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

May 20, 2019

Shawn Tester, Director
Northeastern Vermont Regional Hospital
1315 Hospital Drive
Saint Johnsbury, VT 05819-9758

Dear Mr. Tester:

The Division of Licensing and Protection completed a survey at your facility on **May 7, 2019**. The purpose of the survey was to determine if your facility met the conditions of participation for Critical Access Hospitals found in 42 CFR Part 485.

Following the survey, your facility submitted a Plan of Corrections (POC) which was found to be acceptable on **May 20, 2019.**

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 05/07/2019

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 An unannounced on-site Critical Access Hospital (CAH) survey was conducted from 5/6/19 - 5/7/19 by the Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The purpose of the survey was to investigate a complaint (#17640). The following regulatory violations were found.	C 000		
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 interviews and record reviews, the Critical Access Hospital failed to assure that its health care services were furnished in accordance with written policies and procedures for 3 of 10 patients in the total sample who received care in the ED (Emergency Department). (Patients #1, #3 and #4). Findings include: 1. Upon arrival in the ED, Patient #1 was assessed to require restraints for the safety of themselves and others. The physician (MD) who ordered restraints failed to initiate new orders for changes in the restraint application while the patient was cared for on 3/8/19. The patient arrived in police protective custody for suicidal ideation with a plan and was attempting to elope from the ED, combative to staff and screaming. The MD arrived in the room and the patient refused to calm down and cooperate with staff, physically combative and posing a safety risk to his/herself and others present. During interview on 5/6/19 at 3:25 PM, the MD confirmed that s/he	C 271	PATIENT CARE POLICIES CFR() 485.635(a)(1) Existing Order sets for restraints in the EMR did not prevent the ordering provider from editing the original order It was possible to simply edit the order to change from 4 point to upper extremities as a selection. The edit removed the original order and it appeared as if the original selection was upper extremities even though the Physician Progress note outlined the change from 4 point restraint to a 2 point restraint based on observed behaviors. Policy states that a new order must be obtained for each change in level of restraint use. **Corrective Action:** 1. New electronic Restraint Order set 'template has been developed which prompts and requires that the previous order must be discontinued and a new order submitted. Each order will remain as part of the record. tag C-271 POC accepted 5/20/19 [handwritten initials]/MB (Continued on page 2 of 6)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: VP Quality Management Programs
(X6) DATE: 5/14/19

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 271	Continued From page 1 had written orders for 4 point restraints after the patient would not stop screaming, yelling, and had twice attempted to elope from the ED (confirmed also in the MD notes). Later (at 2108 HR.), when the patient had calmed some, nurses documented that 2 restraints (ankles) were removed. Some time later, the patient again exhibited unsafe disruptive behaviors and the patient was again placed in 4 point restraints for safety. Per review, the only written mechanical restraint order in the medical record, dated 3/8/19 at 2054 HR. stated: "Restraints stat.. reason: patient safety, type of restraint: wrist. When asked about the order stating 2 point rather than 4 point mechanical restraints, the MD stated that the orders were modified when 2 restraints were removed, thus stated 'wrist' only. The MD confirmed that they had not written a new order for the 4 point restraints after the patient had escalated behaviors requiring a change from 2 point to 4 point restraints. The failure to write orders for the new initiation of 4 point restraints was not in accordance with the hospital policy Restraint and Seclusion Policy. Under the section Use of Restraint or Seclusion: Violent/Self-Destructive Behavior, P. 3, PP. 2, Staff cannot discontinue a restraint or seclusion intervention, and then re-start it under the same order. During interview on 5/6/19, the QA staff confirmed that the MD 's order was not in accordance with the hospital's restraint policy/procedure for restraint orders 2. Per record review and staff interviews, mechanical restraints were not released at the earliest possible time for the following 2 ED patients in the sample	C 271	**Continued from page 1 of 6** PATIENT CARE POLICIES (cont.) CFR(s) 485.635(a)(1) __Corrective Action: (Cont.)__ 2. Ordering Providers will receive education regarding the process change required with use of the new Restraint Order Sets RN-Clinical Informaticists are responsible for creating and implementing the new electronic restraint order sets. CMO and ED Medical Director are responsible for educating providers. New order sets will be in use and provider education will be completed by 5/31/19. VP Quality Management Programs is responsible for monitoring and compliance. 2. Response is on page 3 of 6	

