

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
<a href="http://www.dail.vermont.gov">http://www.dail.vermont.gov</a>
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

amlaMCotaPN

Licensing Chief



PRINTED: 02/26/2018 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERICLIA IDENTIFICATION NUMBER:		A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF I	PROVIDER OR SUPPLIER	470003	B WING	STREET ADDRESS, CITY, STATE, ZIP CODE		/14/2018
	SITY OF VERMONT		1	111 COLCHESTER AVE BURLINGTON, VT 05401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
A 000		ITS on-site complaint investigation	A 000			
A 130	was conducted by Protection on 2/13 the Centers for Medetermine complia Participation: Patie Planning. As a resviolations were ide complaint #01637	the Division of Licensing and /18 - 2/14/18 as authorized by edicare and Medicaid to ince with the Conditions of ent Rights and Discharge rult, the following regulatory entified associated with 5:	A 130			
	The patient has the development and plan of care.	e right to participate in the implementation of his or her		MACHEY ACHEY		4151
	Based on staff int hospital failed to e actively involved in implementation ar	is not met as evidenced by: erview and record review, the nsure that a patient was the development, d revision of his/her plan of arge (Patient #2). Findings	Constitution of the consti	PLAN OF CONTENTS	01	
The state of the s	admitted involunta the hospital on 8/2 facilitate the admir psychotropic medi implemented at hi- placement. S/he ri to a period of med in an inability to ca	diagnosis of schizophrenia, was rily for psychiatric treatment to 4/2017 from another facility to histration of court ordered cations, which could not be sher previous hospital equired inpatient treatment due ication noncompliance resulting are for his/herself and ms of delusions and		P.OC plod Accepted FOR A-130 HIS	118	
BORATORY	DIRECTOR'S OR PROV	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(XE) DAJE

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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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		470003	B WING	02/	02/14/2018	
	PROVIDER OR SUPPLIE	R MEDICAL CENTER	111	EET ADDRESS, CITY, STATE, ZIP COI COLCHESTER AVE RLINGTON, VT 05401	DE	f.
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 130	plan was develop was to "return to agency supports' and Initial Discha Worker on 8/25/2 collateral informathe patient, famili Progress Note on Social Worker habis/her communi  On 9/4/2017 at Ophysical altercating unit, requiring state-escalate the cin Patient #2 sus scalp requiring the Patient #2 was pasafety interven was involved in a the same patient de-escalate verb implement seclu Nursing Progresstated "sheriffs: explain to patient to another hospifurther states," Puthis information. accompanied by Psychiatry Disch signed 9/6/2017 transferred to an conflict" and the patients due to a Per record review	page 1 ultidisciplinary Treatment Team ned and stated Patient #2's plan apartment with designated '. The Psychosocial Assessment arge Plan written by the Social 2017 included the plan to, "gather ation from and collaborate with y and outpatient providers." A n 9/1/2017 documented that the ad spoken to the patient and ty case manager.  109, Patient #2 was involved in a on with another patient on the aff to implement seclusion to conflict. This altercation resulted taining a laceration on his/ her wo staples. Subsequently, laced on constant observation as tion. On 9/4/2017, Patient #2 a second physical altercation with the which staff were able to leally without the need to sion or restraint. The next day, a s note on 9/5/17 at 11:45 AM arrived to the unit, writer in to t that s/he was being transferred" tal. The Nursing Progress note attent surprised but accepting of Went willingly, without protest, 2 sheriffs". The Inpatient large Summary electronically states that Patient #2 was wother hospital, "due to continued "inability to separate these architectural constraints".  w, there was no evidence that myolved in the development of the		SEE PLAN COTTENTO		4/15/12

