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

July 19, 2018

Paul Bengtson, Administrator
Northeastern Vermont Regional Hospital
1315 Hospital Drive
Saint Johnsbury, VT 05819-9758

Dear Mr. Bengtson:

The Division of Licensing and Protection completed a follow up survey at your facility on **June 12, 2018**. 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 **July 11, 2018.**

Sincerely,

Suzanne E. Leavitt RN, MS

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

PRINTED: 06/20/2018
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
	471303	A. BUILDING ______ B. WING ______	R-C 06/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHEASTERN VERMONT REGIONAL HOSPITAL	1315 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

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{C 000}	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced on-site follow-up visit on 6/11/2018 through 6/12/2018 to a survey conducted 4/2/2018- 4/4/2018. The facility was found to be in substantial compliance with the Conditions of Participation for Emergency Services, Staffing and Staff Responsibilities, and Periodic Evaluation and Quality Assurance review. The following regulatory violations were identified.	{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 interview and record review, the Critical Access Hospital (CAH) failed to ensure that sufficient staffing was available at all times to prevent non-hospital staff from placing hands on a patient during an attempted elopement from the Emergency Department for 1 applicable patient. (Patient #6) On 5/27/18 at approximately 14:41 Patient #6 arrived in the Emergency Department (ED) with a chief complaint of depression and expressing suicidal ideation. Patient #6 was medically screened and a psychiatric screening evaluation was ordered. Shortly after the mental health screener's arrival at approximately 16:24, Patient #6 becomes upset with the screener and decides to leave the ED. Patient #6 makes threatening statements toward ED staff and state s/he was "aggressively suicidal". Patient #6 exited the ED and was followed by 2 staff members who	{C 253}	**C253 Staffing CFR(s): 485.631(a)(3)** The staff is sufficient to provide the services essential to the operation of the CAH. Based on staff interviews and record review the surveyor is correct. NVRH did request assistance from the contracted Security person on duty to prevent Patient #6 from elopement from the facility. NVRH contracts with the Caledonia County Sheriff Office to provide 24/7 Security service. Security Contract does not include involvement in patient care. Patient #6 was expressing SI and HI with a plan. Patient #6 was a danger to himself and others. The Sheriff on duty as security for the hospital did assist staff and subdue Patient #6 as well as assist staff in returning #6 to the Emergency Department to continue his evaluation and treatment. Patient #6 was not arrested and placed in custody of law enforcement due to the fact that he was in need of continued Psychiatric treatment and care. Patient #6 was evaluated and placed in EE-Involuntary Status awaiting bed availability for Inpatient Psychiatric Facility Admission.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Colleen Sinon, VP Quality Improvement Programs   TITLE   (X6) DATE 7/9/18

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{C 253}	Continued From page 1 attempted to provide verbal redirection. Staff notified the Sheriff stationed in an office in the ED waiting area who proceeded to pursue Patient #6. When the sheriff arrived outside the ED in the parking area adjacent to the ED entrance, a physical altercation occurred between Patient #6 and the sheriff. Patient #6 was physically subdued by the sheriff, brought to the ground and handcuffed by the sheriff. Patient #6 was then returned to the ED handcuffed and accompanied by the sheriff. Patient #6 was placed on a stretcher, hand cuffs were removed and 4 point restraints were applied. In addition, involuntary emergency medications were administered to Patient #6 by intramuscular injection to include: Haldol 5 mg (antipsychotic); Benadryl 50 mg; and Ativan 2 mg (antianxiety). At the time of the incident there was no evidence of additional hospital staff being alerted to respond and assist with the management and redirection of Patient #6. As a result, there was a failure to prevent non-hospital staff from placing hands-on Patient #6, which consequently resulted in Patient #6 being subjected to both physical restraint by a sheriff and having handcuffs applied, although Patient #6 was not in custody of law enforcement, but remained a patient in need of psychiatric services and hospitalization. This is a repeat deficiency.	{C 253}	**C253 Staffing CFR(s): 485.631(a)(3)** The staff is sufficient to provide the services essential to the operation of the CAH. (Continued from Page 1 of 6) **<u>Corrective Action Plan</u>** 1. Implement a response team for the management of aggressive/disruptive patients and potential elopement situations. Team will consist of staff members who are available at the time of the incident. 2. Revise Code Gray (Violent Patient/Employee/Family Member) policy to include appropriate use of the response team. 3. Develop new policies: Patient Elopement, Safety in the ED 4. Continue providing CPI Training for staff and Security each month. Seleem Choudhury, DNP, Chief Nursing Officer in collaboration with Michael Moss, DNP, Emergency Services Director; Sharon Mallett, DNP, MS/Pedi/Inf Director, Carol Hodges, Nursing Education and the House Supervisors, are responsible for development and ongoing education of the Code Gray Response Team. Policies and Response Team to be in place by July 31, 2018.	
{C 302}	RECORDS SYSTEMS CFR(s): 485.638(a)(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized.	{C 302}	**C 302 Records System** **CFR(s): 485.638(a)(2)** Response located on page 3 of 6	

