VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

August 24, 2018

Ms. Emily Hawes, CEO
Vermont Psychiatric Care Hospital
350 Fisher Road
Berlin, VT 05602

Dear Ms. Hawes:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 11, 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

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Northeast Division of Survey & Certification

VPCH
JUL 24 2018
Executive Office

July 17, 2018

Ms. Emily Hawes, CEO
Vermont Psychiatric Care Hospital
350 Fisher Road
Berlin, VT 05602

Re: CMS Certification Number (CCN): 474004
Survey ID: XHHD11, 07/11/2018

Dear Ms. Hawes:

I am pleased to inform you that as a result of the substantial allegation survey conducted on July 11, 2018 by the Division of Licensing and Protection (State Survey Agency), Vermont Psychiatric Care Hospital was found in compliance with the Medicare Conditions of Participation for Hospitals at 42 CFR Part 482 and will continue to be "deemed" to meet applicable Medicare requirements based upon accreditation by The Joint Commission (TJC).

The State Survey Agency advised you of the Medicare deficiencies noted during the substantial allegation survey of your hospital, and we are enclosing a complete listing of all deficiencies found by the State. We have forwarded a copy of this letter to The Joint Commission and to the State.

Since your hospital has been found to be "in compliance," you do not have to submit a plan for correcting any of the Medicare deficiencies cited by the State Survey Agency. However, you should be aware that copies of the Form CMS-2567 and subsequent plans of correction are releasable to the public upon request in accordance with the provisions of Section 1864(a) of the Act and the Secretary's regulation set forth at 42 CFR §401.133(a) and (b). You may therefore wish to submit for public disclosure, if you have not already done so, your comments on the survey findings, and any plans you may have for correcting the cited deficiencies.

We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program.

Sincerely,

Kathy Mackin, Health Insurance Specialist
Survey Branch

Enclosure: CMS-2567
cc: State Survey Agency
TJC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474004	A. BUILDING _____ B. WING _____	C 07/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERMONT PSYCHIATRIC CARE HOSPITAL	350 FISHER ROAD BERLIN, VT 05602

(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 survey was completed on 7/11/18 by the Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services. The following standard level finding regarding QAPI (Quality Assurance and Performance Improvement) was cited.	A 000		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to ensure that the Quality	A 286	POC amnt 8.17.18 M Burton/CR	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Hamm	CEO	8/7/18

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 286	Continued From page 1	A 286		

Assurance and Performance Improvement (QAPI) program conducted a thorough analysis and implemented preventive actions to mitigate the potential risk identified during the investigative process for an attempted suicide for 1 applicable patient. (Patient #1). Findings include:

Per information received via an anonymous complainant, an investigation by the State Survey Agency into an alleged patient attempted suicide revealed that the potential risk identified during the hospital's investigation of the event was not effectively mitigated by corrective actions taken by the hospital. Review of the QAPI notes of the investigation as of the date of survey (7/9/18), Patient #1 had attempted suicide by using multiple unstretchable, non-slideable nylon locking ties, secured together and locked around the neck.
Patient #1 was admitted on 1/01/18 with a history of violent, unpredictable, assaultive behaviors towards others and a history of multiple prior involuntary hospital admissions. In the previous 2 year period, he had denied thoughts of suicide and had no known suicide attempts until the suicide attempt on 6/11/18.

ON 6/11/18, the patient was found in their room (the patient had triggered the door sensor alarm) with three attached, locked ties around their neck; the facial area was 'purple'. The nurse at the scene cut the ties and the patient was assessed. There were ligature marks observed around the neck, with some petichiae visible in the facial area. Per review of the Patient Event Form dated 6/11/18, the severity of the event was categorized as a "Category D - Event/error increased the need for treatment/intervention/monitoring and caused temporary patient/resident harm."

