

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

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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 black ink, appearing to read "Kathy Mackin". The signature is written in a cursive, flowing style.

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: 05/17/2013  
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  04/18/2013
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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
A 000	INITIAL COMMENTS	A 000	A000 Summary Statement	
A 020	<p>An unannounced full survey was conducted on 4/14/13 - 4/18/13 to assess compliance with the Acute Care Hospital Regulations as authorized by the Federal Centers for Medicare and Medicaid Services. The survey also included investigation of multiple complaints (Acts numbers 9498, 9630, 9640, 9648, 9660, 9685, 9698, 9705, 9699, 9717, 9679, 9724, 9737, 9793, 9792 and 9794) and facility reports. Based on the information gathered, the hospital was determined to not be in compliance with Conditions of Participation for Federal State and Local Laws and Patient Rights.</p> <p>482.11 COMPLIANCE WITH LAWS</p> <p>Compliance with Federal, State and Local Laws</p> <p>This CONDITION is not met as evidenced by: Based on record review, staff and patient interview, the hospital failed to be in compliance with the Condition of Participation for Federal, State and Local Laws. The hospital failed to be in compliance with The State of Vermont Statute Title 18, Chapter 42: Bill of Rights for Hospital patients for 1 applicable patient (Patient #5) and Title 33, Chapter 69 "Reports of Abuse, Neglect and Exploitation of Vulnerable Adults" for 1 applicable patient. (Patient #3). Findings include:</p> <p>1. Per State Statute 1852 Patients' Bill of Rights for Hospital patients: "(1) The patient has the right to considerate and respectful care at all times and under all circumstances with recognition of his or her own personal dignity."</p> <p>Per record review Patient #5, who had been admitted to the AIU (Adult Intensive Unit) on an involuntary basis on 3/10/13, was involved in 3</p>	<p>A 020 482.11 COMPLIANCE WITH LAWS</p> <p>1.) Patient Bill of Rights 1852 (1) – Respectful and Considerate Care</p> <p>PLAN OF CORRECTION FOR CITED DEFICIENCY Immediately following survey, on 4/18/13, the governing body consisting of the CEO, CMO, CNO and other executive team members conducted a comprehensive review of all policies and procedures that govern restraint and seclusion and requirements for reporting allegations of mistreatment and determined that existing policies meet regulatory requirements and that the citations noted reflect individual performance and/or systemic issues. The CEO immediately informed the Chairman of the Board of Trustees of the initial survey findings to ensure that the governing body is sufficiently informed and that the layering of governance between the board, executive and management teams ensures that transparency of all regulatory concerns is achieved and that the organization remains in compliance with Conditions of Participation for Federal, State and Local Laws and Patient Rights.</p> <p>There are several important components that are in place to assure that executive leadership and the board are working together to ensure the support of</p>	5/3/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dr. DSO, MPH* TITLE: President & CEO (X8) 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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A 020	<p>Continued From page 1</p> <p>separate incidents, on 3/22/13, 4/10/13 and 4/14/13, respectively, in which staff treated him/her in a disrespectful and undignified manner as evidenced by the following:</p> <p>a.) A nurse's note, dated 4/10/13 at 7:54 AM, stated Patient #5 had requested Seroquel 100 mg at 5:30 AM and when provided the patient bit the pill in half, "spit out, refused to comply with medication mouth check. When taught to regarding this safety issue threw dirty water (that [s/he] had been drinking when taking meds and allowing fluids from mouth back into cup). Instructed to QR (Quiet Room), refused, immediately escorted to QR - began kneeling and kicking staff....Refused to redirect - secluded for immediate risk of harm to others due to assaultive behavior." The note further indicated that the patient was grabbing at staff, attempting to exit the QR, and subsequently received an injection of zyprexa, at 5:50 AM. The note stated there had been an attempt to process the events leading to seclusion with the patient who reportedly stated his/her intent to continue to attempt to assault staff, engage in disruptive behavior with goal of expediting discharge and "stated, as well, intent of lodging allegations against staff/hospital..." The patient reportedly refused to contract for safety and remained in seclusion at the end of the shift.