

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



Northeast Division of Survey & Certification

June 10, 2013

Dr. Robert Simpson, President & CEO
Brattleboro Retreat
Anna Marsh Lane, P.O. Box 803
Brattleboro, VT 05301

**Re: CMS Certification Number: 474001
Survey ID: XLXO11, 04/18/2013**

Dear Dr. Simpson:

I am pleased to inform you that the Brattleboro Retreat's plans of correction for its Medicare deficiencies, and the time schedule for completion of the plans, have been found acceptable.

When Brattleboro Retreat's plans of correction have been implemented and we have concluded that the hospital meets the Medicare Conditions of Participation at 42 CFR Part 482, it will no longer be subject to State Survey Agency follow-up. Failure to correct deficiencies in a timely manner will result in termination of the Medicare provider agreement.

A copy of this letter will be forwarded to the VT Division of Licensing and Protection.

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,

A handwritten signature in cursive script, appearing to read "Kathy Mackin". The signature is written in dark ink and is positioned above the typed name of the sender.

Kathy Mackin, Health Insurance Specialist
Certification & Enforcement Branch

cc: VT Division of Licensing and Protection

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

Printed: 05/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 474001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/17/2013
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NAME OF PROVIDER OR SUPPLIER BRATTLEBORO RETREAT	STREET ADDRESS, CITY, STATE, ZIP CODE ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301
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(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
B 000	INITIAL COMMENTS	B 000	BOOO Summary Statement	
	An unannounced full survey after removal of deemed status was conducted by federal consulting surveyors in conjunction with state surveyors from 4/15/13 to 4/17/13. The census at the time of the survey was 105 patients; the sample of active patients was 10.		Subsequent to the three day survey completed by a federal team on 4/17/13 the Brattleboro Retreat and governing body has undertaken a series of significant targeted actions that address all areas of noncompliance in the standard level findings. We are fully committed as an organization to correct any deficiencies and achieve and sustain a high level of quality patient care.	
B 108	482.61(a)(4) DEVELOPMENT OF ASSESSMENT/DIAGNOSTIC DATA	B 108	482.61(a)(4) DEVELOPMENT OF ASSESSMENT/DIAGNOSTIC DATA	6/28/13
	The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.		Of note, this survey was a follow up to the 2/21/13 seven day survey. The plan of correction for that survey was approved on 4/24/13.	
	This Standard is not met as evidenced by: Based on record review, policy review, and interview it was determined that in a sample of 10 records (A1, A2, A3, A4, A5, A6, A7, A8, A9, and A10) the facility failed in 4 records (A4, A5, A6, and A9) to provide social work assessments that included conclusions and recommendations that described anticipated social work roles in treatment and discharge planning. This failure results in treatment plans that do not reflect a comprehensive, integrated, individualized approach to multidisciplinary treatment		PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: To ensure that social work services are appropriate and represent quality care the Director of Social Work on 4/16/13 and 5/23/13 provided clarification to social work staff that: • Psychosocial assessments must provide conclusions and recommendations that describe anticipated social work roles in treatment and discharge planning. • That the conclusion or clinical formulation will guide an integrated and individualized approach to multidisciplinary treatment. • Interventions noted on the master treatment plan will be specific to social work activities. • Information obtained from the patient and/or family will be included in the psychosocial assessment. • The role of patient and/or family members in treatment planning. • The modality of family therapy will be incorporated into the patient's plan of care as clinically appropriate.	
	Findings Include: A. Record Review: 1. Patient A4: Admitted 4/8/13. Psychosocial Assessment dated 4/8/13 failed in the summary to describe a specific social work role in A4's inpatient treatment, instead listing "Medication adjustment," "Build distress tolerance and social skills," "Work with outpatient providers and referrals to support (Patient name) in the		The current psychosocial assessment will be revised in the electronic health record to include prompts that ensure completeness in documentation standards by 6/28/13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *President & CEO* (X6) DATE: *6/5/13*

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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B 108	Continued From page 1 community" 2. Patient A5: Admitted 4/10/13. Psychosocial Assessment dated 4/11/13 failed in the summary to describe a specific social work role in A5's inpatient treatment, instead listing "Patient is working with the Howard Center and will continue with this"; "Patient wants to work with Suboxone provided as well. [S/he] will continue to go to AA." 3. Patient A6: Admitted 4/9/13. Social Work (SW) assessment lists "SW will work with Pt and Tx team to develop safe plan for discharge." 4. Patient A9: Admitted 3/28/13. SW assessment lists "SW will collaborate with patient, team, DCF guardian, and outpatient providers to craft a discharge plan to facilitate Pt.'s recovery, academic performance, and attainment and maintenance of sobriety." B. Interview Surveyor interviewed the Director of Social Services at 3:30 PM on 4/16/13. The above findings were presented to the Director who acknowledged them.	B 108	B 108 482.61(a)(4) DEVELOPMENT OF ASSESSMENT/DIAGNOSTIC DATA Continued The Director of Social Work will formally train all social workers on psychosocial assessments standards. 100% social workers will be retrained by 6/28/13 and will complete a competency assessment that will become part of social work orientation and an annual competency. The Director of Social Work will provide monthly seminars to social work staff on conducting psychosocial assessments for 4 months to ensure that assessments meet standards. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Staff Education and Training. Competency Assessment. Modification to the electronic psychosocial assessment. MONITORING/TRACKING: (method, frequency and responsible person) The Director of Social Work will conduct random chart audits, 2 charts per week per inpatient unit (total of 12 charts representing greater than 10% of the total hospital beds) for 4 months to assess comprehensiveness of psychosocial assessments. Her findings will be reported to the Executive Leadership (CMO, CNO, and Vice President of Operations) and unit based leadership teams. TITLE OF RESPONSIBLE PERSONS(s): Director of Social Work Vice President of Operations	
B 116	482.61(b)(6) PSYCHIATRIC EVALUATION Each patient must receive a psychiatric evaluation that must estimate intellectual functioning, memory functioning and orientation. This Standard is not met as evidenced by: Based upon record review and interview it was determined that the hospital failed to assure that in 6 of 10 active sample records (A3, A5, A6, A7, A8, and A10) the Psychiatric Evaluation contained reports of findings of assessments of patient's	B 116		

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B 116	Continued From page 2 orientation functioning. This compromises the data base from which the individualized treatment plan is formulated. Findings include: A. Record Review: 1. Patient A8, admitted 2/15/13. Psychiatric Assessment dated 2/16/13 made no mention of Orientation. 2. Patient A3, admitted 4/04/13. Psychiatric Evaluation dated 4/05/13 made no mention of orientation findings. 3. Patient A10, admitted 4/04/13. Psychiatric Assessment dated 4/05/13: Orientation reported as "Alert." 4. Patient A6, admitted 4/09/13. Psychiatric Evaluation dated 4/10/13: Orientation findings reported as "Alert." 5. Patient A7, admitted 4/10/13. Psychiatric Assessment dated 4/11/13: Orientation findings reported as "Alert." 6. Patient A5, admitted 4/10/13. Psychiatric Evaluation dated 4/11/13: Orientation findings reported as "Alert." B. Interview: Surveyor interviewed the Hospital Medical Director on 4/17/13 at 4 PM. The above findings were presented to the Medical Director who acknowledged them.	B 116	B 116 482.61(b)(6) PSYCHIATRIC EVALUATION PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: On 5/22/13 the Chief Medical Officer made revisions to the physician's initial assessment and physician progress note in the Electronic Health Records to ensure that all intellectual and memory functioning and orientation are incorporated into the physician's evaluation. The following revisions were made: • Four sections on memory: o Memory: Deficits, No Deficits, Other. o Immediate memory (intact or not intact). o Immediate memory assessment: 1 of 3, 2 of 3, 3 of 3. o Comment box for remote memory assessment. • Orientation o New check boxes for person, place, time, situation. • Intellectual Assessment. o Three boxes: below average, average, above average. The Chief Medical Officer provided education to the medical staff regarding changes made to the psychiatric assessment and requirements for evaluation and documentation on 5/29/13. The Brattleboro Retreat is currently in the process of implementing an electronic health record (E.H.R.). The clinical documentation components (assessments, progress notes) are live. Physician order entry and the pharmacy interface are scheduled for go live later this summer. The medical staff has been closely involved in the implementation of the electronic health record and participates in a weekly E.H.R Advisory Council to ensure that quality concerns are addressed and that processes for improvement are identified. The Executive Team reviews the progress of the E.H.R Implementation plan on a weekly basis.	5/29/13	
B 120	482.61(c)(1)(i) TREATMENT PLAN	B 120			

