Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

April 6, 2018

Ms. Eileen Whalen, CEO
University Of Vermont Medical Center
111 Colchester Ave
Burlington, VT 05401

Dear Ms. Whalen:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 14, 2018.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	470003	A. BUILDING _____ B. WING _____	C 02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY OF VERMONT MEDICAL CENTER	111 COLCHESTER AVE BURLINGTON, VT 05401

(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
A 000	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 2/13/18 - 2/14/18 as authorized by the Centers for Medicare and Medicaid to determine compliance with the Conditions of Participation: Patient Rights and Discharge Planning. As a result, the following regulatory violations were identified associated with complaint #016375:	A 000		
A 130	PATIENT RIGHTS:PARTICIPATION IN CARE PLANNING CFR(s): 482.13(b)(1) The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to ensure that a patient was actively involved in the development, implementation and revision of his/her plan of care prior to discharge (Patient #2). Findings include: Patient #2, with a diagnosis of schizophrenia, was admitted involuntarily for psychiatric treatment to the hospital on 8/24/2017 from another facility to facilitate the administration of court ordered psychotropic medications, which could not be implemented at his/her previous hospital placement. S/he required inpatient treatment due to a period of medication noncompliance resulting in an inability to care for his/herself and increasing symptoms of delusions and hallucinations.	A 130	SEE ATTACHED PLAN OF CORRECTION P.O.C. Accepted for A-130 [illegible] 4/5/18	4/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: DIRECTOR (X6) DATE: 4/1/18

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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A 130	Continued From page 1 On 9/1/2017 a Multidisciplinary Treatment Team plan was developed and stated Patient #2's plan was to "return to apartment with designated agency supports". The Psychosocial Assessment and Initial Discharge Plan written by the Social Worker on 8/25/2017 included the plan to, "gather collateral information from and collaborate with the patient, family and outpatient providers." A Progress Note on 9/1/2017 documented that the Social Worker had spoken to the patient and his/her community case manager. On 9/4/2017 at 0109, Patient #2 was involved in a physical altercation with another patient on the unit, requiring staff to implement seclusion to de-escalate the conflict. This altercation resulted in Patient #2 sustaining a laceration on his/ her scalp requiring two staples. Subsequently, Patient #2 was placed on constant observation as a safety intervention. On 9/4/2017, Patient #2 was involved in a second physical altercation with the same patient, which staff were able to de-escalate verbally without the need to implement seclusion or restraint. The next day, a Nursing Progress note on 9/5/17 at 11:45 AM stated, "sheriffs arrived to the unit, writer in to explain to patient that s/he was being transferred" to another hospital. The Nursing Progress note further states,"Patient surprised but accepting of this information. Went willingly, without protest, accompanied by 2 sheriffs". The Inpatient Psychiatry Discharge Summary electronically signed 9/6/2017 states that Patient #2 was transferred to another hospital, "due to continued conflict" and the "..inability to separate these patients due to architectural constraints..". Per record review, there was no evidence that Patient #2 was involved in the development of the	A 130	SEE Plan of Correction	4/15/18

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A 130	Continued From page 2 discharge plan which included the transfer to another hospital on 9/5/17. Physician and Nursing Progress notes following the incidents of physical violence on 9/4/2017 did not address a possible transfer, either with the patient or among treatment team members, following the physical altercations on the unit. There were no Physician, Nursing or Social Work Progress notes documenting clinical indicators necessitating the transfer, transfer arrangements, or planning associated with Patient #2's discharge from the hospital. In interview, the Team Lead for Case Management and Social Work confirmed the lack of discussion with Patient #2 regarding the transfer plan, and the absence of Progress Notes or a Discharge Summary reflecting the implementation of Patient #2's discharge plan. The lack of evidence of Patient #2's involvement in the development and implementation of his/her discharge plan was confirmed with the Director of Emergency Care, Access and Patient Transitions and the Team Leader for Case Management and Social Work at 10:30 AM on 2/14/18.	A 130	A-130 P.O.C. Accepted 4/5/18 See Plan of Correction 4/15/18	
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to provide sufficient interventions to assure each patient's rights were protected by maintaining care in a safe setting as evidenced by the failure to recognize and implement a plan of care to reduce or eliminate the potential for	A 144	A-144 P.O.C. Accepted 4/5/18	

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A 144	Continued From page 3 harm for all patients. Findings include: On 9/4/17 at approximately 1:09 PM Patient #1 and Patient #2 became involved in a significant altercation on Shepardson 6. Patient #1, was admitted to psychiatry for psychosis experiencing paranoid delusions. Patient #1 had a history of violence towards others and impulsivity and upon admission was assigned to 1:1 constant observations. While Patient #1 sat at a computer located in a hallway, Patient #2, also experiencing psychosis and paranoia, approached MHT (Mental Health Technician) who was providing 1:1 constant observations for Patient #1. An altercation erupted between Patient #1 and Patient #2. A fist fight resulted, with both patients sustaining injuries. Patient #1 was diagnosed with a left medial blowout orbital fracture (traumatic injury to the bone of the eye socket). Patient #2 fell to the floor resulting in a laceration to the occipital area (back of skull) of the patient's head requiring staples to close the laceration. Once separated, Patient #2 stated s/he wanted to "finish" the fight. As a result of imminent threats and inability to deescalate, Patient #2 was placed in seclusion for a period of time and also placed on 1:1, no other interventions were documented in the record. Per Psychiatry Emergency Note for 9/4/17 at 1:54 Patient #1 was "...euphoric following fight..". Again on 9/4/17 and within 2 hours of first incident, Patient #1 assaulted a Mental Health Technician (MHT) punching the employee 4 times on the head. Shortly after this assault both Patient #1 and Patient #2 were able to engage in further conflict. Despite being on 1:1, Patient #1 was able to approach and confront Patient #2 further threatening and challenging Patient #2 to fight.	A 144	See Plan of Correction	4/15/18