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		470003	B WING	Consider the Constant of the C	02/1	4/2018
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY OF VERMONT MEDICAL CENTER		ST 11	REET ADDRESS, CITY, STATE, ZIP CODE 1 COLCHESTER AVE URLINGTON, VT 05401		4/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 130	another hospital of Nursing Progress physical violence possible transfer, treatment team maltercations on the Physician, Nursing notes documentin necessitating the or planning associal discharge from the lack of evider in the development discharge plan was Emergency Care, and the Team Leas Social Work at 10 PATIENT RIGHTS CFR(s): 482.13(c)  The patient has the setting.  This STANDARD Based on staff in hospital failed to passure each patie maintaining care in by the failure to residence of the setting.	ich included the transfer to n 9/5/17. Physician and notes following the incidents of on 9/4/2017 did not address a either with the patient or among embers, following the physical a unit. There were no g or Social Work Progress g clinical indicators transfer, transfer arrangements, iated with Patient #2's a hospital.  Deam Lead for Case Social Work confirmed the lack Patient #2 regarding the the absence of Progress Notes immary reflecting the Patient #2's involvement and implementation of his/her is confirmed with the Director of Access and Patient Transitions and of the Case Management and 30 AM on 2/14/18.	A 130	A-130 c. ded Acceptal Sec ac Stand Converted Ricela History	tos, tor	4/15/10

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	. & MEDICAID SERVICES	2.		OMB NO	0930-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A BUILDING	PLE CONSTRUCTION	COM	E SURVEY PLETED	
		470003	B WING			14/2018	
	PROVIDER OR SUPPLIER	EDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  111 COLCHESTER AVE  BURLINGTON, VT 05401				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCE)) TO THE APPL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
A 144	On 9/4/17 at approand Patient #2 becaltercation on Shell admitted to psychic paranoid delusions violence towards of admission was assobservations. Whill located in a hallwal psychosis and para (Mental Health Tecconstant observation altercation erupted Patient #2. A fist figure sustaining injuries a left medial blowd injury to the bone of fell to the floor resulting staples to separated, Patient "finish" the fight. A and inability to deein seclusion for a process of the secusion for	sege 3 s. Findings include:  ximately 1:09 PM Patient #1 ame involved in a significant bardson 6. Patient #1, was atry for psychosis experiencing by Patient #1 had a history of thers and impulsivity and upon signed to 1:1 constant be Patient #1 sat at a computer y, Patient #2, also experiencing anoia, approached MHT shnician) who was providing 1:1 bons for Patient #1. An between Patient #1 and ght resulted, with both patients Patient #1 was diagnosed with but orbital fracture (traumatic of the eye socket). Patient #2 builting in a laceration to the k of skull) of the patient's head oclose the laceration. Once #2 stated s/he wanted to s a result of imminent threats escalate, Patient #2 was placed terventions were documented	A 14	SCE PLAN OF Collection		4/15/18	
9	1:54 Patient #1 wa Again on 9/4/17 ar incident, Patient # Technician (MHT) on the head. Shor #1 and Patient #2 conflict. Despite be to approach and c	nergency Note for 9/4/17 at is "euphoric following fight", and within 2 hours of first it assaulted a Mental Health punching the employee 4 times by after this assault both Patient were able to engage in further eing on 1:1, Patient #1 was able on front Patient #2 further hallenging Patient #2 to fight.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		470003	B WING_		C 02/14/2018	
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY OF VERMONT MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401	57	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 167	injured left eye. Sta separated On 9/5 Patient #1 and Pat breakfast. Althoughthrew a breakfast of #2. Subsequently, seclusion. Besides constant observation Psychiatry Multidisto develop a timely effort among staff each patient's rightenvironment that is physical and emot PATIENT RIGHTS SECLUSION CFR(s): 482.13(e)  [The use of restraidelemented in appropriate restraidelemined by hos State law.  This STANDARD Based on staff inthospital failed to repolicy for Psychiatric policy for Psychiatric appropriate regulation.  Per review the hos Mechanical Restra Psychiatric Emerg effective 6/17/2016	d Patient #1 in the previously aff intervened, patients were //17 at approximately 08:35, ient #2 were co-mingled during in unprovoked. Patient #1 tray towards the face of Patient Patient #1 was placed in the initiation of 1:1 and ons for Patient #1 the ciplinary Treatment Team failed to maximize safety and ensure it to receive care in an is safe, protecting both the ional well being for all patients. : RESTRAINT OR	A 14	14		4/15/11

