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

October 18, 2018

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

Dear Mr. Bengtson:

The Division of Licensing and Protection completed a survey at your facility on **September 18, 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 **October 18, 2018.**

Sincerely,

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

Enclosure

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 _____	C 09/18/2018

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

(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 investigation was conducted on 9/17/18 & 9/18/18 by the Division of Licensing and Protection to determine compliance with Conditions of Participation for Critical Access Hospitals at 42 CFR. Part 485, Subpart F. Based on information gathered, the hospital was determined not to be in compliance with the Federal Condition of Participation for Critical Access Hospitals to include: COP: Staffing and Staffing Responsibilities and CoP: Periodic Evaluation and Quality Assurance Review. The following regulatory deficiencies are the result of complaint #16999:	C 000		
C 250	STAFFING AND STAFF RESPONSIBILITIES CFR(s): 485.631 Staffing and Staff Responsibilties This CONDITION is not met as evidenced by: Based on observation, interview and record review, the Condition of Participation: Staffing and Staffing Responsibilities was not as evidenced by the failure of the CAH to ensure sufficent staff coverage was available at all times and able to respond to emergent events or procedures and to be sufficent to meet the needs of patients demonstrating psychosis or other behavioral symptoms. Findings include: Refer tp Tag: C-0253	C 250	C250 STAFFING AND STAFF RESPONSIBILITIES CFR(s): 485.631) Staffing and Staff Responsibilities	
C 253	STAFFING CFR(s): 485.631(a)(3) The staff is sufficient to provide the services	C 253	C253 Staffing CFR(s) 485.631(a)(3) Response is on page 2 of 13 Ac accepted 10.18.18 FM/SL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: P+R B — TITLE: CEO — (X6) DATE: 10/15/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 253	Continued From page 1 essential to the operation of the CAH. This STANDARD is not met as evidenced by: There was a failure of the Critical Access Hospital (CAH) to ensure sufficient staff coverage was available at all times and available to respond to emergent events and to be sufficient to meet the needs of patients demonstrating behavioral symptoms; and the CAH failed to ensure non-hospital personnel cannot be drawn upon for behavior management or care which is the responsibility of the CAH staff in meeting the individuals assessed health needs for 1 of 10 applicable patients. (Patient #1) Findings include: After threatening staff at a health center, Patient #1 was brought by police to the Emergency Department (ED) on 8/23/18 at 18:00 to be evaluated for acute mental health issues. Patient #1 was determined to be a threat to self and others and was placed on an involuntary status for psychiatric hospitalization. Due to lack of a available psychiatric bed, Patient #1 was initially held in the ED but then transferred to the CAH medical-surgical patient care unit under observation status pending transfer to a psychiatric facility. The initial plan was to start treatment by offering Patient #1 medication to assist in the management of bipolar disorder with psychotic features. Patient #1 refused the prescribed medication to include Depakote (anticonvulsant used to treat bipolar disorders) and Seroquel (antipsychotic). Over the course of 9 days, Patient #1 remained on the medical-surgical unit and nursing staff were able to redirect the patient to remain in his/her hospital room and able to manage Patient #1's	C 253	C253 CFR(s) 485.631(a)(3) (Continued from Page 1) Patient #1 was on hold waiting for an available bed and Inpatient Psychiatric admission. There were no available beds in Vermont when he arrived on 8/22/18 through until his eventual transfer to an appropriate Inpatient Psychiatric Hospital on 9/4/18. The whole team including DMH actively sought an appropriate treatment placement each of the 13 days he remained on hold at this hospital. The patient was on involuntary status and in the custody of the Commissioner of Mental Health. Second Certification had been completed and confirmed that the patient would remain on involuntary status and warranted the use of Sheriff Level Cadre. DMH has a contract with the Lamoille County Sheriff Department and Sheriff staff are deployed to Vermont Hospitals to assist with this patient population. Lamoille sends two Officers to serve as Cadre. If no Officers are available from Lamoille Co. they request assistance from other Vermont County Sheriff Offices. There were no Officers available from Lamoille and the Caledonia County Sheriff's Office was able to provide one Officer for Patient #1. The Officer serving as Cadre for DMH on that shift is also part of the NVRH Security Staff. Hospital Security is provided by one person 24/7 and they are part of the healthcare team. (Continued on Page 3 of 13) POC accepted 10.18.18 for 18	

PeRBy CEO 10/15/2018

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C 253	Continued From page 2 intrusive and threatening behaviors. A Clinical Patient Safety Observer (CPSO) was assigned to continuously provide direct one-on-one observation of Patient #1 in order to redirect unsafe patient behaviors. Due to safety concerns, additional monitoring was provided by CAH contracted security (local Caledonia Sheriffs) and when available Sheriffs were also provided by Department of Mental Health (DMH). On 9/2/18 Patient #1's behaviors escalated, demonstrating an increase in delusions and paranoia with verbal threats to harm staff and especially aggressive to any individual in uniform, to include Sheriffs. At 11:00 PM on 9/2/18 Sheriff #1, contracted through DMH, was assigned to provide a presence outside Patient #1's room on the patient care unit. Sheriff #1 was advised by CAH contracted security officers to stay out of Patient #1's view, due to Patient #1's expressed dislike for individuals in uniforms, specifically Sheriff's. During the late evening of 9/2/18 Patient #1's behavior continued to escalate and s/he became more intrusive with movement in and outside assigned hospital room. As a result, the night nursing supervisor notified the attending physician for Patient #1's reporting concerns regarding increased paranoia and agitated behaviors. A physician's order was received for the application of physical restraints and involuntary medication administration due to concern for the physical safety of staff and other hospitalized patients. Once the physician's order was received the night nursing supervisor called a "Code Gray" (requesting immediate assistance from assigned CAH staff to assist with a safety or behavioral situation/event). Additional hospital staff arrived on the patient care unit to include 2	C 253	C253 CFR(s) 485.631(a)(3) (Continued from Page 2) Sheriff #1 was serving as Cadre hired by DMH for Patient #1. Sheriff #1 is also part of the NVRH Security Team and has participated in education and training with staff at the hospital. In collaboration with clinical staff members de-escalation techniques were consistently used to manage Patient #1 and maintain a safe environment including the safety of staff, other patients and visitors. Use of restraints, both chemical and physical, is a measure of last resort when all attempts at de-escalation have failed placing the patient, staff and others at risk for harm. Application of physical restraints and administration of chemical restraint may involve the need for physical contact as the healthcare team controls and minimizes the risk for physical harm to the patient and staff members. Patient #1 was not responding to the team efforts at de-escalation and in fact continued to escalate with verbal threats and physical challenges. Physician Order appropriately obtained for Use of Restraint, physical and chemical, and the Code Gray Team was staged out of sight of the patient. Team members are qualified NVRH staff from all areas of the hospital who are available to respond when the Code is called. Qualified staff include the Security staff on duty. Security staff members have participated in Code Gray Drills and completed CPI training alongside the clinical staff POC ant 10.18.18 fm/sl	