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A 286	Continued From page 2	A 286		

The Mental Health Specialist (MHS) who found the patient on 6/11/18 was interviewed by surveyors on 7/9/18 at 4:05 PM. The MHS said s/he had checked on the patient, who was on every 30 minute observation checks, at 2:55 PM. Approximately 15 minutes later, the MHS heard the door sensor alarm go off for this patient's room. Upon entering, s/he saw the patient standing in the middle of the room, the face was very discolored with the ties encircling the patient's neck. The Registered Nurse (RN) arrived and was attempting to cut the ties and the patient was trying to grab the RN's hands. The MHS and coworker held the patient's hands so the RN could cut the ties....Patient #1 stated "I'm OK". The RN and physician present continued to assess the patient.

Per interview on 7/9/18 at 3:30 PM, the RN present on 6/11/18 stated that staff did a thorough search of Patient #1's room after the event. The MHS stated during interview (7/9/18) that staff on duty did not search any other patient rooms at that time.

The Chief Nursing Executive (CNE) stated during interview on 7/11/18 at 10:35 AM that s/he responded to the psychiatric emergency crisis on 6/11/18. S/he stated that they instructed to staff to get rid of all of the ties on the unit. S/he confirmed that ties were to be removed from patients utilizing them on the B Unit. (The Quality Administrator had stated earlier that the hospital had used the locking ties as a safer alternative to shoe laces and belts, to secure the clothing items for patients in the hospital). The CNE confirmed that Patient #1's room was searched. When asked if unit searches were completed on all 4 units after the suicide attempt, s/he stated that it is hospital policy to conduct weekly unit searches,

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A 286	Continued From page 3	A 286		

which also includes a thorough search of all patient rooms.

Per review of the weekly Unit Search forms used to document the weekly searches, none of the 4 patient units was following the hospital policy to conduct the searches on a weekly basis. The only documented unit/room search completed on B Unit during June, 2018, was on 6/7/18, 4 days prior to the event. After the suicide attempt, the next unit/room search was not completed until 7/5/18, weeks after the event. Based on a review of the other 3 units and review of the searches documented since since March, 2018, none of the units had done the required checks every week per the facility's policy. (Most searches were done 2 x per month).
Per review, the policy titled Restricted Items Search, under "Room Search: A room search is a thorough search of a patient room for potentially dangerous and restricted items. Room searches shall be conducted weekly and whenever there is a suspicion that restricted items are on the unit or in a patient room. Room searches are also conducted as part of unit searches.
A Unit Search: A unit search is a thorough search of all patient rooms and all common areas of the unit. Unit searches shall be conducted weekly and whenever there is a suspicion that restricted items are on the unit."

Per interview on 7/9/18, the Nurse Quality Management Administrator for the hospital stated that leadership staff met after the event and initiated an investigation into the facts immediately after the attempted suicide. A RCA (Route Cause Analysis) was initiated and leadership staff were involved at the time of survey. A plan had been put into place that

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A 286	Continued From page 4 included searching Patient #1's room for possible additional unused locking ties. Although the leadership team (QAPI members) had identified the type of ties used during the attempted suicide (unstretchable and non-slideable) as a potential risk as a ligature device, there was no organized plan to search all 4 units and patient rooms in the immediate period after the event to assure that the identified risk was removed and the potential danger mitigated.	A 286		

Vermont Psychiatric Care Hospital
Improvements following verbal feedback from CMS surveyors, July 9-11, 2018
Improvements to be overseen by VPCH Executive Leadership Team

Improvement	Next Steps
Inform all employees by email that zip ties are no longer to be used in patient care areas, and the actions an employee who sees a zip-tie in use is expected to take	Completed July 17, 2018
Develop checklist that specifies actions to be completed in each routine weekly room search	Safety Council has drafted guidelines that will be reviewed at the next meeting. Guidelines will be integrated into a revision of the Restricted Items and Search Policy and Procedure
Assign oversight responsibility for monitoring and record keeping of routine weekly room searches to nursing supervisors	Completed July 11, 2018
Create After Action Report template to be completed by leadership and distributed to all affected employees following a high risk near-miss or adverse event	Completed August 2, 2018
Revise the Org Chart to display all hospital services in a single visual snapshot that includes all hospital services and that illustrates how Quality is interconnected	Completed July 31, 2018

POC complete 8.17.18
M Baker