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

April 29, 2019

Dan Bennett, Administrator
Gifford Medical Center
44 South Main Street
Randolph, VT 05060

Dear Mr. Bennett:

The Division of Licensing and Protection completed a survey at your facility on **April 4, 2019**. 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 29, 2019.**

Sincerely,

Suzanne E. Leavitt RN, MS

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

Enclosure

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
	471301	A. BUILDING _____ B. WING _____	C 04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIFFORD MEDICAL CENTER	44 SOUTH MAIN STREET RANDOLPH, VT 05060

(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
C 000	INITIAL COMMENTS An unannounced, on-site complaint survey was conducted by the Division of Licensing and Protection from 4/2/19 - 4/4/19, as authorized by the Centers for Medicare and Medicaid Services to determine compliance with the following Conditions of Participation: Emergency Services, Staffing and Staff Responsibilities, and Provision of Services. The following regulatory violations were identified associated with complaint #17444. Findings include:	C 000		
C 253	STAFFING CFR(s): 485.631(a)(3) The staff is sufficient to provide the services essential to the operation of the CAH. This STANDARD is not met as evidenced by: Based on staff interviews and record review, the Critical Access Hospital failed to assure that there were sufficient trained staff available at all times to provide the services required in the Emergency Department related to care provision for 1 of 10 applicable patients reviewed. (Patient #1). Finding include: A complaint investigation subsequent to allegations of a lack of appropriate restraint application for Patient #1, who was treated in the hospital Emergency Department (ED) during January, 2019, revealed that non-hospital employed persons participated in physical restraint procedures for the patient during 2 separate instances. Per record review on 4/2/19, Patient #1, who was at risk of harming self or others, and had left the ED without receiving treatment earlier the same day, was brought back to the ED by a law enforcement officer on 1/19/19	C 253	See attached POC account on attached 4.29.19 MB/BLP	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	CEO	4/24/2019

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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C 253	Continued From page 1 at 2309 hours (HR). The patient had been found by police after several hours of exposure to the freezing temperatures. The patient presented with psychosis and a history of aggressive, violent behaviors when medications were not taken regularly. It was reported that s/he had stopped taking medications and was becoming a significant risk to his/herself and others due to severe mania. The patient was seen by the ED provider and then evaluated by the crisis clinician, placed on EE (involuntary status) and was awaiting a bed for inpatient psychiatric treatment. Per review of nursing documentation, two deputies from the sheriff's department were in the ED to assist with safety monitoring on 1/23/19 at 0918 AM. At that time, a crisis clinician was prevented from exiting the patient's room when the patient suddenly jumped over the bed and placed themselves between the door and the clinician, "arms up, using increased vocalizations at an elevated level". Sheriff's deputies quickly (2) entered the room and initiated a ...."therapeutic hold...on the bed". During interview with the nurse author, no ED staff had made a request of the sheriffs to enter the room and initiate a physical hold on the patient. The note stated the episode had lasted "less than 5 minutes". Later the same day, at 1950 HR, a nurse's note stated that the nurse requested the patient hand over a sharp implement they had devised by breaking a plastic utensil. The patient's behaviors were escalating at the time. The patient made threatening gestures with the sharp utensil and then "PT was taken to the floor by sheriffs". The note stated the patient had then attempted to assault the "sheriffs.....kicking,biting:." The patient was administered Ativan, 2 mg. IM (intramuscularly) by the nurse, while remaining in	C 253	See attached POC accepted on attached 4.29.19 MB RN	

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C 253	Continued From page 2 the sheriffs' hold on the floor. After the patient had calmed themselves, s/he was released by the sheriffs. During interview with the RN ED Clinical Director on 4/3/19 at 10 AM, s/he confirmed that there was no ED staff directive or request to the sheriffs present for their assistance with this patient's care at the time of these events. It was confirmed by the RN that the sheriffs had acted 'on their own accord' in these 2 cases of restraint use. During interview, the Director of Quality (QA) and Risk Management who was present at the time of the interview stated that the hospital had not developed a written plan/document to address the expectations of law enforcement when in the ED to address a significant safety risk to persons in the ED. The Director of QA also confirmed that sheriffs may be in the hospital for safety concerns related to violent/threatening persons at times and that, as of the date of survey, the hospital had not finalized a new draft policy to address the specific areas and ways in which law enforcement staff presence may be utilized to assure patient safety in the hospital setting.	C 253	See attached	
C 271	PATIENT CARE POLICIES CFR(s): 485.635(a)(1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on staff interview and record review, the Critical Access Hospital failed to assure that health care services were furnished in accordance with it's approved written policies, consistent with applicable State law for 1 of 10 patients in the targeted sample. (Patient #1).	C 271	POC accepted 4.29.19 on attachment MB/BH	