PerRy CEO 10/15/2018

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C 253	Continued From page 3 contracted security guards employed by the CAH, who are Caledonia County Sheriffs. A staff huddle transpired and a plan was formulated by the nursing supervisor which included the application of restraints to a stretcher; transporting the stretcher to Patient #1's room; with staff assistance position Patient #1 on stretcher; apply 4-point restraints and safely administered behavioral medication. Per telephone interview on 9/18/18 at 9:00 AM, Sheriff #1 confirmed s/he saw a group of nurses pull out a restraint bed and was then informed by the nursing supervisor of the intention to restrain Patient #1, however Sheriff #1 had not been included in the initial Code Gray plan. Sheriff #1, although not employed or trained by CAH, choose to become involved with the emergency procedure and entered Patient #1's room with the nursing supervisor. Upon seeing the uniformed Sheriff approaching with the nursing supervisor into his/her hospital room and staff moving a stretcher with attached restraints, Patient #1 became defensive and lunged towards Sheriff #1, hitting the Sheriff in the head, resulting in both individuals falling to the floor. Sheriff #1 confirmed s/he was able to return punches, hitting the left side of Patient #1's face. Once on the floor, Patient #1 remained on top of Sheriff #1 despite other staff attempting to remove the patient off Sheriff #1. The 2 CAH security guards/County Sheriffs also became involved in the behavioral management of Patient #1. Security guard/Sheriff #2 confirmed on 9/18/18 at 12:00 s/he was able to "...deliver strikes with his/her baton.." onto Patient #1 when attempting to intervene between the patient and Sheriff #1. When Patient #1 was attempting to	C 253	C253 CFR(s) 485.631(a)(3) (Continued from Page 3) The Code Gray Team led by the Nursing Supervisor entered Patient #1's room. The Team also brought in the stretcher with the 4 point restraints in place. Patient #1 did not agree to being placed in restraints and an intense physical altercation ensued. Physical and Chemical restraints were used successfully as ordered by the physician and Patient #1 was able to calm down. Sheriff #1 joined the Code Gray Team and entered ahead of the Nursing Supervisor in an attempt to protect staff from harm. Upon reviewing the surveillance video, Sheriff #1 was included in the Team Huddle prior to entering the patient room. The House Supervisor directed Sheriff #1 to enter the room first, she followed and the 10 remaining members of the Code Gray Team followed bringing the stretcher into the room as well. There was no visual for the several minutes in the room. We have only the descriptions given by the staff members involved. 3 Staff members assembled for the Code Gray remained outside of the room. One staff member entered the room and passed the hospital bed out to the other two waiting just outside the door. The recliner was passed out as well. All three of the remaining staff then entered into the patient room with the	

Accept 10.18.18 [illegible]

PoR By CEO 10/15/2018

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C 253	Continued From page 4 reach Sheriff #1's service revolver, security guard (Sheriff #3) deployed his/her tazer hitting Patient #1 in close proximity, landing 2 tazer darts into the patient's upper torso. After being tazed, Patient #1 was extracted off of Sheriff #1, hand cuffed by the sheriffs, and with staff assistance was then placed on the stretcher, handcuffs were removed and restraints were applied to Patient #1's arms and legs. Involuntary emergency medication was administered to include Haldol (antipsychotic) 5 mg. IM (intramuscular) and Ativan (sedative) 1 mg IM. Eventually, Patient #1 became less agitated, and remained in restraints for several hours. Patient #1 sustained an abrasion to right eyebrow and redness to left and right flank was observed by nursing staff on 9/3/18 at 8:00 AM. On 9/4/18, Patient #1 was transferred to a psychiatric hospital. Per CAH policy Behavioral Health Patient-Management of the Admitted approved 7/19/18 states: "All patients presenting with a Behavioral Health concern will be cared for in the same manner as all other patients presenting for care. The behavioral concerns can include poor impulse control, a low frustration tolerance, difficulty in communicating needs, and an inability to think clearly." Patient #1 demonstrated all characteristics as described. It was evident that the event on 9/3/18 represented a failure of the CAH to have sufficient and knowledgeable staff made available at all times to provide the necessary interventions during a behavioral emergent event The use of non-hospital staff for behavioral management resulted in both the patient and staff being subjected to potential safety hazards and injury.	C 253	C253 CFR(s) 485.631(a)(3) (Continued from Page 4) joining the rest of the Code Gray Team. Patient #1 was placed in 4 point restraints and chemical restraint was also administered. Code gray Team exited the room. House Supervisor had a brief discussion and then the staff members returned to their regularly assigned duties. Entire episode from initial Code Gray Huddle to completion and return to assigned duties was 12 minutes. This CAH did have sufficient and knowledgeable staff available to provide necessary interventions during multiple episodes of behavioral crisis throughout Patient #1's 13 day stay. Clarification is needed regarding the use of our Security Staff and the use of a Sheriff contracted through Lamoille County at the direction of the Commissioner of DMH including role clarification when the person is also one of our regular Security Staff members. **Corrective Action Plan** 1. Revise Code Gray (Violent Patient/ Employee/Family Member) policy to address appropriate use of the Security Staff as part of the response team. 2. Develop new Security Management Policy outlining role of NVRH Security Staff, DMH contracted Sheriff and use of weapons. **(Continued on page 6 of 13)**	

10.18.18

RcRB CEO 10/15/2018

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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 CAH failed to ensure that care was provided in accordance with written policies and procedures regarding the use of mechanical restraints for 1 out of 10 applicable patients (Patient #2). There was also a failure to develop policies and procedures to direct the role and responsibilities of contracted security utilized by the CAH. Findings include: 1. On 08/03/2018, Patient #2 was brought to the Emergency Department with a chief complaint of a psychiatric problem and presented with agitation, hallucinations and paranoia. A mental health evaluation was conducted which determined that Patient #2 met criteria for inpatient psychiatric hospitalization. Due to a lack of an available psychiatric bed, Patient #2 was transferred to the medical-surgical floor of the CAH until transfer from the CAH on 08/08/2018. Per Physician order, Patient #2 was placed under constant observation by a Clinical Patient Safety Observer (CPSO) to maintain safety. During the first 24 hours period following Patient #2's transfer to the medical-surgical floor, staff placed Patient #2 in mechanical restraints. At approximately 5:52 PM on 08/03/2018, Patient #2 began demonstrating an increase in agitation and aggressive behavior. Nursing staff and Security attempted to verbally redirect Patient #2 when s/he exited their room and, "bolted" to the	C 271	C253 CFR(s) 485.631(a)(3) (Continued from Page 5) **Corrective Action Plan (cont.)** 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. New Policy for Security Management and the revised Code Gray clarification for use of Security and contracted DMH Sheriff in response to behavioral emergent events to be in place by October 31, 2018. **C271 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. The Surveyors are correct. Staff failed to remove mechanical restraints during periods of time when Patient #2 was calm. The Surveyors are also correct that a Security Management Policy defining the role and responsibilities of NVRH Security and Sheriffs contracted through DMH was not available for staff. (Continued on Page 7 of 13)	

