VERMONT

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

August 28, 2019

Dr. Louis Josephson, President And Ceo
Brattleboro Retreat
Anna Marsh Lane Po Box 803
Brattleboro, VT 05301-0803

Dear Dr. Josephson,

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 25, 2019**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Suzanne Leavitt, RN, MS
Assistant Division Director
State Survey Agency

PRINTED: 08/19/2019
FORM APPROVED
OMB NO. 0938-0391

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

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 07/25/2019

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 An unannounced complaint investigation was conducted by the Division of Licensing and Protection on 7/22/19 through 7/25/19 as authorized by the Centers for Medicare and Medicaid to determine compliance with the Conditions of Participation: Patient Rights; Quality Assurance/Performance Improvement; and Nursing Services for Complaint #17856. The following regulatory violations were identified: Based on information obtained through observations, staff interviews and record review, an immediate Jeopardy situation was determined to exist based upon the hospital's failure to provide and maintain care in a safe setting for all patients and the hospital's failure to initiate immediate action after a significant patient event occurred. NOTE: The hospital was notified of the Immediate Jeopardy (IJ) on 7/25/19 at 12:35 PM. An IJ removal plan was submitted on 7/25/2019 at 4:15 PM which alleged removal of the IJ. The IJ removal plan to correct the IJ as of 7/24/2019 included the following interventions: all plastic trash liners found in trash receptacles were removed from all inpatient units; any purchased items/ supplies delivered in plastic bags or sleeves will be brought to the units in paper bags or totes; the contraband policy will be updated; staff communication regarding the adverse event and immediate changes were in progress; the Patient Safety Officer will conduct a Root Cause Analysis when an Adverse Event occurs; and staff will identify potentially dangerous items and remove them from the units.	A 000	See attached	
A 115	PATIENT RIGHTS	A 115	See attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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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 115	Continued From page 1 CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observations, interviews and record review the Condition of Participation: Patient Rights has not been met as evidenced by the hospital's failure to ensure the provision of patient care was provided in a safe setting. Refer to tags A: 144; 154; 168; 179	A 115	See Attached	
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation, interview and record review, care was not provided in a safe setting because patients had access to plastic bags. The hospital also failed to initiate a hospital-wide action plan to mitigate the further use of plastic bags on inpatient units after a patient confiscated and ingested a piece of a plastic bag. (Patient #1) Findings include: 1. Patient #1 was admitted involuntarily to the psychiatric hospital on 4/19/19 with a diagnosis of bipolar disorder and symptoms of psychosis, paranoia and a history of medication noncompliance. Upon admission, the attending psychiatrist completed a suicide risk assessment identifying Patient #1 to be at moderate risk for suicide noting the patient had attempted suicide by overdose twice, once in 2017 and more recently on 4/4/19. During the course of	A 144	See attached	

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A 144	Continued From page 2 hospitalization Patient #1 presented as delusional and demonstrated behaviors requiring interventions including being placed in seclusion and being assigned to the ALSA (low stimulation area). At times, Patient #1 was permitted to leave ALSA and integrate onto the general milieu on Tyler 2. However, after a significant behavioral event on the evening of 6/12/19 Patient #1 was placed in locked door seclusion for 1 hour. Subsequent to the involuntary emergency event, Patient #1 was described in a Physicians Progress note "as declining" and the patient expressed fear of not getting out of the hospital alive. During the late morning of 6/13/19 nursing staff assessed Patient #1 for safety and behavior control and determined it was safe to allow Patient #1 to integrate into the general milieu on Tyler 2 and was monitored by staff every 15 minutes. However, a Nursing Progress Note on 6/13/19 states a Mental Health Worker (MHW) overheard Patient #1 state: " I want to kill myself. I want to die. I cannot take this anymore all my life...I am going to die. I want to die." At 11:38 AM on 6/13/19 a MHW alerted the nurse, after finding Patient #1 laying on the bathroom floor with a portion of a plastic bag hanging from their mouth, attempting to swallow the plastic. The piece of plastic bag was removed and the patient was assessed to be medically stable but was sent to an emergency department for evaluation to rule out potential respiratory and gastrointestinal obstruction from the plastic bag ingestion. After being medically cleared, and upon return to the hospital, Patient #1 was placed on constant visual observations. After the ingestion event on 6/13/19 on Tyler 2, an internal investigation determined that Patient #1 was able to access the trash barrel plastic bag	A 144	See attached	

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A 144	Continued From page 3 liner despite the locked cover on the trash barrel. The overlapping and exposed plastic bag was accessible to Patient #1 who was able to tear a piece of the plastic bag resulting in the ingestion and serious attempt at self-harm. Within hours after the event, the Tyler 2 Nurse Manager; the Director of Patient Safety and Nursing Quality; and the Director of Environmental Services took action by removing the plastic bags from the trash barrel only on Tyler 2. No further action was taken to ensure the safety of all hospitalized patients. On 7/24/19 at 2:20 PM, the Nurse Surveyor, accompanied by the Director of Regulatory Affairs, conducted a tour of the hospital's 6 additional inpatient units. All units were observed to have locked trash barrels with excessive plastic bag exposure. Of note, two trash receptacles on Osgood I (Child unit) were observed. One trash receptacle in the child's dining room had approximately 3 inches overhanging of plastic bag from the trash receptacle which was in close proximity to children eating in the dining room. On Tyler 3 (Adolescent unit) the trash barrel was observed in the kitchenette located behind a half door with an additional bag hanging freely from the barrel. The potential for further patient self-harm on any of the other 6 patient care units was not identified or considered by hospital staff. A hospital wide plan to mitigate conditions of an unsafe environment were not assessed or enacted upon until it was brought to the attention of the hospital administration by the Nurse Surveyor. In assessing the potential global risk for the 88 patients hospitalized on 7/25/19 at 11:05 AM, the Unit Chief of Adult Inpatient Units confirmed 48 patients would be considered at a higher risk for harm due to suicidality.	A 144	See attached	

