Brattleboro Retreat
MENTAL HEALTH AND ADDICTION CARE

APR 09 2018

April 6, 2018

Kathy Mackin, Health Insurance Specialist
Department of Health and Human Services
Centers for Medicare and Medicaid Services
JFK Federal Building, Government Center
Room 2325
Boston, MA 02203

April 6, 2018

Dear Ms. Mackin:

Please find enclosed the response to CMS survey ID QU2F11 of the Brattleboro Retreat on March 14, 2018 conducted by the Vermont Division of Licensing and Protection. We have noted the deficiencies, and are committed to continuously improving the systems and procedures for providing safe quality care for our patients.

Please do not hesitate to contact me if you have questions or further feedback.

Sincerely,

Kirk J. Woodring, LICSW
Chief Clinical Officer
The Brattleboro Retreat

c. Vermont Department of Licensing and Protection

www.brattlebororetreat.org

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1.800.RETREAT (738.7328) / TDD 802.258.3770
Administrative Offices: 802.257.7785 / f 802.258.3782
Central Intake / Admissions: 802.258.3700 / f 802.258.3791

Anna Marsh Behavioral Care Clinic
802.258.3707
f 802.258.3788

Primarilink
1.800.320.5895
f 802.258.3749

Mulberry Bush Early Learning Center
802.258.4350
f 802.258.6146

Starting Now
802.258.3705
f 802.258.3788

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474001	A. BUILDING ______ B. WING ______	C 03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

(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 The Division of Licensing and Protection conducted an unannounced on-site investigation from 3/12/2018-3/14/2018 of two complaints as authorized by the Centers for Medicare and Medicaid. Complaint #16426 and complaint #16455 were investigated for compliance with the Condition of Participation: Patient Rights. The following regulatory violations were identified with complaint #16455.	A 000	See attached -	
A 164	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the least restrictive interventions were based on a comprehensive assessment of an individual's condition to include medical co-morbidities and age and were considered prior to the initiation of seclusion and restraint for 1 of 6 applicable patients. (Patient #1) Findings include: Upon admission on 3/2/18, Patient #1 informed staff s/he was experiencing difficulty with organization, finding words and remembering individuals names. Upon admission, Patient #1 demonstrated confusion questioning why s/he was admitted and was anxious about being kept against his/her will. Patient #1 demonstrated anxiety and impaired cognition, which included wandering throughout Tyler 2 unit looking for	A 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Chief Clinical Officer (X6) DATE: April 4 2018

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 164	Continued From page 1 his/her cat. Patient #1 had no prior history of suicidal ideation, drug abuse, depression or psychiatric hospitalization. On 3/4/17 Patient #1, age 75, became anxious and aggressive towards staff. When the patient was resistant to redirection, staff response included emergency medications to include Haldol 5 mg IM (antipsychotic) and Ativan 1 mg (benzodiazepine) IM (intramuscular), hands on restraint and locked door seclusion (involuntary confinement & prevented from leaving). On 3/5/17 at 11:15 PM staff observed Patient #1 suddenly become unresponsive and cyanotic. Vital signs and oxygen levels had decreased and staff called a "Code Blue" (cardiac emergency). The patient was emergently transferred to the emergency department for evaluation and treatment. It was determined, Patient #1 had experienced a adverse reaction to Seroquel 50 mg in combination with Metoprolol (blood pressure medication). Patient #1 had never received Seroquel prior to admission to the Retreat. Per the Emergency Department (ED) record for 3/6/17, the ED physician who provided treatment to Patient #1 stated "...given the patient's advanced age s/he is metabolizing more slowly than expected". In addition, a MRI performed on 3/6/17 did note some ischemia of the brain. On 3/6/18 Patient #1 returned from the Emergency Department. Within 2 hours after returning to Tyler 2, Patient #1 was involved in a second behavioral emergency. After demonstrating agitation and not responding to redirection, Patient #1 was restrained by Tyler 2 staff; administered emergency medications (Haldol 5 mg IM and Ativan 1 mg. IM); and placed	A 164		