PerRy CED 10/15/2018

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C 271	Continued From page 6 elevators in an attempt to leave the hospital floor. Per Nursing Progress note, "This RN kept pace with the patient and was trying to calmly talk this patient into going back" to their room. When additional staff responded to the area for assistance, Patient #2, "became hostile", "grabbed" at staff, starting fighting, and screamed threats that they would kill staff members present. Per Nursing Progress note, Patient #2 was placed in restraints at 6:10 PM. Patient #2, "fought against the restraints" and continued to scream and, "fight the restraints" requiring emergent does of Benadryl 25 mg, Haldol 5mg, and Ativan 3mg given intramuscularly in order to manage self-injurious behavior while restrained. Per documentation by Licensed Nursing Assistant (LNA), Patient #2, "appears to be asleep in restraints" at 11:12 PM. The CAH policy, "Restraints and Management of a Restraint-Free Environment" (approved 07/05/2018) states, "Chemical and/or physical restraints may be needed in severe cases once all other options are exhausted. The judicious use of restraints may need to be considered when it is perceived that imminent danger may occur to self or others...to ensure safety. When restraint is necessary, the patient should be treated with humane care that preserves human dignity." Following the application of restraints with Patient #2 on 08/03/2018 there were documented periods when Patient #2 was calm and/or asleep demonstrating s/he was no longer posing an immediate threat to staff or their own safety. Between 11:30 PM and 3:00 AM on 08/04/2018, Patient #2 was documented to be, "asleep", "lying quietly in bed, and "sleeping" when observed by Registered Nurses and	C 271	**C271 PATIENT CARE POLICIES** **CFR(s) 485.635(a)(1)** **(Continued from page 6 of 13)** **Corrective Action Plan** 1. Revise the "Restraints and Management of a Restraint Free Environment policies to specifically address appropriate removal of restraints. 2. Develop new Security Management Policy outlining role of NVRH Security Staff, DMH contracted Sheriff and use of weapons on individuals not in custody of law enforcement. 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 "Restraints and Management of a Restraint Free Environment" Policies. Colleen Sinon, VP Quality Management Programs is responsible for development and communication of the new Security Management Plan. New Policy for Security Management and the revised "Restraints and Management of a Restraint Free Environment" Policies to be in place by October 31, 2018. Account 10.18.18 fm/sl	

for RB/ CEO 10/15/2018

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C 271	Continued From page 7 Licensed Nursing Assistants. There was no documented evidence of attempt to begin to discontinue the restraints, and no documented evidence of imminent danger requiring continued restraints to ensure safety. The Vice President Of Quality Management Programs and Clinical Informatics RN confirmed Patient #2's documented calm behavior while restrained at 1:40 PM on 9/18/2018. During a review of the policy, "Restraints", the VP of Quality Management Programs confirmed that the CAH policy did not include instructions for staff to remove restraints when discharge criteria were demonstrated by patients. S/he confirmed the lack of policy interventions to guide staff with the discontinuation of restraints when risk of imminent harm was no longer present at 2:00 PM on 9/18/2018. In addition, upon review of recent behavioral interventions which occurred on 9/3/18 during which time contracted security staff (Caledonia Sheriffs) had become involved with the behavioral management of a patient, it was further confirmed the CAH had not developed a policy and procedure to direct this contracted service/staff and to further stipulate the prevention of Sheriff's utilizing weapons on patients not in police custody. Refer to C-253	C 271	C271 PATIENT CARE POLICIES CFR(s) 485.635(a)(1) **(Response is on Page 7 of 13)**	
C 330	PERIODIC EVALUATION & QA REVIEW CFR(s): 485.641 Periodic Evaluation and Quality Assurance Review	C 330	**PERIODIC EVALUATION & QA REVIEW CFR(s): 485.641** Qualified Staff members were available and appropriately responded to the Code Gray situation involving Patient #1. Immediate corrective action was taken regarding Security and prohibiting the use of a tazer in patient care areas of the hospital. Surveyors are correct that the actions taken were not reflected in documentation or staff interviews. The Corrective Action Plans outlined for C253 on page 6 of 13 and C271 on page 7 of 13 will provide accurate guidance for management and documentation requirements for Restraint Free Environment, Use of Restraints and the role of Security Staff during Code Gray situations. Opportunities for Improvement were immediately identified in the following categories based on the initial Trajectory Analysis performed: Physical Environment, New Employee Orientation, Ongoing Education, Clearly defined roles and responsibilities for Security staff, Use of weapons, resource allocation for ongoing performance evaluation and improvement activity, clear policies. **(Continued on Page 9 of 13)** POC accept 10.18.18 FM/8	

PeRB/ CEO 10/15/2018

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C 330	Continued From page 8 This CONDITION is not met as evidenced by: The Condition of Participation: Periodic Evaluation and Quality Assurance Review was not met based on staff interview and record review the CAH failed to evaluate the quality and appropriateness of treatment and services, in a timely manner, and develop corrective actions as the result of an adverse patient event. Findings include: There was a failure to identify opportunities for improvement to include the failure to ensure sufficient staff coverage was available at all times and available to respond to emergent events and to be sufficient to meet the needs of patients demonstrating behavioral symptoms; and the CAH failed to ensure non-hospital personnel cannot be drawn upon for behavior management or care which is the responsibility of the CAH staff in meeting the individuals assessed health needs.	C 330	PERIODIC EVALUATION & QA REVIEW CFR(s): 485.641 **Response is on page 8 of 13**	
C 337	Refer to C-253 QUALITY ASSURANCE CFR(s): 485.641(b)(1) 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- all patient care services and other services affecting patient health and safety are evaluated.	C 337	**Refer to C-253** **QUALITY ASSURANCE** **CFR(s): 485.641(b)(1)** **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. Surveyors did not find documented evidence to support an effective program. Patient #1 and Patient #2 are individuals within the population that has been a focus for this CAH for several years. Individuals within this category are experiencing an acute Mental Health crisis and pose a real physical threat of harm and are a danger to themselves and others. When an individual is screened by the QMHP and/or Crisis Worker from our local deemed agency and it has been determined that they are in need of inpatient psychiatric treatment but are unwilling or incapable of agreeing to the plan it is necessary to provide an Emergency Evaluation (EE) to determine if Involuntary Admission Status is needed. Both Patient #1and Patient #2 were Involuntary admissions on hold for an available inpatient Psychiatric bed.	

10.18.18

Perry CEO 10/15/2018

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 _____	C 09/18/2018

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 337	Continued From page 9 This STANDARD is not met as evidenced by: Based on staff interview and record review, there was a failure to identify opportunities for improvement to include the failure to ensure sufficient staff coverage was available at all times and available to respond to emergent events and to be sufficient to meet the needs of patients demonstrating behavioral symptoms and the failure to ensure non-hospital personnel cannot be drawn upon for behavior management or care which is the responsibility of the CAH staff in meeting the individuals assessed health needs. Findings include: On 9/2/18 Patient #1, with a diagnosis of bipolar/mania, was held involuntarily on the medical-surgical unit while awaiting placement in a psychiatric hospital. During the late evening of 9/2/18, Patient #1's symptoms of paranoia and delusions escalated and the patient made increased verbal threats to harm staff. At 11:00 PM on 9/2/18 Sheriff #1, contracted through DMH, was assigned to provide a presence outside Patient #1's room on the medical-surgical unit. Sheriff #1 was advised by CAH contracted security officers to stay out of Patient #1's view, due to Patient #1's expressed dislike for individuals in uniforms, specifically Sheriff's. As a result of increased symptoms and wandering in and out of hospital room, the night nursing supervisor notified the attending physician for the patient and received a physician orders for the application of physical restraints and involuntary medication administration due to concern for the safety and risk of harm to staff and other hospitalized patients. Once the physician's order was received the night nursing supervisor called	C 337	**Continued from Page 9 of 13)** Refer to C-253 QUALITY ASSURANCE CFR(s): 485.641(b)(1) Patient #1 and #2 exhibited verbal and threatened physical harm to the staff. Qualified licensed staff members trained in CPI techniques were provided to care for our patients each day. This CAH recognizes that Patient #1 (bipolar disorder with acute psychosis) remained at this facility 13 days on bed hold awaiting an admission to a Psychiatric Inpatient setting and this is not the the best situation for all involved. Patient #2 (acute psychosis and aggressive behavior) remained at this facility for 6 days also awaiting an opening for admission for inpatient psychiatric stabilization and treatment. This CAH is interested in the clinical outcomes for similar patients, but we do not currently have access to the results of treatment from the Psychiatric facilities; neither do we have a communication to inform us of a return to the community and the plan for follow up care. This CAH will continue to provide qualified staff to manage the needs of our patients and seek opportunities to improve communication across the continuum. **Continued on page 11 of 13** POC appt 10.18.18 fm/sl	

