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

November 13, 2020

Joseph Perras, Ceo, Administrator
Mt Ascutney Hospital
289 County Road
Windsor, VT 05089-9000

Dear Dr. Perras,

The Division of Licensing and Protection completed an Investigation survey at your facility on **September 23, 2020**. 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 **November 12, 2020.**

Sincerely,

Suzanne Leavitt, RN, MS
State Survey Agency Director
Assistant Director, Division of Licensing & ProtectionEnclosure

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
	471302	A. BUILDING _____ B. WING _____	C 09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT ASCUTNEY HOSPITAL	289 COUNTY ROAD WINDSOR, VT 05089

(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 investigation of two anonymous complaints (#18679 & #19114) was conducted on 9/21/20 through 9/23/20 by the Division of Licensing and Protection to determine compliance with the Conditions of Participation for Critical Access Hospitals at 42 CFR. Part 485, Subpart F. There were no regulatory violations identified for complaint #19114. The following regulatory violations were identified for complaint #18679 under Provision of Services: Patient Care Policies; and Infection Control. In addition to the complaint investigations, a Focused Infection Survey was conducted on 09/21/20 through 09/22/20. The facility was found to be in substantial compliance with the infection control requirements related to COVID-19.	C 000	See "plan of correction" document enclosure	
C1006	PATIENT CARE POLICIES CFR(s): 485.635(a)(1) (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 (CAH) failed to ensure that care was provided in accordance with written policies and procedures regarding the use of restraints for 2 of 2 applicable patients (Patient #1 and Patient #7). Findings include: 1.) Per review of a nursing triage note from 2/27/20 at 5:30 PM, Patient #1 was brought into the emergency department (ED) by police. The patient refused to answer questions and was "replying only with threats and profane language". The patient was "agitated, hostile,	C1006	tag 1006 POC accepted TD/SS 11/12/2020 see attached POC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO/CMO — (X6) DATE: 10/21/20

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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C1006	Continued From page 1 uncooperative". Per review of a provider's note from 2/27/20, Patient #1 had a history of post-traumatic stress syndrome, attention deficit disorder, sleep apnea and anxiety. S/He had recently been charged with domestic violence and assault; and over the last couple of days had made several homicidal threats to staff at a local hospital and in the community. Due to significant concerns from Patient #1's crisis provider and police, a mental health warrant was drawn up and the patient was transported to the hospital for a psychiatric evaluation. The patient arrived with police in handcuffs. The patient denied any medical complaints or pain. The patient "is rambling and racing through different thoughts and very quickly becomes aggressive and violent". The patient wanted to be "let go and let out" of the emergency department. "The patient continued to amp up and become even more aggressive and violent in the emergency department significantly disrupting operation of the emergency department as well as endangering other patients here in the department. At that point time a decision was made to sedate and restrain the patient for" his/her "own protection as well as the protection of other staff and patients in the emergency department." At 6:40 PM, the provider ordered "Zyprexa (antipsychotic medication) 10 mg (milligrams) IM" (intramuscularly) and "Ativan (antianxiety/sedative medication) 2 mg IM"; and at 6:41 PM, the provider ordered "Restraints Violent 18 Years and Older-physical abuse to others, bilateral lower extremities, bilateral upper extremities, order valid for 4 hours". Per review of the "Nursing Annotations" from 2/27/20 at 7:00 PM, "Pt in 4 point restraints,	C1006		