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C 271	Continued From page 3 Findings include: 1. Per record review on 4/3/19, the ED provider failed to include all of the required elements for restraints ordered for medical reason for Patient #1 on 1/20/19. Patient #1 needed an urgent infusion of potassium (an electrolyte) due to a critically low level (life threatening) that posed a risk of significant harm to the patient if not corrected. The patient refused to have the IV (intravenous catheter) inserted. The physician documented on the Orders for Restraint: Medical need based form, Indication for Restraint: "medical need for immobilization of arm to allow potassium infusion for critically low potassium, this after being sedated with IM Lorazepam for being a danger to staff." The type of restraint ordered was checked as Soft Wrist Restraints x 2. The provider failed to document the duration of the order, per policy# NUR-200, entitled Restraints for Non-behavioral Health (Medical) Reasons, under "I. Procedure:, C. The order set will include: * Duration of order, *level of observation and *Clinical criteria for discontinuation". (None of these last 3 elements were included on the order form.) The RN note of 1/20/19 at 0245 HR stated that the patient "refuses to take PO (by mouth) potassium, IV initiated. See restraint order and restraint flowsheet for medical need." Per review of the flowsheet used for medical need, the sheet is not worded to include the requirements for medical restraints, per the policy/procedure. The physician provider had altered the form to denote the restraint was for medical use, since the form stated "Restraint/Seclusion Flow Sheet". During interview on the morning of 4/3/19, the Director of Quality confirmed that the hospital did not have a flow sheet to be used for monitoring patients who	C 271	See attached POC accepted on attachment 4.29.19 MB RN	

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C 271	Continued From page 4 are restrained for a medical need. (Refer also to 0336). 2. Per review of the ED records for Patient #1, the ED nurses involved in the behavioral restraint events on 1/23/19 failed to complete a debriefing for the staff and the patient after the event was over, per the hospital policy entitled Restraints and Seclusion for Behavioral Health Patients, which stated under II. Restraint or Seclusion for Behavioral Health Reasons: A. 7. Termination of restraints will be documented. As appropriate, both the patient and staff will participate in a debriefing about the restraint or seclusion procedure. There was no documented evidence of any use or offering of a debriefing completed based on a review of 5 applicable behavioral restraint records. The staff's lack of including a debriefing process, per policy, was confirmed during interview with Director of QA on the afternoon of 4/3/19. 3. Patient #1 was physically restrained 1/23/19 at 0918 and again at 1950 and nurses failed to obtain an order for the restraints used after the emergent, violent situations were over, in accordance with the policy/procedure entitled Restraints and Seclusion for Behavioral Health Patients, # NUR - 199. Under II. Restraint or Seclusion for Behavioral health Reasons: A. Nursing Responsibilities for Patient in restraint or Seclusion, 3. "As soon as the patient is clinically safe and secure in restraints or seclusion, an RN (registered nurse) will immediately notify the physician or LIP (Licensed Independent Practitioner) about the patient's physical and psychological condition and obtain a Physician's order for the restraint or seclusion. The Physician's order will include the following:	C 271	See attached POC account on attached 4.29.19 MB RN	

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C 271	Continued From page 5 * Type of restraint or seclusion * Duration of order * Level of monitoring * Clinical criteria for discontinuation of restraint/seclusion The lack of of written physician orders for these 2 restraint occurrences was confirmed during interview with the Director of QA on the morning of 4/4/19. 3. Per record reviews and confirmed during interviews with the Director of Quality and the RN ED Clinical Director on 4/3/19 commencing at 10 AM, ED nurses failed to complete event reports in the Quantros reporting system per the hospital's policy # QM-101. Based on a review of the medical records for Patient #1 and subsequent interviews with ED staff RNs, there were no event reports completed after the 2 instances of behavioral restraint use for this patient on 1/23/19. Per interview on 4/3/19 at 3:15 PM, the CNO confirmed that no staff had completed event reports for Patient #1 during the ED stay. Although it was confirmed during interview that during the weekly Nursing Leadership Meeting, nursing staff review all instances of documented restraints, the nurses failed to note that there were no event reports completed, in accordance with the Event Reporting policy # QM- 101. The committee reviewing the restraint events also had not noted that there were no provider orders for these event occurrences on 1/23/19. The policy entitled Incident/Adverse Event Reporting, # QM-101 stated: under Procedure: IV, "All events and near miss situations should be reported within 24 hours using the Safety Event	C 271	See attached POC account on attachment 4.29.19 MB BSN	