Carrie Sim—, VP Quality Management Programs 5/13/19

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C 271 Continued From page 2

a. Per record review on 5/6/19, Patient #1 was placed into 4 point restraints by the RN (Registered Nurse) to protect the patient and staff due to highly combative and self- harming behaviors, and multiple attempts at elopement from the ED. The patient was brought to the ED by 2 police and was in protective custody. The reporter who called police said the patient was combative, yelling and agitated and had a plan to harm themselves. Upon review in the ED, the Provider placed stat orders for 4 point mechanical restraints for Patient #1 on 3/8/19 at 2054 Hr. Per review, the staff every 15 minute documentation of 1:1 observations, showed that the patient was in 4 point restraints at 2045 HR. Further documentation showed that 2 of the 4 restraints were released at 2108. At 2245 HR., the flow sheet stated that the "pt appears to be sleeping at this time". at 2259 HR., "pt is sleeping at this time...". All documentation noted that the patient was sleeping from 2311 HR on 3/8/19 to 0001 HR. on 3/9/19. A nursing progress note dated 3/9/19 at 0002 HR documented "upper extremity restraints removed restraints at this time...Patient not happy about being in restraints." The restraints remained on during a time period that the patient was sleeping and not at risk of imminent harm to self or others, in violation of the hospital's restraint policy/procedure.

During interview (5/6/19 at 3:45 PM) the RN providing care to the patient on 3/8/19 confirmed that the patient was asleep for a period of time while in restraints and that s/he did not discontinue the restraints because 'the patient might awaken during the process' The justification for continuing the restraints was not in accordance with the policy, as stated above, since there was no unsafe situation for a period of over 1 hour, per medical record documentation

C 271 The NVRH Restraint and Seclusion Policy clearly states that the restraints are to be removed as soon as the unsafe conditions no longer exist. Restraints are applied according to the order received and discontinued as soon as the behaviors requiring the application of restraint are no longer observed. There are no "trial" releases of one limb at a time.

Corrective Action:

1. Restraint documentation template for Nursing has been revised and prompts the nurse to document the reasons for initial restraint use, reason for continued use and reason for discontinuance of use. The same documentation standard is used for all clinical locations.
2. Nursing Education Director and Unit Based Clinical Nurse Educators will provide initial re-education on the topic of Restraint Use and Management of Violent and Non-Violent Behavioral Health patients.
3. RN-Clinical Informaticists will provide education to Nursing regarding the change in workflow and process for documenting restraint use with the new templates in Meditech.

Continued on page 4 of 6

Callen Sisson VP Quality Management Programs 5/19/19

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C 271 Continued From page 3

The Quality Assurance (QA) staff confirmed during interview on 5/7/19 at 2:00 PM that the restraints should have been removed after it was determined that the patient was asleep and no longer a safety risk.

b. On 4/10/19 at 12:59 Patient #3 was brought to the ED by police for a psychiatric evaluation after demonstrating threatening and aggressive behaviors in the community which were precipitated by command hallucinations. After first agreeing to voluntarily accept psychiatric hospitalization, Patient #3 demonstrated increased agitation and threatened staff. A Code Gray (behavioral emergency response) was called at 16:47 and restraints were ordered by the ED provider at 17:06. Per review of the 15-minute observation documentation completed by assigned Continuous Patient Safety Observer (CPSO) notes at 18:24 the patient's behavior is noted to be "cooperative, crying" and mood description as "calm, sad" From 18:38 through 19:24 Patient #3's behavior and mood continued to remain "calm and cooperative" Although the patient had not demonstrated harm to self or others and remained "cooperative, calm & relaxed" at 19:40 staff release only 2 of the 4 restraints. It was not until 20:25 staff removed the 2 remaining restraints. The delay in discontinuing restraints at the earliest possible time was confirmed with the Director of Operations for the ED on 5/7/19 at 2:05 PM.