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A 144	Continued From page 4 Patient #2 punched Patient #1 in the previously injured left eye. Staff intervened, patients were separated. On 9/5/17 at approximately 08:35, Patient #1 and Patient #2 were co-mingled during breakfast. Although unprovoked, Patient #1 threw a breakfast tray towards the face of Patient #2. Subsequently, Patient #1 was placed in seclusion. Besides the initiation of 1:1 and constant observations for Patient #1 the Psychiatry Multidisciplinary Treatment Team failed to develop a timely plan with a more coordinated effort among staff to maximize safety and ensure each patient's right to receive care in an environment that is safe, protecting both the physical and emotional well being for all patients.	A 144		
A 167	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(4)(ii) [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to revise the restraint/seclusion policy for Psychiatric Emergencies for the inpatient psychiatry unit to reflect the current required regulation. Findings include: Per review the hospital's policy Manual Restraint, Mechanical Restraint and Use of Seclusion: Psychiatric Emergency - Inpatient Psychiatry effective 6/17/2016 states: "Restraints and seclusion will only be used when an individual is in imminent danger of harm to self and	A 167	SEE Plan of Correction A-167 P.O.C. Accepted 4/5/18	4/15/18

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A 167	Continued From page 5 others...The staff's goal will be to release restraints or end seclusion as soon as possible while protecting the safety of the individual and others. This will occur when the unsafe behavior ends or a least restrictive alternative is feasible." However, the hospital policy further states: " 8. If the individual in seclusion falls asleep, unlock seclusion room door within one hour..." Per interview on 2/14/17 at 2:15 PM, the nurse manager for Shepardson 3 & 6 confirmed staff will continue to keep the seclusion door locked for up to 1 hour although the patient who was placed in seclusion is sleeping and no longer poses a threat of harm to self and others. The nurse manager acknowledged this was in accordance with hospital policy. However, the process and present hospital policy does not comply with the requirement for the Condition of Participation for Acute Hospital Regulations/Appendix A: A-0174 (482.13(e)(9) which states: "Restraints or seclusion must be discontinued at the earliest possible time, regardless of length of time identified in the order".	A 167	SEE Plan of Correction	4/15/18
A 174	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to ensure that episodes of seclusion were discontinued at the earliest possible time for 5 out of 10 patients in the sample (Patient #1, Patient #3, Patient #7, Patient #9, and Patient #10) Findings include:	A 174	A-174 P.O.C. Accepted Q. Dettmash 4/15/18	

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A 174	Continued From page 6 1. Per record review, Patient #1 was admitted to Shepardson 6 on 9/2/17 with schizophrenia and psychosis. Patient #1 demonstrated impulsive and violent behaviors. On the morning of 9/5/17 Patient #1 became involved in an incident with another patient on the unit. Patient #1 threw a meal tray at a patient s/he had targeted. After the event Patient #1 went to his/her room but demonstrated increased anxiety, anger and became threatening to staff resulting in seclusion being ordered. Per review of the Seclusion Monitoring Flowsheet seclusion began at 09:05. Every 15 minutes the MHT would document Patient #1's behaviors while in seclusion. At 09:15; 09:30 documentation noted Patient #1 was "sleeping". At 09:44 documentation describes Patient #1 as "calm/composed" and at 09:45 "in blanket", however seclusion door remained locked. At 10:05 a nursing assessment was conducted, at which time patient awakened and became agitated. From that point on, Patient #1 remained in seclusion until finally discontinued at 12:15. 2. Patient #3 was admitted on 10/4/17 voluntarily with a diagnosis of paranoia, delusions and depression. On 10/5/17 Patient #3 became intrusive, grabs and pulls a physician towards him/herself. With assistance from security Patient #3 was escorted to seclusion which began at 0430. Per review of Seclusion Monitoring Flowsheet, Patient #3 was agitated and restless, by 05:15 the patient's behavior was subdued and from 05:30 to 06:15 the MHT recorded the patient as "Asleep". It was not until 06:28 seclusion was discontinued and the door was opened. Patient #3 remained in seclusion for almost 60 minutes beyond criteria for the use of seclusion.	A 174	See Plan of Correction	4/15/18