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C 271	Continued From page 6 Reporting link found in Gifnet". The event reporting system will automatically notify Quality Management and the appropriate department managers. V. The Department Managers/Supervisors/Designee will monitor all events occurring in their area. they will: B. Report or assist staff to report the event using the Safety Event Reporting link found on Gifnet. E. Review aggregated event data to identify opportunities for performance improvement or system changes. The Director of QA also confirmed during interview on the afternoon of 4/3/29 that she had not received any event reports related to the 2 behavioral restraint occurrences for the patient. She stated that she had not received timely notification regarding the use of the behavioral restraints in the ED on 1/23/19. When she learned about the events weeks later, she immediately instituted a corrective action plan, which was in the process of completion during the complaint survey, with more actions to be initiated in the near future. (Refer to 0336)	C 271	See attached POC accent on attach 4.29.19 mB/RN	
C 336	QUALITY ASSURANCE CFR(s): 485.641(b) The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that -- This STANDARD is not met as evidenced by: Based on staff interview and record review, the	C 336		

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C 336	Continued From page 7 hospital's Quality/Performance Improvement Department failed to have a formal, effective review process related to patient restraint occurrences, to identify problems, prevention strategies and and on-going analysis of data. Findings include: Per staff interview and record review, ED nursing staff failed to use the hospital's Quantros Event Reporting System effectively and in accordance with written policy/procedures related to restraint use in the ED on 3 occasions during Patient #1's stay in the ED. Based on the review of restraints utilized for Patient #1 in the ED on 1/20/19 (medical use restraint) and 1/23/19 (behavioral use restraint), ED nursing staff failed to follow hospital policy for event reporting. Per review, the policy entitled Incident/Adverse Event Reporting, # QM-101, stated under the section titled Procedure: "IV. All events and near misses should be reported within 24 hours using the Safety Event Reporting link founds on Gifnet. The event reporting and management system will automatically notify Quality Management and the appropriate department managers." During interview on 4/2/19 at 10:05 AM, the Director of QA confirmed that there was a delay in notifying h/her regarding the restraint procedures for Patient #1 due to nurses' lack of completing the required event reports. S/he stated that upon learning of the restraint events weeks after the events occurred, s/he commenced a quality review of the patient's care provision by staff related to the restraint processes. The review included ED nurses and providers and nursing leadership staff. A corrective action plan was implemented on 3/6/19. Although significant progress had been made, the plan had not been fully implemented as of the date of the survey	C 336	See attached POC sent on attach 4.29.19 MB	

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C 336	Continued From page 8 (4/2/19). Areas needing correction reviewed with the Dir. of QA include the following: The forms used for restraint provider orders and nursing flow sheet monitoring forms had inaccurate language that did not meet the regulatory requirements for the maximum duration of behavioral restraint orders; flow sheets had inaccurate language for documentation; and there were no existing flow sheets for use with restraints ordered for medical use. The review also revealed that there was no adopted hospital policy to address the use of law enforcement assistance in assuring safety in the ED. (Refer also to 0253 and 0271)	C 336	See attached POC acceptance 4.29.19 MB	

Gifford Medical Center

Provider ID: 471301
Plan of correction for deficiencies noted April 2 – 4, 2019
Date submitted: April 25, 2019