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A 144	Continued From page 4 Despite the Environmental Safety Rounds conducted twice yearly on each Inpatient unit by a team of several department managers, the access and use of plastic bags on all of the inpatient psychiatric units was not identified or considered as a patient safety risk for the potential for self-harm by suffocation through ingestion and/or as a ligature risk using torn strips from plastic bags. In addition, assigned MHWs conduct "Baseline Safety checks" which also assess the environment every 15 minutes and during the change of shift. The document used by staff during safety rounds does include monitoring for plastic bags, however the use of the plastic trash bags was not considered as a safety concern. The presence of this identified risk in the psychiatric patient's physical environment had compromised each patient's right to receive care in a safe environment.	A 144	See attached	
A 154	USE OF RESTRAINT OR SECLUSION CFR(s): 482.13(e) Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to perform a comprehensive assessment to ensure that restraints were	A 154	See attached	

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A 154	Continued From page 5 discontinued at the earliest possible time for 2 applicable patients in the sample (Patient # 3 and Patient #8). There was a failure by staff to ensure all safety interventions were implemented during the course of manual restraint holds for 1 of 7 applicable patients. (Patient #1) Findings include: 1. Per record review, Patient #3 has a history of bipolar disease (A mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behavior) and presented to the hospital because s/he was displaying behaviors that made it unsafe for him/her to be in the community. S/he also had a history of not taking medications as prescribed and was in need of some medication adjustments. Per review of a nursing progress note from 6/24/19 at 10:30 PM, the patient was in the unit community area and was very chatty with his/her peers. S/he was making statements about having power and rights to others; and was instigating behaviors that required redirection. S/he was wearing all white clothing and another patient was wearing all black clothing. The patient wearing black clothing took a hold of a nurse's computer, and then Patient #3 charged a mental health worker and knocked him/her into the nurse's station. The staff called a "code green" (Emergency response by additional staff to assist with behavioral emergencies). . Per review of the Certificate of Need (CON) from 6/24/19, it read, "Patient incited a riot, asking other patients to join with ... 'to take on the unit staff. Patient charged at a staff member slamming ... across the milieu into the nurses station, who ended up injured. Patient was posturing, threatening staff, disrupting the milieu, pulled the kitchen refrigerator out from the kitchen area to barricade ... ... and ... peer down the	A 154	See attached	

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A 154	Continued From page 6 long hallway of Tyler 2". Patient #3 refused medications by mouth and at 9:50 PM was given involuntary medications (Haldol (antipsychotic) 5 milligrams (mg) and Ativan (anti-anxiety) 1 mg) intramuscularly. S/he was restrained in the restraint chair and then escorted to the ALSA (Adult Low Stimulation Area) at 9:52 PM. At 10:08 PM, the nursing assessment read, "Patient continues to exhibit unsafe behavior". At 10:23 PM, "Patient continues to exhibit unsafe behavior". At 10:38 PM, "Patient continues to exhibit unsafe behavior". At 11:08 PM, "Patient continues to exhibit unsafe behavior". At 11:23, "Patient continues to exhibit unsafe behavior". At 11:38 PM, "Patient continues to exhibit unsafe behavior". Per interview on 7/24/19 at approximately 1:45 PM with a Registered Nurse (RN) Clinical Educator, s/he confirmed that the above fifteen minute nursing assessments for Patient #3 did not contain sufficient reasons for the patient to remain in the restraint chair. Per record review Patient #8 has the following diagnoses: schizoaffective disorder, bipolar type (disorder in which a person experiences hallucinations, delusions and mood symptoms like depression/mania) post-traumatic stress disorder, nicotine use disorder, dental caries, dysphagia (difficulty swallowing), and dyspepsia (general stomach discomfort). Per review of a physician's progress note from 5/21/19, the patient had a chronic, debilitating psychotic illness in which s/he had been institutionalized for the past 5 years. S/he was transferred to the hospital to continue his/her care and develop further aftercare management. His/her long psychiatric history included many hospitalizations and an abusive past. The physician's mental status exam revealed that the patient was disheveled,	A 154	See attached	

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A 154	Continued From page 7 hostile, belligerent, agitated, irritable, and uncooperative. A nursing progress note from 6/23/19 at 8:12 AM, stated, "Pt cursing and screaming in staff's face taking no verbal redirection. In people's personal space swinging closed fists and trying to pull at staff's hair, shooting them with ...finger gun yelling 'bang' and slicing staff in half in the air. Pt spit out ...morning medications on the floor, offered PRN (as needed) medication later where pt took all the pills and threw them at the RN. Pt received IM Haldol/Benadryl and Ativan and was in locked door seclusion from 10:26 AM to 12:20 PM". Per review of the CON-Emergency Involuntary Procedure (EIP) documentation from 6/23/19, the details of the procedure read, "seclusion to allow medications to become effective". Per interview on 7/24/19 at 2:35 PM with a Registered Nurse (RN) Clinical Educator, s/he confirmed that the justification for the patient being put into seclusion did not contain sufficient reasons for initiating and/or continuing seclusion for Patient #8. Per review of the policy "Restraint and Seclusion"-last reviewed 9/2017, under "Documentation of Restraint and/or Seclusion" it read, "Complete a Certificate of Need Form (CON) and document reason for the restraint/seclusion, description of patient's behavior, alternative or less restrictive interventions attempted and the patient's response to the interventions and restraint/seclusion, and the criteria for release from restraint or seclusion." 2. During the late evening of 6/11/19 Patient #1 became agitated and threatening to staff demanding to be allowed out of ALSA to use the bathroom on Tyler 2. Due to safety concerns, and	A 154	See attached	