The hospital policy entitled Restraint and Seclusion Policy, under Policy , 7) Restraint or seclusion use is to be discontinued at the earliest possible time when there is no longer adequate and appropriate justification for continued use. Additional guidelines in the policy under

C 271 (continued from page 4 of 6)

Corrective Action Plan: (cont.)

RN-Clinical Informaticists will be responsible for completion and implementation of the new documentation templates for Nursing. Nursing Education Director, Emergency Department Nursing Director, M/S/P/ Infusion Director, ICU Director and the Department based Nurse educators are responsible for communicating the documentation changes as well as reinforcing previous education regarding the use of restraints and management of the admitted behavioral health patient to all Nursing staff.

New documentation templates will be in use and nursing education will be completed by 5/31/19. VP Quality Management Programs is responsible for monitoring and compliance.

Colleen [signature] — VP Quality Management Programs, 5/15/19

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C 271 Continued From page 4

Termination of Restraint or Seclusion, 1) "Restraint or seclusion will be terminated a the earliest possible time regardless of the length of time identified in the order. Restraint or seclusion may only be employed while the unsafe situation (clinical justification) continues. Once the unsafe situation ends, the use of restraint or seclusion must be discontinued."

3. Per CAH policy Restraint & Seclusion /Assessment of the Patient in Restraint and Seclusion states: "1. " ... ...Appropriately qualified RN staff will assess/evaluate the following: Patients placed in restraint or seclusion for violent or self-destructive behavior will be assessed at least every hour by the RN .....2. Assessment means that the patient will be evaluated to determine the patient's response to the restraint or seclusion, and if the patient has any care needs.". However, after being admitted to the ED for alcohol and drug intoxication on 4/28/19 Patient #4 became assaultive and combative with a threat of harm to self and others. The ED provider ordered the application of 4-point restraints which were initiated at 15:45. Per review of "Restraint Assessment" documentation completed by nursing, the 1-hour assessment of Patient #4's response to restraints and evaluation of care needs was not conducted as per policy. At 18:10, after 2 hours and 25 minutes and without hourly assessments the restraints were removed when Patient #4 contracted for safety. On 5/7/19 at 12:40 PM the Informatics Nurse, assisting with review of the Electronic Medical Record (EMR) confirmed the failure of nursing to conduct hourly assessments of the restrained patient. In addition, the Director of Operations for the ED confirmed on 5/7/19 2:00 PM it is his/her expectation documentation and assessments

C 271 **Response located on page 4 of 6**

Hourly Nursing Assessment of a restrained patient by a qualified RN is required by policy.

Corrective Action Plan:

1. Emergency Department Nursing Staff will review the Restraint and Seclusion policy again and discuss key points outlined on the Restraint and Seclusion Checklist at the May staff meeting.
2. Hourly Nursing Assessment template for Behavioral Health patients has been revised and supports efficient documentation of clinical observations. The same documentation standard is used for all clinical locations.

RN-Clinical informaticists, will be responsible for completion and implementation of the new documentation templates. Nursing Education Director, Emergency Department Nursing Director, M/S/P/Infusion Director, Intensive Care Unit Director and the Department based Nurse Educators are responsible for communicating the documentation changes as well as reinforcing previous education regarding the use of restraints and management of the admitted Behavioral Health patient to the Nursing staff.

New electronic documentation templates and education of Nursing will be completed by 5/31/19. VP Quality Management Programs is responsible for monitoring and compliance.

