patients will be assessed by nursing and/or case management within 24 hours of admission for initial discharge needs. Case manager will assess patient within 48 hours of admission unless he/she does not meet criteria determined to meet needs for discharge assistance. Case Management and Social Work were educated on the policy changes through a combination of electronic communications and staff meetings during the month of March.
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- A RN Clinical Analyst will review cases monthly for appropriate documentation of a patient specific, safe discharge plan. Performance data will be provided to the Director and Manager of Case Management for feedback as required.
- All actions will be completed effective 3/31/2017.

A812 482.43 (b)(6) DOCUMENTATION OF EVALUATION

[The hospital must] include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan ...This STANDARD is not met as evidenced by: Based on staff

interview and record review the hospital failed to include the discharge planning evaluation in the medical record for 2 of 10 applicable patients in the sample (Patient #1, Patient #8) Findings include:

1. Per record review, Patient #1 has Alzheimer's dementia, heart, kidney, and other nervous system conditions. On 12/16/16, Patient #1 was admitted to the hospital and was newly diagnosed with pneumonia and a pleural effusion. Per interview with Patient #1's legal guardian, Patient #1 needed help getting dressed and had trouble getting in and out of vehicles; and upon discharge would need a wheelchair van and/or ambulance for transportation back to the residential care home where s/he resided. Patient #1 was discharged two days later, dressed only in a hospital gown, covered with blankets, and sent back to the home, alone in a cab. Per record review there was no evidence of an admission assessment/evaluation for his/her initial discharge needs in the medical record. Per review of the policy "Discharge Planning and Patient Discharge" (revised/reviewed 2/3/17) under procedure it states, "2. All patients will be assessed within 24 hours of admission for initial discharge needs." Per interview on 2/21/17 at 2:35 PM with the Manager and Supervisor Df Case Management and Social Work, each stated that it was the responsibility of the Case Manager to complete an initial discharge planning assessment/evaluation within 24 hours of admission. They each confirmed that the Case Manager failed to complete and document in the medical record, an assessment/evaluation of the initial discharge needs for Patient #1, per hospital policy/procedure.

2. Per record review, Patient #8 was admitted to the hospital on 1/30/17 with pneumonia and discharged home five days later, S/he has a history of asthma (chronic lung disease that inflames and narrows the airways), diabetes (metabolic disorder characterized by high blood sugar, insulin resistance and lack of insulin), some cognitive and memory deficits, and multiple hospital admissions for recurrent pneumonia. Upon further record review, there was no evidence of an admission assessment/evaluation for his/her initial discharge needs in the medical record. Per review of the policy "Discharge Planning and Patient Discharge". (revised/reviewed 2/3/17) under procedure it states, "2. All patients will be assessed within 24 hours of admission for initial discharge needs." Per interview on 2/22/17 at 1:58 PM with the Director of Clinical Operations and Manager of Case Management and Social Work, each stated that it was the responsibility of the Case Manager to complete an initial discharge planning assessment/evaluation within 24 hours of admission. They each confirmed that the Case Manager failed to complete and document in the medical record, an assessment/evaluation of the initial discharge needs for Patient #8, per hospital policy/procedure.

ACTION PLAN

- A quality review was performed in January 2017 by a multidisciplinary team including physician, case management & social work and nursing representatives. Opportunities were identified to better clarify roles and accompanying responsibilities.
- The UVMHC policy Transitions to Sub Acute and Post-Acute Care Rehabilitation Facilities has been reviewed and updated under the direction of the Manager of Case Management and Social Work. The updated referenced policy specifically states discharge planning will be facilitated by Case Management/Social Work, who will assess the patient/family needs through communication with providers, the patient and family members/surrogate as well as from direct observation of the patient. Case Management and Social work were educated by the Manager on the policy changes through a combination of electronic communications and staff meetings during the month of March.
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- Documentation to support the Discharge Planning and Patient Discharge was added to the medical record during the month of March 2017. Specifically, an Initial Assessment Status complete/pending documentation prompt was added to the Case Management and Social Work documentation. This supports being able to discern timely completion of assessments in real time to ensure care planning is occurring
- In February 2017, the importance of a safe patient discharge plan individualized to each patient's needs was reinforced through the UVMMC Nursing Initiatives. Nursing Initiatives is an educational tool that was sent to Nurse Educators and Nursing Managers to review with all staff during the month of February 2017.
- A RN Clinical Analyst will review cases monthly for appropriate documentation of a patient specific, safe discharge plan. Performance data will be provided to the Director and Manager of Case Management for feedback as required.
- All actions will be completed effective 3/31/2017.

MAR 27 2017

THE
University of Vermont
MEDICAL CENTER

March 23, 2017

Jeffords Institute for Quality
Accreditations & Regulatory Affairs Department
111 Colchester Avenue
Burlington, VT 05401

Suzanne Leavitt, RN, MS
Assistant Division Director
Director, State Survey Agency
Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060

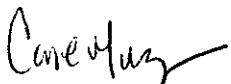
Dear Suzanne Leavitt:

I am very pleased to submit form CMS – 2567 and the attached Plan of Correction in response to the Statement of Deficiencies and findings from the survey completed by the Division on February 22, 2017.

The University of Vermont 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 any questions about the attached Plan of Correction or require further clarification, please feel free to contact me.

Sincerely,



Carol Muzzy, Director
Accreditations and Regulatory Affairs
The University of Vermont Medical Center
111 Colchester Avenue
Burlington, VT 05401
Telephone: 802-847-5007
Fax: 802-847-6274