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A 154	Continued From page 8 accelerating behaviors, staff attempted to provide toiletries and redirected Patient #1 to utilize the ALSA bathroom. Patient #1 refused to use the ALSA bathroom and again was redirected to return to his/her room or go to the quiet room to calm his/herself. Patient #1's behaviors did not subside and s/he grabbed and pushed RN who was attempting to address Patient #1's demands and reached out to assault the MHW. A "code green" was called and Emergency Involuntary Procedure was initiated by placing Patient #1 in a "J" hook (manual physical restraint) hold by 2 MHWs and brought to the quiet room at 10:40 PM. Once in the quiet room, staff placed Patient #1 in a standing "wall hold" as per CPI (Crisis Prevention Institute) training. Patient #1 continued to make verbal threats and staff was directed by the RN to place Patient #1 in a floor hold. The patient was placed in a prone (face down) position and turned to a supine position. Oral medication was offered and accepted by Patient #1 receiving Thorazine 100 mg (antipsychotic) and Klonopin (sedative) 1 mg. The quiet room door was closed and the patient remained in locked door seclusion. At 11:53 PM seclusion ended and Patient #1 was assisted from seclusion and returned to his/her assigned room in ALSA. The patent immediately complained to a RN of left shoulder pain, and required medication for pain which was administered twice during the early morning hours of 6/12/19. Patient #1 rated the level of pain as 10/10 (extreme pain). A clinic consult was placed and Patient #1 was examined by a APRN (Advanced Practice Registered Nurse). Patient #1 reported to the APRN when being placed on the floor in the seclusion room s/he struck his/her left elbow and did have a previous shoulder injury. The x-ray of the clavicle and left shoulder results showed "subacute	A 154	See attached	

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A 154	Continued From page 9 middle shaft fracture, incomplete bony union. Some residual deformity...viewed showed a prior clavicular fracture". The 6/12/19 Inpatient Progress Note completed by the APRN states "this result is consistent with patient's prior history of clavicular fracture". Per Patient's # 1 Admission Assessment dated 4/19/19 "Reported significant medical issues" states patient reported a left shoulder injury on 3/2019. Per observation of the Tyler 2 ALSA on 7/25/19 at 4:10 PM, accompanied by the Tyler 2 nurse manager and the Director of Regulatory Affairs, the quiet room (used for locked door seclusion) was noted to be constructed of cement floors and walls. At the time of the observation, the quiet room did not have a mattress. The nurse manager stated the mattress had been removed from the room because it was considered a "tripping hazard" for staff. As a result, restraint floor holds would involve a patient to be manually restrained on the cement floor and patients kept in locked door seclusion must lay or sit on the cement floor for variable periods of time. Per interview on 7/23/19 at 3:25 PM, MHW #1 confirmed being a responder during the "code green" event on 6/11/19 involving Patient #1 stating s/he had applied "hands on" taking part in both the "J" hook hold, wall hold and the "take down" of the patient to the cement floor in the quiet room. S/he further acknowledged not being appraised that Patient #1 had a shoulder injury or precautions to take at the time of the Emergency Involuntary Procedure. MHW #1 further stated "...during take downs is where injures can occur".	A 154	See attached	
A 168	PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 168	See attached	

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A 168	Continued From page 10 CFR(s): 482.13(e)(5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to ensure that a physical restraint was implemented in accordance with an order from a physician or a licensed independent provider for 2 applicable patients (Patient #5 and Patient #8). Findings include: Per review of a nursing triage note from 6/23/19, Patient #5 arrived at the hospital in tears asking for help. S/he stated that s/he was not able to get into the Sub Oxone (prescription medication used to treat those addicted to opioids) clinic until the coming week. S/he was discharged 3 days ago from the hospital after being treated for alcohol and opioid abuse. S/he stated that s/he was suicidal and had been using heroin and drinking since his/her discharge on 6/14/19. Per review of a nursing progress note from 6/24/19 at 11:00 PM, Patient #5 was reporting a "blah" mood, s/he denied suicidal ideation, depression, anxiety or pain. The patient wanted to get into the "Hub" in the morning. The patient went to the nurse's station several times requesting medication as s/he felt s/he was withdrawing. The nursing assessment showed that his/her Clinical Opiate Withdrawal Scale (COWS) at two different times did not show active withdrawal. The patient was offered comfort medications on two separate	A 168	See attached	

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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 07/25/2019