</p> <p>During interview, at 4:05 PM on 4/15/13, Patient #5 stated s/he had some concerns with some staff whom s/he felt used restraints/seclusion as punishment. The patient gave examples of this concern stating that on one occasion s/he threw a cup of fluid at a staff member when angry, and that particular staff member engaged the patient</p>	A 020	<p>A 020 482.11 COMPLIANCE WITH LAWS Continued</p> <p>quality improvement initiatives.</p> <p>The quality department monitors all plans of correction and creates a dashboard that reports this data.</p> <p>The CEO and the Board meet regularly to review dashboard quality indicators and the CEO regularly informs the Board Chair of any concerning trends. Immediate action steps are discussed and implemented including the initiation of a relevant quality action/ performance improvement team.</p> <p>In review of the specific citations related to patient rights and the appropriate use of restraint and seclusion we identified the following:</p> <ul style="list-style-type: none"> <li>• That staff are experiencing significant challenges related to treating involuntary patients, some of whom are forensic, who are often undertreated as a result of their prolonged noncompliance with medication recommendations and external system issues that pose barriers to treatment.</li> <li>• That we have opportunity for increased staff education, training, support and supervision regarding treatment challenges and patient rights.</li> <li>• As a Just Culture organization we have an opportunity for promoting a "learning culture" that will lead to improvement in patient care and reduction of risk.</li> <li>• That a component of the learning culture we envision is tied to the development of our leaders. We are currently engaged in this process with a nationally renowned expert and believe that developing our leaders will help change the organizational culture.</li> <li>• That we have an opportunity to enhance our supervision of the leadership team on the Adult Intensive Unit as this unit treats the majority of patients who are admitted on an involuntary basis. Our goals are to improve internal processes and to enhance teamwork.</li> <li>• That at an internal system's level we have the opportunity to improve oversight of emergency</li> </ul>	

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A 020	<p>Continued From page 2</p> <p>in conversation which helped to de-escalate his/her anger. Patient #5 stated that, however, on other recent occasions, s/he had become angry when staff members had been, what s/he felt, was disrespectful in their treatment of him/her and s/he had thrown fluid at them. S/he stated the response had been to immediately punish him/her; by use of restraints, at times just grabbing his/her arms and causing pain, and/or seclusion. S/he further indicated that staff, at times make comments to him/her such as "I'm going to take you down". Patient #5 also stated that s/he has filed multiple complaints and staff didn't like that s/he reported them, but s/he would continue to report concerns related to treatment and safety.</p> <p>Per interview, at 7:38 AM on 4/16/13 and at 7:50 AM on 4/17/13, both MHW (Mental Health Worker) #1 and MHW #2 stated, during each of their respective individual interviews, that they had been witness to the following events during the early morning hours of 4/10/13: at approximately 5:00 AM Patient #5 had requested a specific amount of Seroquel, was informed the only available dose was a larger dose and s/he agreed to take it. When Nurse #1 brought the medication the patient bit the pill in half, swallowed half and put the remaining piece back in the plastic med cup. Each MHW stated that Nurse #1 then started to speak to Patient #5 in a loud voice telling the patient s/he was tired of the patient manipulating his/her meds. The patient, who was sitting in a chair, became angry and threw the remaining water from the cup at Nurse #1 who immediately grabbed the patient by the arm, pulled him/her from the chair in which s/he was sitting, and placed him/her in locked door</p>	A 020	<p>A 020 482.11 COMPLIANCE WITH LAWS Continued</p> <p>procedures of restraint and seclusion. The citations noted for patient #5 that occurred on 3/22/13; 4/10/13, and 4/15/13 were each internally investigated by the Clinical Manager, CNO, P/Risk Manager and all were reported to Adult Protective Services. The CNO and Clinical Manager provided staff retraining, education and progressive disciplinary action as indicated.</p> <p>* 1/1/13 to 5/31/13 forensic admissions were 14 or 1% of the total 1488 admissions. The nature of the legal charges include: unlawful trespass, simple assault, violation of a condition of release, violation of an abuse/prevention order.