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A BUILDING	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
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UNIVER	UNIVERSITY OF VERMONT MEDICAL CENTER			REET ADDRESS, CITY, STATE ZIP CODE I COLCHESTER AVE JRLINGTON, VT 05401		14,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (FACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 167	restraints or end so while protecting the others. This will oce ends or a least rest However, the hosp the individual in se seclusion room do interview on 2/14/1 manager for Shepa will continue to kee up to 1 hour althour in seclusion is sleet threat of harm to standard to the Acute Hospital policy present hospital porequirement for the Acute Hospital Reg (482.13(e)(9) which seclusion must be possible time, regardentified in the ord PATIENT RIGHTS SECLUSION CFR(s): 482.13(e)(e). Restraint or seclusion time identified in This STANDARD Based on staff into hospital failed to enseclusion were dispossible time for 5	goal will be to release eclusion as soon as possible a safety of the individual and cur when the unsafe behavior trictive alternative is feasible." ital policy further states: "8. If clusion falls asleep, unlock or within one hour" Per 7 at 2:15 PM, the nurse ardson 3 & 6 confirmed staff ep the seclusion door locked for gh the patient who was placed ping and no longer poses a elf and others. The nurse adged this was in accordance. However, the process and oblicy does not comply with the accondition of Participation for gulations/Appendix A: A-0174 in states: "Restraints or discontinued at the earliest ardless of length of time fer".  RESTRAINT OR	A 174	P-OC-cested P-OC-c	Nos N	4/15/18

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

OLIVI LI	TO TON MILDIONITE	E & MEDICAID SERVICES			CIVID INC.	0930-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C  02/14/2018	
	0 <sup>26</sup>	470003	B WING			
	NAME OF PROVIDER OR SUPPLIER  UNIVERSITY OF VERMONT MEDICAL CENTER			REET AUDRESS, CITY, STATE, ZIP CODE COLCHESTER AVE IRLINGTON, VT 05401	1 021	14/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 174	1. Per record reviet Shepardson 6 on Spsychosis. Patient and violent behavin Patient #1 became another patient #1 became tray at a patie event Patient #1 widemonstrated incribecame threatenin being ordered. Pel Monitoring Flowsh Every 15 minutes Patient #1's behaving 15; 09:30 docu "sleeping". At 09:4 Patient #1 as "calriblanket", however locked. At 10:05 a conducted, at which became agitated. remained in sector 12:15.  2. Patient #3 was with a diagnosis of depression. On 10 intrusive, grabs ar him/herself. With a #3 was escorted to 0430. Per review Flowsheet, Patien by 05:15 the patien from 05:30 to 06:1 as "Asleep". It was discontinued and #3 remained in sectors.	ew, Patient #1 was admitted to 2/2/17 with schizophrenia and #1 demonstrated impulsive ors. On the morning of 9/5/17 involved in an incident with the unit. Patient #1 threw a ent s/he had targeted. After the vent to his/her room but eased anxiety, anger and ing to staff resulting in seclusion review of the Seclusion eet seclusion began at 09:05. The MHT would document fors while in seclusion. At mentation noted Patient #1 was 4 documentation describes in/composed and at 09:45 "in seclusion door remained nursing assessment was the time patient awakened and From that point on, Patient #1 sion until finally discontinued at admitted on 10/4/17 voluntarily f paranoia, delusions and 0/5/17 Patient #3 became ind pulls a physician towards assistance from security Patient of Seclusion which began at of Seclusion Monitoring the seclusion Monitoring the seclusion was subdued and 15 the MHT recorded the patient is not until 06:28 seclusion was the door was opened. Patient clusion for almost 60 minutes the use of seclusion.		SEE OF PLAN CONCINEN		411511