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 168	Continued From page 11 occasions and refused. The nurse expressed concerns to his/her supervisor because the patient was interacting with a peer on the unit that was manic. Upon further review of the nursing progress note from 6/24/19, it read, "Within a couple of minutes patient and co patient entered the community area, patient wearing all black clothing and co patient wearing all white clothing. Patient walked up to writer sitting at the front of the nurses station and ..grabbed my computer screen, yanking it up and slamming it back down. Writer jumped up to call code green ... ...Per MHW(Mental Health Worker) standing near nurses station in milieu co patient began to grab chairs and then charged at ...throwing ... into the nurses station. Writer called code green again times two. ... .Writer remained in med room, contacting on call MD obtaining orders for both patients .....Per staff on unit, patient was restrained in the milieu and was escorted to ALSA". Per review of the EIP from 6/24/19, it read, "Client proceeded to remove shirt and turn over tables, shoving refrigerator from kitchen to the hallway using other chairs and objects to block the hallway. Closing hallway door barricading [himself/herself] and co patient behind. Encouraging staff to 'try to come at me, you will see what you are going to get'. Encouraging other patients to join in. Posturing, shouting expletives and requesting 'Sub Oxone' Client had to be placed in a standing wall hold and walked back to ALSA". Per review of the medical record from 6/24/19 for Patient #5, there was no evidence that an order was written by a physician or licensed independent practitioner for the physical restraint. Per interview on 7/24/19 at 2:30 PM with the Director of Patient Safety and Nursing Quality, s/he confirmed that the there was no order for the physical restraint and there	A 168	See attached	

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PRINTED: 08/19/2019
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OMB NO. 0938-0391

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A 168	Continued From page 12 should have been one. Per record review Patient #8 has the following diagnoses: schizoaffective disorder, bipolar type (disorder in which a person experiences hallucinations, delusions and mood symptoms like depression/mania) post-traumatic stress disorder, nicotine use disorder, dental caries, dysphagia (difficulty swallowing), and dyspepsia (general stomach discomfort). Per review of a physician's progress note from 5/21/19, the patient had a chronic, debilitating psychotic illness in which s/he had been institutionalized for the past 5 years. S/he was transferred to the hospital to continue his/her care and develop further aftercare management. His/her long psychiatric history included many hospitalizations and an abusive past. The physician's mental status exam revealed that the patient was disheveled, hostile, belligerent, agitated, irritable, and uncooperative. A nursing progress note from 5/22/19 at 4:04 PM, read, "Pt angry, following staff and peer.., getting in their face, posturing and throwing objects. Pt grabbed an MHW's (Mental Health Worker) arm and pinched them. Pt was in LDS (Locked Door Seclusion) from 10:44 AM to 10.59 AM and received Haldol 5 mg and Ativan 2mg IM (intramuscular). Pt has poor boundaries and needs much verbal redirection from staff." Per review of the EIP procedure documentation from 5/22/19, at 10:43 AM, it read, "CPI J-Hook (type of physical hold), pt did not struggle, released into the quiet room and LDS began". Per review of the medical record from 5/22/19 for Patient #8, there was no evidence of an order written by a physician or licensed independent practitioner for the physical restraint. Per interview on 5/22/19 at 2:06 PM with a Registered Nurse (RN) Clinical Educator, s/he	A 168	See attached	

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A 168	Continued From page 13 confirmed that there was no order for the physical restraint and there should have been one. Per review of the policy "Restraint and Seclusion"-last reviewed 9/2017 under "CLINICAL PERSONS RESPONSIBLE FOR ASSESSMENT OF PATIENTS TO DETERMINE NEED FOR RESTRAINT AND/OR SECLUSION AND THE INITIATION OF ORDERS:" it read, "The LIP (licensed independent provider) who is responsible for the care of the patient is required to provide an order for the use of restraint or seclusion. The LIP is authorized to order restraint or seclusion by hospital policy in accordance with state law. The use of restraint or seclusion must be in accordance with the order of an LIP responsible for the care of the patient prior to the application of restraint or seclusion".	A 168	See attached	
A 179	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(12) [the patient must be seen face-to-face within 1 hour after the initiation of the intervention --] §482.13(e)(12)(ii)To evaluate - 1. The patient's immediate situation; 2. The patient's reaction to the intervention; 3. The patient's medical and behavioral condition; and 4. The need to continue or terminate the restraint or seclusion. This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to show evidence that a physician, licensed independent provider (LIP), and/or trained registered nurse (RN), had conducted a	A 179	See attached	

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A 179	Continued From page 14 one hour face to face assessment after the initiation of physical restraints for 1 applicable patient (Patient #5). Findings include: Per review of a nursing triage note from 6/23/19, Patient #5 arrived at the hospital in tears asking for help. S/he stated that s/he was not able to get into the Sub Oxone (prescription medication used to treat those addicted to opioids) clinic until the coming week. S/he was discharged 3 days ago from the hospital after being treated for alcohol and opioid abuse. S/he stated that s/he was suicidal and had been using heroin and drinking since his/her discharge on 6/14/19. Per review of a nursing progress note from 6/24/19 at 11:00 PM, Patient #5 was reporting a "blah" mood; s/he denied suicidal ideation, depression, anxiety or pain. The patient wanted to get into the "Hub" in the morning. The patient went to the nurse's station several times requesting medication as s/he felt s/he was withdrawing. The nursing assessment showed that his/her Clinical Opiate Withdrawal Scale (COWS) at two different times did not show active withdrawal. The patient was offered comfort medications on two separate occasions and refused. The nurse expressed concerns to his/her supervisor because the patient was interacting with a patient on the unit that was manic. Upon further review of the nursing progress note from 6/24/19, it read, "within a couple of minutes patient and co patient entered the community area, patient wearing all black clothing and co patient wearing all white clothing. Patient walked up to writer sitting at the front of the nurses station and ..grabbed my computer screen, yanking it up and slamming it back down. Writer jumped up to call code green ... ...Per MHW(Mental Health Worker) standing near nurses station in milieu co patient began to	A 179	See attached	