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B 120	<p>Continued From page 3</p> <p>The written plan must include a substantiated diagnosis.</p> <p>This Standard is not met as evidenced by: Based on record review and interview the facility failed to identify a diagnosis that served as the primary focus in the treatment plans of 9 of 10 active sample patients (A1, A2, A3, A4, A5, A6, A7, A8, and A9). This practice compromises the staff's ability to deliver clinically focused treatment.</p> <p>Findings Include:</p> <p>A. Record Review</p> <ol style="list-style-type: none"> 1. Patient A8, admitted 2/15/13, Master Treatment Plan initiated 2/19/13; section titled Psychiatric Diagnosis (DSM-IV) was blank. 2. Patient A9, admitted 3/28/13, Master Treatment Plan initiated 3/29/13; section titled Psychiatric Diagnosis (DSM-IV) was blank. 3. Patient A2, admitted 4/2/13, Master Treatment Plan initiated 4/3/13; section titled Psychiatric Diagnosis (DSM-IV) was blank. 4. Patient A3, admitted 4/4/13, Master Treatment Plan initiated 4/5/13; section titled Psychiatric Diagnosis (DSM-IV) was blank. 5. Patient A1, admitted 4/5/13, Master Treatment Plan initiated 4/6/13; section titled Psychiatric Diagnosis (DSM-IV) was blank. 6. Patient A4, admitted 4/6/13, Master Treatment Plan initiated 4/8/13; section titled Psychiatric Diagnosis (DSM-IV) was blank. 	B 120	<p>B 116 482.61(b)(6) PSYCHIATRIC EVALUATION Continued</p> <p>PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION</p> <p>Modification of Psychiatric Evaluation Medical staff education</p> <p>MONITORING/TRACKING: (method, frequency and responsible person) The Director of Social Work will conduct random chart audits, 2 charts per week per inpatient unit, (total of 12 charts representing greater than 10% of the total hospital beds) to ensure that the psychiatric assessments contain all required elements. Her findings will be reported to the Executive Leadership (CMO, CNO, and Vice President of Operations) and unit based leadership teams.</p> <p>TITLE OF RESPONSIBLE PERSONS(s):</p> <p>Chief Medical Officer Director of Social Work</p> <p>B 120 482.61 (c)(1)(i) TREATMENT PLAN</p> <p>PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES:</p> <p>The Chief Medical Officer approved revisions to current treatment plans that include a prompt for a substantiated patient diagnosis. Treatment plan modifications will be implemented by 6/7/13 and will carry forward to the Electronic Health Record upon implementation of treatment plans.</p> <p>The senior triad/ leadership team (CMO, CNO, and Vice President of Operations) will conduct and in-service on treatment planning by 6/14/13 to unit-based leadership teams ensures that all documentation standards are met.</p>	8/28/13

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B 120	Continued From page 4 7. Patient A6, admitted 4/9/13, Master Treatment Plan initiated 4/10/13: section titled Psychiatric Diagnosis (DSM-IV) was blank. 8. Patient A5, admitted 4/10/13, Master Treatment Plan initiated 4/11/13: section titled Psychiatric Diagnosis (DSM-IV) was blank. 9. Patient A7, admitted 4/10/13, Master Treatment Plan initiated 4/11/13: section titled Psychiatric Diagnosis (DSM-IV) was blank. B. Interview During an interview with the Manager of Performance Improvement and Risk Management on 4/16/13 at 9:10 AM, when shown a copy of the facility form titled "Interdisciplinary Treatment Plan Signature Page," section labeled "Psychiatric Diagnosis (DSM-IV)" she stated that "it is my understanding that this should be filled in but I will check." At 9:30 AM, the Manager Performance Improvement and Risk Management returned and stated "I spoke with one of the Nurse Managers and they tell me that this is not to be completed because it had been determined that the other forms (referring to pre-printed treatment plans that are problem specific) are a part of the treatment plan and they have been written in patient understandable language." The signature page for patient A10 was shown to the Manager by the surveyor who asked why this one in particular had a DSM diagnosis listed when none of the others did; the Manager replied "I can't answer that, you are right the diagnosis should be there."	B 120	B 120 482.61 (c)(1)(i) TREATMENT PLAN Continued The unit leadership will conduct a similar in-service to unit treatment team members by 6/28/13. Elements of Reeducation on Treatment Planning for medical, nursing and social work staff will include: • Individualized plans of care. • Role of patient and/or family in the treatment planning process. • The modality of family therapy will be incorporated into the patient's plan of care as clinically appropriate. • Incorporation of behavioral plans of care into the treatment planning process. • Review of emergency procedures and incorporation of events into plans of care. • Use of the therapeutic inventory completed by each patient in the identification of triggers on potential coping strategies. • Identification of short and long term goals. • Assignment of responsible party. • Duration and frequency of interventions. • Use of substantiated diagnosis in the treatment planning process. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Revision to Treatment Plan Staff Education MONITORING/TRACKING: (method, frequency and responsible person) The Director of Social Work will conduct chart audits on a weekly basis 2 per unit, (total of 12 charts representing a sample size greater than 10% of the total hospital beds) to ensure that treatment plans contain a substantiated diagnosis.	
B 121	482.61(c)(1)(ii) TREATMENT PLAN The written plan must include short-term and long	B 121	Results of audits will be reported to the Chief Medical Officer.	