Calle Simm, VP Quality Management Programs, 5/13/19

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

PRINTED: 05/09/2019
FORM APPROVED
OMB NO. 0938-0391

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C 271	Continued From page 5 would be conducted as per policy.	C 271	Response located on page 5 of 6	

[handwritten signature], VP Quality Management Programs 5/15/19

The following screens are all within the Restraint Intervention

This is the screen for intitial restraint application when an order is placed. This screen will be addressed whenever a new order is placed for restraints.

Behavior Requiring Restraints/Seclusion — ☐ Harm to patient ☐ Harm to Staff & Others

Alternatives to Avoid Restraints/Seclusion — ☐ Re-orientation ☐ De-escalation ☐ Limit Setting ☐ Increased observation/monitoring ☐ Change in pt's physical environment ☐ Review/modification of meds ☐ Use of one on one monitor ☐ Oral Medication Offered

Date of Initiation

Time of Intiation

Initiation

Actions Taken Related to Restraints/Seclusion — ☐ Non-Physical Intervention ☐ Restraints Initiated ☐ Seclusion Initiated ☐ MD Notified ☐ Order Obtained ☐ Evaluated by MD ☐ Family Notified/Educated ☐ D/C Criteria Given to Pt. ☐ Order Renewed ☐ Order Discontinued ☐ Medication Administered ☐ Medication Adjusted ☐ Restraints Continued ☐ Seclusion Continued

Education

Education Provided at this time? — O Yes O No Comment:

Clinical justification of restraints provided to — ☐ Patient ☐ Both ☐ Family ☐ Other, See Comment

Purpose and use of restraints provided — ☐ Patient ☐ Both ☐ Family ☐ Other, See Comment

Criteria by which restraints will be released provided to — ☐ Patient ☐ Both ☐ Family ☐ Other, See Comment

Explanation of Monitoring and Care that will be provided — ☐ Patient ☐ Both ☐ Family ☐ Other, See Comment

Other information to assure patient's well-being

Mechanical Restraint

New Mechanical Restraint Location — Add a Mechanical Restraint Location

Mechancial Restraint Type

Other Restraint

Chemical — O Chemical

Seclusion — O Seclusion

Manual Restraint — O CPI Manual Hold

Medication

Seclusion

Manual

Staff Debrief

Debrief done immediately following application of restraints — O Yes O No Comment:

Note (Specify behavior and current situation) ✔

Justification of Initiation/Continuation/ D/C(including consideration) of Restraints

*Note

When the Location of the Mechanical Restraint is added The Mechanical Restraint Type field will display

Under Other Restraint: When Chemical is documented- the Medication fields will open for further doc.

When Seclusion is documented –The seclusion field will open for further doc.

When manual is documented-The Manual field will open for further doc.

Left UE
Mechancial Restraint Type — ☐ Soft Limb ☐ 4 Point/ Neoprene
New Mechanical Restraint Location
Other Restraint
Chemical — ◉ Chemical
Seclusion — ◉ Seclusion
Manual Restraint — ◉ CPI Manual Hold
Medication
Medication Administered
Time of Adminstration
Seclusion
Describe Seclusion

Manual
Describe Manual Restraint

The following section is for documenting the reassessment. The note section is required in order to save the Restraint intervention.

Restraint Reassessment ✔
Continuation of Restraints
Actions Taken Related to Restraints/Seclusion
☐ Non-Physical Intervention ☐ Medication Adjusted
☐ Restraints Initiated ☐ Restraints Continued
☐ Seclusion Initiated ☐ Seclusion Continued
☐ MD Notified
☐ Order Obtained
☐ Evaluated by MD
☐ Family Notified/Educated
☐ D/C Criteria Given to Pt.
☐ Order Renewed
☐ Order Discontinued
☐ Medication Administered

Education
Education Provided at this time? — O Yes O No Comment:
Clinical Justification of restraints provided to — ☐ Patient ☐ Both ☐ Family ☐ Other, See Comment
Purpose and use of restraints provided to — ☐ Patient ☐ Both ☐ Family ☐ Other, See Comment
Criteria by which restraints will be released provided to — ☐ Patient ☐ Both ☐ Family ☐ Other, See Comment
Explanation of Monitoring and Care that will be provided — ☐ Patient ☐ Both ☐ Family ☐ Other, See Comment
Other information to assure patient's well being
Comment