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A 179	Continued From page 15 grab chairs and then charged at ...throwing ... into the nurses station. Writer called code green again times two. ... .Writer remained in med room, contacting on call MD obtaining orders for both patients .....Per staff on unit, patient was restrained in the milieu and was escorted to ALSA". Per review of the EIP from 6/24/19, it read, "Client proceeded to remove shirt and turn over tables, shoving refrigerator from kitchen to the hallway using other chairs and objects to block the hallway. Closing hallway door barricading [himself/herself] and co patient behind. Encouraging staff to 'try to come at me, you will see what you are going to get'. Encouraging other patients to join in. Posturing, shouting expletives and requesting 'Sub Oxone' Client had to be placed in a standing wall hold and walked back to ALSA". Per review of the CON from 6/24/19 for Patient #5 there was no evidence that a one hour face to face assessment was done after the application of a physical restraint. There was no evidence of a face to face assessment that included the patient's immediate situation; the patient's reaction to the intervention; the patient's medical and behavioral condition; or the need to continue or terminate the restraint or seclusion. Per interview on 7/24/19 at 2:34 PM with the Director of Patient Safety and Nursing Quality, s/he confirmed that a one hour face to face assessment was not done and should have been done. Per review of the policy "Restraint and Seclusion"-last reviewed 9/2017 under "PATIENT ASSESSMENT following INITIATION OF SECLUSION/RESTRAINT & REASSESSMENT at every 15 minutes and WITHIN ONE HOUR:" It read, "When restraint or seclusion is used, the	A 179	See attached	

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A 179	Continued From page 16 patient shall be seen face to face within 15 minutes after the initiation of the intervention by an LIP or specially trained RN. The patient shall be monitored by an LIP or specially trained registered nurse to determine the continued need for the EIP. The within one hour assessment must evaluate: The patient's immediate situation; The patient's reaction to the intervention The patient's medical and behavioral condition; Any complications resulting from intervention Whether the individual is aware of what is required to be released from restraint and/or seclusion and the need to continue or terminate the EIP".	A 179	See attached	
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observations, interview and record review the Condition of Participation Quality Assurance/Performance Improvement (QA/PI)	A 263	See attached	

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A 263	Continued From page 17 was not met due to the failure to ensure that its program activities included a timely and complete review and analysis of an adverse patient event and the causes, and failed to develop and implement hospital wide interventions to prevent adverse events. Refer to Tag A-286	A 263	See attached	
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities. The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the hospital failed to identify a serious	A 286	See attached	

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A 286	Continued From page 18 hospital safety risk and conduct a comprehensive assessment of an adverse patient event and implement timely preventative actions to ensure patient safety throughout the hospital. Findings include: After learning on 6/13/19 a patient on Tyler 2 was found laying on the bathroom floor and had ingested a piece of a plastic bag, the nurse manager on Tyler 2; the Director of Patient Safety and Nursing Quality; and the Director for Environmental Services conducted an investigation to determine how the patient accessed a plastic bag. The investigation identified that despite the locked cover on the trash barrel stored on Tyler 2, the patient was able to obtain access to the trash barrel plastic bag liner. The overlapping and exposed plastic bag was visible and accessible to the patient who was able to tear a piece of the plastic bag resulting in the ingestion and serious attempt at self-harm. Per review of hospital policy Event Review and Reporting last reviewed on 07/2019 states: "The safe operations of these systems include but are not limited to conducting the following activities: Identifying, documenting, reporting and investigating significant adverse event on a timely basis; reviewing events to identify opportunities for performance improvement; and developing and implementing corrective action plans that address both human and systemic factors that contributed to reportable adverse event....." However, a more comprehensive hospital wide assessment was not conducted. Despite the fact plastic bags were also utilized on the other 6 inpatient units, no further action was taken to ensure no other patients were at risk for self harm	A 286	See attached	

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A 286	Continued From page 19 resulting from access to plastic bags. The quality assurance and performance improvement program activities failed to fully analyze the cause of the adverse patient event or implement preventive actions and mechanisms including feedback and learning throughout the hospital. On 7/24/19 at 2:20 PM, the Nurse Surveyor, accompanied by the Director of Regulatory Affairs, conducted a tour of the hospital's 6 additional inpatient units. Locked trash barrels with excessive plastic bag exposure were observed on all units. Of note, on Osgood I (Child unit) 2 trash receptacles were observed. One trash receptacle in the child's dining room had approximately 3 inches overhanging of plastic bag from the trash receptacle which was in close proximity to the children eating in the dining room. On Tyler 3 (Adolescent unit) the trash barrel was observed in the kitchenette located behind a half door with an additional bag hanging freely from the barrel. The potential for further patient self-harm on any of the other 6 patient care units was not identified or considered by hospital QA/PI staff, nor was a plan to mitigate conditions of an unsafe environment enacted upon until it was brought to the attention of the hospital administration by the Nurse Surveyor. Per Interview on 7/25/19 at 11:25 AM the Director of Patient Safety confirmed there was no decision to expand the analysis for safety on the other patient units, although s/he was fully aware plastic bags remained in use. In assessing the potential global risk for the 88 patients hospitalized on 7/25/19 at 11:05 AM, the Unit Chief of Adult Inpatient Units confirmed 48 patients would be considered at a higher risk for harm due to suicidality, compounding the	A 285	See attached	