RcR By CEO 10/15/2018

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

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C 337	Continued From page 10 a "Code Gray" (requesting immediate assistance from assigned CAH staff to assist with a safety or behavioral situation/event). Additional hospital staff arrived on the patient care unit to include 2 contracted security guards employed by the CAH, who are Caledonia County Sheriffs. A staff huddle transpired and a plan was formulated by the nursing supervisor which included the application of restraints to a stretcher; transporting the stretcher to Patient #1's room; with staff assistance position Patient #1 on stretcher; apply 4-point restraints and safely administered behavioral medication. Per telephone interview on 9/18/18 at 9:00 AM, Sheriff #1 confirmed s/he saw a group of nurses pull out a restraint bed and was then informed by the nursing supervisor of the intention to restrain Patient #1, however Sheriff #1 had not been directly included in the Code Gray plan. Sheriff #1, although not employed or trained by CAH, choose to become involved with the emergency procedure and entered Patient #1's room with the nursing supervisor. Upon seeing the uniformed Sheriff approaching with the nursing supervisor into his/her hospital room and staff moving a stretcher with attached restraints, Patient #1 became defensive and lunged towards Sheriff #1, hitting the Sheriff in the head, resulting in both individuals falling to the floor. Sheriff #1 confirmed s/he was able to return punches, hitting the left side of Patient #1's face. Once on the floor, Patient #1 remained on top of Sheriff #1 despite other staff attempting to remove the patient off Sheriff #1. The 2 CAH security guards/County Sheriffs also became involved in the behavioral management of Patient #1. Security guard/Sheriff #2 confirmed	C 337	**Continued from page 10 of 13** **The Corrective Action Plans listed for C253 and C271 address the changes for Code Gray,the Security Management Plan and use of Restraints** **Corrective Action Plan** 1.Revise the "Restraints and Management of a Restraint Free Environment policies to specifically address appropriate removal of restraints. 2.Develop new Security Management Policy outlining role of NVRH Security Staff, DMH contracted Sheriff and use of weapons on individuals not in custody of law enforcement. 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 "Restraints and Management of a Restraint Free Environment" Policies. Colleen Sinon, VP Quality Management Programs is responsible for development and communication of the new Security Management Plan. New Policy for Security Management and the revised "Restraints and Management of a Restraint Free Environment" Policies to be in place by October 31, 2018. poc amt 10.18 · 18 fm RL	

Ron Bty CEO 10/15/2018

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C 337	Continued From page 11 on 9/18/18 at 12:00 s/he was able to "...deliver strikes with his/her baton.." onto Patient #1 when attempting to intervene between the patient and Sheriff #1. When Patient #1 was attempting to reach Sheriff #1's service revolver, security guard (Sheriff #3) deployed his/her tazer hitting Patient #1 in close proximity, landing 2 tazer darts into the patient's upper back torso. After being tazed, Patient #1 was extracted off of Sheriff #1, hand cuffed by the sheriffs, and with staff assistance was then placed on the stretcher, handcuffs were removed and restraints were applied to Patient #1's arms and legs. Involuntary emergency medication was administered to include Haldol (antipsychotic) 5 mg. IM (intramuscular) and Ativan (sedative) 1 mg IM. Eventually, Patient #1 became less agitated, and remained in restraints for several hours. The patient sustained bruising of face and upper torso. On 9/4/18 the patient was discharged to a psychiatric hospital. After the event on 9/3/18 a staff member completed a adverse event report via the Risk Management Reporting System. However, as of 9/18/18 there has not been a formal review of the significant chain of events to include the use of a tazer by contracted security on a hospitalized patient; the seriousness of the altercation that pursued; the effective use of the the Code Gray team; and the lack of psychiatric consultation and direction to staff to assist in the management of the patient's behavioral symptoms. Per interview on 9/18/18 at 11:00 AM, the Chief Nursing Officer confirmed awareness of the events on 9/3/18 and confirmed informal conversations with the VP of Quality Management Program had occurred. There has	C 337	Continued from page 9 of 13 **Refer to C-253** **QUALITY ASSURANCE** **CFR(s): 485.641(b)(1)** Surveyors are correct. An incident report was submitted following this described event. The chain of events was addressed with the individuals involved in the actual incident. Patient #1 would agree to take only medications for things unrelated to management of his psychiatric and behavioral symptoms. There is limited availability for Psychiatric consultation and we do not provide treatment at this facility. Use of weapons was immediately addressed with the Supervisor of Security and clarified that tazers, pepper spray and firearms were prohibited from use in patient care areas. The nursing Supervisor serving as team leader for the Code Gray was individually debriefed and the need for policy revisions was acknowledged. Involved staff members participated in a debriefing with our Employee Assistance Program Counselor. The group was not gathered together for a formal review of the events. **Corrective Action Plan** 1. Formal Review of incidents and completion of Trajectory Analysis and/or RCA will take place when there has been harm or potential for significant harm to a patient. Immediate change in practice implemented. Colleen Sinon, VP Quality Management Programs is responsible for ongoing monitoring and evaluation.	

P+R By CEO 10/15/2018

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C 337	Continued From page 12 not been a formal review to evaluate the quality and appropriateness of the treatment and services provided to Patient #1 on 9/3/18. This was further confirmed by the VP of Quality Management on the afternoon of 9/18/18, acknowledging a failure to examine and review all the circumstances which had occurred on 9/3/18 and to identify preliminary opportunities for improvement especially associated with the use of non-hospital employees during behavioral interventions and the use of weapons on hospitalized patients who are not in police custody.	C 337	**Continued from page 9 of 13** Refer to C-253 QUALITY ASSURANCE CFR(s): 485.641(b)(1) **Response on Page 10 of 13**	