AND DIAN OF CORRECTION INCIDENTIFICATION NUMBER.		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED			
		470003	B. WING			C 02/14/2018	
	NAME OF PROVIDER OR SUPPLIER  UNIVERSITY OF VERMONT MEDICAL CENTER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 11 COLCHESTER AVE FURLINGTON, VT 05401		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 174	on 9/20/17 with B delirium. On 9/24 a Psychiatry Eme of acute mania Code 8 (behavior security and othe assist as needed emergency media seclusion starting Monitoring Flows documented Pati 06:30 and 06:45 sleeping. At 06:4 unlocked. Patient for greater than 3 be calm.	s admitted to the psychiatric unit sipolar affective disorder and /17 the patient was described in argency Note to be "in a state "After assaulting a MHT, a ral emergency which alerts r staff to come to the unit to ). The patient received cations and was placed in at 06:06. Per the Seclusion heet at 06:15 the MHT ent #7 was "awake & calm". At Patlent #7 was noted to be 9 the seclusion room door was the #7 had remained in seclusion in minutes although observed to sedmitted involuntarily to the	A	174	See of pron Carparon		4/15/11
	symptoms includ hallucinations. O agitated while do his/her room and staff conducting The patient was 12:15 Patient #9 "asleep". At 12:3 subdued " At 13: On 1/9/18 around meal trays on the physician in the f contract for safel and accepted or Seclusion was in #9 was "agitated describes Patien	B due to worsening psychotic ing command auditory in 1/6/18 Patient #9 became ing laundry. S/he returned to shortly after threw a meal tray at 1:1 supervision with Patient #9. placed in seclusion at 11:56. By was observed by MHT to be 0, 12:45 & 13:00 "awake and 09 seclusion was discontinued. d noon Patient #7 threw several exitchen floor and slapped a face. Patient # 9 could not by and was escorted to seclusion at Ativan and Olanzapine. itiated at 12:22. At 12:30 Patient & restless". At 12:45 the MHT t #7 as laying down and calm. At attent #9 was "awake &		2			