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B 121	<p>Continued From page 5 range goals.</p> <p>This Standard is not met as evidenced by: Based on record review and interview the facility failed to provide treatment plans that identified patient-related long term goals stated in observable, measurable, behavioral terms for 10 of 10 active sample patients. Specifically, the facility failed to write long term goals that reflect behavioral outcomes for the patient (A1, A2, A3, A4, A4, A5, A6, A7, A8, A9 and A10). These goals were written in terms of expected behavior for staff. Short term goals were pre-printed and generic without individualization for 7 of 10 active sample patients (A1, A2, A3, A4, A8, A9 and A10). These failures hinder the ability of the treatment team to measure change in the patient as a result of treatment interventions and may contribute to failure of the team to modify plans in response to patient needs, as well as to patient stays beyond the resolution of the behaviors requiring admission.</p> <p>Findings Include:</p> <p>A. Record Review</p> <p>1. Patient A8, admitted 2/15/13, Master Treatment Plan Initiated 2/19/13 (based on interdisciplinary team signatures for the Psychiatrist, the nurse and the social worker) had the following long term goal written: "stabilize mood, evaluate alcohol use, develop effective discharge plan." Short term goals on preprinted treatment plans for the following problem titled "risk of harm to others and/or self, resulting from impaired insight/judgment" were pre-printed generic goals that were not individualized for this patient. Generic goals included "patient will take</p>	B 121	<p>B 120 482.61 (c)(1)(I) TREATMENT PLAN Continued</p> <p>TITLE OF RESPONSIBLE PERSONS(s):</p> <p>Chief Medical Officer Chief Nursing Officer and Vice President of Patient Care Vice President of Operations Director of Social Work</p> <p>B 121 482.61(c)(1)(II) TREATMENT PLAN</p> <p>PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES:</p> <p>The senior leadership team (CMO, CNO, Vice President of Operations) will conduct and in-service on treatment planning by 6/14/13 to unit-based leadership teams ensure that short and long term goals are clearly identified and stated in observable and measurable terms</p> <p>The unit leadership will conduct a similar in-service to unit treatment team members by 6/28/13.</p> <p>Elements of Reeducation on Treatment Planning for medical, nursing and social work staff will include:</p> <ul style="list-style-type: none"> • Individualized plans of care. • Role of patient and/or family in the treatment planning process. • The modality of family therapy will be incorporated into the patient's plan of care as clinically appropriate. • Incorporation of behavioral plans of care into the treatment planning process. • Review of emergency procedures and incorporation of events into plans of care. • Use of the therapeutic inventory completed by each patient in the identification of triggers on potential coping strategies. • Identification of short and long term goals. • Assignment of responsible party. • Duration and frequency of interventions. • Use of substantiated diagnosis in the treatment planning process. 	6/28/13
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B 121	Continued From page 6 all medications as prescribed and patient will discuss effectiveness and side effects of medications with MD; and patient will demonstrate an improved ability to control impulses of aggression and self harm." 2. Patient A9, admitted 3/28/13, Master Treatment Plan initiated 3/29/13 had the following long term goal written: "medication management, psychiatric evaluation, collaborative outpatient plan, family meetings or DCF (Department of Children and Families) visit." Short term goals on preprinted treatment plans for the following problems titled "Adolescent with depression and suicidal ideation"; "Adolescent with self-harming behaviors" and "Adolescent with PTSD" all were pre-printed generic goals that were not individualized for this patient. Generic goal for both problems identified stated "patient will verbally commit to not self-harm." 3. Patient A2, admitted 4/2/13, Master Treatment Plan initiated 4/3/13 had the following long term goals written: "mood and symptom stabilization and diagnostic assessment and medication evaluation." Short term goals on preprinted treatment plan for problem titled "Risk of Harm due to Impulsive Behavior" were not individualized to include a specific number of days for which the "patient will follow unit-based schedule and days." Other goals for this problem included "patient will agree to follow parental rules or rules in current living situation and patient will demonstrate the ability to maintain personal safety." 4. Patient A3, admitted 4/4/13, Master Treatment Plan initiated 4/5/13 had the following long term goal written: "stabilize mood, develop effective discharge plan." Short term goals on pre-printed	B 121	B 121 482.61(c)(1)(ii) TREATMENT PLAN Continued PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Staff Training Competency Assessment MONITORING/TRACKING: (method, frequency and responsible person) The Director of Social Work will conduct chart audits on a weekly basis 2 per unit (total of 12 charts representing a sample size greater than 10% of the total hospital beds)) to ensure that treatment plans contain a measurable short and long term goals. Results of audits will be reported to the Executive and Unit-based Leadership Teams TITLE OF RESPONSIBLE PERSONS(s): Chief Medical Officer Chief Nursing Officer and Vice President of Patient Care Vice President of Operations Director of Social Work B 122 4S2.61(c)(1)(iii) TREATMENT PLAN PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: The Executive Leadership Team has approved revisions to the current treatment plans that ensure that all therapeutic service interventions are incorporated into specific nursing and social work interventions. Modifications will be implemented by 6/7/13 and will carry forward to the Electronic Health Record upon implementation of treatment plans.	6/28/13

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B 121	Continued From page 7 treatment plan for the problem titled "Suicidal with depression" were pre-printed generic goals that were not individualized for this patient. Generic goals included "the patient will comply with medication regime and report effectiveness." 5. Patient A10, admitted 4/4/13, Master Treatment Plan initiated 4/5/13 had the following long term goals written: "medication evaluation and adjustment as indicated; stabilization of symptoms and collaboration with providers and return to services." Short term goals on the pre-printed treatment plan for the problem titled "Psychosis interfering with functioning" were pre-printed generic goals that were not individualized for this patient. Generic goals included "patient will take all medications as prescribed, and patient will discuss effectiveness and side effects of medications with MD; patient will attend groups in order to interact with peers, practice appropriate social skills and/or improve interpersonal skills; patient will demonstrate an improved ability to care for himself/patient will demonstrate an ability to avoid being exploited by others and patient will evidence ability to adhere to treatment at a less restrictive level of care." 6. Patient A1, admitted 4/5/13, Master Treatment Plan initiated 4/6/13 had the following long term goal written: "mood and symptom stabilization and medication evaluation." Short term goals on pre-printed treatment plans for the following problems titled "Suicidal ideation and/or self-harming behaviors"; and "Risk of harm to others and/or self, resulting from impaired insight/judgment" were pre-printed generic goals that were not individualized for this patient. Generic goals included "patient will demonstrate future orientation; patient will take all medications as prescribed and patient will discuss	B 121	B 122 4S2.61(c)(1)(iii) TREATMENT PLAN Continued The senior leadership team (CMO, CNO, VP Operations) will conduct an in-service on treatment planning by 6/14/13 to unit-based leadership teams ensure that all interventions are individualized with duration and frequency specified by appropriate discipline to ensure that treatment plans are comprehensive, integrated and offer an individualized approach to multidisciplinary treatment. The unit leadership will conduct a similar in-service to unit treatment team members by 6/28/13. Elements of Reeducation on Treatment Planning for medical, nursing and social work staff will include: • Individualized plans of care. • Role of patient and/or family in the treatment planning process. • The modality of family therapy will be incorporated into the patient's plan of care as clinically appropriate. • Incorporation of behavioral plans of care into the treatment planning process. • Review of emergency procedures and incorporation of events into plans of care. • Use of the therapeutic inventory completed by each patient in the identification of triggers on potential coping strategies. • Identification of short and long term goals. • Assignment of responsible party. • Duration and frequency of interventions. • Use of substantiated diagnosis in the treatment planning process. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Revision to Treatment Plan Staff Education	

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B 121	<p>Continued From page 8 effectiveness and side effects of medication with MD; and patient will demonstrate an improved ability to control impulses of aggression and self harm."</p> <p>7. Patient A4, admitted 4/6/13, Master Treatment Plan initiated 4/8/13 had the following long term goal written: "stabilize mood." Short term goals on the pre-printed treatment plan form titled "Suicidal with depression" listed a pre-printed goal as "the patient will demonstrate no suicidal ideation for (blank) of days."</p> <p>8. Patient A6, admitted 4/9/13, Master Treatment Plan initiated 4/10/13 had the following long term goals written: "opiod detox; monitor mood meds; safety."</p> <p>9. Patient A5, admitted 4/10/13, Master Treatment Plan initiated 4/11/13 section had the following long term goals written: "suboxone referral; detox, increase coping skills and education for recovery and collaborate with outpatient."</p> <p>10. Patient A7, admitted 4/10/13, Master Treatment Plan initiated 4/11/13 had the following long term goals written: "safely detox; Intensive Outpatient."</p> <p>B. Interview</p> <p>During an interview with the Vice President for Patient Care (Director of Nursing), on 4/16/13, at 4:50 PM, the treatment plans for patients A3 and A4 were reviewed, the Vice President stated "the treatment goals for these patients are written for the problems identified, but you are right because they are pre-printed they do not address the individual patient needs."</p>	B 121	<p>B 122 4S2.61(c)(1)(iii).TREATMENT PLAN Continued</p> <p>MONITORING/TRACKING: (method, frequency and responsible person)</p> <p>The Director of Social Work will conduct chart audits on a weekly basis 2 per unit, (total of 12 charts representing a sample size greater than 10% of the total hospital beds) to ensure that treatment interventions are individualized and state duration and frequency of such interventions.</p> <p>Results of audits will be reported to the Executive and Unit-based Leadership Teams</p> <p>TITLE OF RESPONSIBLE PERSONS(s):</p> <p>Chief Medical Officer Chief Nursing Officer and Vice President of Patient Care Vice President of Operations Director of Social Work</p> <p>B 123 4S2.61(c)(1)(iv) TREATMENT PLAN</p> <p>PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES:</p> <p>On 5/29/13 the Chief Medical Officer approved changes to the Treatment Planning Policy that outlines documentation standards that include the responsibilities of each member of the treatment team.</p> <p>The senior leadership team (CMO, CNO, Vice President of Operations) will conduct an in-service on treatment planning by 6/14/13 to unit-based leadership teams ensure that responsibilities of each team member are clearly noted on treatment plans.</p> <p>The unit leadership will conduct a similar in-service to unit treatment team members by 6/28/13.</p> <p>Elements of Reeducation on Treatment Planning for</p>	6/28/13	