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A 174	Continued From page 7 3. Patient #7 was admitted to the psychiatric unit on 9/20/17 with Bipolar affective disorder and delirium. On 9/24/17 the patient was described in a Psychiatry Emergency Note to be "...in a state of acute mania...." After assaulting a MHT, a Code 8 (behavioral emergency which alerts security and other staff to come to the unit to assist as needed). The patient received emergency medications and was placed in seclusion starting at 06:06. Per the Seclusion Monitoring Flowsheet at 06:15 the MHT documented Patient #7 was "awake & calm". At 06:30 and 06:45 Patient #7 was noted to be sleeping. At 06:49 the seclusion room door was unlocked. Patient #7 had remained in seclusion for greater than 30 minutes although observed to be calm. 4. Patient #9 was admitted involuntarily to the hospital on 1/5/18 due to worsening psychotic symptoms including command auditory hallucinations. On 1/6/18 Patient #9 became agitated while doing laundry. S/he returned to his/her room and shortly after threw a meal tray at staff conducting 1:1 supervision with Patient #9. The patient was placed in seclusion at 11:56. By 12:15 Patient #9 was observed by MHT to be "asleep". At 12:30, 12:45 & 13:00 "awake and subdued " At 13:09 seclusion was discontinued. On 1/9/18 around noon Patient #7 threw several meal trays on the kitchen floor and slapped a physician in the face. Patient # 9 could not contract for safety and was escorted to seclusion and accepted oral Ativan and Olanzapine. Seclusion was initiated at 12:22. At 12:30 Patient #9 was "agitated & restless". At 12:45 the MHT describes Patient #7 as laying down and calm. At 13:00 & 13:15 Patient #9 was "awake &	A 174	see Plan of Correction	4/15/18

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A 174	Continued From page 8 subdued". Seclusion is discontinued at 13:25, despite the earlier opportunity to end seclusion when Patient #9 was calm/subdued. In addition, on 2/14/18 at 2:30 PM the nurse manager for Shepardson 3 & 6 further confirmed seclusion had not been discontinued at the earliest possible time for Patients # 1, 3, 7 & 9 who were not demonstrating a risk of harm to selves or others. The nurse manager acknowledged staff presently utilize the hospital policy which allows staff to keep patients in seclusion for up to 1 hour despite meeting criteria for discontinuing seclusion. 5. Per record review, Patient #10, with a diagnosis of schizophrenia, was admitted to the facility on 9/19/2017 following a period of psychiatric overcompensating due to medication noncompliance. Patient #10 exhibited deficits in self-care and symptoms of paranoid delusions and hallucinations. The Seclusion/ Restraint Note written by the Registered Nurse on 11/7/2017 documented that Patient #10 "appeared to be getting more and more agitated throughout the shift". S/he exhibited behavior including clenched fists, physically advancing toward the RN, and swinging their arms at the RN. S/he was escorted to seclusion without the need for manual restraint. The episode of seclusion was initiated at 1728. Per review of the Seclusion Monitoring Flowsheet, Patient #10's behavior was documented by Mental Health Technicians in 15 minute intervals Per documentation, at 1815, Patient #10 was, "laying with eyes closed but making facial expressions." At 1830, Patient #10 was documented as "asleep" At 1845,	A 174	SEE PLAN OF CORRECTION	4/15/18

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A 174	Continued From page 9 documentation states, "seems to be back at baseline". At 1901, Patient #10 was documented as being "subdued". Per documentation, at 1828 the Registered Nurse justified the continuing need of the seclusion due to, "imminent risk of harm to self or others". Documentation by the RN indicated the discontinuation criteria for the seclusion included, "absence of behavior that required restraint". The seclusion was discontinued at 1912. Descriptions of Patient #10's behavior did not indicate a risk of serious harm after 1815. The lack of evidence of continued need for seclusion for Patient #10 was confirmed with the Psychiatry Nurse Manager on 2/14/2018 at 2:15 PM.	A 174	SEE PLAN OF Correction	4/15/18
A 821	REASSESSMENT OF A DISCHARGE PLAN CFR(s): 482.43(c)(4) The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan. This STANDARD is not met as evidenced by: Based on staff interview and record review, there was a failure of hospital staff to appropriately reassess a discharge plan after changes in a patient's condition warranted adjustments to previously identified continuing care needs for 1 of 10 patients in the sample (Patient #2). Patient #2 was admitted involuntarily to the hospital on 8/24/2017 from another facility to facilitate the administration of court ordered psychotropic medications, which could not be implemented at the prior facility. S/he initially required psychiatric admission due to a period of medication noncompliance, which resulted in an	A 821	A.821 POC Accepted 4/5/18 Jo Ann Tosh	

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A 821	Continued From page 10 inability to care for his/her self and increasing symptoms of delusions and hallucinations. Per record review, Patient #2 was diagnosed with schizophrenia, had a prior history of community mental health services and previous inpatient psychiatric admissions. On 9/1/2017 a Multidisciplinary Treatment Team plan was developed and documented Patient #2's plan to "return to apartment with designated agency supports". The Psychosocial Assessment and Initial Discharge Plan developed by the Social Worker on 8/25/2017 included interventions to, "gather collateral information from and collaborate with the patient, family and outpatient providers in the Discharge Plan. A Social Work Progress Note on 9/1/2017 states, "Spoke with community case manager and patient". On 9/4/2017 at 0109, Patient #2 was involved in a physical altercation with another patient on the unit, requiring staff to implement seclusion to de-escalate the conflict. This altercation resulted in a laceration on his/ her scalp requiring two staples, and Patient #2 was subsequently placed on constant observation as a safety intervention. On 9/4/2017, Patient #2 was involved in a repeated physical altercation with the same patient, which staff were able to de-escalate verbally without the need to implement seclusion or restraint. On 9/4/2017 at 20:25, an Attending On-Call note states, "Events of the past 24 hours reviewed with nursing staff and written sign-out reviewed. See multiple chart notes about emergency events. Patient sleeping when I did rounds and I did not wake him given the necessity of sleep to improve his condition". The Attending On-Call note states under Plan:	A 821	SEE Plan of Correct	4/15/18