</p> <p>EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES:</p> <p>1.) On 4/15/13, during the survey, executive leadership team (comprised of the Chief Medical Officer, Chief Nursing Officer and Vice President of Operations) immediately conducted training sessions with inpatient clinical teams to address:</p> <ul style="list-style-type: none"> <li>• Emergency procedures including seclusion and restraint.</li> <li>• Compliance with federal, state and local laws including reporting of suspected abuse, neglect and exploitation.</li> <li>• Requirements for treatment planning.</li> <li>• Legal aspects of care.</li> <li>• Documentation standards including use of the Internal on line incident reporting module for all incidents. <ul style="list-style-type: none"> <li>o All staff receives training and orientation on incident reporting upon hire. Each unit maintains a training manual for reporting on each unit. The incident reporting provides a database for quality and regulatory review.</li> </ul> </li> </ul> <p>The Clinical Managers disseminated this information to all staff via staff meetings and /or written correspondence.</p>	

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A 020	<p>Continued From page 3</p> <p>seclusion. Both MHWs stated there had been no attempt to verbally de-escalate the patient, no discussion at all prior to hands on by Nurse #1. Nurse #1 then left the ALSA unit and returned with Nurse #2 who brought medication for the patient to take by mouth. Nurse #1 made a statement that the patient had spit the medication out and then both Nurse #1 and Nurse #2 left and returned, within several minutes, to the seclusion room where Patient #5 was sitting quietly on the floor. The patient was placed in a face down position on the floor and restrained in that position by 3 staff members while Nurse #2 gave the patient an injection. All staff then left the room. MHW #1 stated that Nurse #1 continued to check on the patient every 10 to 15 minutes and discussed the conditions of release from seclusion. S/he stated that in addition to asking the patient if s/he could contract for safety and not be assaultive, Nurse #1 also asked the patient if s/he was going to continue to make allegations against staff.</p> <p>Nurse #1 confirmed, during interview at 9:13 AM on 4/18/13, that the patient had been given Seroquel, broke the pill in half and returned half to the med cup. S/he stated that Patient #5 refused to allow a mouth check and became angry and threw the water (in which Nurse #1 felt the patient had spit oral secretions), into Nurse #1's face and the nurse responded by telling the patient, in a loud voice, "seclusion room now." Nurse #1 confirmed that there had been no attempt to employ less restrictive measures to de-escalate the patient's behavior. S/he also agreed that in hind sight s/he could have stepped away from the patient to give time to de-escalate but felt, based on past experience with the patient</p>	A 020	<p>A 020 482.11 COMPLIANCE WITH LAWS Continued</p> <p>The Executive Triad Leadership Team held follow up sessions with the all staff on the Adult Intensive Unit on Tyler 4 (location of primary citations) on 4/23/13, 5/8/13 and 5/10/13.</p> <p>2.) On 4/25/13 the Executive Triad Leadership Team, comprised of the Chief Medical Officer, Chief Nursing Officer and Vice President of Operation increased formal supervision and oversight of the adult intensive unit (AIU) from monthly to weekly scheduled meetings to provide operational oversight. In addition the Executive Triad Team has increased its presence on the Adult Intensive Unit to provide additional clinical supervision, role-modeling and support.</p> <p>3.) On 4/4/13 the CMO and Senior Medical Director implemented a formal case consultation seminar/series, meeting twice per month to provide opportunity for comprehensive case review for patients who pose significant treatment challenges. The consultation forum is designed to promote a collaborative problem solving non-blaming culture of patient care and professional development. Patient # 5 was the first patient reviewed. In attendance were six board certified psychiatrists, several nursing staff and mental health workers, several social work/clinicians, quality and risk personnel and several executive team members including the CEO.</p> <p>Topics discussed during this consultation included:</p> <ul style="list-style-type: none"> <li>• What constitutes an emergency procedure (restraint/seclusion)?</li> <li>• Balancing of Patient Rights and Safety.</li> <li>• Challenges of caring for a patient with a significant mental illness and a traumatic brain injury who refuses pharmacological interventions.</li> <li>• Patient # 5's behavior and its impact on other patients' treatment.</li> <li>• Staff responses to patient # 5 and "compassion fatigue."</li> </ul> <p>The expertise provided in this case consultation identified the need for increased case discussion with staff of all disciplines and on each shift and the need</p>		