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A 164	Continued From page 2 in a restraint chair for 64 minutes. On 3/7/18 Patient #1 was involved in a third behavioral incident when Patient #1 placed hands on staff and was exit seeking. Patient #1 was subjected to Emergency Involuntary Procedures to include hands on restraint; administration of Haldol 5 mg. IM and Ativan 1 mg. and locked door seclusion. Per review of the Client Treatment Plan Report initiated on 3/2/18 there was a failure of the Treatment Team which includes psychiatry, nursing and social services to develop a individualized assessment of factors after each episode of behavioral emergency with consideration of Patient #1's vulnerability, age and identified co-morbidities. It was not until 3/13/18 the treatment plan acknowledges the patient's medical emergency, behavioral emergencies and interactions of medications leading to confusion and disorientation. A comprehensive treatment plan also failed to take into account the patient's specific needs after weighing factors to include the patient's health condition, age, behaviors, recent history and the unfamiliar hospital environment. Per interview on 3/14/18 at 2:10 PM a attending psychiatrist confirmed at the time of admission, Patient #1 was experiencing delirium and had overcompensated.	A 164		
A 167	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(4)(ii) [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.	A 167		

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A 167	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that seclusion and restraint were implemented appropriately and safely as evidenced by an adverse outcome including back pain, right sided pain and upper body bruising for 1 of 6 applicable patients. (Patient #1) Findings include: Patient #1, age 75, was voluntarily admitted to the hospital on 3/2/17 after demonstrating altered mental status with no prior history of psychiatric hospitalization. The patient's insight, judgement and cognition were identified as impaired. Shortly after admission, Patient #1 was requesting to be discharged and lacked understanding how and why s/he had been admitted, expressing concern about who would provide care to his/her cat left alone in Patient #1's residence. Patient #1 acknowledged a recent history of difficulty with memory, using incorrect words when in conversation and feeling disorganized. Per Nursing Progress Note on the afternoon of 3/4/18 Patient #1 became upset, wandering Tyler 2 unit looking for his/her cat, crying. Attempts were made by staff to redirect the patient who refused to accept Seroquel (antipsychotic) 25 mg orally for agitation. At approximately 4:15 PM, Patient #1 entered the nurses station, a restricted area for patients, and staff intervened by removing the patient from the nurses station using a "J hooked" (hands on physical restraint used for escorting an individual from one location to another). Patient #1 was then transferred to the Quiet Room where staff proceeded to place Patient #1 in a "wall hold". From the "wall hold", Patient #1 was placed in a "supine floor hold" and	A 167		

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A 167	Continued From page 4 administered Emergency Involuntary Medication to include: Haldol 5 mg IM (intramuscular) and Ativan 1 mg IM. Once medicated, Patient #1 was then placed in locked door seclusion where s/he remained until 5:38 PM when the door to the seclusion room was unlocked. On 3/6/17 at 6:00 PM, Patient #1 returned from receiving treatment in a Emergency Department where s/he was transferred after experiencing a medical event on the evening 3/5/17 involving a adverse reaction to Seroquel. Patient #1, now assigned to ALSA (Adult Low Stimulation Area) became disruptive pounding on doors and windows and attempted to pull keys from staff hands resulting in scratches to 2 nurses. At 8:10 PM on 3/6/18, Patient #1 was again placed in a "J-Hook", escorted to the Quiet Room and restrained for 27 minutes on the floor mattress in a supine position. Emergency Involuntary Medications were administered IM to include Haldol 5 mg & Ativan 1 mg. At 8:37 PM Patient #1 was then lifted and placed in a restraint chair and restrained until 9:41 PM. On 3/7/18 at 8:30 AM when Patient #1 became intrusive with staff, pushed staff, tore at a physician's ID/lanyard, banged on windows and doors and refused oral medication. Emergency Involuntary Medications were administered to Patient #1 after being restrained on the floor mat in the seclusion room. The door was locked and seclusion was initiated at 08:45 AM until 09:32 AM. Per Nursing Progress Note for 3/11/17 at 9:24 AM stated Patient #1 was complaining of pain related to healing diffuse bruising on right side of his/her body. On 3/12/18 a "skin assessment" was	A 167		