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C1006	Continued From page 2 agitated and yelling verbal obscenities at staff, threatening staff members". At 7:30 PM, "pt continues to be agitated, sitter at bedside, restraints remain in place". At 9:00 PM, "Sitter at bedside, pt sedated and breathing easily, see vitals. Pt continues to intermittently pull against restraints. Restraint continuation needed for staff safety and patient safety. At 9:30 PM, "Sitter remains at bedside, no other changes". At 11:30 PM, "status unchanged, sitter at bedside". On 2/28/20 at 12:00 AM, "Pt restrained, sitter at bedside". At 12:42 AM, "pt continues to pull against restraints but will not answer questions without yelling". At 2:00 AM, "Sitter at bedside, pt status unchanged". At 3:00 AM, "Pt intermittently pulling at restraints, no other change in assessment. sitter at bedside". At 4:29 AM, "Pt HR dropped to 40 on heart monitor, new EKG performed, PA notified". At 4:39 AM, "Pt R arm taken out of restraints". At 6:55 AM, "Pt became belligerent /agitated. Placed back in all 4points". At 8:00 AM, "removed right restraint; cooperative; provided with water. 1:1 at bedside". At 8:30 AM, "resting on" his/her "side. 1:1 at bedside". At 10:00 AM, "removed left leg restraint; 1:1 at bedside". At 7:04 PM, "Report received from AM RN, pt in bed lying down with 1 restraint in place, intermittently yelling obscenities". At 8:44 PM, "Pt out of ED in police custody". Per review of the nursing neurological assessment of the patient on 2/27/20 at 6:45 PM, the patient's level of consciousness was "Drowsy". At 7:00 PM, "Drowsy". At 7:15 PM, "Stuporous". At 7:30 PM, "Stuporous". At 7:45 PM, "Stuporous". At 8:00 PM, "Stuporous". At 8:30 PM, "Stuporous". At 9:15 PM, "Sedated". At 9:30 PM, "Sedated". At 10:00 PM, "Sedated". At 11:30 PM, "Sedated". On 2/28/20 at 12:00 AM,	C1006		

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C1006	Continued From page 3 "Sedated". At 12:30 AM, "Stuporous". At 2:00 AM, "Stuporous". At 3:00 AM, "Sedated". At 4:00 AM, "Sedated, Stuporous". At 4:15 AM, "Sedated". At 5:00 AM, "Sedated, sleeping". At 5:15 AM, "Sedated, sleeping". At 5:30 AM, "Sedated, Sleeping". At 5:45 AM, "Sedated, Sleeping". At 6:00 AM, "Sedated, Sleeping". At 6:15 AM, "Sedated, Sleeping". At 6:30 AM, "Sedated, Sleeping". At 6:45 AM, "Hyperalert". At 7:00 AM, "Alert, Drowsy, Sleeping". At 7:00 PM, "Alert". Per review of the "One on One observation status form" (completed by a staff member assigned to provide constant observations) on 2/27/20 at 7:15 PM, "Pt resting/calm". At 7:30 PM, "Pt thrashing in the restraints and yelling". At 8:00 PM, "Thrashing around and yelling with eyes closed". At 8:15 PM, "Pt thrashing/nurse gave meds". At 8:30 PM "Pt sleeping/hooked up to EKG IV". At 9:15 PM, "Pt sleeping, calm". At 9:30 PM, "Pt sleeping". At 10:15 PM, "Pt is sleeping and calm". At 11:30 PM, "Pt is sleeping and calm". On 2/28/20 at 12:00 AM, "sleeping-calm". At 12:30 AM, "sleeping, calm". At 2:00 AM, "sleeping, calm". At 3:00 AM, "sleeping-calm". At 4:00 AM, "sleeping". At 4:15 AM, "sleeping-staff changed hands nurse in room-EKG". At 4:30 AM, "sleeping". At 4:35 AM, "staff released one arm". At 5:00 AM, "sleeping-calm". At 5:15 AM, "sleeping-calm". At 5:30 AM, "sleeping-calm". At 5:45 AM, "sleeping-calm". At 6:00 AM, "sleeping-calm". At 6:15 AM, "sleeping-calm". At 6:30, "sleeping-calm". At 6:45, "sputtering-staff restrained" his/her "free arm". At 7:00 AM, "sleeping/talking in sleep". At 7:45 AM, "one restraint removed". At 8:00 AM, "resting on" his/her "side". At 8:30 AM, "Sleeping on" his/her "side". At 10:00 AM, "Sleeping". At 7:00 PM,	C1006		

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C1006	Continued From page 4 "Sleeping". At 7:15 PM, "Sheriffs Arrived". Patient #1 was admitted to the ED on 2/27/20 at approximately 5:10 PM and discharged/transferred from the ED on 2/28/20 at approximately 8:47 PM. The providers' and nursing documentation from 2/27/20 and 2/28/20, indicates that Patient #1 was placed in 4-point restraints, was decreased to 3-point restraints, was put back into 4-point restraints; and then was down to a 1-point restraint which s/he had remained in for the rest of his/her ED stay. There was no clear indication of what interventions were tried by staff prior to the restraints being placed. Per review of the "Nursing Annotations", "Neurological Assessment", and the "One to One observation status forms", there was evidence that there were periods of time where Patient #1 was observed to be "Sedated, Sleeping, Calm" and there was no consistent evidence that there was any attempt by staff to remove the restraints from Patient #1 at the earliest possible time. Per review of the "Restraint and Seclusion Policy"- approved 9/27/2018 it read, "Physical restraints or seclusion are used only when warranted by a patient's violent/self-destructive behavior that threatens the immediate physical safety of the patient, staff or others. Restraint or seclusion may only be used when less restrictive interventions have been determined ineffective to protect the patient, staff or others from harm. A comprehensive assessment of the patient's behavior and needs is performed prior to or immediately following the use of physical restraints or seclusion. Safety enhancements/interventions are made prior to the use of physical restraints or seclusion in an attempt to maintain the least restrictive	C1006		