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B 122 B 122	Continued From page 9 482.61(c)(1)(iii) TREATMENT PLAN The written plan must include the specific treatment modalities utilized. This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility failed to assure on the Master Treatment Plans (MTP) patient specific physician, nursing, social work and therapeutic support services treatment interventions, and/or their frequency, and duration based on the individual needs of all of the active sample patients (A1, A2, A3, A4, A5, A6, A7, A8, A9, A10) These deficiencies resulted in a lack of guidance for staff in providing individualized patient treatment that was purposeful and goal-directed and results in treatment plans that do not reflect a comprehensive, integrated, individualized approach to multidisciplinary treatment Findings include: A. Record Review 1. Patient A8, admitted 2/15/13. MTP initiated 2/19/13. Generic Physician (Psychiatry) "modalities" were checked on a preprinted list of interventions. Example: "In collaboration with team MD will assess for and make any changes in any increase in privileges and/or decrease in degree of observation based on and safety risks [sic] related to degree of impaired judgment or insight." "MD will collaborate with outpatient prescriber and/or PCP (Primary Care Physician)." Generic nursing interventions included, "RN/LPN will administer medications, educate patient regarding medication, assess for effectiveness	B 122 B 122	B 123 482.61(c)(1)(iv) TREATMENT PLAN Continued medical, nursing and social work staff will include: • Individualized plans of care. • Role of patient and/or family in the treatment planning process. • The modality of family therapy will be incorporated into the patient's plan of care as clinically appropriate. • Incorporation of behavioral plans of care into the treatment planning process. • Review of emergency procedures and incorporation of events into plans of care. • Use of the therapeutic inventory completed by each patient in the identification of triggers on potential coping strategies. • Identification of short and long term goals. • Assignment of responsible party. • Duration and frequency of interventions. • Use of substantiated diagnosis in the treatment planning process. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Policy Revision Staff Education MONITORING/TRACKING: (method, frequency and responsible person) The Director of Social Work will conduct chart audits on a weekly basis 2 per unit, (total of 12 charts representing a sample size that is greater than 10% of the total hospital beds) to ensure that treatment interventions are individualized and state duration and frequency of such interventions. Results of audits will be reported to the Executive and Unit-based Leadership Teams	

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B 122	<p>Continued From page 10 and observe for side effects." Social Work generic interventions included "Social Worker will collaborate with family or other caregiver to gather recent history and course of illness." In addition, the section titled "Therapeutic Services Staff" was left blank. No frequency or duration of modalities was designated on the preprinted list.</p> <p>2. Patient A9, admitted 3/28/13; MTP initiated 3/29/13. Generic Physician (Psychiatry) "modalities" were checked on a preprinted list of interventions. Examples are: "MD will complete a Psychiatric evaluation within 24 hrs to determine diagnosis." "MD will collaborate with outpatient prescriber and/or PCP re. Med plan. [sic]" "MD will prescribe medications and titrate for effectiveness." Generic nursing interventions included, "Nursing will administer medications as ordered and reinforce benefits and possible side effects." Social Work generic interventions included, "Social Worker will meet with patient, talk to parent/guardian and complete social history within 72 hours of admission." In addition, the section titled "Therapeutic Services Staff" was left blank. No frequency or duration of modalities were designated on the preprinted list.</p> <p>3. Patient A2, admitted 4/02/13; MTP initiated 4/3/13. Generic Psychiatry Interventions were checked: "In collaboration with team MD will assess for and make any changes in any increase in privileges and/or decrease in degree of observation based upon demonstrated ability to control impulsive behavior." "MD will assess need for psychological testing and order if indicated." "MD will assess the patient for psychiatric disorders, and prescribe medications and titrate and monitor for effectiveness and side effects." Generic nursing interventions included, "RN/LPN will administer medication, educate</p>	B 122	<p>B 123 4S2.61(c)(1)(iv) TREATMENT PLAN Continued</p> <p>TITLE OF RESPONSIBLE PERSONS(s):</p> <p>Chief Medical Officer Chief Nursing Officer and Vice President of Patient Care Vice President of Operations Director of Social Work</p> <p>B 144 482.62(b)(2) MEDICAL STAFF</p> <p>PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES:</p> <p>On 5/29/13 the Chief Medical Officer approved revisions to the treatment planning policy to ensure that he implements procedures to monitor and evaluate the quality and appropriateness of services are provided by the medical staff. Modifications to the policy and treatment planning documents will include prompts for individualized interventions by specific physicians with frequency and durations clearly outlined.</p> <p>The Chief Medical Officer approved revisions to the current treatment plans that include the provision for documentation of a substantiated patient diagnosis. Modifications will be implemented by 6/7/13 and will carry forward to the Electronic Health Record upon implementation of treatment plans.</p> <p>The Chief Medical Officer will provide education to the medical staff regarding changes made to the treatment planning process by 6/14/13.</p> <p>PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION</p> <p>Policy and documentation revisions Medical Staff education</p>	6/14/13	

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B 122	<p>Continued From page 11</p> <p>patient regarding medication, assess for effectiveness, and observe for side effects." In addition, the section titled "Therapeutic Services Staff" was left blank. No frequency or duration of modalities was designated on the preprinted list.</p> <p>In addition, this patient had one episode of physical hold and locked seclusion documented on 4/2/13; the treatment plan for this patient failed to include interventions or modalities that could be utilized to prevent the further use of physical hold and/or locked seclusion.</p> <p>4. Patient AS, admitted 4/04/13; MTP initiated 4/5/13. Generic Physician (Psychiatry) "modalities" were checked on a preprinted list of interventions. Generic psychiatry interventions included "MD will assess previous suicide attempts and current suicide plans or intent, with special emphasis on lethality of methods, intent to die, previous attempts and family history of suicide; MD will coordinate care with previous and future prescribers to discuss treatment plan and possible adjustments; MD will assess whether the patient requires a significant change in medication or other treatment regimen including considerations of ECT and combination medications; MD will assess medication adherence, and promote adherence by removing barriers and developing strategies; MD will recommend Depression workbook or other reading material; MD will evaluate and recommend treatment for co-occurring disorders, especially related to PTSD or Trauma." Generic nursing interventions included, "RN/LPN will administer medication, educate patient regarding medication, assess for effectiveness, and observe for side effects." Generic Social Work interventions included, "Social Worker will meet with patient and complete social history and</p>	B 122	<p>B 144 482.62(b)(2) MEDICAL STAFF Continued</p> <p>MONITORING/TRACKING: (method, frequency and responsible person)</p> <p>The Director of Social Work will conduct chart audits on a weekly basis, 2 per unit, (total of 12 representing a sample size greater than 10% of the total hospital beds) to ensure that treatment interventions are individualized, d state duration and frequency of interventions and include a substantiated diagnosis.</p> <p>Results of audits will be reported to the Executive and Unit-based Leadership Teams</p> <p>TITLE OF RESPONSIBLE PERSONS(6):</p> <p>Chief Medical Officer Chief Nursing Officer and Vice President of Patient Care Vice President of Operations Director of Social Work</p> <p>B148 482.62(d)(1) NURSING SERVICES</p> <p>PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES:</p> <p>1 & 2 Face to face assessment within one hour of a patient placed in restraint and/or seclusion & patient and staff debriefing</p> <p>On 4/22/13 the CNO provided training to clinical educators, clinical managers to review emergency procedures and regulations for MD, LIP or Nursing assessment within one hour of event and the identification of patient specific triggers and role of patient and staff debriefing following a restraint and/or seclusion.</p>	6/28/13