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A 286	Continued From page 20 significance for not utilizing plastic bags within any of the inpatient psychiatric units. Per review of an incident that occurred on 6/24/19, both Patient #3 and Patient #5 incited a type of riot against the staff where they were able to barricade themselves from staff with a refrigerator that was located in the Tyler 2 kitchen. During a tour at 10:25 AM on 7/23/19 of the Tyler 2 Unit, patients were observed going in and out of the kitchen with full access. The surveyors went into the kitchen area and were able to gain access to the refrigerator and noted that the refrigerator was not secured in any manner. Per interview on 7/24/19 at 1:36 PM with the Director of Patient Safety and Nursing Quality, s/he stated that a root cause analysis was done regarding the incident, however, the final plan had not yet been completed. Despite the known safety risk in a psychiatric setting there was a failure to ensure the provision of all patient's right to care in a safe setting. There was no evidence that the QA/PI process included the implementation of preventive actions following an adverse event to eliminate patient safety risks.	A 286	See attached	
A 396	NURSING CARE PLAN CFR(s): 482.23(b)(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on interview and record review the hospital failed to ensure that a nursing care plan was developed for Patient #4 which identified specific health concerns and was kept current for	A 396	See attached	

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A 396	Continued From page 21 Patient #6. Findings include: 1. Patient #4 was admitted to the hospital on 6/7/19 after demonstrating symptoms of mania, delusions and noncompliance with medications. During hospitalization the patient required nebulizer breathing treatments for asthma and experienced peripheral edema and redness of both lower legs. On 6/12/19 Patient #4 was seen by hospital clinic staff and was prescribed Lasix (diuretic) to help reduce the leg edema and compression stockings were ordered. Review of treatment plans developed by the interdisciplinary team during Patient #4's hospitalization (6/7/19 - 6/24/19) did not reflect the patient's ongoing health issues or ordered interventions. Per interview on 7/24/19 at 12:05 PM the Director of Nursing Operations confirmed it was his/her expectation the Treatment Plan should have identified Patient #4's health issues and nursing interventions for the provision of care related to the patient's ongoing issues with asthma and peripheral edema. 2. Per review of a nursing progress note from 5/9/19, Patient #6 was transferred to the hospital from a tertiary facility in an involuntary admission status. The patient presented with acute psychosis and s/he reportedly tried to lure children away from their homes with candy to get them away from "terrorists" ("their parents"). Patient #6 had two nursing care plans developed on 5/10/19, one for being delusional and paranoid; and one for acute psychosis. The care plan for acute psychosis was updated on 5/11/19, 5/13/19, 5/17/19, 5/20/19, 5/23/19, 5/24/19, 5/31/19, 6/6/19, 6/7/19, 6/14/19, 6/19/19, 6/21/19, 6/22/19, 6/28/19, 7/5/19, 7/12/19, 7/15/19, and 7/19/19. The care plan for being delusional and	A 396	See attached	

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A 396	Continued From page 22 paranoid did not have any evidence in the medical record that it was updated. Per interview on 7/25/19 at 1:59 PM with a RN Clinical Educator, s/he confirmed that the care plan for being delusional and paranoid was not updated and should have been.	A 396	See attached	
A 398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by Based on record review and confirmed by staff interview, the hospital failed to ensure that one contracted Registered Nurse (RN) out of three nursing staff sampled was properly oriented to the duties of his/her role. Findings include: Per review of 3 training records of three contracted clinical staff persons on 7/25/19, there was no evidence of orientation or competencies for one of the three contracted/ traveler nurses. Per Interview on 7/25/19, the Vice President of Human Resources confirmed there was a lack of evidence of orientation in the employee's record.	A 398	See attached	
A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(I) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as	A 405	See attached	

CEO

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

PRINTED: 08/19/2019
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
	474001	A. BUILDING _____ B. WING _____	C 07/25/2019

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 PRECLUDED 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 405	Continued From page 23 specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on staff interview and record review, there was a failure of nursing staff to be vigilant post medication administration to ensure a patient successfully swallowed medications when administered for 1 of 9 applicable patients. (Patient #1) Findings including: Per record review, Patient #1 demonstrated on 2 separate occasions problems with non-compliance after nursing staff administered medication. Per review of Nursing Progress note dated 5/23/19 "...found to be cheeking meds ...." and the patient confirmed "I raise my my tongue..they can not see it ...." later a Thorazine tablet was found under the patient's bed. A second incident on 6/12/19 at 04:30 AM a Nursing Progress note states ... .."Pt also reported to me that s/he has been "cheeking" some of his/her meds specifically his/her Thorazine. Will inform day nurse.."	A 405	See attached	

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

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A 405	Continued From page 24 Per hospital policy Administration and Scheduled Time Medication last reviewed on 12/2018 states " IV. Mouth Checks-Standard & Advanced, Definition: Mouth Check- the act of visually inspecting the inside of the patient's mouth after a medication has been administered. Advanced Mouth Checks : For patients considered at high risk for cheeking/palming not taking meds according to policy: The physician orders Advanced Mouth Checks". However, although Patient #1 was admitting to cheeking medications and 1 pill was found under the patient's bed, no further follow-up was conducted by nursing to ensure Patient #1 was successfully swallowing medication when administered. Per interview on the morning of 7/25/19, the attending psychiatrist was unable to validate or confirm awareness of Patient #1's issues with "cheeking" medications nor had a order for Advanced Mouth Checks been requested by nursing as per hospital policy.	A 405	See attached	

CEO

Brattleboro Retreat
Plan of Correction for Survey ID 4XLH11

CMS §482.13: Patient's Rights

A115: A hospital must protect and promote each patient's rights
A144: The patient has the right to receive care in a safe setting

2019 CMS Findings:
Patient Rights has not been met as evidenced by the hospital's failure to ensure the provision of patient care was provided in a safe setting.

Measure of Success: No plastic bags or wrappers identified in patient care areas.