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A 821	Continued From page 11 "Unchanged, refer to orders and multidisciplinary team treatment plan. Per Nursing Progress note on 9/5/17 at 11:45 AM, "sheriffs arrived to the unit, writer in to explain to patient that s/he was being transferred" to another hospital. Per RN note, "Patient surprised but accepting of this information. Went willingly, without protest, accompanied by 2 sheriffs". The Inpatient Psychiatry Discharge Summary electronically signed 9/6/2017 states that Patient #2 was transferred to another hospital, "due to continued conflict" and the "inability to separate these patients due to architectural constraints". Per review of Patient #2's record, there was no evidence of a re-assessment of his/her discharge needs following his/her change in clinical presentation and involvement in physical altercations at the hospital. The Initial Treatment Plan completed by the Social Worker on 8/25/2017 was not updated to reflect a reassessment, nor did it indicate a need to transfer to another hospital. The last social work progress note was dated 9/1/2017, and there was no evidence in the medical record of communication with Patient #2, his/her family, or community treatment providers regarding the clinical events necessitating transfer to another hospital. The hospital policy, "Discharge Planning and Patient Discharge" effective 2/3/2017 lacks an identified process for triggering a reassessment of a patient's post-discharge needs, capabilities and discharge plan following a change in condition. During an interview, the Team Lead of Case Management and Social Work (identified as clinical supervisor) stated that assessments completed by the social workers are expected to	A 821	See Plan of Correction	4/6/18

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UNIVERSITY OF VERMONT MEDICAL CENTER	111 COLCHESTER AVE BURLINGTON, VT 05401

(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
A 821	Continued From page 12 be incorporated into the multidisciplinary treatment plan and form the basis of the discharge plan. The lack of re-assessment of Patient #2's discharge plan following a change in his/her status was confirmed with the Director of Emergency Care, Access and Patient Transitions and the Team Lead for Case Management and Social Work on 2/14/2018 at 10:30 AM.	A 821	SEE Plan of Correctn	4/10 hr

A 000 INITIAL COMMENTS:

An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 2/13/18 - 2/14/18 as authorized by the Centers for Medicare and Medicaid to determine compliance with the Conditions of Participation: Patient Rights and Discharge Planning. As a result, the following regulatory violations were identified associated with complaint #016375:

A 130 PATIENT RIGHTS PARTICIPATION IN CARE PLANNING CFR(s) 482.13(b)(1)

The patient has the right to participate in the development and implementation of his or her plan of care.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to ensure that a patient was actively involved in the development, implementation and revision of his/her plan of care prior to discharge (Patient #2). Findings include:

Patient #2, with a diagnosis of schizophrenia, was admitted involuntarily for psychiatric treatment to the hospital on 8/24/2017 from another facility to facilitate the administration of court ordered psychotropic medications, which could not be implemented at his/her previous hospital placement. S/he required inpatient treatment due to a period of medication noncompliance resulting in an inability to care for his/herself and increasing symptoms of delusions and hallucinations.

On 9/1/17 a Multidisciplinary Treatment Team plan was developed and stated Patient #2's plan was to "return to apartment with designated agency supports". The Psychosocial Assessment and Initial Discharge Plan written by the Social Worker on 8/25/2017 included the plan to, "gather collateral information from and collaborate with the patient, family and outpatient providers". A Progress Note on 9/1/2017 documented that the Social Worker had spoken to the patient and his/her community case manager.

On 9/4/2017 at 0109, Patient #2 was involved in a physical altercation with another patient on the unit, requiring staff to implement seclusion to de-escalate the conflict. This altercation resulted in Patient #2 sustaining a laceration on his/ her scalp requiring two staples. Subsequently, Patient #2 was placed on constant observation as a safety intervention. On 9/4/2017, Patient #2 was involved in a second physical altercation with the same patient, which staff were able to de-escalate verbally without the need to implement seclusion or restraint. The next day, a Nursing Progress note on 9/5/17 at 11:45 AM stated, "sheriffs arrived to the unit, writer in to explain to patient that s/he was being transferred" to another hospital. The Nursing Progress note further states, "Patient surprised but accepting of this information. Went willingly, without protest, accompanied by 2 sheriffs". The Inpatient Psychiatry Discharge Summary electronically signed 9/6/2017 states that Patient #2 was transferred to another hospital, "due to continued conflict" and the "....inability to separate these patients due to architectural constraints.

Per record review, there was no evidence that Patient#2 was involved in the development of the discharge plan which included the transfer to another hospital on 9/5/17. Physician and Nursing Progress notes following the incidents of physical violence on 9/4/2017 did not address a possible transfer, either with the patient or among treatment team members, following the physical altercations on the unit. There were no Physician, Nursing or Social Work Progress notes documenting clinical indicators necessitating the transfer, transfer arrangements, or planning associated with Patient #2's discharge from the hospital.

In interview, the Team Lead for Case Management and Social Work confirmed the lack of discussion with Patient #2 regarding the transfer plan, and the absence of Progress Notes or a Discharge Summary reflecting the implementation of Patient #2's discharge plan.

The lack of evidence of Patient #2's involvement in the development and implementation of his/her discharge plan was confirmed with the Director of Emergency Care, Access and Patient Transitions and the Team Leader for Case Management and Social Work at 10:30 AM on 2/14/18.