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A 020	<p>Continued From page 4</p> <p>that the patient might attempt to assault staff. Nurse #1 stated that after being placed in LDS (Locked Door Seclusion) Patient #5 was given the option of taking Zyprexa (an antipsychotic drug) by mouth or injection. Nurse #1 stated the patient took the oral Zyprexa and spit it out. Nurse #1 stated s/he left the LDS and contacted the physician by phone and explained that s/he was not certain how much, if any, of the Zyprexa the patient had received orally. S/he stated that the physician ordered Zyprexa IM. The nurse confirmed that upon return to the LDS, despite the fact that Patient #5 was sitting quietly on the floor, s/he was placed in a face down position on the floor, and restrained by 3 staff members while Nurse #2 administered the IM Zyprexa. Nurse #1 further confirmed that s/he returned every 10 to 15 minutes to determine the patient's readiness to be released from LDS. S/he confirmed that s/he asked the patient if s/he was going to continue to assault staff and also asked the patient if s/he was going to continue to make false allegations against staff.</p> <p>b). A Nurse's Note, dated 4/14/13 at 6:53 PM, stated that Patient #5 had been challenging staff on every request. "Pt didn't like redirection and threw red Gatorade on staff person wearing white shirt. Cold jarred staff badly, and jostled pt against wall." A CON (Certificate of Need), dated 4/14/13 at 10:15, indicated a therapeutic hold had been implemented for a period of 1 minute and stated the reason the emergency procedure had been employed; "pt had been challenging staff all day shift, attempting to get out of ALSA, threatening to throw items. At 10:15 pt threw drink at staff, threats of physical harm." Although the documentation indicated the patient had been</p>	A 020	<p>A.020 482.11 COMPLIANCE WITH LAWS Continued</p> <p>for expedited legal/medical counsel.</p> <p>In the days following this consultation the unit and executive triad leadership teams met with unit staff (overlapping shifts) to disseminate relevant case information and treatment strategies; to engage staff in dialogue; and to provide direction and support. The treatment team developed a behavior plan for patient # 5 that included identified coping strategies garnered from the case consultation and from the patient's own therapeutic inventory assessment. As noted during survey the staff on the Adult Intensive Unit continued to have considerable difficulty in managing the very challenging behaviors presented by patient # 5. The unit and executive triad teams provided ongoing supervision and support. It is noteworthy to mention that on 5/24/13 we received permission by the court to provide non-emergent involuntary medication for patient # 5 and that we are now seeing some improvement.</p> <p>4.) Immediately during survey the CNO instructed the Nursing Supervisors (24/7 coverage for the hospital campus) to conduct focal rounds on the adult intensive unit to provide additional supervisory support on off shifts.</p> <p>5.) On 4/4/13 the executive team implemented a system for formal review of all emergency procedures, including restraint and seclusion and associated documentation (Certificate of Need, CON). 100% of CONs are reviewed by Clinical and PI/Risk Manager for appropriate use of emergency procedures, less restrictive interventions attempted prior the procedure, and that all documentation requirements are met.</p> <p>6.) On 5/3/13 the Chief Nursing Officer received executive approval for adding additional resources in the Department of Clinical Education to increase training and supervision of direct care staff. The additional resources will be crucial in developing ongoing skills for mental health workers and organizationally creating a culture of learning.</p>		

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A 020	<p>Continued From page 5</p> <p>challenging staff all day, the only less restrictive interventions employed prior to the therapeutic hold were reported as "pt has had negative responses to redirection by staff." Per review of the formal grievance, filed by Patient #5 and provided to the surveyor by the patient, MHW #3 had treated the patient in a non-therapeutic and disrespectful manner when, in response to the patient throwing Gatorade at MHW #3, the MHW grabbed him/her by the arms and held him/her against the wall and, in reaction to the patient stating "F--- You" to the MHW, MHW #3 responded by saying "F--- You" to the patient. Per review, statements documented by MHWs #4 &amp; #5, both of whom witnessed the event, identified