Corrective Action Taken:

WHO:

The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

1. Environmental Services: Removed all plastic bags from units by July 25, 2019
2. Materials Management: Process all incoming unit products and process for medical supplies was completed by Materials Management by August 5, 2019.
3. Red Book hospital wide communication regarding plastic was created, reviewed by Senior Leadership on 7/26/2019 and distributed to all Clinical Unit Managers and placed in our Red Book Communication on 7/26/2019. Notification of the Red Book Communication was sent through hospital-wide communication 7/26/2019. Signature required acknowledging read.
4. Education through My Learning Point educational PPT and post-test at 100% compliance for all scheduled inpatient staff. Education created by Clinical Educators, approved by CNO, Director of Regulatory Affairs and Director of Patient Safety, assigned to be completed by all scheduled inpatient staff by 8/7/2019. 100% compliance achieved.
5. Environmental rounds form standardized by Director of Regulatory Affairs and implemented 7/31/2019. Form to be completed by a Mental Health Worker on every unit on every shift with sign-off record and audit by Clinical Nurse Manager weekly.
6. Environmental Services: Senior Director of Environmental Services updated rounding checklist for life safety to include plastics. Completed and in place 8/2/2019.
7. Sodexo: Educational PPT and post-test at 100% compliance for all environmental staff: no plastic on the units and change in cleaning cart products.
8. Nursing: Changed Contraband Policy to reflect removal of all plastic bags from incoming patient belongings and visitor items. Completed 7/29/2019

WHEN:

- Removed all plastic bags from inpatient units by July 25, 2019.
- All incoming unit products and process for medical supplies was completed by Materials Management by August 5, 2019.

Brattleboro Retreat
Plan of Correction for Survey ID 4XLH11

- Notification of the Red Book Communication was emailed as a hospital-wide communication 7/26/2019.
- My Learning Point educational PPT and post-test assigned was completed by all scheduled inpatient staff by 8/7/2019. 100% compliance achieved.
- Environmental Rounds form is completed by a Mental Health Worker on every unit on every shift with sign-off record and weekly audits by Clinical Nurse Managers weekly. Form completed 7/31/2019, audits ongoing.
- Director of Sodexo: Educational PPT and post-test at 100% compliance for all environmental staff. Completed 8/7/2019.
- Contraband Policy updated to reflect removal of all plastic bags from incoming patient belongings and visitor items. Completed by Director of Patient Safety, released as education update 7/29/2019 to all staff.

HOW:

- The Mental Health Workers will perform shift environment of care rounds to assess ongoing compliance with safety on our units.
- The Materials Management staff will perform ongoing assessments of our hospital used products for safety and plastics. Product changes will be made as required ensuring safety on an ongoing basis.
- Education via MyLearningPointe, on safe environments and plastic hazards will be required of all new employees and as a yearly refresher.

A115 + A144 PoC accepted 8/28/19 FMcIntoshRN/pmc

Brattleboro Retreat
Plan of Correction for Survey ID 4XLH11

CMS §: 482.13 (e) Use of Restraint and Seclusion

A154: Patients' Rights: Restraint or Seclusion

2019 CMS Findings:
A154 The hospital failed to perform a comprehensive assessment to ensure restraints were discontinued at the earliest possible time.

Measure of Success: Patients time in seclusion or restraint will be discontinued as early as safely possible

Corrective Action Taken:

WHO:

The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

1. Nursing Leadership & Education created the Emergency Involuntary Procedure detailed education including initiating and/or continuing seclusion/restraint and discontinuation.
2. IT modification to our current CON form to create hard stop requiring RN to report detailed reasoning why patient is restrained.
3. Staff Education: Education through MyLearningPointe on differences between seclusion, restraint, and involuntary medication.
4. All quiet rooms will have a mattress.

WHEN:

- Emergency Involuntary Procedure detailed education including initiating and/or continuing/discontinuation of seclusion/restraint completed 8/24/2019.
- IT modification to our current CON form to create hard stop completed 8/26/2019.
- Education through MyLearningPointe on seclusion, restraint, and involuntary medication. Completed 8/26/2019.
- All quiet rooms have a mattress. Completed and verified 8/26/2019.

HOW:

- The Director of Education will maintain the MyLearningPointe on use of the restraint, seclusion, and involuntary medication and initiating and/or continuing seclusion/restraint training which will be required of all new employees and as a yearly refresher.
- The Quiet room will be inspected daily for a mattress being present. Ongoing.

A154 POC accepted 8/28/19 FMcIntosh RN | PMC

Brattleboro Retreat
Plan of Correction for Survey ID 4XLH11

CMS §: 482.13 (e) (5) Use of Restraint and Seclusion
A168: Patients' Rights: Restraint Or Seclusion

A168 Use of Restraint and Seclusion

2019 CMS Findings: The hospital failed to ensure that physical restraint was implemented in accordance with an order form a physician or LIP.

2019 CMS Findings: The hospital failed to ensure that a physical restraint was implemented in accordance with an order for a physician or licensed independent practitioner.

Measure of Success: All restraints or seclusions will have CON's appropriately filled out within specified time frames per policy.

Corrective Action Taken:

WHO:

The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

1. Checklist created for EIP
2. IT: Avatar Widget: created for RN's to show what needs completion by end of shift.
3. Ongoing audits daily by Clinical Nurse managers of all 100% of CON's.
4. Standard work created for Emergency Involuntary Procedures and education via resource binder.

WHEN:

- Checklist created for EIP on 8/23/2019
- IT: Avatar Widget: created for RN's to show what needs completion by end of shift. To be completed on 8/30/2019
- Standard work created for Emergency Involuntary Procedures and education via resource binder. Completed 8/24/2019

HOW:

- Audits completed daily by Clinical Nurse Managers of 100% of CON's; will be ongoing.