ACTION PLAN

- The University of Vermont Medical Center's (UVMMC) procedure titled "Case Management and Social Work Department Documentation Standards for Inpatient Psychiatry" was created by the Director of Emergency Care and Access Services, Manager of Call Center and Supervisor of Case Management in March 2018. The referenced document articulates clear expectations regarding a standardized documented process that actively involves each patient, discharge plan reassessment criteria and documentation of discharge readiness for expected date of discharge and time of discharge. It describes the expectations that the case manager documents the patient involvement in the plan of care related to transfer and discharge planning.

- The UVMMC Family Treatment Team template that documents that various care team members of the patient's team and includes the expectation of documentation of the patient's participation in the meeting or the clinical rationale was created by the Director in March 2018 to support the process outlined in the reference policy. The templates document the care team members and the patient in the discharge planning.

- The Director of Emergency Care and Access Serviced educated applicable Case Management and Social Work Staff on the UVMMC procedure Case Management and Social Department Documentation Standards for Inpatient Psychiatry through department meetings effective 4/1/2018.

- Monitoring for compliance with the referenced procedure of patient involvement in the development, implementation of and revision of plan of care will be carried out by direct observation by the Director of Emergency Care and Access Services or designee to ensure complete documentation to the policy. Direct observation will continue until performance is sustained. The Director based on performance will reevaluate frequency. Performance data will be shared at the Standard of Operation Committee, Chaired by the Chief Medical Officer.

- All actions will be complete effective 4/15/18.

A-130 P.O.C Accepted JR. McIntosh 4/5/18

A 144 PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s) 482.13(c)(2)

The patient has the right to receive care in a safe setting.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to provide sufficient interventions to assure each patient's rights were protected by maintaining care in a safe setting as evidenced by the failure to recognize and implement a plan of care to reduce or eliminate the potential for harm for all patients. Findings include:

On 9/4/17 at approximately 1:09 PM Patient#1 and Patient #2 became involved in a significant altercation on Shepardson 6. Patient #1, was admitted to psychiatry for psychosis experiencing paranoid delusions. Patient #1 had a history of violence towards others and impulsivity and upon admission was assigned to 1:1 constant observations. While Patient #1 sat at a computer located in a hallway, Patient #2, also experiencing psychosis and paranoia, approached MHT (Mental Health Technician) who was providing 1:1 constant observations for Patient #1. An altercation erupted between Patient #1 and Patient #2. A fist fight resulted, with both patients sustaining injuries. Patient #1 was diagnosed wi.th a left medial blowout orbital fracture (traumatic

injury to the bone of the eye socket). Patient #2 fell to the floor resulting in a laceration to the occipital area (back of skull) of the patient's head requiring staples to close the laceration. Once separated, Patient #2 stated s/he wanted to "finish" the fight. As a result of imminent threats and inability to deescalate, Patient #2 was placed in seclusion for a period of time and also placed on 1:1, no other interventions were documented in the record.

Per Psychiatry Emergency Note for 9/4/17 at 1:54 Patient #1 was "...euphoric following fight". Again on 9/4/17 and within 2 hours of first incident, Patient #1 assaulted a Mental Health Technician (MHT) punching the employee 4 times on the head. Shortly after this assault both Patient#1 and Patient #2 were able to engage in further conflict. Despite being on 1:1, Patient #1 was able to approach and confront Patient #2 further threatening and challenging Patient #2 to fight Patient #2 punched Patient #1 in the previously injured left eye. Staff intervened, patients were separated. On 9/5/17 at approximately 08:35, Patient #1 and Patient #2 were co-mingled during breakfast. Although unprovoked, Patient #1 threw a breakfast tray towards the face of Patient

#2. Subsequently, Patient #1 was placed in seclusion. Besides the initiation of 1:1 and constant observations for Patient #1 the Psychiatry Multidisciplinary Treatment Team failed to develop a timely plan with a more coordinated effort among staff to maximize safety and ensure each patient's right to receive care in an environment that is safe, protecting both the physical and emotional wellbeing for all patients

ACTION PLAN

- A multidisciplinary team meeting of nursing, physician, social workers was held in February, 2018 to explore options for interventions to reduce or eliminate potential harm.
- The nurse manager of Inpatient Psychiatry instituted a change in the shift workflow to allow for an assessment of need for creation of a safety plan. This workflow change was operationalized 3/23/18.
- Modifications were made to the use of the safety plan by the Nurse Manager of Inpatient Psychiatry under the direction of the Inpatient Psychiatry Medical Director to allow for broader use of safety plan creation to be utilized for any perception of a patient/staff for that there is an element of care that will be enhanced by utilization of the safety plan. This operation was completed by 3/23/18
- Creation of educational materials on workflow, safety plan utilization was completed by the Inpatient Psychiatry Nurse Manager on 3/9/18.
- Education to all inpatient psychiatry nursing staff, mental health technicians, physicians, on use of the Safety Plan was provided by the Nurse Manager of Inpatient Psychiatry and will be completed by 4/15/18
- The Inpatient Psychiatry Nurse Manager (or designee) will perform a weekly manual audit for all post events specific to use and documentation of Safety Plan tool. Performance data will be shared quarterly at the Standards of Operations Committee chaired by the CMO for action as required.