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B 122	<p>Continued From page 12 assessment." In addition, the section titled "Therapeutic Services Staff" was left blank.</p> <p>5. Patient A10, admitted 4/04/13; MTP initiated 4/5/13. Generic Psychiatry interventions were checked on the preprinted list of modalities: "MD will complete a Psychiatric evaluation within 24 hours to determine Axis 1, 2, 3 diagnoses." "MD will collaborate with outpatient prescriber and/or PCP re. Med plan. [sic]" "MD will prescribe medications and titrate for effectiveness." Generic nursing interventions included, "RN/LPN will administer medication, educate patient regarding medication, assess for effectiveness, and observe for side effects" Generic Social Work Interventions included, "Social Worker will collaborate with family and providers." In addition, the section titled "Therapeutic Services Staff" was left blank. No frequency or duration of modalities were designated on the preprinted list.</p> <p>6. Patient A1, admitted 4/05/13; MTP initiated 4/6/13. Generic Psychiatry interventions were checked on the preprinted list of modalities. Examples are: "MD will complete a Psychiatric evaluation within 24 hours to determine Axis 1, 2, 3 diagnoses." "In collaboration with team MD will assess for and make any changes in any increase in privileges and/or decrease in degree of observation based on and safety risks [sic] related to degree of impaired judgment or insight." "MD will collaborate with outpatient prescriber and/or PCP." Generic nursing interventions included, "RN/LPN will administer medication, educate patient regarding medication, assess for effectiveness, and observe for side effects." Generic Social Work interventions included, "Social Worker will complete psychosocial within 72 hours of admission." In addition, the section titled</p>	B 122	<p>B148 482.82(d)(1) NURSING SERVICES Continued</p> <p>The training included:</p> <ul style="list-style-type: none"> • Clarification regarding the intent of the one hour assessment following an emergency procedure. The assessment must take place within 1 hour for all emergency procedures, even those whose duration is very short. • Elements of the one hour assessment include: <ul style="list-style-type: none"> o Patient's immediate situation. o Patient's reaction to the event. o Behavioral and/or medical conditions that may have contributed to the event. o The need to continue or terminate the restraint or seclusion. • Review of debriefing guidelines including the use of the therapeutic inventory assessment in identification of triggers and potential coping strategies. <p>On 5/13/13 CNO approved an on line educational module for certificate of need documentation and assessment within one hour requirements that clinical managers will incorporate into unit based training.</p> <p>On 5/25/13 the on line training was activated on MyLearningPointe.com. 100% nursing staff will receive this training and complete the required competency to ensure that nursing staff are trained in accordance with the one hour assessment requirement by 6/28/13.</p> <p>PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION</p> <p>Staff education and training Development of a comprehensive on line training module for emergency procedures that will be used for orientation and as an annual competency requirement.</p> <p>MONITORING/TRACKING: (method, frequency and responsible person)</p> <p>CNO will ensure that all nursing staff completes the</p>	

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B 122	<p>Continued From page 13</p> <p>"Therapeutic Services Staff" was left blank. No frequency or duration of modalities was designated on the preprinted list.</p> <p>7. Patient A4, admitted 4/06/13; MTP initiated 4/8/13/ 13. Generic Physician (Psychiatry) "modalities" were checked on a preprinted list of interventions. Examples are: "Contact patient's PCP if necessary for collaboration in managing medical issues." "Collaborate with medical clinic LIP's in managing patient's pain, and consider non medication approaches." Generic nursing interventions included, "RN/LPN will administer medication, educate patient regarding medication, assess for effectiveness, and observe for side effects." Generic Social Work interventions included, "Social Worker will meet with patient and complete the Social History and Assessment." In addition, the section titled "Therapeutic Services Staff" was left blank. No frequency or duration of modalities was designated on the preprinted list.</p> <p>8. Patient A6, admitted 4/9/13; MTP initiated 4/10/13. Generic Physician (Psychiatry) "modalities" were checked on a preprinted list of interventions. Examples are: "MD will complete a Psychiatric evaluation within 24 hours to determine Axis1, 2, 3 diagnoses." "MD will collaborate with outpatient prescriber and/or PCP re. Med plan [sic]." Generic Social Work interventions included, "Social Worker will meet with patient and gather social history and assessment." In addition, the section titled "Therapeutic Services Staff" was left blank. No frequency or duration of modalities was designated on the preprinted list.</p> <p>9. Patient A5, admitted 4/10/13; MTP initiated 4/11/13. Generic Physician (Psychiatry)</p>	B 122	<p>B148 482.62(d)(1) NURSING SERVICES Continued</p> <p>comprehensive training module for emergency procedures at orientation and on annual basis.</p> <p>Clinical Managers will conduct 5 chart audits per week to ensure that one hour assessments are completed and that all elements are evaluated.</p> <p>Audit results will be reviewed and analyzed by PI/Risk Manager and reported to Patient Safety and Board of Trustee Quality Meetings</p> <p>TITLE OF RESPONSIBLE PERSONS:</p> <p>Chief Nursing Officer and Vice President of Patient Care PI/Risk Manager Clinical Manager</p> <p>3 & 4 Nursing interventions provide treatment focus and responsibilities of therapeutic activity modalities are included in the patient's treatment plan.</p> <p>The Chief Nursing Officer approved revisions to the current treatment plans that ensure that all interventions are individualized and provide treatment focus and that the therapeutic service interventions are incorporated into specific nursing and social work interventions.</p> <p>Modifications will be implemented by 6/7/13 and will carry forward to the Electronic Health Record upon implementation of treatment plans.</p> <p>The senior leadership team (CMO, CNO, Vice President of Operations) will conduct and in-service on treatment planning by 6/14/13 to unit-based leadership teams ensure that all interventions are individualized with duration and frequency specified by appropriate discipline to ensure that treatment plans are comprehensive, integrated and offer an individualized approach to multidisciplinary treatment.</p>	
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B 122	<p>Continued From page 14</p> <p>"modalities" were checked on a preprinted list of interventions. Examples are: "MD will complete a Psychiatric evaluation within 24 hours to determine Axis 1, 2, 3 diagnoses." "MD will order lab tests and medical consults as needed and incorporate results into the treatment plan." Generic Social Work Interventions included, "Social Worker will meet with patient and gather social history and assessment." In addition, the section titled "Therapeutic Services Staff" was left blank. No frequency or duration of modalities was designated on the preprinted list.</p> <p>10. Patient A7, admitted 4/10/13; MTP initiated 4/11/13. Generic Physician (Psychiatry) "modalities" were checked on a preprinted list of interventions. Examples are: "MD will complete a Psychiatric evaluation within 24 hours to determine Axis 1, 2, 3 diagnoses." "MD will order lab tests and medical consults as needed and incorporate results into the treatment plan." Generic Social Work Interventions included, "Social Worker will meet with patient and gather social history and assessment." In addition, the section titled "Therapeutic Services Staff" was left blank. No frequency or duration of modalities were designated on the preprinted list.</p> <p>B. Interview</p> <p>1. During an interview, on 4/16/13 at 11:00 AM, Clinical Manager 1 was questioned about the blank areas noted under therapeutic services on the treatment plans for patients A1 and A2. Clinical Manager 1 stated "because nursing has really picked up the groups and activities from this section when the changes occurred with the activities department, we really should be including these interventions in our section, under nursing." During this same interview, Clinical</p>	B 122	<p>B148 482.62(d)(1) NURSING SERVICES Continued</p> <p>The unit leadership will conduct a similar in-service to unit treatment team members by 6/28/13.</p> <p>Elements of Reeducation on Treatment Planning for medical, nursing and social work staff will include:</p> <ul style="list-style-type: none"> • Individualized plans of care • Incorporation of behavioral plans of care into the treatment planning process • Review of emergency procedures and incorporation of events into plans of care • Use of the therapeutic inventory completed by each patient in the identification of triggers on potential coping strategies. • Identification of short and long term goals • Assignment of responsible party • Duration and frequency of interventions • Use of substantiated diagnosis in the treatment planning process <p>PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION</p> <p>Revision to Treatment Plan. Staff Education.</p> <p>MONITORING/TRACKING: (method, frequency and responsible person)</p> <p>The Director of Social Work will conduct chart audits on a weekly basis 2 per unit, total of 12 representing a sample size greater than 10% of the total hospital beds to ensure that treatment interventions are individualized and state duration and frequency of such interventions.</p> <p>Results of audits will be reported to the Executive and Unit-based Leadership Teams</p>		