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C1006	Continued From page 5 environment ... .The use of restraint or seclusion is undertaken as a last resort in the management of the patient's violent/self-destructive behavior ... .Reassessment addresses the: Use of the least restrictive methods of restraint/seclusion, and Changes in the patient's behavior or clinical condition warranting removal of restraints or removal from seclusion ...Reassessment includes review of: Level of consciousness/behavior of the patient, Need for continued restraint/seclusion". Per interview on 9/22/20 at 1:53 PM with the Chief Nursing Officer (CNO), s/he stated that the house supervisor, ED nurse, and provider determine the need for a restraint. Restraints were typically removed once patients gained composure. Patients were assessed frequently, and the goal was to remove restraints from patients as soon as possible. S/He stated that s/he reviewed Patient #1's case and confirmed that there was, "no nursing documentation for restraint application and/or trying to take off/removal at earliest possible time". On 9/23/20 at 9:44 AM during a second interview, the CNO re-confirmed that there was "Gaps in documentation, not following policy". 2.) Per review of provider note from 3/11/20 at 2:20 PM, Patient #7 had a history of depression, self-cutting, suicidal ideation, and diabetes. S/He presented to the ED via ambulance after an intentional overdose. Patient #7 had gotten into an argument with his/her caregiver and took 3 to 4 days' worth of his/her medications. Per the provider's exam Patient #7 was alert and cooperative with an appropriate mood and affect. The provider ordered lab-work, cardiac	C1006		

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C1006	Continued From page 6 monitoring, and intravenous fluids; and had discussed the case with poison control. On 3/12/20, Patient #7 was medically cleared and was waiting to be evaluated by the crisis screeners. Per review of a nursing progress note from 3/13/20 at 6:18 PM, Patient #7 came out of the ED treatment room holding his/her cell phone and was yelling. The Registered Nurse (RN) tried to de-escalate the patient; however, s/he walked out of the ED and into the ED waiting room. The provider went to the waiting room and attempted to verbally de-escalate the patient. The patient walked back into the ED where s/he remained agitated and stated to the provider, "I'm going to kill you" and as the provider continued to speak to Patient #7 s/he pushed the provider connecting with the provider's chest. Patient #7 agreed to take medication by mouth to help calm him/her; however, s/he continued to be agitated, and threatening to staff. S/He banged his/her head against the wall and attempted to take out screws and take items off the walls to hurt him/herself and staff. Despite the staff's attempt to verbally de-escalate and use other methods of distraction Patient #7 continued to make threats. The staff manually held the patient's limbs and administered intramuscular medications. Patient #7's limbs were held for approximately ten minutes. Per review of the provider's orders for Patient #7 there was no evidence that an order was written for the physical hold to Patient #7. Per review of the "Restraint and Seclusion Policy"- approved 9/27/2018 it read, "Physical Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilized or reduces the ability of a patient to	C1006		

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C1006	Continued From page 7 move his or her arms, legs, body, or head freely ... ...Restraints or seclusion must be ordered by a physician/APRN(advanced practiced registered nurse)/PA (physician's assistant) who has a working knowledge of MAHHC policy on the use of restraint or seclusion prior to, or during/immediately following restraint application. PRN (as needed) orders and standing orders are not acceptable". Per interview on 9/22/20 at approximately 3:00 PM with the Director of Quality/Risk, s/he stated that a physical hold was a type of restraint and that an order needed to be written by a provider. During an interview on 9/23/20 at 9:51 AM with the CNO, s/he confirmed that an order was not written for a physical hold for Patient #7 on 3/13/20.	C1006		
C1206	INFECTION PREVENT & CONTROL POLICIES CFR(s): 485.640(a)(2) The infection prevention and control program, as documented in its policies and procedures, employs methods for preventing and controlling the transmission of infections within the CAH and between the CAH and other healthcare settings; This STANDARD is not met as evidenced by: Based on observation and staff interview the CAH failed to ensure that the methods for preventing and controlling the transmission of infections were followed for cleaning and disinfecting patient care equipment. Findings include: On 9/22/20 at approximately 3:00 PM, the Director of Quality/Risk Management brought the surveyors, a locked wrist restraint and a locked ankle restraint to show the surveyors the type of	C1206	tag 1206 POC accepted TD/SS 4/12/2020 see attached POC	