that MHW #3 had grabbed onto Patient #5's upper arms while facing him/her and pushed him/her against the wall. Both MHWs #4 &amp; #5 also confirmed the above response by MHW #3 to Patient #5. MHW #5 further indicated that MHW #3 had stated to Patient #5 "I'm going to take you down" (meaning to the floor). During interview, at 1:11 PM on 4/17/13, the RN Unit Manager of AIU confirmed that MHW #4 had held onto the arms of Patient #5 and had made the statement, "F... You" to the patient. In addition to the above, the RN Unit Manager further stated that a separate, previous incident had occurred on 3/22/13 in which Patient #5 had stated "F... You" to another MHW #6 and that MHW had also admitted that s/he had responded "F--- You" back to the patient.</p> <p>2. Per State Statute Chapter 42: Bill of Rights For Hospital Patients 1852 (18) The patient has the right to know the maximum patient census and the full-time equivalent numbers of registered</p>	A 020	<p>A 020 482.11 COMPLIANCE WITH LAWS Continued</p> <p>7.) Immediately following survey the Chief Executive and Medical Officer obtained legal and regulatory consultation from the Department of Mental Health regarding the expedition of non-emergant involuntary medication to ensure that patient # 5 receives needed treatment.</p> <p>8.) On 5/30/13 the Executive Leadership and team met with the Department of Mental Health (DMH) and key legislators with mental health oversight jurisdiction to review the recent CMS findings and proposed plan of correction. Following this meeting DMH has offered additional allocation of resources that include on site collaboration and consultation by the DMH Director of Quality.</p> <p>9.) In adherence to the Brattleboro Retreat Human Resource policies and procedures the Chief Nursing Officer and Clinical Manager placed two of the three employees cited in this survey on administrative leave and conducted an immediate investigation to ensure patient safety. Specifically, in adherence to the code of conduct policy the CNO addressed the performance issues named in the citation as follows:</p> <p>Nurse #1 – Clinical Manager conducted an investigation to the allegations cited on 4/10/13. Nurse # 1 was placed on suspension during the investigation.</p> <p>Based upon the findings of the internal investigation that Nurse #1 's actions resulted from human error, that s/he was truthful, remorseful and amenable for retraining, on 4/18/13 the CNO provided performance counseling, coaching, and education on use of less restrictive alternatives to care. She reviewed the criteria for release from restraint or seclusion and established guidelines for appropriate levels of communication during a behavioral emergency. She also reviewed Crisis Prevention Intervention (CPI) standards and techniques with Nurse #1. Nurse #1 was able to understand that his/her actions may have been perceived by the patient as coercive but was clear that his/her intent was to document clearly the</p>	

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A 020	<p>Continued From page 6</p> <p>nurses, licensed practical nurses, and licensed nursing assistants who provide direct care for each shift on the unit where the patient is receiving care".</p> <p>Based on observations during a tour of the inpatient units beginning on 4/14/13 and 4/17/13 and staff interview, the facility failed to assure completion of staffing sheets and to post them in area that was accessible to patients. Findings include:</p> <p>The "Direct Caregiver Full Time Equivalents" dated 4/9/13 to 4/16/13, which provided the number of RN's, LPN's and Mental Health Workers (MHW) was incomplete on Tyler 4 for the day shift from 4/12/13 to 4/14/13 and the evening and night shift on 4/11/13 and 4/12/13. In addition, the document was posted at the nurse's station in an area not accessible to patients. This was confirmed during interview with the Clinical Manager on 4/18/13 at 9:15 AM. The Clinical Manager stated the Charge Nurse was responsible for completing this document. Per observation on Tyler on 3 4/17/13, the "Direct Caregiver Full Time Equivalents" staffing sheet was not posted in an area accessible to patients. The documentation was incomplete and failed to display staffing for the previous 7 days. Per interview on the afternoon of 4/17/13 the Nurse Manager on Tyler 3 confirmed the form was not completed or displayed as required.</p> <p>3. Based on record review and staff interview, the hospital failed to report to the appropriate State Agency allegations of alleged abuse and financial exploitation in 1 of 30 records review. ( Patient #</p>	A 020	<p>A 020 482.11 COMPLIANCE WITH LAWS</p> <p>Continued</p> <p>patient's statements and behaviors that justified the emergency procedure.