DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/09/2018 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				DIMR NO	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A_BUILDING				E SURVEY PLETED	
	Van	470003	B WING			06/	27/2018
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY STATE, ZIP CODE		
LIMILVED	SITY OF VERMONT M	EDICAL CENTER		111	COLCHESTER AVE		1
ONIVER	SITTOP VERMONT IN	EDICAL CENTER		BU	RLINGTON, VT 05401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 000	INITIAL COMMENT	S	Α0	000			
A 131	completed on 6/27/ and Protection, as a Medicare and Medi standard level finding was cited,	on-site complaint survey was 18 by the Division of Licensing authorized by the Centers for caid Services. The following ng regarding Patient Rights INFORMED CONSENT	A 1	31			
	allowed under State	r her representative (as a law) has the right to make regarding his or her care.					
	or her health status planning and treatm or refuse treatment construed as a med provision of treatme	include being informed of his being involved in care tent, and being able to request This right must not be thanism to demand the ent or services deemed ary or inappropriate.			PLAN OF Correction		t e!
	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:				Correction		
	Agency regarding a right to request or rethe Emergency Dep 2018. Specifically, the was not offered mervia the oral route principal specific and th	implaint with the State Survey in alleged violation of his/her efuse care and treatment in partment (ED) during March, the patient alleged that s/he dications to be administered for to receiving the involuntary intramuscular		e.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DIRECTA

JIAG (BX)

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.

Facility ID 470003

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

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO 0938-0391
STATEMENT OF DEFICIENCIES (X1) PR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER-		PLE CONSTRUCTION 3	C C C C C C C C C C C C C C C C C C C
NAME OF	DOONOUS OF STREET	470003		STREET ADDRESS CITY, STATE, ZIP CODE	06/27/2018
	PROVIDER OR SUPPLIER SITY OF VERMONT M	EDICAL CENTER		111 COLCHESTER AVE BURLINGTON, VT 05401	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
A 131	the patient's time in on 3/31/18. The Patient was bro receiving informatic threatening and ass at a group residence (Doctor of Osteopa Psychiatry Consultative patient had refuvoluntarily and had dangerousness of the commendations in the patient had refuvoluntarily and had dangerousness of the commendations in the patient had refuvoluntarily and had dangerousness of the commendations in the certification of the certification	s happened on 2 dates during the ED, on 3/30/18 and again bught to the ED by police after on regarding the patient's saultive actions against others e. Per review of the D.O. 's thic Medicine) Emergency ation on 3/30/18 at 1108 hours, sed to stay in the ED 'no insight into the heir behavior'. The Patient stures towards me in a clongstanding mental illness nice can occur while ill.' The included: Patient is on an EE tion), may not leave, do not patient until a second ompleted'. Additional by the D.O. included the event of a psychiatric 5 mg. Lorazepam 2 mg. and 0 mg. IM X 1" was written, but by the Physician Assistant ming care for this patient on a 'Patient became very erativerequired Haldol (IM), madryl (oral). The provider ent an assessment of the nor the imminent danger to bired I.M. administration of the izepam. The provider placed it.M. medications on 3/30/18	A 13	SEE ATTACHED PLAN of Correman	

The RN providing nursing care wrote '...awoke

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

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		470003	B WING					06	/27/2018	
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UNIVER	SITY OF VERMONT M	IEDICAL CENTER		BURLING	STON, VT	05401				
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A 131	Continued From pa	age 2	A 1	31						
		agitatedaggressive								
		y called' The patient								
		ng. (milligrams) IM, Benadryl								
		an 2 mg IM with good								
		cumented no specific less								
		ions attempted to calm the								
	,	ed that only one of the								
		dered orally. (Later the same	37							
	medications orally.)	willingly take these same								
		atient's MAR (medication								
		rd) and interview (6/27/18 at								
		who administered the								
140		at another RN providing care								
		administer the two I.M.								
	medications after s	tating to her/him that the								
	Patient won't take	e them PO (by mouth) The								
		ed the I.M. medications was								
		any type of physical hold on								
		ne medication administration								
	and s/he stated that	t they could not remember.								
	On 2121/10 at 2:51	DM another DA provider								
	ordered Haloperido	PM, another P.A. provider								
	Diphenhydramine 5									
		njection after the patient								
		There was no evidence of any								
		ordering the medications via								
		re was no documentation of								
		osed a risk of serious harm at								
	the time. There we	re no orders to administer PO								
	if the patient allower	d. 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								
		ninistered the medications.								
		that if there was a behavioral								
		ost of the time, s/he would								
	follow the recomme	indations of the consulting								

provider. The RN who administered the

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CENTER	RS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-	0391
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		470003	B. WING	- 13 mm - 2	06/27/201	8
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE ZIP 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLE E APPROPRIATE DAT	ETION
A 131	left gluteus medius	jected the medications into the muscle; there was no whether there was a physical	A 13	I	5	
ė	Emergency Depart when patients pose self or others, we need through a thorough redirection, offer Properties, intervention, Medical	26/28 at 9:12 AM, the RN ment Manager stated that a a serious threat of harm to hay give LM. medications, we had process, attempting O medications (draw both using the least restrictive ations used in the ED for its behaviors are only used to ymptoms.		SCE ATTACHED PLAN OF CONCETTON		ļ
	medical records an	view of the sample of 10 d interviews with hospital staff Patient #1 was not offered arally) prior to I.M.		~		
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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.

A 131 PATIENT RIGHTS: INFORMED CONSENT 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 (l.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 certificationcompleted! 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. uncooperativerequired 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 l.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 l.M. medications on 3/30/18 as 'now X 1, at 1011 hours and was extremely agitatedaggressive....yellingsecurity 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 s/he administer the two IM medications after stating to her/him that the'.. Patient won't take them PO (by mouth)...' The RN who administered the IM 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 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 LM 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.

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

and Myn

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