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 06/27/2018

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	A 000		

An unannounced, on-site complaint survey was completed on 6/27/18 by the Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The following standard level finding regarding Patient Rights was cited.

A 131 PATIENT RIGHTS: INFORMED CONSENT A 131
CFR(s): 482.13(b)(2)

The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care.

The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the hospital failed to ensure a patient's rights were protected regarding the right to refuse treatment related to medication administration in the Emergency Department for 1 of 10 patients in the targeted sample. (Patient #1) Findings include:

Patient #1 filed a complaint with the State Survey Agency regarding an alleged violation of his/her right to request or refuse care and treatment in the Emergency Department (ED) during March, 2018. Specifically, the patient alleged that s/he was not offered medications to be administered via the oral route prior to receiving the medications via an involuntary intramuscular

SEE ATTACHED PLAN OF CORRECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: DIRECTOR | (X6) DATE: 9/28/18

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 131	Continued From page 1	A 131		

(I.M.) injection. This happened on 2 dates during the patient's time in the ED, on 3/30/18 and again on 3/31/18.

The Patient was brought to the ED by police after receiving information regarding the patient's threatening and assaultive actions against others at a group residence. Per review of the D.O. 's (Doctor of Osteopathic Medicine) Emergency Psychiatry Consultation on 3/30/18 at 1108 hours, the patient had refused to stay in the ED voluntarily and had 'no insight into the dangerousness of their behavior'. The Patient '...stands up and gestures towards me in a threatening way ....longstanding mental illness ....episodes of violence can occur while... ill.' The recommendations included: Patient is on an EE (emergency evaluation), may not leave, do not d/c ....hold the patient until a second certification ... .completed'. Additional recommendations by the D.O. included the following: "In the event of a psychiatric emergency: Haldol 5 mg., Lorazepam 2 mg. and Diphenhydramine 50 mg. IM X 1" was written. Per review of the note by the Physician Assistant (PA) provider assuming care for this patient on 3/30/18 at 0653, the 'Patient became very agitated ....uncooperative ....required Haldol (IM), Ativan, (IM) and Benadryl (oral). The provider note did not document an assessment of the patient at the time, nor the imminent danger to self/others that required I.M. administration of the Haldol and the Lorazepam. The provider did not order oral medications to be offered first for the Haldol and the Lorazepam. The provider placed the orders for these I.M. medications on 3/30/18 as 'now X 1, at 1011 hours.

The RN providing nursing care wrote '...awoke

SEE ATTACHED PLAN of Correction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 131	Continued From page 2	A 131		

and was extremely agitated ....aggressive ....yelling ....security called ....' The patient received Haldol 5 mg. (milligrams) IM, Benadryl 50 mg. PO and Ativan 2 mg IM ....with good effect'. The RN documented no specific less restrictive interventions attempted to calm the patient. It was noted that only one of the medications was ordered orally. (Later the same day, the patient did willingly take these same medications orally.)
Per review of the patient's MAR (medication administration record) and interview (6/27/18 at 10:30 AM), the RN who administered the injections, stated that another RN providing care requested that s/he administer the two I.M. medications after stating to her/him that the '...Patient won't take them PO (by mouth)...' The RN who administered the I.M. medications was asked if there was any type of physical hold on the patient during the medication administration and s/he stated that they could not remember.

On 3/31/18 at 3:51 PM, another P.A. provider ordered Haloperidol 5 mg. injection, Diphenhydramine 50 mg. injection and Lorazepam 2 mg. injection after the patient became 'agitated'. There was no evidence of any assessment prior to ordering the medications via the I.M. route. There was no documentation of the behavior that posed a risk of serious harm at the time. There were no orders to administer PO if the patient allowed. During a telephone interview with the P.A. on 6/27/19 at 7:35 AM, the provider confirmed that s/he was not in the room when the nurse administered the medications. S/he further stated that if there was a behavioral emergency, then most of the time, s/he would follow the recommendations of the consulting provider. The RN who administered the

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A 131	Continued From page 3 medications I.M. injected the medications into the left gluteus medius muscle; there was no documentation of whether there was a physical hold used during the injection. Per interview on 6/26/28 at 9:12 AM, the RN Emergency Department Manager stated that when patients pose a serious threat of harm to self or others, we may give I.M. medications. we go through a thorough process, attempting redirection, offer PO medications (draw both medication routes), using the least restrictive intervention. Medications used in the ED for violent or dangerous behaviors are only used to treat the patient's symptoms. In summary, per review of the sample of 10 medical records and interviews with hospital staff who provided care, Patient #1 was not offered medications PO (orally) prior to I.M. administrations.	A 131	SEE ATTACHED PLAN of CORRECTION	11/1/18

A 000 INITIAL COMMENTS

An unannounced, on-site complaint survey was completed on 6/27/18 by the Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The following standard level finding regarding Patient Rights was cited.