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B 122	Continued From page 15 Manager 1 acknowledged that "staff does put check marks next to the interventions and in many cases all are selected but you are right there is nothing that individualizes these interventions from patient to patient." Clinical Manager 1 further acknowledged that after patient A2 experienced a physical hold restraint and locked seclusion episode, "nursing did not modify interventions for this patient."	B 122	B148 482.62(d)(1) NURSING SERVICES Continued TITLE OF RESPONSIBLE PERSONS(s): Chief Medical Officer Chief Nursing Officer and Vice President of Patient Care Vice President of Operations Director of Social Work B 152 482.62(f) SOCIAL SERVICES PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: To ensure that social work services are appropriate and represent quality care the Director of Social Work on 4/16/13 and 5/23/13 provided clarification to social work staff that: • Psychosocial assessments must provide conclusions and recommendations that describe anticipated social work roles in treatment and discharge planning. • That the conclusion or clinical formulation will guide an integrated and individualized approach to multidisciplinary treatment. • Interventions noted on the master treatment plan will be specific to social work activities. • Information obtained from the patient and/or family will be included in the psychosocial assessment. • The role of patient and/or family members in treatment planning. • The modality of family therapy will be incorporated into the patient's plan of care as clinically appropriate. The current psychosocial assessment will be revised in the electronic health record to include prompts that ensure completeness in documentation standards by 6/28/13. The Director of Social Work will formally train all social workers on psychosocial assessments standards. 100% social workers will be retrained by 6/28/13 and will complete a competency assessment that will become part of social work orientation and an annual competency.	6/28/13
B 123	482.61(c)(1)(iv) TREATMENT PLAN The written plan must include the responsibilities of each member of the treatment team. This Standard is not met as evidenced by: Based on record review and interview the facility failed to ensure that the name of staff persons responsible for specific aspects of care were listed on the Master Treatment Plans for 10 of 10 active sample patients (A1, A2, A3, A4, A5, A6, A7, A8, A9 and A10). This practice resulted in the facility's inability to monitor staff accountability for specific modalities. Findings Include: A. Record Review 1. Patient A8, admitted 2/15/13, Master Treatment Plan initiated 2/19/13: no responsible person was identified for carrying out the interventions identified in the physician, social work, nursing or therapeutic support activities sections of the treatment plan.	B 123		

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B 123	Continued From page 16 2. Patient A9, admitted 3/28/13, Master Treatment Plan initiated 3/29/13: no responsible person was identified for carrying out the interventions identified in the physician, social work, nursing or therapeutic support activities sections of the treatment plan. 3. Patient A2, admitted 4/2/13, Master Treatment Plan initiated 4/3/13: no responsible person was identified for carrying out the interventions identified in the physician, social work, nursing or therapeutic support activities sections of the treatment plan. 4. Patient A3, admitted 4/4/13, Master Treatment Plan initiated 4/5/13: no responsible person was identified for carrying out the interventions identified in the physician, social work, nursing or therapeutic support activities sections of the treatment plan. 5. Patient A10, admitted 4/4/13, Master Treatment Plan initiated 4/5/13: no responsible person was identified for carrying out the interventions identified in the physician, social work, nursing or therapeutic support activities sections of the treatment plan. 6. Patient A1, admitted 4/5/13, Master Treatment Plan initiated 4/6/13: no responsible person was identified for carrying out the interventions identified in the physician, social work, nursing or therapeutic support activities sections of the treatment plan. 7. Patient A4, admitted 4/6/13, Master Treatment Plan initiated 4/8/13: no responsible person was identified for carrying out the interventions identified in the physician, social work, nursing or	B 123	B 152 482.62(f) SOCIAL SERVICES Continued The Director of Social Work will provide monthly seminars to social work staff on conducting psychosocial assessments for 4 months to ensure that assessments meet standards. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Staff Education and Training Competency Assessment Modification to the electronic psychosocial assessment MONITORING/TRACKING: (method, frequency and responsible person) The Director of Social Work will conduct random chart audits, 2 charts per week per inpatient unit, to assess comprehensiveness of psychosocial assessments. Her findings will be reported to the Executive Leadership (CMO, CNO, and Vice President of Operations) and unit based leadership teams. TITLE OF RESPONSIBLE PERSONS(s): Director of Social Work Vice President of Operations B 158 482.62(g)(2) THERAPEUTIC ACTIVITIES PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: The Chief Nursing Officer and Vice President of Operations have implemented a formal structure for training of staff and monitoring the activity therapy program. Clinical Managers will conduct a formal assessment of mental workers currently running groups and activities to ensure the competency of mental health workers in group programming.	6/28/13

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B 123	<p>Continued From page 17</p> <p>therapeutic support activities sections of the treatment plan.</p> <p>8. Patient A6, admitted 4/9/13, Master Treatment Plan initiated 4/10/13 had no responsible person identified for carrying out the interventions identified in the nursing or therapeutic support activities sections of the treatment plan.</p> <p>9. Patient A5, admitted 4/10/13, Master Treatment Plan initiated 4/11/13 had no responsible person identified for carrying out the interventions in the therapeutic support activities section of the treatment plan.</p> <p>10. Patient A7, admitted 4/10/13, Master Treatment Plan initiated 4/11/13: no responsible person was identified for carrying out the interventions identified in the physician, social work, nursing or therapeutics activities sections of the treatment plan.</p> <p>11. Facility policy titled "Treatment Planning Policy and Procedure," dated 09/2011 states "a patient's treatment plan will provide documentation of interventions with the name of the staff member responsible."</p> <p>B. Interview</p> <p>1. During an interview, on 4/16/13, Clinical Manager 1 was asked how it is determined who has the responsibility for carrying out a particular intervention. She stated "everyone is responsible, the charge nurse each shift should have this responsibility for nursing." She agreed that the treatment plans of patients A1 and A2 did not identify any particular person in any discipline that has the ultimate responsibility for carrying out the interventions. She also stated when</p>	B 123	<p>B 158 482.62(g)(2) THERAPEUTIC ACTIVITIES Continued</p> <p>Relevant competencies will include:</p> <ul style="list-style-type: none"> • How to run a group • Basics of group process • Motivational interviewing and treatment • Running recovery groups • Other as determined by manager <p>Each competency assessment will include demonstration testing and documentation of previous group experience and or training and identification of goals for individual supervision and professional development.</p> <p>100% of MHWs running groups will complete competency by 6/21/13. No MHW may run a group without completion of the required competency. Copies of competencies will be kept in HR file.</p> <p>The Clinical Manager will conduct random audits of two groups per week to evaluate curriculum and to assess staff skill and patient response.</p> <p>Additionally the Department of Clinical Education will be expanded to include an advanced practice clinician or clinical nurse specialist whose primary responsibility will be on group programming, supervision and training of MHW staff, curriculum development and oversight.</p> <p>PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION</p> <p>Implementation of formal supervisory structure for group programming Implementation of competency assessment Expansion of Clinical Education Department</p> <p>MONITORING/TRACKING: (method, frequency and responsible person)</p> <p>Clinical Managers will conduct random audit of two groups per week to evaluate curriculum and assess</p>	

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B 123	Continued From page 18 questioned about the blank areas, noted under therapeutic services, on the treatment plans for patients A1 and A2 "because nursing has really picked up the groups and activities from this section when the changes occurred with the activities department, we really should be including these interventions in our section, under nursing. We had a meeting a few weeks ago but the forms have not been revised yet." 2. During an interview with the Vice President for Patient Care (DON), on 4/16/13, at 4:50 PM, the treatment plans for patients A3 and A4 were reviewed. She stated "nursing should have included those interventions from the section on therapeutic activities by writing them in under the pre-printed section for nursing."	B 123	B 158 482.62(g)(2). THERAPEUTIC ACTIVITIES Continued staff skill and patient response. Commencing 6/28/13 the CNO will conduct random quarterly audit of HR competency file to ensure that staff are appropriately trained. TITLE OF RESPONSIBLE PERSONS(s): Chief Nursing Officer and Vice President of Patient Care Vice President of Operations Clinical Managers	
B 144	482.62(b)(2) MEDICAL STAFF The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff. This Standard is not met as evidenced by: Based on record review and interview it was determined that the Medical Director failed: 1. To assure that treatment plans for 10 of 10 active sample patients records (A1, A2, A3, A4, A5, A6, A7, A8, A9, and A10) were individualized. Physician Interventions were generic, and similar for all treatment plans, regardless of the patients' problems. These deficiencies resulted in a lack of guidance for staff in providing individualized patient treatment that was purposeful and goal-directed. Refer to B122 for examples of generic physician interventions. 2. To assure that the facility identified a diagnosis	B 144		

