Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

IMPORTANT NOTICE – PLEASE READ CAREFULLY
SENT VIA INTERNET EMAIL to chad.fitzgerald@vumc.org
(Receipt of this notice is presumed to be November 16, 2018 – date notice e-mailed)

November 16, 2018

Chad Fitzgerald, JD
Regulatory Officer, VUMC
Sr. Director, Quality, Safety and Risk Prevention
Vanderbilt University Medical Center
1211 Medical Center Drive
Nashville, Tennessee 37232

Re: CMS Certification Number (CCN): 44-0039

Dear Mr. Fitzgerald:

Section 1864 of the Social Security Act authorizes the Secretary of Health and Human Services to conduct complaint surveys of hospitals deemed, by an accrediting organization, to meet the Medicare Conditions of Participation (COP) if there are "substantial allegations" indicating serious deficiencies that could potentially affect the health and safety of patients. A complaint survey was completed at Vanderbilt University Medical Center on November 8, 2018. The survey identified an immediate and serious threat to patient health and safety. As a result, effective November 8, 2018, your deemed status by Joint Commission is removed and survey jurisdiction has been transferred to the Tennessee State Survey Agency. A copy of the deficiencies cited during this survey is enclosed. Specifically, the facility does not meet the following COP:

42 CFR 482.13 Patient Rights
42 CFR 482.23 Nursing Services

When a hospital is found to be out of compliance with one or more COP, and immediate and serious threat to patient health and safety exists, a determination must be made that the facility no longer meets the requirements for participation as a provider of services in the Medicare program. Such a determination has been made in the case of Vanderbilt University Medical Center, and accordingly, the Medicare provider agreement between Vanderbilt University Medical Center and the Secretary of the Department of Health and Human Services is being terminated effective **December 9, 2018**, if the immediate jeopardy is not removed by this date.

The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted on or after **December 9, 2018**. For patients admitted prior to **December 9, 2018**, payment may continue to be made for a maximum of 30 days for inpatient hospital services furnished on or after **December 9, 2018**.

Termination can only be averted by correction of these deficiencies by **December 9, 2018**. If you believe that compliance has been achieved, you should notify CMS and the Tennessee State Survey Agency in writing on or before **November 26, 2018,** describing in detail the specific corrective measures taken to resolve the deficiencies. **An acceptable plan of correction must contain the following elements:**

1) The plan of correcting the specific deficiency cited. The plan should address the processes that lead to the deficiency cited;
2) The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
3) The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
4) The title of the person responsible for implementing the acceptable plan of correction.

If your plan of correction is accepted, the Tennessee State Survey Agency will conduct a resurvey to determine if the conditions which constituted immediate jeopardy have been removed. Please be advised, however, that failure to remove the immediate jeopardy will result in your hospital's termination under Medicare, effective **December 9, 2018**. If the Centers for Medicare & Medicaid Services determine that the reasons for termination remain, the effective date of the termination remains **December 9, 2018**. If corrections have been made, the termination procedures will be halted, and you will be notified in writing.

Appeal Rights

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. A copy of the hearing request shall be submitted electronically to **Region4_DAB_HearingRequest@cms.hhs.gov**.

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense.

If there are any questions, please contact Jackie Whitlock at (404) 562-7437 or by email at jacqueline.whitlock@cms.hhs.gov.

Sincerely,

Linda D. Smith
Associate Regional Administrator
Division of Survey & Certification

Enclosure: CMS 2567, Statement of Deficiencies

cc: Tennessee State Survey Agency
Joint Commission