Mechanical Restraints
If Restraint Type has been modified: A new Restraint order is needed and previous restraint order Dc'd
New Mechanical Restraint Location — Add a Mechanical Restraint Location
Mechancial Restraint Type
Other Restraint
Chemical — O Chemical
Seclusion — O Seclusion
Manual Restraint — O CPI Manual Hold

Medication
Seclusion
Manual
Patient Care

Patient Care Performed	☐ Nutrition Provided ☐ Elimination ☐ Fluids Provided ☐ ROM ☐ Hygiene ☐ Comfort Needs Met
Status	○ Appropriately Applied ○ Removed&Appropriately Reapplied ○ Rotated ○ Removed ○ Other, See Comment
Comment	
Signs of Injury Related to Restraints/Seclusion	○ Yes ○ No Comment:
Discontinuation of Restraints being Considered at this time?	○ Yes ○ No

Vital Signs

Temperature (97.6 F-99.6 F)	
Temperature Source	○ Tympanic ○ Rectal ○ Oral ○ Skin ○ Temporal Artery Scan ○ Axillary ○ Core
Pulse (60-90 beats/min)	
Pulse Assessment Method	○ Monitor ○ Palpation ○ Doppler ○ Autocuff ○ Auscultation
Respiratory Rate (12-24 breaths/min)	
Respiratory Effort	☐ Normal ☐ Stridor ☐ Non-Labored ☐ Agonal ☐ Short of Breath ☐ Mechanically Ventilated ☐ Labored ☐ Grunting ☐ Accessory Muscle Use ☐ Drooling ☐ Nasal Flaring ☐ Tripod ☐ Pursed Lip ☐ Incrsd Work of Breathing ☐ Splinting
Blood Pressure Source	○ Automatic Cuff ○ Manual Cuff/Palpation ○ Manual Cuff/Auscultation ○ Arterial Line ○ Manual Cuff/Doppler
Comment	

Circulatory/Skin Assessment

Skin Temperature	○ Warm ○ Hot ○ Cool ○ Cold
Skin Moisture	○ Dry ○ Moist ○ Diaphoretic ○ Clammy
Skin Color	○ Normal ○ Dusky ○ Jaundiced ○ Pink ○ Mottled ○ Hypopigmentation ○ Pale ○ Ashen ○ Petechiae ○ Flushed ○ Cyanotic ○ Ecchymosis ○ Erythema ○ Blackened ○ Hyperpigmentation ○ Ruddy ○ Tan
Skin Problem	☐ None ☐ Scar ☐ Skin Tear ☐ Incision ☐ Rash ☐ Abrasion ☐ Bruise ☐ Burn ☐ Maceration ☐ Pressure Ulcer ☐ Fistula ☐ Fibrotic ☐ Amputation ☐ Puncture Wound ☐ Stasis Ulcer ☐ Laceration ☐ Skin Flap ☐ Scratch(s)
Capillary Refill	○ Less than 3 seconds ○ None ○ Delayed ○ Greater than 3 seconds ○ Immediate
Sensation Description	☐ Within Normal Limits ☐ Burning ☐ Paresthesia ☐ Itching ☐ Hyperesthesia ☐ Coldness ☐ Numbness ☐ Heaviness ☐ Tingling ☐ Pain ☐ Pins & Needles ☐ Phantom Pain
Comment	

Restraint Discontinued section will documented when order is Dc'd

Restraint Discontinued

Criteria for Restraint Removal	○ no longer immediate threat to self ○ No longer immediate threat to staff & others ○ Behavior Change
Date Restraints Removed	
Time Restraints Removed	
Was Restraint order discontinued	○ Yes ○ No

POC accepted
5/20/19 SS/MB