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A 167	Continued From page 5 conducted to identify multiple bruises on Patient #1's upper arms, left chest, left hip and buttock. Physicians Progress Note for 3/13/18 states "There was a report yesterday of her/him noting bruising in various places, thought likely secondary to medical and behavioral emergencies occurred earlier in hospitalizations." A medical consult Patient Progress Note for 3/13/18 describes Patient #1's complaints to include: "....states after emergency procedures and holds several days ago, s/he developed some pain in his/her R (right) biceps and pain in her/his R breast, and notes bruising in these areas but said pain is mostly gone........more frustrated with back/right sided pain s/he experiences when trying to lie down... skin purple/red ecchymosis over lateral side of right breast...". Per interview on 3/14/18 at 11:45 AM, the Nurse Manager for Tyler 2 acknowledged bruising had been noted after the documented behavioral emergencies, however further follow-up with all staff involved has not occurred, nor was an adverse event report completed regarding the injuries sustained to the 75 year old patient. According to material from the Crisis Prevention Institute (CPI) utilized in the facility's restraint training, "all reasonable and alternative nonphysical interventions should be used if the duration of the physical restraint exceeds 10 minutes" due to risks associated with prolonged restraint. Per interview on 3/14/18 at 2:25 PM, the Clinical Training Administrator stated although s/he reviews staff debriefing reports completed after each behavioral emergency, s/he "was not aware" of the clinical indication for the restraints involving Patient #1 that exceeded 10 minutes. Further investigation has not been conducted to	A 167		

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A 167	Continued From page 6 assure all staff involved in all 3 behavioral emergencies were compliant with training and hold procedures.	A 167		
A 174	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to provide evidence of documentation justifying the continued use of seclusion and restraint and failed to release a patient from seclusion and/or restraint at the earliest possible time for 1 of 6 applicable patients. (Patient #1) Findings include: Per Nursing Progress Note on the afternoon of 3/4/18 Patient #1 became upset, wandering Tyler 2 unit looking for his/her cat and crying. Attempts were made by staff to redirect the patient and the patient refused to accept Seroquel (antipsychotic) 25 mg orally for agitation when offered. At approximately 4:15 PM, Patient #1 pushed nursing staff and entered the nurses station, a restricted area for patients. Staff "J hooked" (hands on physical restraint used for escorting individual from one location to another) Patient #1 to the Quiet Room where staff proceeded to place Patient #1 in a "wall hold". From the "wall hold", Patient #1 was placed in a "supine floor hold" and injected with Emergency Involuntary Medication to include: Haldol (antipsychotic) 5 mg IM (intramuscular) and Ativan (benzodiazepine) 1 mg IM. Once medicated, Patient #1 was then placed	A 174		

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A 174	Continued From page 7 in locked door seclusion, where s/he remained until 5:38 PM when the door to the seclusion room was unlocked. A Certificate of Need (CON), is completed by nursing staff after a Emergency Involuntary Procedure (EIP) has transpired which includes 15 minute observations and assessment checks of the patient, which can then determine the readiness for discontinuation of a restraint and/or seclusion. Per review of CON at 4:45 PM, 5:00 PM, 5:15 PM & 5:30 PM justification for the continued use of seclusion, nursing documents Patient #1 "Has not met criteria". The CON states: "identified conditions for release: from seclusion included: "No agitation, No threatening behavior". There was a lack of documentation confirming Patient #1's behavior at the time of closed door seclusion except for what is noted on the Milieu Observation record. From 5:00 PM - 5:30 PM Patient #1 was described to be "laying down". At 5:45 PM again Patient #1 was noted to be "awake-laying down". The risk of threatened harm to herself/himself or others was not identified to exist. The unsafe situation which staff defined to have existed was no longer occurring, as per documentation. However the locked door seclusion was not discontinued until approximately 5:30 PM. On 3/6/17 at 6:00 PM Patient #1 returned from the Emergency Department after experiencing a medical event on the evening 3/5/17 involving a adverse reaction to Seroquel. Patient #1, now assigned to ALSA (Adult Low Stimulation Area) became disruptive by pounding on doors and windows and attempted to pull keys from staff hands resulting in scratches to 2 nurses. At 8:10 PM, Patient #1 was again placed in a "J-Hook", escorted to the Quiet Room and restrained for 27 minutes on the floor mattress in a supine position.	A 174		