PeRB CEO 10/15/2018

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C 337	Continued From page 12 not been a formal review to evaluate the quality and appropriateness of the treatment and services provided to Patient #1 on 9/3/18. This was further confirmed by the VP of Quality Management on the afternoon of 9/18/18, acknowledging a failure to examine and review all the circumstances which had occurred on 9/3/18 and to identify preliminary opportunities for improvement especially associated with the use of non-hospital employees during behavioral interventions and the use of weapons on hospitalized patients who are not in police custody.	C 337	**Continued from page 12 of 13** QUALITY ASSURANCE CFR(s): 485.641(b)(1) **Corrective Action Plan (cont.)** 2. The incident report on file for Patient #1 was fully investigated and closed on September 19, 2018. Areas for improvement were identified for new employee orientation, ongoing education and training, use of security staff, policy development, code gray drills. Improvement activity will be ongoing. Seleem Choudhury, DNP, Chief Nursing Officer in collaboration with Michael Moss, DNP, Emergency Services Director; Sharon Mallett, DNP, MS/Pedi/ Inf Director; Laura Sophrin, MSN,ICU Director; Carol Hodges, Nursing Education Coordinator; Colleen Sinon, VP Quality Management Programs and the House Supervisors, are responsible for ongoing education, training, orientation and policy development. POC mt 10.18.18 fm/8	9/19/18

10/18/2018

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C 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted on 9/17/18 & 9/18/18 by the Division of Licensing and Protection to determine compliance with Conditions of Participation for Critical Access Hospitals at 42 CFR. Part 485, Subpart F. Based on information gathered, the hospital was determined not to be in compliance with the Federal Condition of Participation for Critical Access Hospitals to include: COP: Staffing and Staffing Responsibilities and CoP: Periodic Evaluation and Quality Assurance Review. The following regulatory deficiencies are the result of complaint #16999:	C 000		
C 250	STAFFING AND STAFF RESPONSIBILITIES CFR(s): 485.631 Staffing and Staff Responsibilties This CONDITION is not met as evidenced by: Based on observation, interview and record review, the Condition of Participation: Staffing and Staffing Responsibilities was not as evidenced by the failure of the CAH to ensure sufficent staff coverage was available at all times and able to respond to emergent events or procedures and to be sufficent to meet the needs of patients demonstrating psychosis or other behavioral symptoms. Findings include: Refer tp Tag: C-0253	C 250	C250 STAFFING AND STAFF RESPONSIBILITIES CFR(s): 485.631) Staffing and Staff Responsibilities	
C 253	STAFFING CFR(s): 485.631(a)(3) The staff is sufficient to provide the services	C 253	C253 Staffing CFR(s) 485.631(a)(3) Response is on page 2 of 13 poc amt 10.18.18 fm/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: FPRB — TITLE: CEO — (X6) DATE: 10/15/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 253	Continued From page 1 essential to the operation of the CAH. This STANDARD is not met as evidenced by: There was a failure of the Critical Access Hospital (CAH) to ensure sufficient staff coverage was available at all times and available to respond to emergent events and to be sufficient to meet the needs of patients demonstrating behavioral symptoms; and the CAH failed to ensure non-hospital personnel cannot be drawn upon for behavior management or care which is the responsibility of the CAH staff in meeting the individuals assessed health needs for 1 of 10 applicable patients. (Patient #1) Findings include: After threatening staff at a health center, Patient #1 was brought by police to the Emergency Department (ED) on 8/23/18 at 18:00 to be evaluated for acute mental health issues. Patient #1 was determined to be a threat to self and others and was placed on an involuntary status for psychiatric hospitalization. Due to lack of a available psychiatric bed, Patient #1 was initially held in the ED but then transferred to the CAH medical-surgical patient care unit under observation status pending transfer to a psychiatric facility. The initial plan was to start treatment by offering Patient #1 medication to assist in the management of bipolar disorder with psychotic features. Patient #1 refused the prescribed medication to include Depakote (anticonvulsant used to treat bipolar disorders) and Seroquel (antipsychotic). Over the course of 9 days, Patient #1 remained on the medical-surgical unit and nursing staff were able to redirect the patient to remain in his/her hospital room and able to manage Patient #1's	C 253	C253 CFR(s) 485.631(a)(3) (Continued from Page 1) Patient #1 was on hold waiting for an available bed and Inpatient Psychiatric admission. There were no available beds in Vermont when he arrived on 8/22/18 through until his eventual transfer to an appropriate Inpatient Psychiatric Hospital on 9/4/18. The whole team including DMH actively sought an appropriate treatment placement each of the 13 days he remained on hold at this hospital. The patient was on involuntary status and in the custody of the Commissioner of Mental Health. Second Certification had been completed and confirmed that the patient would remain on involuntary status and warranted the use of Sheriff Level Cadre. DMH has a contract with the Lamoille County Sheriff Department and Sheriff staff are deployed to Vermont Hospitals to assist with this patient population. Lamoille sends two Officers to serve as Cadre. If no Officers are available from Lamoille Co. they request assistance from other Vermont County Sheriff Offices. There were no Officers available from Lamoille and the Caledonia County Sheriff's Office was able to provide one Officer for Patient #1. The Officer serving as Cadre for DMH on that shift is also part of the NVRH Security Staff. Hospital Security is provided by one person 24/7 and they are part of the healthcare team. (Continued on Page 3 of 13)	

Per RB CEO 10/15/2018

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C 253	Continued From page 2 intrusive and threatening behaviors. A Clinical Patient Safety Observer (CPSO) was assigned to continuously provide direct one-on-one observation of Patient #1 in order to redirect unsafe patient behaviors. Due to safety concerns, additional monitoring was provided by CAH contracted security (local Caledonia Sheriffs) and when available Sheriffs were also provided by Department of Mental Health (DMH). On 9/2/18 Patient #1's behaviors escalated, demonstrating an increase in delusions and paranoia with verbal threats to harm staff and especially aggressive to any individual in uniform, to include Sheriffs. At 11:00 PM on 9/2/18 Sheriff #1, contracted through DMH, was assigned to provide a presence outside Patient #1's room on the patient care unit. Sheriff #1 was advised by CAH contracted security officers to stay out of Patient #1's view, due to Patient #1's expressed dislike for individuals in uniforms, specifically Sheriff's. During the late evening of 9/2/18 Patient #1's behavior continued to escalate and s/he became more intrusive with movement in and outside assigned hospital room. As a result, the night nursing supervisor notified the attending physician for Patient #1's reporting concerns regarding increased paranoia and agitated behaviors. A physician's order was received for the application of physical restraints and involuntary medication administration due to concern for the physical safety of staff and other hospitalized patients. Once the physician's order was received the night nursing supervisor called a "Code Gray" (requesting immediate assistance from assigned CAH staff to assist with a safety or behavioral situation/event). Additional hospital staff arrived on the patient care unit to include 2	C 253	C253 CFR(s) 485.631(a)(3) (Continued from Page 2) Sheriff #1 was serving as Cadre hired by DMH for Patient #1. Sheriff #1 is also part of the NVRH Security Team and has participated in education and training with staff at the hospital. In collaboration with clinical staff members de-escalation techniques were consistently used to manage Patient #1 and maintain a safe environment including the safety of staff, other patients and visitors. Use of restraints, both chemical and physical, is a measure of last resort when all attempts at de-escalation have failed placing the patient, staff and others at risk for harm. Application of physical restraints and administration of chemical restraint may involve the need for physical contact as the healthcare team controls and minimizes the risk for physical harm to the patient and staff members. Patient #1 was not responding to the team efforts at de-escalation and in fact continued to escalate with verbal threats and physical challenges. Physician Order appropriately obtained for Use of Restraint, physical and chemical, and the Code Gray Team was staged out of sight of the patient. Team members are qualified NVRH staff from all areas of the hospital who are available to respond when the Code is called. Qualified staff include the Security staff on duty. Security staff members have participated in Code Gray Drills and completed CPI training alongside the clinical staff	