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This STANDARD is not met as evidenced by Based on staff interview and record review, the hospital failed to ensure a patient's rights were protected regarding the right to refuse treatment related to medication administration in the Emergency Department for 1 of 10 patients in the targeted sample. (Patient #1) Findings include:

Patient #1 filed a complaint with the State Survey Agency regarding an alleged violation of his/her right to request or refuse care and treatment in the Emergency Department (ED) during March, 2018. Specifically, the patient alleged that s/he was not offered medications to be administered via the oral route prior to receiving the medications via an involuntary intramuscular (I.M.) injection. This happened on 2 dates during the patient's time in the ED, on 3/30/18 and again on 3/31/18.

The Patient was brought to the ED by police after receiving information regarding the patient's threatening and assaultive actions against others at a group residence. Per review of the D.O's (Doctor of Osteopathic Medicine) Emergency Psychiatry Consultation on 3/30/18 at 1108 hours, the patient had refused to stay in the ED voluntarily and had 'no insight into the dangerousness of their behavior'. The Patient'...stands up and gestures towards me in a threatening way ...longstanding mental illness....episodes of violence can occur while.. ill. 'the recommendations included: Patient is on an EE (emergency evaluation), may not leave, do not d/c ...hold the patient until a second certification ....completed! Additional recommendations by the D.O. included the following: "In the event of a psychiatric emergency Haldol 5 mg, Lorazepam 2 mg. and Diphenhydramine 50 mg. IM X 1" was written.

Per review of the note by the Physician Assistant (PA) provider assuming care for this patient on 3/30/18 at 0653, the 'Patient became very agitated. .uncooperative ....required Haldol (IM), Ativan, (IM) and Benadryl (oral). The provider note did not document an assessment of the patient at the time, nor the imminent danger to self/others that required I.M. administration of the Haldol and the Lorazepam. The provider did not order oral medications to be offered first for the Haldol and the Lorazepam. The provider placed the orders for these I.M. medications on 3/30/18 as 'now X 1, at 1011 hours and was extremely agitated ....aggressive....yelling ....security called ....' The patient received Haldol 5 mg. (milligrams) IM, Benadryl 50 mg. PO and Ativan 2 mg IM ... with good *effect'* The RN documented no specific less restrictive interventions attempted to calm the patient It was noted that only one of the medications was ordered orally. (Later the same day, the patient did willingly take these same medications orally.)

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On 3/31/18 at 3:51 PM, another PA provider ordered Haloperidol 5 mg. injection, Diphenhydramine 50 mg. injection and Lorazepam 2 mg. injection after the patient became 'agitated'. There was no evidence of any assessment prior to ordering the medications via the I.M route. There was no documentation of the behavior that posed a risk of serious harm at the time. There were no orders to administer PO if the patient allowed. During a telephone interview with the PA on 6/27/19 at 7:35 AM, the provider confirmed that s/he was not in the room when the nurse administered the medications. S/he further stated that if there was a behavioral emergency, then most of the time, s/he would follow the

recommendations of the consulting provider. The RN who administered the medications I.M. injected the medications into the left gluteus medius muscle; there was no documentation of whether there was a physical hold used during the injection.

Per interview on 6/26/28 at 9:12 AM, the RN Emergency Department Manager stated that when patients pose a serious threat of harm to self or others, we may give I.M. medications. We go through a thorough process, attempting redirection, offer PO medications (draw both medication routes), using the least restrictive intervention. Medications used in the ED for violent or dangerous behaviors are only used to treat the patient's symptoms.

In summary, per review of the sample of 10 medical records and interviews with hospital staff who provided care, Patient #1 was not offered medications PO (orally) prior to I.M. administrations

ACTION PLAN

- Under the direction of the Division Chief of Emergency Medicine and Emergency Department Nurse Manager, updates were made to the Emergency Department (ED) Acute Psychiatric Order Sets. The updates align the ED orders sets with the Inpatient Psychiatry Order Sets and prompt the clinician to document that the least restrictive alternative was offered.

- Under the direction of the Emergency Department Assistant Medical Director and Emergency Department Nurse Manager, Education on offering and documenting the least restrictive intervention was completed through a combination of electronic communication, Nursing and Provider meetings held in October 2018. Effective 11/1/18 the education will be embedded into the Emergency Department physician and nursing onboarding curriculum

- Monitoring documentation for the least restrictive alternative being offered will be accomplished through a combination of electronic and manual review. Data will be shared with the ED Department Leadership for necessary follow-up as needed.

- All actions will be completed by 11/1/18.

THE
University of Vermont
MEDICAL CENTER

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

September 26, 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: 00K111, 6/27/2018

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 June 27, 2018.

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