A-144
COP Accepted
4/5/18

A 167 PATIENT RIGHTS: RESTRAINT OR: SECLUSION: CFR(s): 482.13(e)(4)(iii)

The use of restraint or seclusion must be (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law,

This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to revise the restraint/seclusion policy for Psychiatric Emergencies for the inpatient psychiatry unit to reflect the current required regulation. Findings include:

Per review the hospital's policy Manual Restraint, Mechanical Restraint and Use of Seclusion: Psychiatric Emergency - Inpatient Psychiatry, effective 6/17/2016 states. "Restraints and seclusion will only be used when an individual is in imminent danger of harm to self and others. The staff's goal will be to release restraints or end seclusion as soon as possible while protecting the safety of the individual and others. This will occur when the unsafe behavior ends or a least restrictive alternative is feasible. "However, the hospital policy further states: "8. if the individual in seclusion falls asleep, unlock seclusion room door within one hour..." Per interview on 2/14/17 at 2:15 PM, the nurse manager for Shepardson 3 & 6 confirmed staff will continue to keep the seclusion door locked for up to 1 hour although the patient who was placed in seclusion is sleeping and no longer poses a threat of harm to self and others. The nurse manager acknowledged this was in accordance with hospital policy. However, the process and present hospital policy does not comply with the requirement for the Condition of Participation for Acute Hospital Regulations/Appendix A: A-0174 (482.13(e)(9) which states: "Restraints or seclusion must be discontinued at the earliest possible time, regardless of length of time identified in the order".

ACTION PLAN

- The University of Vermont Medical Center's (UVMMC) policy titled " Manual Restraint, Mechanical Restraint and use of Seclusion: Psychiatric Emergency/Inpatient Psychiatry" was revised on 2/20/18 by the Nurse Manager for Inpatient Psychiatry under the direction of the Psychiatry Medical Director to assure inclusion of the language around ending seclusion at the earliest possible time. The referenced policy now articulates "if the individual in seclusion falls asleep, the RN will end the seclusion at that time" The policy was approved on 3/14/18.

- Electronic health record documentation has been updated to support the revisions outlined in the UVMMC policy Manual Restraint, Mechanical Restraint and use of Seclusion: Psychiatric Emergency/Inpatient Psychiatry.

- The Nurse Manager for Inpatient Psychiatry effective 4/15/18 will educate existing Staff appropriate to their role on the policy and documentation revisions.

- All Emergency Involuntary Procedures events will be reviewed by the Nurse Manager or designee for compliance with the UVMMC policy "Manual Restraint, Mechanical Restraint and use of Seclusion: Psychiatric Emergency/Inpatient Psychiatry". Performance feedback will be given at the individual level. Aggregate performance data will be shared at the Standard of Operation Committee chaired by the Chief Medical Officer.

A-167 ROC Accepted 2. Letter

A 174 PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR9S0: 482.13(e)(9)

*Restraint or seclusion must be discontinued **at** the earliest possible time, regardless of the length of time identified in the order.*

This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to ensure that episodes of seclusion were discontinued at the earliest possible time for 5 out of 10 patients in the sample (Patient#1, Patient#3, Patient#7, Patient#9 and Patient#10). Findings Include:

1. Per record review, Patient #1 was admitted to Shepardson 6 on 9/2/17 with schizophrenia and psychosis. Patient #1 demonstrated impulsive and violent behaviors. On the morning of 9/5/17 Patient #1 became involved in an incident with another patient on the unit. Patient #1 threw a meal tray at a patients/he had targeted. After the event Patient #1 went to his/her room but demonstrated increased anxiety, anger and became threatening to staff resulting in seclusion being ordered: Per review of the Seclusion Monitoring Flowsheet seclusion began at 09:05. Every 15 minutes the MHT would document Patient #1's behaviors while in seclusion. At 09:15; 09:30 documentation noted Patient #1 was "sleeping" At 09:44 documentation describes Patient #1 as "calm/composed" and at 09:45 "in blanket", however seclusion door remained locked. At 10:05 a nursing assessment was conducted, at which time patient awakened and became agitated. From that point on, Patient#1, remained in seclusion until finally discontinued at 12:15.

2. Patient #3 was admitted on 10/4/17 voluntarily with a diagnosis of paranoia, delusions and depression. On 10/5/17 Patient #3 became intrusive, grabs and pulls a physician towards him/herself. With assistance from security Patient#3 was escorted to seclusion which began at 0430. Per review of Seclusion Monitoring Flowsheet, Patient #3 was agitated and restless, by 05:15 the patient's behavior was subdued and from 05:30 to 6:15 MHT recorded the patient as "Asleep". It was not until 06:28 seclusion was discontinued and the door was opened. Patient#3 remained in seclusion for almost 60 minutes beyond criteria for the use of seclusion.

Patient #7 was admitted to the psychiatric unit on 9/20/17 with bipolar affective disorder and delirium. On 9/24/17 the patient was described in a Psychiatry Emergency Note to be "...in a state of acute mania...." After assaulting a MHT, a Code 8 (behavioral emergency which alerts security and other staff to come to the unit to assist as needed). The patient received emergency medications and was placed in seclusion starting at 06:06. Per the Seclusion Monitoring Flowsheet at 06:15 the MHT documented Patient #7 was "awake & calm". At 06:30 and 06:45 Patient #7 was noted to be sleeping. At 06:49 the seclusion room door was unlocked. Patient #7 had remained in seclusion for greater than 30 minutes although observed to be calm.