POC sent 10.18.18 fx/bl

PER RJ CEO 10/15/2018

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C 253	Continued From page 3 contracted security guards employed by the CAH, who are Caledonia County Sheriffs. A staff huddle transpired and a plan was formulated by the nursing supervisor which included the application of restraints to a stretcher; transporting the stretcher to Patient #1's room; with staff assistance position Patient #1 on stretcher; apply 4-point restraints and safely administered behavioral medication. Per telephone interview on 9/18/18 at 9:00 AM, Sheriff #1 confirmed s/he saw a group of nurses pull out a restraint bed and was then informed by the nursing supervisor of the intention to restrain Patient #1, however Sheriff #1 had not been included in the initial Code Gray plan. Sheriff #1, although not employed or trained by CAH, choose to become involved with the emergency procedure and entered Patient #1's room with the nursing supervisor. Upon seeing the uniformed Sheriff approaching with the nursing supervisor into his/her hospital room and staff moving a stretcher with attached restraints, Patient #1 became defensive and lunged towards Sheriff #1, hitting the Sheriff in the head, resulting in both individuals falling to the floor. Sheriff #1 confirmed s/he was able to return punches, hitting the left side of Patient #1's face. Once on the floor, Patient #1 remained on top of Sheriff #1 despite other staff attempting to remove the patient off Sheriff #1. The 2 CAH security guards/County Sheriffs also became involved in the behavioral management of Patient #1. Security guard/Sheriff #2 confirmed on 9/18/18 at 12:00 s/he was able to "...deliver strikes with his/her baton.." onto Patient #1 when attempting to intervene between the patient and Sheriff #1. When Patient #1 was attempting to	C 253	C253 CFR(s) 485.631(a)(3) (Continued from Page 3) The Code Gray Team led by the Nursing Supervisor entered Patient #1's room. The Team also brought in the stretcher with the 4 point restraints in place. Patient #1 did not agree to being placed in restraints and an intense physical altercation ensued. Physical and Chemical restraints were used successfully as ordered by the physician and Patient #1 was able to calm down. Sheriff #1 joined the Code Gray Team and entered ahead of the Nursing Supervisor in an attempt to protect staff from harm. Upon reviewing the surveillance video, Sheriff #1 was included in the Team Huddle prior to entering the patient room. The House Supervisor directed Sheriff #1 to enter the room first, she followed and the 10 remaining members of the Code Gray Team followed bringing the stretcher into the room as well. There was no visual for the several minutes in the room. We have only the descriptions given by the staff members involved. 3 Staff members assembled for the Code Gray remained outside of the room. One staff member entered the room and passed the hospital bed out to the other two waiting just outside the door. The recliner was passed out as well. All three of the remaining staff then entered into the patient room with the	

Rec'd 10.18.18 for ISL

POR B COO 10/15/2018

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C 253	Continued From page 4 reach Sheriff #1's service revolver, security guard (Sheriff #3) deployed his/her tazer hitting Patient #1 in close proximity, landing 2 tazer darts into the patient's upper torso. After being tazed, Patient #1 was extracted off of Sheriff #1, hand cuffed by the sheriffs, and with staff assistance was then placed on the stretcher, handcuffs were removed and restraints were applied to Patient #1's arms and legs. Involuntary emergency medication was administered to include Haldol (antipsychotic) 5 mg. IM (intramuscular) and Ativan (sedative) 1 mg IM. Eventually, Patient #1 became less agitated, and remained in restraints for several hours. Patient #1 sustained an abrasion to right eyebrow and redness to left and right flank was observed by nursing staff on 9/3/18 at 8:00 AM. On 9/4/18, Patient #1 was transferred to a psychiatric hospital. Per CAH policy Behavioral Health Patient-Management of the Admitted approved 7/19/18 states: "All patients presenting with a Behavioral Health concern will be cared for in the same manner as all other patients presenting for care. The behavioral concerns can include poor impulse control, a low frustration tolerance, difficulty in communicating needs, and an inability to think clearly." Patient #1 demonstrated all characteristics as described. It was evident that the event on 9/3/18 represented a failure of the CAH to have sufficient and knowledgeable staff made available at all times to provide the necessary interventions during a behavioral emergent event The use of non-hospital staff for behavioral management resulted in both the patient and staff being subjected to potential safety hazards and injury.	C 253	C253 CFR(s) 485.631(a)(3) (Continued from Page 4) joining the rest of the Code Gray Team. Patient #1 was placed in 4 point restraints and chemical restraint was also administered. Code gray Team exited the room. House Supervisor had a brief discussion and then the staff members returned to their regularly assigned duties. Entire episode from initial Code Gray Huddle to completion and return to assigned duties was 12 minutes. This CAH did have sufficient and knowledgeable staff available to provide necessary interventions during multiple episodes of behavioral crisis throughout Patient #1's 13 day stay. Clarification is needed regarding the use of our Security Staff and the use of a Sheriff contracted through Lamoille County at the direction of the Commissioner of DMH including role clarification when the person is also one of our regular Security Staff members. **Corrective Action Plan** 1. Revise Code Gray (Violent Patient/ Employee/Family Member) policy to address appropriate use of the Security Staff as part of the response team. 2. Develop new Security Management Policy outlining role of NVRH Security Staff, DMH contracted Sheriff and use of weapons. **(Continued on page 6 of 13)** POC and A 10.18.18 fm/sl	

Pre RR CEO 10/15/2018

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 _____	C 09/18/2018

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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 CAH failed to ensure that care was provided in accordance with written policies and procedures regarding the use of mechanical restraints for 1 out of 10 applicable patients (Patient #2). There was also a failure to develop policies and procedures to direct the role and responsibilities of contracted security utilized by the CAH. Findings include: 1. On 08/03/2018, Patient #2 was brought to the Emergency Department with a chief complaint of a psychiatric problem and presented with agitation, hallucinations and paranoia. A mental health evaluation was conducted which determined that Patient #2 met criteria for inpatient psychiatric hospitalization. Due to a lack of an available psychiatric bed, Patient #2 was transferred to the medical-surgical floor of the CAH until transfer from the CAH on 08/08/2018. Per Physician order, Patient #2 was placed under constant observation by a Clinical Patient Safety Observer (CPSO) to maintain safety. During the first 24 hours period following Patient #2's transfer to the medical-surgical floor, staff placed Patient #2 in mechanical restraints. At approximately 5:52 PM on 08/03/2018, Patient #2 began demonstrating an increase in agitation and aggressive behavior. Nursing staff and Security attempted to verbally redirect Patient #2 when s/he exited their room and, "bolted" to the	C 271	C253 CFR(s) 485.631(a)(3) (Continued from Page 5) **Corrective Action Plan (cont.)** 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. New Policy for Security Management and the revised Code Gray clarification for use of Security and contracted DMH Sheriff in response to behavioral emergent events to be in place by October 31, 2018. **C271 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. The Surveyors are correct. Staff failed to remove mechanical restraints during periods of time when Patient #2 was calm. The Surveyors are also correct that a Security Management Policy defining the role and responsibilities of NVRH Security and Sheriffs contracted through DMH was not available for staff. (Continued on Page 7 of 13) PR amnt 10.18.18 fm/pl	