Tag ID	Program Criteria	Deficiency	Resolution & Monitoring	Status
C 253	Staffing	On multiple occasions law enforcement intervened to restrain a patient.	Gifford maintains adequate staffing to manage situations involving patient care. ADM-132 Law Enforcement Involvement with patient care policy created Staff education on involvement of law enforcement related to patient care. Re-education on use of Code Grey (ADM-121) for assistance with violent or aggressive situations. Of note, Code Grey events are included in the annual report on "Incident Reporting/ Significant Events" to the Quality Committee. Conduct code grey drills on off shifts	Completed 4/3/2019 Education as follows: Hospitalist Committee: 3/27 & via minutes ED Committee: 4/9 & via minutes ED nurse staff meeting: 3/11 & via email HP nurse staff meeting: 4/24 & 4/25 & via email Quarterly staff meetings (all staff): 4/2 & 4/4 All Staff memo: 4/8 Security: 4/5 via email Birthing Center staff meeting: Scheduled 5/21/2019 100% of (non per diem) clinical, Facilities, and Security staff will sign off as having received this education. Completed by: 5/21/2019 Department Managers will ensure communication to per diem staff. Emerg Preparedness will coordinate 3 drills over the next 3 months.
C 336	Quality Assurance	Quality Assurance failed to provide adequate review and analysis of use of restraint/seclusion	Formed a Restraint/Seclusion Review Committee. Committee is a multi-disciplinary team and will use a restraint/seclusion tool to guide review of restraint/seclusion events. Documentation of these reviews	Committee formed as of 4/5/2019. Meeting frequency will be determined based on use of restraint/seclusion. Findings from this Committee will be included in the presentation to Quality Committee at least annually with

POC accnd MB/sl 4.29.19

			will be kept in the form of minutes. Action plans following the review will be created, as needed. Feedback regarding suggestions for improvement in documentation/management of patients will be provided to individual staff, as appropriate. Additionally, excerpts from documentation will be shared at staff/provider meetings periodically. Use of restraint/seclusion will be included in the annual report on "Incident Reporting/ Significant Events" to the Quality Committee	Incident Reporting and Significant Events (typically in July).
C 271	Patient Care Policies	Forms for orders and documentation of restraint (both medical and behavioral) were outdated and did not include all required elements.	Forms have been revised to be in compliance with the regulations.	Completed: 4/25/2019
		Language used in NUR-199 Restraints and Seclusion for Behavioral Health Patients and accompanying documentation forms/orders are out of date and/or not in compliance with regulations Failure to follow policies regarding obtaining orders for and appropriate documentation of use of restraint Failure to follow policy regarding debriefing following use of restraints	Policy and forms have been revised to be in compliance with the regulations Staff education regarding policy and forms revision Review of documentation will occur per resolution to tag C 336 above. Feedback regarding suggestions for improvement in documentation/management of patients will be provided to individual staff, as appropriate. Additionally, excerpts from documentation will be shared at staff/provider meetings periodically.	Completed: 4/25/2019 100% of (non per diem) clinical staff will sign off as having received this education. Completed by: 5/21/2019 Department Managers will ensure communication to per diem staff.
		Failure to follow policy regarding submitting a Safety Event Report	Staff education regarding QM-101. Additionally, to prompt staff: Added Complete a Safety Event Report to the NUR-199 Restraints and Seclusion for Behavioral Health Patients policy	HP nurse staff meeting 4/24 & 4/25 & via email ED nurse staff meeting: Scheduled 5/6/2019 All Staff memo: 4/8 Birthing Center staff meeting: Scheduled 5/21/2019 100% of (non per diem) clinical

POC accept 4.24.19
MB RE

			Created a restraint checklist for use of behavioral restraint to prompt completion of a Safety Event Report.	staff will sign off as having received this education. Completed by: 5/21/2019 Department Managers will ensure communication to per diem staff.

Director of Quality Management will provide oversight and monitor completion of this corrective action plan through weekly check-in with each responsible party above and monitor progress on policy review.

AOC accepts 4.29.19 MB/SO

Gifford Medical Center

44 South Main Street, P.O. 2000 • Randolph, Vermont 05060
802-728-7000 • *fax* 802-728-4245

April 25, 2019

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

Provider ID: 471301

Dear Ms. Leavitt,

Enclosed pleased find the plan of correction addressing deficiencies cited during the April 4th complaint investigation. I am also enclosing copies of the revised policies and forms. As you will see from the plan of correction, staff education was already underway at the time of the investigation and is on-going.

If you have any questions please don't hesitate to contact me.

Sincerely,

Monica Boyd

Monica Boyd
Director Quality/Risk Management

accepted POC
4.29.19
MB/BL
* includes P/P.