Patient #9 was admitted involuntarily to the hospital on 1/5/18 due to worsening psychotic symptoms including command auditory hallucinations. On 1/6/18 Patient #9 became agitated while doing laundry. S/he returned to his/her room and shortly after threw a meal tray at staff conducting 1:1 supervision with Patient #9. The patient was placed in seclusion at 11:56. By 12:15 Patient #9 was observed by MHT to be "asleep". At 12:30, 12:45 & 13:00 "awake and subdued" At 13:09 seclusion was discontinued. On 1/9/18 around noon Patient #7 threw several meal trays on the kitchen floor and slapped a physician in the face. Patient# 9 could not contract for safety and was escorted to seclusion and accepted oral Ativan and Olanzapine. Seclusion was initiated at 12:22. At 12:45 the MHT describes Patient#7 as laying down and calm. At 13:00 & 13:5 Patient#9 was "awake & subdued". Seclusion is discontinued at 13:25, despite the earlier opportunity to end seclusion when Patient#9 was calm subdued.

In addition, on 2/14/18 at 2:30 PM the nurse manager for Shepardson 3 & 6 further confirmed seclusion had not been discontinued at the earliest possible time for Patients # 1, 3, 7 & 9 who were not demonstrating a risk of harm to selves or others. The nurse manager acknowledged staff presently utilize the hospital policy which allows staff to keep patients in seclusion for up to 1 hour despite meeting criteria for discontinuing seclusion

5. Per record review, Patient #10, with a diagnosis of schizophrenia, was admitted to the facility on 9/19/2017 following a period of psychiatric overcompensating due to medication noncompliance. Patient #10 exhibited deficits in self-care and symptoms of paranoid delusions and hallucinations. The Seclusion/ Restraint Note written by the Registered Nurse on 11/7/2017 documented that Patient#10 "appeared to be getting more and more agitated throughout the shift". S/he exhibited behavior including clenched fists, physically advancing toward the RN, and swinging their arms at the RN. S/he was escorted to seclusion without the need for manual restraint

The episode of seclusion was initiated at 1728.Per review of the Seclusion Monitoring Flowsheet, Patient #1O's behavior was documented by Mental Health Technicians in 15 minute intervals per documentation, at 1815, and Patient #10 was, "laying with eyes closed but making facial expressions." At 1830, Patient #10 was documented as "asleep". At 1845, documentation states, "seems to be back at baseline". At 19:01, Patient#10 was documented as being "subdued".

Per documentation, at 1828 the Registered Nurse justified the continuing need of the seclusion due to, "imminent risk of harm to self or others".

Documentation by the RN indicated the discontinuation criteria for the seclusion included, "absence of behavior that required restraint". The seclusion was discontinued at 1912. Descriptions of Patient #1O's behavior did not indicate a risk of serious harm after 1815. The lack of evidence of continued need for seclusion for Patient #10 was confirmed with the Psychiatry Nurse Manager on 2/14/2018 at 2:15 PM.

ACTION PLAN

- The University of Vermont Medical Center's (UVMMC) policy titled" Manual Restraint, Mechanical Restraint and use of Seclusion: Psychiatric Emergency/Inpatient Psychiatry" was revised on 2/20/18 by the Nurse Manager for Inpatient Psychiatry under the direction of the Psychiatry Medical Director to assure inclusion of the language around ending seclusion at the earliest possible time. The referenced policy now articulates, "if the individual in seclusion falls asleep, the RN will end the seclusion at that time". In addition, the policy was approved on 3/14/18.

- Electronic health record documentation was updated to support the revisions outlined in the UVMMC policy Manual Restraint, Mechanical Restraint and use of Seclusion: Psychiatric Emergency/Inpatient Psychiatry.

- Effective 4/15/18, the Nurse Manager for Inpatient Psychiatry has educated existing Staff appropriate to their role on the policy and documentation revisions. Educational content has been incorporated into orientation.

- All Emergency Involuntary Procedures events will be reviewed by the Nurse Manager or designee for compliance with the UVMMC policy "Manual Restraint, Mechanical Restraint and use of Seclusion: Psychiatric Emergency/Inpatient Psychiatry". Performance feedback will be given at the individual level. Performance data will be shared at the Standard of Operation Committee chaired by the Chief Medical Officer.

A-174 POC Accepted 4/5/18

A 821 REASSESSMENT OF A DISCHARGE PLAN CFR(s): 482.43 (c)(4)

The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.

This STANDARD is not met as evidenced by: Based on staff interview and record review, there was a failure of hospital staff to appropriately reassess a discharge plan after changes in a patient's condition warranted adjustments to previously identified continuing care needs for 1 of 10 patients in the sample (Patient #2).

Patient #2 was admitted involuntarily to the hospital on 8/24/2017 from another facility to facilitate the administration of court ordered psychotropic medications, which could not be implemented at the prior facility. S/he initially required psychiatric admission due to a period of medication noncompliance, which

resulted in an inability to care for his/her self and increasing symptoms of delusions and hallucinations. Per record review, Patient #2 was diagnosed with schizophrenia, had a prior history of community mental health services and previous inpatient psychiatric admissions

On 9/1/2017 a Multidisciplinary Treatment Team plan was developed and documented Patient #2's plan to "return to apartment with designated agency supports". The Psychosocial Assessment and Initial Discharge Plan developed by the Social Worker on 8/25/2017 included interventions to, "gather collateral information from and collaborate with the patient, family and outpatient providers in the Discharge Plan. A Social Work Progress Note on 9/1/2017 states, "Spoke with community case manager and patient".