</p> <p>Nurse # 1 returned on 4/23/13 and was temporarily transferred to day shift for increased supervision and training until 5/11/13. S/he has subsequently returned to the night shift. Nurse #1 reports that this retraining was helpful and felt supported by administrative actions.</p> <p>MHW #6 - The clinical manager conducted an immediate investigation that indicated that MHW #6's behavior though was unprofessional, it was not intentional and resulted from an emergency situation and a response to physical injury. MHW # 6 was cooperative, showed remorse and immediately engaged in corrective action. On 3/22/13 MHW # 6 received a verbal warning for unprofessional behavior and also counseling, coaching, and retraining regarding the patient's bill of rights.</p> <p>MHW #3 - Clinical manager conducted an investigation. MHW #3 was placed on suspension during the investigation from 4/14/13 to 4/21/14. The internal investigation indicated that MHW # 3's behavior toward patient # 5 was conscious and disregarded potential risk that disciplinary action was warranted. As his/her first disciplinary action s/he was given a verbal warning for unprofessional behavior and received counseling, coaching, and retraining regarding the patient's bill of rights.</p> <p>PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION</p> <p>Comprehensive staff education and training. Increased supervision and staff support. Increased resources approved for clinical education. Implementation of enhanced review of all emergency procedures and associated documentation. Approval for additional resources in clinical education. Legal/regulatory consultation. Progressive disciplinary action taken for staff</p>	

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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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A 020	Continued From page 7 3 ) Findings include:  1. Per record review, Patient #3 has been hospitalized since December 5, 2012 with Schizophrenia - Paranoid Type. Physician notes on 3/14/13 stated the patient spoke "at length" about past sexual assaults "while in this facility as well as other hospitals. Doesn't think these beliefs are delusional or the result of hallucinated experiences". On 3/21/13, the physician documented that Patient #3 believed that an outside agency stole \$106.00 from h/her. On 3/22/13, the physician documented that Patient #3 "repeats [h/her] request to have [h/her] treatment team investigate [h/her] report that #106.00 is missing from [h/her] possessions."  Based on interview on 4/17/13 at 10:10 AM, the physician confirmed that these allegations were not reported to Adult Protective Services in accordance with Vermont State Statute Title 33 Chapter 69 "Reports of abuse, Neglect and Exploitation of Vulnerable Adults" and facility policy.	A 020	A 020 482.11 COMPLIANCE WITH LAWS Continued  involved in citations.  MONITORING/TRACKING: (method, frequency and responsible person The executive leadership team will meet weekly and as needed with the adult intensive unit and will document progress in meeting minutes for a minimum of four months. Review of all emergency procedures, including restraint and seclusion will remain an ongoing practice. Results of any deficiency noted will be immediately reported to the CMO, CNO, and Performance Improvement/ Risk Manager. The Performance Improvement/Risk Manager will monitor 100% of all incidents and APS reports on ongoing basis.  2.) Bill of Rights 1852 (18) – Patient has right to know maximum census and FTE data.  PLAN OF CORRECTION FOR CITED DEFICIENCY On 4/19/13 the CNO conducted an informative session with clinical managers regarding compliance with federal, state, and local laws and reviewed the requirement for posting census and FTE data on inpatient units in an area that is accessible to patients. On 4/22/13 all inpatient units posted FTE and census data for a seven day retrospective review. For units that required secure mechanisms for FTE and census display, secure display cases were installed on or before 5/21/13. Clinical Managers of inpatient units will incorporate a visual inspection of the FTE and census data on each unit into the environmental scan checklist that is completed during each shift each day to ensure that FTE and census data remains posted on each inpatient unit.	4/22/13	
A 115	482.13 PATIENT RIGHTS  A hospital must protect and promote each patient's rights.  This CONDITION is not met as evidenced by: The Condition is not met based on failure to implement appropriate use of restraints and/or seclusion in accordance with federal requirements and facility policy and to report allegations of mistreatment.  Refer to Tags: A-144, 145, 154, 162, 164, 166, 168, 178, 179	A 115			