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B 144	Continued From page 19 that served as the primary focus in the treatment plans of 9 of 10 active sample patients. Refer to B120.	B 144			
B 148	482.62(d)(1) NURSING SERVICES The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished. This Standard is not met as evidenced by: Based on record review and interview the Vice President for Patient Care (Director of Nursing) failed to: 1) Implement policies and procedures for proper training of RNs who were authorized to conduct 1-hour face-to-face evaluations of patients placed in restraint and/or seclusion. The training did not include instruction on how to assess for medical causes of behavior that may require restraint, and the form used to document the evaluation did not include a section that promoted the performance and documentation of a medical evaluation. In addition, in the case of patient A2, who was placed in restraint, the 1-hour face-to-face evaluation was performed by a RN with no documentation of any training at all. This resulted in patient A2 not being properly assessed to determine the clinical reason for the assaultive behavior, and could result in the same outcome for other patients who require seclusion and/or restraint. 2) Ensure that nursing completed a proper debriefing of patient and staff after an incident of physical restraint and locked seclusion on patient	B 148			

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B 148	<p>Continued From page 20</p> <p>A2, and ensure the patient's Master Treatment Plan included interventions directed at de-escalation techniques to be utilized prior to the future need for seclusion or restraint.</p> <p>These failures have the potential for staff to control patient behaviors by the most restrictive measures, because triggers leading to aggressive/assaultive behaviors are not being evaluated post episode.</p> <p>3) Ensure that nursing interventions provided a treatment focus and responsible person for 10 of 10 active sample patients (A1, A2, A3, A4, A5, A6, A7, A8, A9 and A10) rather than implementing interventions that were generic routine functions expected of the nursing discipline. This results in a lack of treatment clarity;</p> <p>4) Ensure that the responsibilities of therapeutic activity modalities delegated to nursing be included in the patient's treatment plan for 10 of 10 active sample patients (A1, A2, A3, A4, A5, A6, A7, A8, A9 and A10). This failure results in the interventions not being included to assist the patient in meeting their treatment goals.</p> <p>Findings include:</p> <p>Face to Face Evaluation</p> <p>A. Record Review</p> <p>1. Patient A2, admitted 4/2/13, required a physical hold (6:11-6:12 PM) and locked seclusion on 4/6/13 (6:12 PM-6:49 PM) for assaultive behavior. The face to face evaluation required to be</p>	B 148		

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B 148	<p>Continued From page 21</p> <p>completed within one hour of the episode of physical hold and locked seclusion was documented as completed at 7:54 PM on 4/6/13 by RN1. The face to face evaluation completed by RN1 did not include a comprehensive physical assessment of the patient. The one hour assessment form utilized by the facility did not include a component for completion of a physical assessment of the patient.</p> <p>2. Facility Policy titled "Safety Emergencies: Restraint, Seclusion and Therapeutic Holding of Patients" last approved 4/2013, in the section titled "In-Person Evaluation of Patient" states, "all Brattleboro Retreat RN's shall complete one hour face to face competency prior to performing this evaluation." Section "Patient record notation" #1 states, "1 hour face to face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior [sic]."</p> <p>3. The employee orientation and annual training file for RN1 was reviewed for documentation of training on how to conduct a face to face evaluation for restraint and/or seclusion. No evidence of training was found in the file.</p> <p>B. Interview</p> <p>1. On 4/17/13 at 9:05 AM, Clinical Educator 1 validated that "there is no evidence of training in this nurse's (RN1's) file."</p> <p>2. During an interview with Clinical Educator 1 on 4/17/13 at 10:00 AM, a copy of the facility "RN Face to Face Assessment of the Patient in Restraint and Seclusion" packet was reviewed, with discussion that there was no section for</p>	B 148			

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B 148	<p>Continued From page 22</p> <p>evaluation of a physical component that would affect the patient's behavior. The Clinical Educator stated, "I was not aware that there is an expectation that the assessment was to determine if there is a medical or other reason for the patient's behavior. I teach the RN's that they are to look at if there were physical complications or injuries as a result of the restraint."</p> <p>Patient and Staff Debriefing</p> <p>A. Record Review</p> <p>1. Patient A2, admitted 4/2/13, required a physical hold (6:11-6:12 PM) and locked seclusion, 4/6/13 (6:12 PM-6:49 PM) for assaultive behavior. After the incident there was no debriefing completed with the patient and/or staff and no addition made to the patient's treatment plan, which had been initiated for "risk of harm due to impulsive behavior" on 4/3/13.</p> <p>2. Facility policy titled, "Safety Emergencies: Restraint, Seclusion and Therapeutic Holding of Patients," dated 04/2013, notes "a debriefing will occur with all staff that participated in the restraint or seclusion or physical hold and be documented on the staff debriefing form."</p> <p>B. Interview</p> <p>During an interview with the Clinical Manager 1, at 10:50 AM on 4/16/13, she stated "we should have done a debriefing and I think that may have gotten lost with our transition to the electronic medical record...."</p> <p>Treatment Plans</p> <p>A. Record Review</p>	B 148		

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B 148	Continued From page 23 1. Patient A8, admitted 2/15/13; MTP Initiated 2/19/13. Generic nursing interventions included, "RN/LPN will administer medications, educate patient regarding medication, assess for effectiveness and observe for side effects." Nursing also did not take responsibility for incorporating the therapeutic activities, which had been delegated to them with the elimination of the Support Services Department, under their section of the treatment plan. Additionally, no nurse was identified as a responsible person for carrying out the interventions. 2. Patient A9, admitted 3/28/13; MTP Initiated 3/29/13. Generic nursing interventions included, "Nursing will administer medications as ordered and reinforce benefits and possible side effects." Nursing also did not take responsibility for incorporating the therapeutic activities, which had been delegated to them with the elimination of the Support Services Department, under their section of the treatment plan. Additionally, no nurse was identified as a responsible person for carrying out the interventions. 3. Patient A2, admitted 4/02/13; MTP initiated 4/3/13. Generic nursing interventions included, "RN/LPN will administer medication, educate patient regarding medication, assess for effectiveness, and observe for side effects." Nursing also did not take responsibility for incorporating the therapeutic activities, which had been delegated to them with the elimination of the Support Services Department, under their section of the treatment plan. Additionally, no nurse was identified as a responsible person for carrying out the interventions. 4. Patient A3, admitted 4/04/13; MTP initiated	B 148			

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B 148	<p>Continued From page 24</p> <p>4/5/13. Generic nursing interventions included, "RN/LPN will administer medication, educate patient regarding medication, assess for effectiveness, and observe for side effects." Nursing also did not take responsibility for incorporating the therapeutic activities, which had been delegated to them with the elimination of the Support Services Department, under their section of the treatment plan. Additionally, no nurse was identified as a responsible person for carrying out the interventions.</p> <p>5. Patient A10, admitted 4/04/13; MTP initiated 4/5/13. Generic nursing interventions included, "RN/LPN will administer medication, educate patient regarding medication, assess for effectiveness, and observe for side effects." Nursing also did not take responsibility for incorporating the therapeutic activities, which had been delegated to them with the elimination of the Support Services Department, under their section of the treatment plan. Additionally, no nurse was identified as a responsible person for carrying out the interventions.</p> <p>6. Patient A1, admitted 4/05/13; MTP initiated 4/6/13. Generic nursing interventions included, "RN/LPN will administer medication, educate patient regarding medication, assess for effectiveness, and observe for side effects." Nursing also did not take responsibility for incorporating the therapeutic activities, which had been delegated to them with the elimination of the Support Services Department, under their section of the treatment plan. Additionally, no nurse was identified as a responsible person for carrying out the interventions.</p> <p>7. Patient A4, admitted 4/06/13; MTP initiated 4/8/13/ 13. Generic nursing interventions</p>	B 148		