On 9/4/2017 at 0109, Patient #2 was involved in a physical altercation with another patient on the unit, requiring staff to implement seclusion to de-escalate the conflict. This altercation resulted in a laceration on his/ her scalp requiring two staples, and Patient #2 was subsequently placed on constant observation as a safety intervention. On 9/4/2017, Patient #2 was involved in a repeated physical altercation with the same patient, which staff were able to de-escalate verbally without the need to implement seclusion or restraint. On 9/4/2017 at 20:25, an Attending On-Call note states, "Events of the past 24 hours reviewed with nursing staff and written sign-out reviewed. See multiple chart notes about emergency events. Patient sleeping when I did rounds and I did not wake him given the necessity of sleep to improve his condition". The Attending On-Call note states under Plan:

"Unchanged, refer to orders and multidisciplinary team treatment plan. Per Nursing Progress note on 9/5/17 at 11:45 AM, "sheriffs arrived to the unit, writer in to explain to patient that s/he was being transferred" to another hospital. Per RN note, "Patient surprised but accepting of this information. Went willingly, without protest, accompanied by 2 sheriffs". The Inpatient Psychiatry Discharge 'Summary electronically signed 9/6/2017 states that Patient #2 was transferred to another hospital, "due to continued conflict" and the "inability to separate these patients due to architectural constraints".

Per review of Patient #2's record, there was no evidence ***of a re****-assessment of his/her discharge needs following his/her change in clinical presentation and involvement in physical altercations at the hospital. The Initial Treatment Plan completed by the Social Worker on 8/25/2017 was not updated to reflect a reassessment, nor did it indicate a need to transfer to another hospital. The last social work progress note was dated 9/1/2017, and there was no evidence in the medical record of communication with Patient #2, his/her family, or community treatment providers regarding the clinical events necessitating transfer to another hospital. The hospital policy, "Discharge Planning and Patient Discharge" effective 2/3/2017 lacks and identified process for triggering a reassessment of a patient's post-discharge plan following a change in condition.*

During an interview, the Team Lead of Case Management and Social Work (identified as clinical supervisor) stated that assessments completed by the social workers are expected to be incorporated into the multidisciplinary treatment plan and form the basis of the discharge plan. The lack of re-assessment of Patient #2's discharge plan following a change in his/her status was confirmed with the Director of Emergency Care, Access and Patient Transitions and the Team Lead for Case Management and Social Work on 2/14/2018 at 10:30 AM

ACTION PLAN

- The University of Vermont Medical Center's (UVMMC) procedure titled "Case Management and Social Work Department Documentation Standards for Inpatient Psychiatry" was created by the Director of Emergency Care and Access Services, Manager of Call Center and Supervisor of Case Management in March 2018. The referenced document articulates clear expectations regarding a standardized documented process that actively involves each patient, discharge plan reassessment criteria and documentation of discharge readiness for expected date of discharge and time of discharge.

It describes the expectations that the case manager documents the patient involvement in the plan of care related to transfer and discharge planning.

- The UVMMC Family Treatment Team template that documents that various care team members of the patient's team and includes the expectation of documentation of the patient's participation in the meeting or the clinical rationale was created by the Director in March 2018 to support the process outlined in the reference policy. The templates document the care team members and the patient in the discharge planning.

- The Director of Emergency Care and Access Serviced educated applicable Case Management and Social Work Staff on the UVMMC procedure Case Management and Social Department Documentation Standards for Inpatient Psychiatry through department meetings effective 4/15/2018.

- Monitoring for compliance with the referenced procedure of patient involvement in the development, implementation of and revision of plan of care will be carried out by direct observation by the Director of Emergency Care and Access Services or designee to ensure complete documentation to the policy. Direct observation will continue until performance is sustained. The Director based on performance will reevaluate frequency. Performance data will be shared at the Standard of Operation Committee, Chaired by the Chief Medical Officer.

- All actions will be complete effective 4/15/18

A-821
On Centrak
POC Accepted
4/5/18

THE
University of Vermont
MEDICAL CENTER

Jeffords Institute for Quality
Accreditation and Regulatory Affairs Department
111 Colchester Avenue
Burlington, VT 05401

April 2, 2018

Department of Health & Human Services
Centers for Medicare and Medicaid Services
JFK Federal Building Government Center
Room 2325
Boston, MA 02203

Re: CMS Certification Number (CCN): 47003
Survey ID: EELJ11 02/14/2018

Dear Kathy Mackin,

Please find attached CMC 2567 form and the attached Plan of Correction in response to the Statement of Deficiencies from the survey completed by the Division on 2/15/18.

The University of Vermont Medical Center is committed to continuously improving the quality of services we provide to our patients. As part of our ongoing performance improvement program, we would like to take this opportunity to respond to the regulatory deficiencies that were cited.

If you have questions regarding the attached Plan of Correction or require further clarification, please do not hesitate to contact me.

Sincerely,

Carol Muzzy, Director
Accreditation & Regulatory Affairs
The University of Vermont Medical Center
111 Colchester Avenue
Burlington, VT 05401
Telephone: 802-847-5007
Fax: 802-847-6274
Carol.Muzzy@UVMHealth.org