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C1206	Continued From page 8 restraints the facility was currently using. When the staff member demonstrated how both the wrist and ankle restraints were applied, there were large areas on the inside of each restraint that were soiled with blood. The Director of Quality/Risk Management confirmed at that time that the restraints were soiled with blood and that they were not clean. Per interview on 9/23/20 at approximately 9:45 AM with the CNO, s/he stated, "I don't know what fell through the cracks, usually when patient discharges, would put equipment in dirty room, would be cleaned and returned to clean room. True for all equipment. Obviously was not adhered to either". Per review of the policy "General Cleaning/Low-Level Disinfection"-approved 6/9/20, it read, "All non-critical patient care equipment must be routinely cleaned/disinfected by responsible staff using only MAHHC approved products, according to the manufacturer's instructions. Equipment must be cleaned/disinfected between patients. Visual indicator of clean items is required e.g. plastic bags over items or paper tape over toilet seats, etc. All equipment without visual indicators of having been cleaned/disinfected are considered dirty and must be cleaned before patient use. Equipment such as: but not limited to vital sign machines that are frequently used from patient to patient are exempt from the visual indicator rule. It is the responsibility of the staff members using the equipment to ensure that items are cleaned/disinfected prior to use on each patient."	C1206		

Mt. Ascutney Hospital and Health Center
Dartmouth-Hitchcock

CMS Conditions of Participation – Complaint Survey
Survey Dates: 9/21/20 – 9/23/20
Response Due: 10/21/20
Revision: 11/11/20

Plan of Correction

Tag C1006: Patient Care Policies – Use of Restraints

Citation	Action Plan	Status	Due Date
Failure to ensure care was provided according to policies and procedures regarding the use of restraints	Standards of Care: Re-educate staff on policy and procedure for restraint utilization. Document staff attestations of understanding.	In progress	11/22/20
	Standards of Care: eLearning development for ED staff including ESNE contracted employees. Content will include: when and why restraints are initiated, what is considered a restraint, documenting evidence that less restrictive measures have been attempted and proved to be ineffective prior to intervention, obtaining provider orders and utilizing the templates in the EMR, the importance of on-going assessment and documentation during the use of restraints, how to report in the Occurrence Management system.	In progress	11/22/20
	Quality monitoring: Each application of a restraint or use of a chemical restraint will result in nursing reporting into the Occurrence Management system. The nurse manager is required to complete a Restraint QA Checklist by reviewing the patient's chart.	Complete	11/3/20
	Quality monitoring: The Restraint QA Checklist review will be added to the monthly ED dashboard and reported to the Quality Committee- % of patients reviewed and % of deficiencies identified.	In progress	11/22/20
	Quality monitoring: Revise comparison audit of restraint utilization comparison reports between EMR and Occurrence Reporting system from annually to monthly for 6 months, and then quarterly thereafter for a total of 2 years. At that time, will re-evaluate utility and frequency of review.	Complete	10/16/20

Tag C1206: Patient Care Policies – Infection Control

Citation	Action Plan	Status	Due Date
Failure to follow policy for cleaning and disinfecting patient care equipment	Order in "Clean" indicator tags for equipment as a visual indicator	Complete	10/23/20
	Write SBAR for communication to ED staff	Complete	10/30/20
	Provide SBAR to department leadership; educate staff (role specific) on policy and job aid through team huddles and staff meetings; document staff attestations of understanding.	In progress	11/22/20

Respectfully Submitted,
Otelah M. Perry MS, MT, CPPS, CMQOE
Director, Quality, Patient Safety, and Compliance
Otelah.Perry@mahhc.org
Phone: 802-674-7071

POC accepted
TD/SS 11/12/2020