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B 148	<p>Continued From page 25</p> <p>included, "RN/LPN will administer medication, educate patient regarding medication, assess for effectiveness, and observe for side effects." Nursing also did not take responsibility for incorporating the therapeutic activities, which had been delegated to them with the elimination of the Support Services Department, under their section of the treatment plan. Additionally, no nurse was identified as a responsible person for carrying out the interventions.</p> <p>8. Patient A6, admitted 4/9/13; MTP initiated 4/10/13. Nursing did not take responsibility for incorporating the therapeutic activities, which had been delegated to them with the elimination of the Support Services Department, under their section of the treatment plan.</p> <p>9. Patient A5, admitted 4/10/13; MTP initiated 4/11/13. Nursing did not take responsibility for incorporating the therapeutic activities, which had been delegated to them with the elimination of the Support Services Department, under their section of the treatment plan.</p> <p>10. Patient A7, admitted 4/10/13; MTP initiated 4/11/13. Nursing did not take responsibility for incorporating the therapeutic activities, which has been delegated to them with the elimination of the Support Services Department, under their section of the treatment plan.</p> <p>B. Interview</p> <p>1. During an interview, on 4/16/13, Clinical Manager 1 was asked how it is determined who has the responsibility for carrying out a particular intervention. She stated "everyone is responsible, the charge nurse each shift should have this responsibility for nursing." She agreed</p>	B 148		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 474001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER BRATTLEBORO RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301		
(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
B 148	Continued From page 26 that the treatment plans of patients A1 and A2 did not identify any particular person in any discipline that had the ultimate responsibility for carrying out the interventions. When questioned about the blank areas noted under therapeutic services on the treatment plans for patients A1 and A2 she stated, "because nursing has really picked up the groups and activities from this section when the changes occurred with the activities department, we really should be including these interventions in our section, under nursing. We had a meeting a few weeks ago but the forms have not been revised yet." 2. During an interview with the Vice President Patient Care (DON), on 4/16/13, at 4:50 PM, the treatment plans for patients A3 and A4 were reviewed; she stated "nursing should have included those interventions from the section therapeutic activities by writing them in under the pre-printed section for nursing."	B 148		
B 152	482.62(f) SOCIAL SERVICES There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. This Standard is not met as evidenced by: Based upon record review, policy review, and interview it was determined that the Director of Social Services failed: 1. To assure the completeness of the Psychosocial Assessments. Assessments did not include specific roles for the Social Worker in the inpatient care of each patient. (Refer to B-108) 2. To assure that the Master Treatment Plans of 10 of 10 active sample patients (A1, A2, A3, A4,	B 152		

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B 152	<p>Continued From page 27</p> <p>A5, A6, A7, A8, A9 and A10) included social work interventions. The listed social work interventions were generic social work activities. This deficiency can result in the lack of integrated focus for patient treatment and fragmented care coordination.</p> <p>Findings include:</p> <p>A. Record Review</p> <ol style="list-style-type: none"> 1. Patient A8, admitted 2/15/13; MTP initiated 2/19/13. Social Work generic interventions included, "Social Worker will collaborate with family or other caregiver to gather recent history and course of illness." 2. Patient A9, admitted 3/28/13; MTP initiated 3/29/13. Social Work generic interventions included, "Social Worker will meet with patient, talk to parent/guardian and complete social history within 72 hours of admission." 3. Patient A2, admitted 4/2/13; MTP initiated 4/3/13. Social Work generic interventions included, "Social Worker will collaborate with family or caregiver, with particular reference to ability to manage impulsive behaviors in a variety of settings." 4. Patient A3, admitted 4/4/13; MTP initiated 4/5/13. Generic Social Work interventions included, "Social Worker will meet with patient and complete social history and assessment." 5. Patient A10, admitted 4/04/13; MTP initiated 4/5/13. Generic Social Work interventions included, "Social Worker will collaborate with family and providers." 	B 152		

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B 152	Continued From page 28 6. Patient A1, admitted 4/05/13; MTP initiated 4/6/13. Generic Social Work interventions included, "Social Worker will complete psychosocial within 72 hours of admission." 7. Patient A4, admitted 4/06/13; MTP initiated 4/8/13/ 13. Generic Social Work interventions included, "Social Worker will meet with patient and complete the Social History and Assessment." 8. Patient A6, admitted 4/9/13; MTP initiated 4/10/13. Generic Social Work interventions included, "Social Worker will meet with patient and gather social history and assessment." 9. Patient A5, admitted 4/10/13; MTP initiated 4/11/13. Generic Social Work interventions included, "Social Worker will meet with patient and gather social history and assessment." 10. Patient A7, admitted 4/10/13; MTP initiated 4/11/13. Generic Social Work interventions included, "Social Worker will meet with patient and gather social history and assessment." B. Interview Surveyor interviewed the Hospital Director of Social Services on 4/17/13 at 3:30 PM. The above findings were presented to the Director of Social Services who acknowledged them.	B 152		
B 158	482.62(g)(2) THERAPEUTIC ACTIVITIES The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.	B 158		

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B 158	<p>Continued From page 29</p> <p>This Standard is not met as evidenced by: Based on record review and interview the facility failed to provide qualified staff to assure that the therapeutic activities being conducted are meeting the needs of the individual patients. Specifically, the facility failed to develop a formal structure for training of staff and monitoring of the activity therapy program. This failure resulted in the lack of therapeutic interventions being incorporated into the individual patient treatment plans to assist the patient in meeting their goals for 10 of 10 active sample patients (A1, A2, A3, A4, A5, A6, A7, A8, A9 and A10).</p> <p>Findings Include:</p> <p>A. Record Review</p> <ol style="list-style-type: none"> 1. Patient A8, admitted 2/15/13, Master Treatment Plan initiated 2/19/13. The section titled Therapeutic Services Staff Intervention was left blank. 2. Patient A9, admitted 3/28/13, Master Treatment Plan initiated 3/29/13. The section titled Therapeutic Services Staff Intervention was left blank. 3. Patient A2, admitted 4/2/13, Master Treatment Plan initiated 4/3/13. The section titled Therapeutic Services Staff intervention was left blank. 4. Patient A3, admitted 4/4/13, Master Treatment Plan initiated 4/5/13. The section titled Therapeutic Services Staff Intervention was left blank. 5. Patient A10, admitted 4/4/13, Master 	B 158		

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B 158	<p>Continued From page 30</p> <p>Treatment Plan initiated 4/5/13. The section titled Therapeutic Services Staff intervention was left blank.</p> <p>6. Patient A1, admitted 4/5/13, Master Treatment Plan initiated 4/6/13. The section titled Therapeutic Services Staff Intervention was left blank.</p> <p>7. Patient A4, admitted 4/6/13, Master Treatment Plan initiated 4/8/13. The section titled Therapeutic Services Staff intervention was left blank.</p> <p>8. Patient A6, admitted 4/9/13, Master Treatment Plan initiated 4/10/13. The section titled Therapeutic Services Staff intervention was left blank.</p> <p>9. Patient A5, admitted 4/10/13, Master Treatment Plan initiated 4/11/13. The section titled Therapeutic Services Staff intervention was left blank.</p> <p>10. Patient A7, admitted 4/10/13, Master Treatment Plan initiated 4/11/13. The section titled Therapeutic Services Staff intervention was left blank.</p> <p>B. Interview</p> <p>1. During an interview with Clinical Manager 1 and Clinical Manager 2, on 4/16/13 at 11:15 AM, they discussed the changes that have occurred with the elimination of the therapeutic activities department in November 2012. Clinical Manager 1 verified with Social Worker 1, via a telephone call, that the activities assessment that had previously been completed by the Activity Therapy staff was currently being done as part of</p>	B 158		

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B 158	<p>Continued From page 31</p> <p>the psychosocial assessment. Social Worker 1 identified the particular component of the psychosocial assessment that currently included the therapeutic activities component. Clinical Manager 1 stated "groups and activities are being done by various people but most are done by nursing, particularly the Mental Health Workers (MHWs)." When questioned what type of training for staff, particularly MHWs was done to prepare for the elimination of the therapeutic activities department, Clinical Manager 2 stated "we have done some training on groups, but it was not mandatory." Later during the day, 3:50 PM, on 4/16/13, Clinical Manager 2 reported to the surveyor that 5 different group training sessions, on different topics, had been offered since December 2012. Currently there are "175 MHW's, but only about 9% of the MHW's attended the training because it was not mandatory." The employee training files for MHW1, MHW2 and MHW3 were reviewed by the surveyor with Clinical Manager 2 who validated that there was no evidence of training on groups in any of these files either as part of orientation upon new hire or during annual training. Clinical Manager 2 stated "this is still very new for us, we are still identifying what training we need to put into place, but certainly 9% is not good."</p> <p>2. As a result of the changes made in November, 2012, currently there is no one person responsible for monitoring the provision of the therapeutic activities. This information was acknowledged by the Vice President of Patient Care during the interview on 4/16/13 at 4:50 PM.</p>	B 158		