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A 174	Continued From page 8 Emergency Involuntary Medications were administered IM to include Haldol & Ativan. At 8:37 PM Patient #1 was then lifted and placed in a restraint chair and restrained until 9:41 PM. There is no documented evidence why Patient #1 was maintained in a supine floor hold for 27 minutes or why a restraint chair was utilized. The 15 minute observations/assessments for 8:25 PM, 8:40 PM, 8:55 PM & 9:25 PM describe the purpose for continued use of the restraint chair was justified for "agitation". Constant observations of Patient #1 while in the restraint chair only notes the chair was in use. There is no documentation justifying for ongoing use of the restraint chair. In regards to the prolong floor hold, per CPI (Crisis Prevention Institute) nonviolent crisis training utilized as the core training for hospital employees states "Prolonged Physical Restraint: In any situation where physical restraint exceeds 10 minutes, staff must take all reasonable actions to end the restraint and seek alternative nonphysical intervention." Per interview on 3/14/15 at 3:30 PM, the RN involved in the EIP on 3/6/17 stated s/he was unsure why Patient #1 was held on the floor for an excessive period of time, except that perhaps staff were seeking to locate the restraint chair. In addition, per interview on 3/14/18 at 2:25 PM, the Clinical Training Administrator and CPI instructor stated although s/he reviews staff debriefing reports completed after each EIP s/he had not been provided the debriefing documentation for this specific EIP involving Patient #1 on 3/6/18. On 3/7/18 at 8:30 AM Patient #1 became intrusive with staff, tore at a physician's ID/lanyard, pushing staff, began banging on windows and doors and refused oral medication. As a result, Patient #1 was placed in a 2 person	A 174		

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A 174	Continued From page 9 wall hold and then lowered to the floor mat, restrained on the floor mat in the seclusion room and at 8:42 AM administered Emergency Involuntary Medications to include Haldol and Ativan IM. Locked door seclusion was initiated at 8:45 AM. Per review of the CON documentation, from 09:00 AM, 09:15 AM & 09:30 AM the continuation of locked door seclusion was justified due to "agitation and unresponsive to questions". Per constant observations documentation Patient #1 at 8:45 AM was "sitting on floor; 9:15 AM: "on floor, resp. noted"; and 9:30 PM: "on floor, resp noted". After 47 minutes in locked door seclusion, Patient #1 was permitted to leave. Per review of the hospital's policy Restraint and Seclusion, last reviewed 09/2007 states: " Seclusion and restraint is only used in emergency situations if needed to ensure the patient's, a staff member, or others" immediate physical safety and after less restrictive interventions have been determined to be ineffective. Restraints/seclusion must be discontinued as soon as safely possible based on the assessment and re-evaluation of the patient." Per interview on 3/14/18 at 11:45 AM, the Nurse Manager for Tyler 2 and the Chief Nursing Officer acknowledged documentation was insufficient to justify ongoing use of restraints and/or seclusion for Patient #1.	A 174		

The Brattleboro Retreat
Corrective Action Plan
Survey Completion Date: 3.14.18
Provider ID 474001

ID Prefix Tab	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency /Goal
A 164	Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that the least restrictive interventions were based on a comprehensive assessment of an individual's condition to include medical co-morbidities and age and were considered prior to initiation of seclusion and restraint for 1 of 6 applicable patients.	The Brattleboro Retreat is committed to a process of continuous improvement. Without admitting that this statement of deficiencies accurately describes the facts elicited in the survey, the Retreat submits the following response: The Brattleboro Retreat is committed to continuously evaluating and reassessing its processes for using the most restrictive interventions only when necessary, and following the review and use of less restrictive means as determined by hospital policy and in accordance with state law. The Brattleboro Retreat is also assessing and continuously working to improve its processes for accurately and thoroughly documenting the quality of care provided to its patients.			

A 167	The use of seclusion or restraint must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy and in accordance with state law	The Brattleboro Retreat is committed to continuously evaluating and reassessing its processes for using the most restrictive interventions only when necessary and as determined by hospital policy and in accordance with state law.			

A 174	Restraint or Seclusion must be discontinued at the earliest possible time.	The Brattleboro Retreat is committed to continuously evaluating and reassessing its processes for the use and discontinuation of the most restrictive interventions, as well as fully, clearly and effectively documenting all aspects of restraint and seclusion in accordance with hospital policy and state law.			

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Corrective Action Plan
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Provider ID 474001