PeR Rg CEO 10/15/2018

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C 271	Continued From page 6 elevators in an attempt to leave the hospital floor. Per Nursing Progress note, "This RN kept pace with the patient and was trying to calmly talk this patient into going back" to their room. When additional staff responded to the area for assistance, Patient #2, "became hostile", "grabbed" at staff, starting fighting, and screamed threats that they would kill staff members present. Per Nursing Progress note, Patient #2 was placed in restraints at 6:10 PM. Patient #2, "fought against the restraints" and continued to scream and, "fight the restraints" requiring emergent does of Benadryl 25 mg, Haldol 5mg, and Ativan 3mg given intramuscularly in order to manage self-injurious behavior while restrained. Per documentation by Licensed Nursing Assistant (LNA), Patient #2, "appears to be asleep in restraints" at 11:12 PM. The CAH policy, "Restraints and Management of a Restraint-Free Environment" (approved 07/05/2018) states, "Chemical and/or physical restraints may be needed in severe cases once all other options are exhausted. The judicious use of restraints may need to be considered when it is perceived that imminent danger may occur to self or others...to ensure safety. When restraint is necessary, the patient should be treated with humane care that preserves human dignity." Following the application of restraints with Patient #2 on 08/03/2018 there were documented periods when Patient #2 was calm and/or asleep demonstrating s/he was no longer posing an immediate threat to staff or their own safety. Between 11:30 PM and 3:00 AM on 08/04/2018, Patient #2 was documented to be, "asleep", "lying quietly in bed, and "sleeping" when observed by Registered Nurses and	C 271	**C271 PATIENT CARE POLICIES** **CFR(s) 485.635(a)(1)** **(Continued from page 6 of 13)** **Corrective Action Plan** 1. Revise the "Restraints and Management of a Restraint Free Environment policies to specifically address appropriate removal of restraints. 2. Develop new Security Management Policy outlining role of NVRH Security Staff, DMH contracted Sheriff and use of weapons on individuals not in custody of law enforcement. 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 "Restraints and Management of a Restraint Free Environment" Policies. Colleen Sinon, VP Quality Management Programs is responsible for development and communication of the new Security Management Plan. New Policy for Security Management and the revised "Restraints and Management of a Restraint Free Environment" Policies to be in place by October 31, 2018. Recvd 10.18.18 fm/sl	

PeRBy CEO 10/15/2018

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C 271	Continued From page 7 Licensed Nursing Assistants. There was no documented evidence of attempt to begin to discontinue the restraints, and no documented evidence of imminent danger requiring continued restraints to ensure safety. The Vice President Of Quality Management Programs and Clinical Informatics RN confirmed Patient #2's documented calm behavior while restrained at 1:40 PM on 9/18/2018. During a review of the policy, "Restraints", the VP of Quality Management Programs confirmed that the CAH policy did not include instructions for staff to remove restraints when discharge criteria were demonstrated by patients. S/he confirmed the lack of policy interventions to guide staff with the discontinuation of restraints when risk of imminent harm was no longer present at 2:00 PM on 9/18/2018. In addition, upon review of recent behavioral interventions which occurred on 9/3/18 during which time contracted security staff (Caledonia Sheriffs) had become involved with the behavioral management of a patient, it was further confirmed the CAH had not developed a policy and procedure to direct this contracted service/staff and to further stipulate the prevention of Sheriff's utilizing weapons on patients not in police custody. Refer to C-253	C 271	C271 PATIENT CARE POLICIES CFR(s) 485.635(a)(1) **(Response is on Page 7 of 13)**	
C 330	PERIODIC EVALUATION & QA REVIEW CFR(s): 485.641 Periodic Evaluation and Quality Assurance Review	C330	**PERIODIC EVALUATION & QA REVIEW CFR(s): 485.641** Qualified Staff members were available and appropriately responded to the Code Gray situation involving Patient #1. Immediate corrective action was taken regarding Security and prohibiting the use of a tazer in patient care areas of the hospital. Surveyors are correct that the actions taken were not reflected in documentation or staff interviews. The Corrective Action Plans outlined for C253 on page 6 of 13 and C271 on page 7 of 13 will provide accurate guidance for management and documentation requirements for Restraint Free Environment, Use of Restraints and the role of Security Staff during Code Gray situations. Opportunities for Improvement were immediately identified in the following categories based on the initial Trajectory Analysis performed: Physical Environment, New Employee Orientation, Ongoing Education, Clearly defined roles and responsibilities for Security staff, Use of weapons, resource allocation for ongoing performance evaluation and improvement activity, clear policies. **(Continued on Page 9 of 13)**	
		C 330	POC amt 10.18.18 fm/pl	

PoC RB/ CEO 10/15/2018

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C 330	Continued From page 8 This CONDITION is not met as evidenced by: The Condition of Participation: Periodic Evaluation and Quality Assurance Review was not met based on staff interview and record review the CAH failed to evaluate the quality and appropriateness of treatment and services, in a timely manner, and develop corrective actions as the result of an adverse patient event. Findings include: There was a failure to identify opportunities for improvement to include the failure to ensure sufficient staff coverage was available at all times and available to respond to emergent events and to be sufficient to meet the needs of patients demonstrating behavioral symptoms; and the CAH failed to ensure non-hospital personnel cannot be drawn upon for behavior management or care which is the responsibility of the CAH staff in meeting the individuals assessed health needs. Refer to C-253	C 330	PERIODIC EVALUATION & QA REVIEW CFR(s): 485.641 **Response is on page 8 of 13** **Refer to C-253**	
C 337	QUALITY ASSURANCE CFR(s): 485.641(b)(1) 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- all patient care services and other services affecting patient health and safety are evaluated.	C 337	**QUALITY ASSURANCE** **CFR(s): 485.641(b)(1)** **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.** Surveyors did not find documented evidence to support an effective program. Patient #1 and Patient #2 are individuals within the population that has been a focus for this CAH for several years. Individuals within this category are experiencing an acute Mental Health crisis and pose a real physical threat of harm and are a danger to themselves and others. When an individual is screened by the QMHP and/or Crisis Worker from our local deemed agency and it has been determined that they are in need of inpatient psychiatric treatment but are unwilling or incapable of agreeing to the plan it is necessary to provide an Emergency Evaluation (EE) to determine if Involuntary Admission Status is needed. Both Patient #1and Patient #2 were Involuntary admissions on hold for an available inpatient Psychiatric bed.	