A168 POC accepted 8/28/19 FMcIntosh RA/ Anw

Brattleboro Retreat
Plan of Correction for Survey ID 4XLH11

CMS §: 482.13 (e) (12) Use of Restraint and Seclusion

A179: Patients' Rights: Restraint Or Seclusion

2019 CMS Findings: The hospital failed to show evidence that a physician, LIP, or trained Registered Nurse had conducted a one hour face-to-face after initiation of physical restraint.

Measure of Success: All seclusion or restraints will have a face to face assessment completed within one hour.

Corrective Action Taken:

WHO:

The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

1. Education: Created standard work for EIP's and educate to the standard.
2. Create EIP Checklist.
3. Education: provided for all Registered Nurses on MLP and added to the resource binder.
4. Audit of EIP's by Clinical Nurse Managers daily.

WHEN:

- Education on standard work for EIP's and educate to the standard completed 8/26/2019
- EIP Checklist developed 8/23/2019
- Education for Registered Nurses on MLP and added to the resource binder on 8/23/2019.

HOW:

Audit of EIP's by Clinical Nurse Managers completed daily.

A179 POC accepted 8/28/19 FinchRN/PMC

Brattleboro Retreat
Plan of Correction for Survey ID 4XLH11

CMS §482.21: QAPI

A263: QAPI Program

2019 CMS Findings: Quality Assurance/Performance Improvement was not met due to the failure to ensure that its program activities included a timely and complete review and analysis of patient event and the causes, and failed to develop and implement hospital wide interventions to prevent adverse events.

Measure of Success: Ongoing review of incidents and assessment of those requiring a RCA based on acuity assessment.

Corrective Action Taken:

WHO:

The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

1. Director of Quality Improvement: Created process of pink "Escalate the Incident" slips which are handed out by the Director of Quality Improvement daily M-F to Clinical Nurse Managers to follow up and report back on identified issues and/or incidents.
2. Director of Quality Improvement: Pink slip reviews daily at Nursing Leadership huddle.

WHEN:

- Process implemented 8/5/2019 and ongoing.

HOW:

- In person review of all incidents reported in the prior 24 hours by Clinical Nurse managers, Director of Quality and Patient Safety and Director of Regulatory Affairs.

A263 POC accepted 8/28/19 FMcIntoshRN/mc

Brattleboro Retreat
Plan of Correction for Survey ID 4XLH11

CMS §: 482.21 (a)(2),(e)(3)

A286: Program Scope

Measure of Success: Incident reporting will increase; review process will remain as daily and serious incidents will decrease.

Corrective Action Taken:

WHO:

The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

1. Verge incident reporting system has been purchased and is in process of configuration for implementation in the fall. This implementation will create ease of use for end users, therefore increasing our reporting and tracking of incidents in a timely manner.
2. Clarification of the Patient Safety Officer's authority related to patient care areas and to Patient Safety.
3. Clear definition of the Chief Nursing Officer's authority related to patient care areas and patient care.
4. Education on how to escalate an incident created and taught through MLP.

WHEN:

- Verge incident reporting system implementation November 2019
- Clarification of the Patient Safety Officer's scope and clear definition of the Chief Nursing Officer's was discussed at both PEC and Executive Team meetings to provide clarity.

HOW:

- Education on how to escalate an incident was taught through MLP placed 8/17/2019.

A286 POC accepted 8/28/19 FMcIntoshRN/pm

Brattleboro Retreat
Plan of Correction for Survey ID 4XLH11

CMS §: 482.23(b)(6)

A396 Nursing Care Plan

2019 CMS Findings: The hospital failed to ensure that a nursing care plan was developed for a patient which identified specific health concerns.

Measure of Success: Nursing staff will develop and maintain a nursing care plan for each patient.

Corrective Action Taken:

WHO:

The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

1. a. Documentation of standard work for the nursing plan of care with resource binders for education.
   b. There will be a MLP education provided for RN's by Clinical Ed. Department.

WHEN:

- MLP education on Nursing Care planning is available.

HOW:

- Clinical Nurse Managers will do daily audits of plans of care.

A396 POC accepted 8/28/19 FMcIntoshRN/PMW

Brattleboro Retreat
Plan of Correction for Survey ID 4XLH11

CMS §: 482.23(b)(6)

A398 Supervision of Contract Staff

Measure of Success: Documentation for all Contract Staff will reside in HR once completed.

Corrective Action Taken:

WHO:

The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

Standard process created for Clinical Nurse Managers to ensure orientation checklists are completed by all staff and returned to Clinical Education in a timely manner.

WHEN:

- A checklist for Clinical Nurse Managers was completed 8/24/2019.

HOW:

- Clinical Nurse Managers will be responsible for ensuring that orientation checklists are completed and returned to HR in a timely manner.

A398 POC accepted 8/28/19 FmcIntoshRN/pmc

Brattleboro Retreat
Plan of Correction for Survey ID 4XLH11

CMS §: 482.23(c)(1), (c)(l) & (c)(2)

A405 Administration of Drugs

Measure of Success: Mouth checks will be completed on all patients.

Corrective Action Taken:

WHO:

The Chief Nursing Officer is ultimately responsible for the corrective action and for overall and ongoing compliance.

WHAT:

1. Educational poster to reinforce mouth checks procedures.
2. Education on mouth checks distributed through our Red Book Communication.

WHEN:

- Educational poster and communication through Red Book Communication completed 8/24/2019.

HOW:

- Incidents of cheeked medications will decrease in incident reports.

A405 POC accepted 8/20/19 FMcIntosh,RN/PMM