Callie Smith, VP Quality Management Programs 7/9/18

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{C 302}	Continued From page 2	{C 302}		

This STANDARD is not met as evidenced by:
Based on staff interview and record review, Emergency Department (ED) staff failed to document continuous observations of a patient who was restrained for 1 hour and 15 minutes for 1 of 6 applicable patients. (Patient # 4) Findings include:

Patient #4 was brought to the ED via ambulance on 5/16/18 at 12:54 after experiencing a seizure while at home. Upon arrival the patient was responding to painful stimulation and vomiting. Per nursing Admission Assessment/Part I describes Patient #4 as "...combative and non compliant with interventions. Minimally responsive. Slurred words, eyes mostly closed." However, Patient #4 remained restlessness and thrashing, and the physician ordered 4 point restraints which ED staff applied. Although a document had been developed to record the management and observations of the patient when restraints are applied, ED staff failed to utilize this or any other documentation to validate the continued use of restraints to include observations of the patient's response while restrained. The restraints were applied at 13:48 and at 14:11 there was one nursing note which states the patient remains resting. After the 14:11 note there was no further documentation to justify the continuous use of the 4 point restraints to include patient observations and tolerance and behavior. The restraints were discontinued at 15:04.

Per interview on 6/13/18 at 1:10 PM the VP of Quality Management confirmed it is the expectation staff would be conducting 15 minute checks of the patient while being held in restraints. Per review of the CAH policy and

C302 Records Systems
CFR(s): 485.638(a)(2)
The records are legible, complete, accurately documented, readily accessible, and systematically organized.

Based on staff interview, policy review and record review the surveyor is correct. Patient #4 was mechanically restrained and there is no documentation of application and management of the use of restraints in the record. The electronic template specifically developed to support accurate documentation of restraint use is available in the Meditech system and was not utilized.

Corrective Action
1. Access to the Emergency Department Module (EDM) in Meditech was restricted only to staff members permanently assigned to the Emergency Department. Clinical Patient Safety Observers (CPSO) coming from other departments to assist did not have access to document using the Restraint template that is associated with the worklist for Patient Observers. Open Access to Meditech will be a required change that will allow all staff assigned to a patient, regardless of permanently assigned location, to provide documentation within the specific templates needed. Open Access status will require an additional level of auditing and reporting.

(Continued on page 4 of 6)

Callie Shaw, VP Quality Improvement Program 7/9/18

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{C 302} Continued From page 3

procedure Restraint Application and Monitoring per Elsevier Performance Manager approved on 3/17/17 states: "The patient should be assessed for: Signs of injury associated with restraint application; Nutrition and hydration needs; Circulation and range of motion; Hygiene and elimination; Physical and psychological status and comfort and readiness for discontinuation or temporary removal of restraints". There was no evidence Patient #4 was assessed as per policy.

{C 336} This is a repeat deficiency
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:
Per staff interview, medical record review and CAH documentation review, the Emergency Department medical and nursing staff failed to utilize the established Risk Management Reporting System to report the Adverse Event of an attempted elopement; an event which had the potential to result in patient harm for 1 applicable patient. (Patient #6) Findings include:

On 5/27/18 at approximately 14:41 Patient #6 arrived in the Emergency Department (ED) with a chief complaint of depression and expressing suicidal ideation. Patient #6 was medically screened and a psychiatric screening evaluation

{C 302} **C 302 Records System**
CFR(s): 485.638(a)(2)

Response continued from page 3 of 6

Corrective Action (cont.)