		TOTAL PROMODER PROMODER STORY	T			T CHOVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING	ECONSTRUCTION	CON	TE SURVEY MPLETED
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A 174	subdued". Seclusi despite the earlier when Patient #9 w	on is discontinued at 13:25, opportunity to end seclusion as calm/subdued.	A 174		П	
	manager for Shep seclusion had not earliest possible ti who were not den selves or others. acknowledged sta policy which allow	4/18 at 2:30 PM the nurse pardson 3 & 6 further confirmed been discontinued at the time for Patients # 1, 3, 7 & 9 monstrating a risk of harm to The nurse manager of presently utilize the hospital is staff to keep patients in a 1 hour despite meeting criteria seclusion.	5	SEC PLUN Crice mon		4115117
	diagnosis of schiz facility on 9/19/20 psychiatric overcononcompliance. It self-care and symand hallucinations Note written by the 11/7/2017 docume "appeared to be gothroughout the shincluding clenched toward the RN, ar RN. S/he was esneed for manual rother than the spisode of self-care in the	eclusion was initiated at 1728.		Crice way		
	Per review of the Flowsheet, Patien documented by M minute intervals Patient #10 was, making facial exp	Seclusion was initiated at 1726. Seclusion Monitoring it #10's behavior was lental Health Technicians in 15 Per documentation, at 1815, "laying with eyes closed but ressions." At 1830, Patient #10 as "asleep" At 1845,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		470003	B. WING	**************************************		14/201B
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY OF VERMONT MEDICAL CENTER			1	TREET ADDRESS, CITY, STATE, ZIP COD 11 COLCHESTER AVE BURLINGTON, VT 05401	E	
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A 174	documentation st	ates, "seems to be back at 11, Patient #10 was documented	A 174			7 7 6 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7
A 821	justified the conti- to, "imminent risk Documentation be discontinuation of "absence of behat seclusion was dis- of Patient #10's be- serious harm after continued need for confirmed with the 2/14/2018 at 2:15	T OF A DISCHARGE PLAN		PLAN C'STREETISM		415/17
	discharge plan if continuing care in the discharge plat This STANDARD Based on staff in was a failure of it reassess a dischipatient's condition previously identified 10 patients in Patient #2 was a hospital on 8/24/facilitate the admission provided in psychotropic me implemented at required psychia	st reassess the patient's there are factors that may affect needs or the appropriateness of an.  It is not met as evidenced by: interview and record review, there inospital staff to appropriately arge plan after changes in a n warranted adjustments to ited continuing care needs for 1 the sample (Patient #2).  I dmitted involuntarily to the 2017 from another facility to hinistration of court ordered dications, which could not be the prior facility. S/he initially tric admission due to a period of ompliance, which resulted in an		1.60 x/2/	Sal Ju	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		TE SURVEY
	an amedical transfer to 1961 to	And the Control of Con	A BUILDING_			С
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NAME OF PROVIDER OR SUPPLIER  UNIVERSITY OF VERMONT MEDICAL CENTER		111	REET ADDRESS, CITY, STATE, ZIP COL 1 COLCHESTER AVE JRLINGTON, VT 05401	DE .		
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A 821	symptoms of delurecord review, Pal schizophrenia, har mental health serv psychiatric admiss On 9/1/2017 a Mu plan was develope plan to "return to a agency supports".	his/her self and increasing sions and hallucinations. Per ient #2 was diagnosed with d a prior history of community vices and previous inpatient sions.  Itidisciplinary Treatment Team and documented Patient #2's apartment with designated The Psychosocial Assessment	A 821	16		
	Social Worker on interventions to, "g from and collabor, outpatient provide Social Work Prog	ge Plan developed by the 8/25/2017 included gather collateral information ate with the patient, family and rs in the Discharge Plan. A ress Note on 9/1/2017 states, nunity case manager and		PLAN of Correct		ahshi
	physical altercation unit, requiring state de-escalate the continuous and Paties on constant observed on constant observed on 9/4/2017, Paties repeated physical patient, which state verbally without the or restraint. On 9 On-Call note state reviewed with nur reviewed. See memergency event rounds and I did in necessity of sleep	09, Patient #2 was involved in a n with another patient on the fit to implement seclusion to onflict. This altercation resulted his/ her scalp requiring two ent #2 was subsequently placed vation as a safety intervention. ent #2 was involved in a altercation with the same ff were able to de-escalate in need to implement seclusion (4/2017 at 20:25, an Attending as, "Events of the past 24 hours sing staff and written sign-out ultiple chart notes about so Patient sleeping when I did not wake him given the land to the states under Plan."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED C
		470003	B WING			/14/2018
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A 821	"Unchanged, refeteam treatment pon 9/5/17 at 11:4 unit, writer in to ebeing transferred note, "Patient sui information. We accompanied by Psychiatry Dischisigned 9/6/2017 transferred to an conflict" and the patients due to a Per review of Patevidence of a reneeds following hypersentation and altercations at the Plan completed by 8/25/2017 was meassessment, no evidence in the progress note was no evidence in the communication we community treatred inical events ne hospital. The holand Patient Dischan identified progressessment of	er to orders and multidisciplinary plan. Per Nursing Progress note 5 AM, "sheriffs arrived to the explain to patient that s/he was "to another hospital. Per RN prised but accepting of this prised but accepting the value of this prised but accepting the providers regarding the providers	A 8	SCE Plan		416111
<i>B</i>	Management and clinical supervisor	ew, the Team Lead of Case d Social Work (identified as r) stated that assessments social workers are expected to		THE REAL PROPERTY AND ADDRESS OF THE PARTY AND		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING			(X3) DATE SURVEY GOMPLETED C 02/14/2018	
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A 821	treatment plan ar discharge plan. The Patient #2's disch his/her status was Emergency Care, and the Team Les	page 12 Into the multidisciplinary Ind form the basis of the The lack of re-assessment of Itarge plan following a change in Its confirmed with the Director of Itarges and Patient Transitions Itarge for Case Management and Itarian Am.	A	SEE PLAN OF CONTROLL	^	410 W	
		a a					
	*			×			
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#### 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, P.OC Acceptagn Chaired by the Chief Medical Officer.
- All actions will be complete effective 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 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 #I 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 first 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 4/15/1
- 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 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 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 #10'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 #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.

### **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 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.

H821 Josh Accorded
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HIS/18

All actions will be complete effective 4/15/18



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

Ciner

Accreditation & Regulatory Affairs

The University of Vermont Medical Center

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Burlington, VT 05401

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