RECD 10/15/2018

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C 337	Continued From page 9 This STANDARD is not met as evidenced by: Based on staff interview and record review, there was a failure to identify opportunities for improvement to include the failure to ensure sufficient staff coverage was available at all times and available to respond to emergent events and to be sufficient to meet the needs of patients demonstrating behavioral symptoms and the failure to ensure non-hospital personnel cannot be drawn upon for behavior management or care which is the responsibility of the CAH staff in meeting the individuals assessed health needs. Findings include: On 9/2/18 Patient #1, with a diagnosis of bipolar/mania, was held involuntarily on the medical-surgical unit while awaiting placement in a psychiatric hospital. During the late evening of 9/2/18, Patient #1's symptoms of paranoia and delusions escalated and the patient made increased verbal threats to harm staff. At 11:00 PM on 9/2/18 Sheriff #1, contracted through DMH, was assigned to provide a presence outside Patient #1's room on the medical-surgical unit. Sheriff #1 was advised by CAH contracted security officers to stay out of Patient #1's view, due to Patient #1's expressed dislike for individuals in uniforms, specifically Sheriff's. As a result of increased symptoms and wandering in and out of hospital room, the night nursing supervisor notified the attending physician for the patient and received a physician orders for the application of physical restraints and involuntary medication administration due to concern for the safety and risk of harm to staff and other hospitalized patients. Once the physician's order was received the night nursing supervisor called	C 337	**Continued from Page 9 of 13)** Refer to C-253 QUALITY ASSURANCE CFR(s): 485.641(b)(1) Patient #1 and #2 exhibited verbal and threatened physical harm to the staff. Qualified licensed staff members trained in CPI techniques were provided to care for our patients each day. This CAH recognizes that Patient #1 (bipolar disorder with acute psychosis) remained at this facility 13 days on bed hold awaiting an admission to a Psychiatric Inpatient setting and this is not the the best situation for all involved. Patient #2 (acute psychosis and aggressive behavior) remained at this facility for 6 days also awaiting an opening for admission for inpatient psychiatric stabilization and treatment. This CAH is interested in the clinical outcomes for similar patients, but we do not currently have access to the results of treatment from the Psychiatric facilities; neither do we have a communication to inform us of a return to the community and the plan for follow up care. This CAH will continue to provide qualified staff to manage the needs of our patients and seek opportunities to improve communication across the continuum. **Continued on page 11 of 13** RC angt 10.18.18 fm/sl	

RcR By CEO 10/15/2018

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C 337	Continued From page 10 a "Code Gray" (requesting immediate assistance from assigned CAH staff to assist with a safety or behavioral situation/event). Additional hospital staff arrived on the patient care unit to include 2 contracted security guards employed by the CAH, who are Caledonia County Sheriffs. A staff huddle transpired and a plan was formulated by the nursing supervisor which included the application of restraints to a stretcher; transporting the stretcher to Patient #1's room; with staff assistance position Patient #1 on stretcher; apply 4-point restraints and safely administered behavioral medication. Per telephone interview on 9/18/18 at 9:00 AM, Sheriff #1 confirmed s/he saw a group of nurses pull out a restraint bed and was then informed by the nursing supervisor of the intention to restrain Patient #1, however Sheriff #1 had not been directly included in the Code Gray plan. Sheriff #1, although not employed or trained by CAH, choose to become involved with the emergency procedure and entered Patient #1's room with the nursing supervisor. Upon seeing the uniformed Sheriff approaching with the nursing supervisor into his/her hospital room and staff moving a stretcher with attached restraints, Patient #1 became defensive and lunged towards Sheriff #1, hitting the Sheriff in the head, resulting in both individuals falling to the floor. Sheriff #1 confirmed s/he was able to return punches, hitting the left side of Patient #1's face. Once on the floor, Patient #1 remained on top of Sheriff #1 despite other staff attempting to remove the patient off Sheriff #1. The 2 CAH security guards/County Sheriffs also became involved in the behavioral management of Patient #1. Security guard/Sheriff #2 confirmed	C 337	**Continued from page 10 of 13** **The Corrective Action Plans listed for C253 and C271 address the changes for Code Gray,the Security Management Plan and use of Restraints** **Corrective Action Plan** 1.Revise the "Restraints and Management of a Restraint Free Environment policies to specifically address appropriate removal of restraints. 2.Develop new Security Management Policy outlining role of NVRH Security Staff, DMH contracted Sheriff and use of weapons on individuals not in custody of law enforcement. 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 "Restraints and Management of a Restraint Free Environment" Policies. Colleen Sinon, VP Quality Management Programs is responsible for development and communication of the new Security Management Plan. New Policy for Security Management and the revised "Restraints and Management of a Restraint Free Environment" Policies to be in place by October 31, 2018. Doc cmt 10.18.18. AM/SL	

PerBy CEO 10/15/2018

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C 337	Continued From page 11 on 9/18/18 at 12:00 s/he was able to "...deliver strikes with his/her baton.." onto Patient #1 when attempting to intervene between the patient and Sheriff #1. When Patient #1 was attempting to reach Sheriff #1's service revolver, security guard (Sheriff #3) deployed his/her tazer hitting Patient #1 in close proximity, landing 2 tazer darts into the patient's upper back torso. After being tazed, Patient #1 was extracted off of Sheriff #1, hand cuffed by the sheriffs, and with staff assistance was then placed on the stretcher, handcuffs were removed and restraints were applied to Patient #1's arms and legs. Involuntary emergency medication was administered to include Haldol (antipsychotic) 5 mg. IM (intramuscular) and Ativan (sedative) 1 mg IM. Eventually, Patient #1 became less agitated, and remained in restraints for several hours. The patient sustained bruising of face and upper torso. On 9/4/18 the patient was discharged to a psychiatric hospital. After the event on 9/3/18 a staff member completed a adverse event report via the Risk Management Reporting System. However, as of 9/18/18 there has not been a formal review of the significant chain of events to include the use of a tazer by contracted security on a hospitalized patient; the seriousness of the altercation that pursued; the effective use of the the Code Gray team; and the lack of psychiatric consultation and direction to staff to assist in the management of the patient's behavioral symptoms. Per interview on 9/18/18 at 11:00 AM, the Chief Nursing Officer confirmed awareness of the events on 9/3/18 and confirmed informal conversations with the VP of Quality Management Program had occurred. There has	C 337	Continued from page 9 of 13 **Refer to C-253** **QUALITY ASSURANCE** **CFR(s): 485.641(b)(1)** Surveyors are correct. An incident report was submitted following this described event. The chain of events was addressed with the individuals involved in the actual incident. Patient #1 would agree to take only medications for things unrelated to management of his psychiatric and behavioral symptoms. There is limited availability for Psychiatric consultation and we do not provide treatment at this facility. Use of weapons was immediately addressed with the Supervisor of Security and clarified that tazers, pepper spray and firearms were prohibited from use in patient care areas. The nursing Supervisor serving as team leader for the Code Gray was individually debriefed and the need for policy revisions was acknowledged. Involved staff members participated in a debriefing with our Employee Assistance Program Counselor. The group was not gathered together for a formal review of the events. **Corrective Action Plan** 1. Formal Review of incidents and completion of Trajectory Analysis and/or RCA will take place when there has been harm or potential for significant harm to a patient. Immediate change in practice implemented. Colleen Sinon, VP Quality Management Programs is responsible for ongoing monitoring and evaluation. POC sent 10.18.18 fm/sl	

P+R By CEO 10/15/2018

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C 337	Continued From page 12 not been a formal review to evaluate the quality and appropriateness of the treatment and services provided to Patient #1 on 9/3/18. This was further confirmed by the VP of Quality Management on the afternoon of 9/18/18, acknowledging a failure to examine and review all the circumstances which had occurred on 9/3/18 and to identify preliminary opportunities for improvement especially associated with the use of non-hospital employees during behavioral interventions and the use of weapons on hospitalized patients who are not in police custody.	C 337	**Continued from page 9 of 13** Refer to C-253 QUALITY ASSURANCE CFR(s): 485.641(b)(1) **Response on Page 10 of 13** POC amt 10.18.18 fm/sl	

PeRB CEO 10/15/2018