Clarence Hallmartel, Director of Health Information Management, is responsible for developing and implementing an additional audit process to take effect when Meditech Open Access is granted to employees. Seleem Choudhury, DNP, Chief Nursing Officer in collaboration with Michael Moss, DNP, Emergency Services Director; Sharon Mallett, DNP, M/S/Pedi/Infusion Director, Rachel Malachuk, Manager of Clinical Informatics and are responsible for final development and full implementation of the Clinical Patient Safety Observer electronic documentation template and reliable auditing of the change to open access for Meditech by July 31, 2018.

{C 336} **C 336 Quality Assurance**
CFR(s): 485.641(b)

Response located on page 5 of 6

Ellen Sisk, VP Quality Management Program 7/9/18

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{C 336} Continued From page 4

was ordered. Shortly after the mental health screener's arrival at approximately 16:24, Patient #6 becomes upset with the screener and decides to leave the ED. Patient #6 makes threatening statements toward ED staff and stated s/he was "aggressively suicidal". Patient #6 exited the ED and was followed by 2 staff members who attempted to provide verbal redirection. Staff notified the Sheriff stationed in an office in the ED waiting area who proceeded to pursue Patient #6. When the sheriff arrived outside the ED in the parking area adjacent to the ED entrance, a physical altercation occurred between Patient #6 and the sheriff. Patient #6 was physically subdued by the sheriff, brought to the ground and handcuffed by the sheriff. Patient #6 was then returned to the ED handcuffed and accompanied by the sheriff. Patient #6 was placed on a stretcher, hand cuffs removed and 4 point restraints were applied. In addition, involuntary emergency medications were administered to Patient #6 by intramuscular injection to include: Haldol 5 mg (antipsychotic); Benadryl 50 mg; and Ativan 2 mg (antianxiety).

The CAH's, Adverse Event and Near Miss Reporting Policy states under the heading Reporting an Adverse Event or Near Miss that, "as soon as an adverse event occurs, or a non-medication near miss is discovered, it should be reported in the Meditech Risk Management System. Reporting adverse events helps us to improve safety in patient care and to create a safe work environment for employees, patients, visitors alike."

Per interview on the afternoon of 6/13/18 the V.P. for Quality Management confirmed the incident of attempted elopement and interactions between

{C 336}

(Response continued from page 4 of 6)

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 .....

Based on staff interview, medical record review and CAH documentation review, the surveyor is correct. The incident involving Patient #6 was not immediately entered into the reporting system. Patient #6 was physically escorted back into the hospital by clinical staff and the Security staff on duty at that time. NVRH did not have a clinical staff response team in place to assist with the management of behavioral health patients attempting to elope while still posing a threat to themselves and others. The surveyors are also correct that the incident was not filed in the electronic system at the time of occurrence as is stated in the policy. It was entered several days later. The educational component submitted for the April 2-4 Complaint survey has not been fully implemented but remains the essential component for compliance with policies.

Corrective Action Plan

1. Provide education for Department Managers to reinforce the information provided at the May 22nd meeting and further clarify the process as well as expectations for Incident Reporting with a second formal presentation at the 24th Managers Meeting.

(Response continued on page 6 of 6)

Callie Sorrow, VP Quality Management Program 7/5/18

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{C 336}	Continued From page 5 Patient #6 and the sheriff should have been reported in the Meditech Risk Management System as an Adverse Event. This would allow further opportunity to review the incident and identify opportunities for improvement and initiate corrective actions if deemed necessary. This is a repeat deficiency.	{C 336}	**(Response continued from page 5 of 6)** **C 336 Quality Assurance** **CFR(s): 485.641(b)** **Corrective Action Plan (cont.)** 2. Attend scheduled Department meetings to discuss the Incident Reporting System requirements and supporting policies with frontline staff throughout the month of July. 3. Assign the review of incident reporting policies to all NVRH staff members as part of annual competencies. Colleen Sinon, VP Quality Management Programs, in collaboration with Kim Darby, RN, QI Specialist and Patty Launer, RN Infection Preventionist/QI Specialist, is responsible for communication of the Incident Reporting System requirements to all NVRH employees and monitoring for use and compliance with documentation requirements. Findings will be reported monthly at the Patient Safety Committee.	

POC accepted
C253/C302/C336
S Shumbrook RN 7/11/18

Colleen Sinon, VP Quality Management Programs 7/9/18