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A 144	<p>482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on patient and staff interviews and record review the facility failed to assure that care and services were provided in an environment that promoted the physical and emotional safety and well being of 1 patient. (Patient #5). Findings include:</p> <p>Per record review Patient #5, who had been admitted to the AIU (Adult Intensive Unit) on an involuntary basis on 3/10/13, was involved in 3 separate incidents, on 3/22/13, 4/10/13 and 4/14/13, respectively, in which staff treated him/her in a disrespectful and intimidating manner as evidenced by the following:</p> <p>a.) A nurse's note, dated 4/10/13 at 7:54 AM, stated Patient #5 had requested Seroquel 100 mg at 5:30 AM and when provided the patient bit the pill in half, "spit out, refused to comply with medication mouth check. When taught to regarding this safety issue threw dirty water (that [s/he] had been drinking when taking meds and allowing fluids from mouth back into cup). Instructed to QR (Quiet Room), refused, immediately escorted to QR - began kneeling and kicking staff....Refused to redirect - secluded for immediate risk of harm to others due to assaultive behavior." The note further indicated that the patient was grabbing at staff, attempting to exit the QR, and subsequently received an injection of Zyprexa, at 5:50 AM. The note stated there had been an attempt to process the events</p>	A 144	<p>A 020 482.11 COMPLIANCE WITH LAWS Continued</p> <p>EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCY Provision of management education and established effective system of monitoring compliance.</p> <p>MONITORING/TRACKING: (method, frequency and responsible person) Any deficiency noted regarding the unit posting of FTE and census data will be noted on the environmental scan checklist and will be reported to the Clinical Manager who will file an incident report and make an immediate correction.</p> <p>3.) Title 33, Chapter 69 - Reports of Abuse, Neglect and Exploitation</p> <p>PLAN OF CORRECTION FOR CITED DEFICIENCY On 4/19/13 the CNO implemented a system for an expedited review of all cases involving external reporting. During a daily review of all incident reports, the Performance Improvement/Risk Manager conducts a full review of any incident that may require reporting to Adult Protective Services (APS) or other external agencies. She reviews all APS reports with clinical managers and CNO to ensure regulatory compliance and quality assurance. On 3/28/13 an external expert provided an educational session covering Vermont Statute for mandating reporting of abuse, neglect and exploitation to the inpatient unit leadership teams, consisting of unit medical director, clinical manager, and social work supervisor. This education emphasized that allegations do not have to be substantiated via an internal investigation in order to be reported to Adult Protective Services (APS).</p> <p>EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCY The Performance Improvement/Risk Manager reviews all incident reports daily and effective 4/19/13 included a full review of any incident reported to Adult</p>	4/19/13
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A 144	<p>Continued From page 9</p> <p>leading to seclusion with the patient who reportedly stated his/her intent to continue to attempt to assault staff, engage in disruptive behavior with goal of expediting discharge and "stated, as well, intent of lodging allegations against staff/hospital...". The patient reportedly refused to contract for safety and remained in seclusion at the end of the shift.</p> <p>During interview, at 4:05 PM on 4/15/13, Patient #5 stated s/he had some concerns with some staff whom s/he felt used restraints/seclusion as punishment. The patient gave examples of this concern stating that on one occasion s/he threw a cup of fluid at a staff member when angry, and that particular staff member engaged the patient in conversation which helped to de-escalate his/her anger. Patient #5 stated that, however, on other recent occasions, s/he had become angry when staff members had been, what s/he felt, was disrespectful in their treatment of him/her and s/he had thrown fluid at them. S/he stated the response had been to immediately punish him/her, by use of restraints, at times just grabbing his/her arms and causing pain, and/or seclusion. S/he further indicated that staff, at times make comments to him/her such as "I'm going to take you down". Patient #5 also stated that s/he has filed multiple complaints and staff didn't like that s/he reported them, but s/he would continue to report concerns related to treatment and safety.</p> <p>Per interview, at 7:38 AM on 4/16/13 and at 7:50 AM on 4/17/13, both MHW (Mental Health Worker) #1 and MHW #2 stated, during each of their respective individual interviews, that they had been witness to the following events during</p>	A 144	<p>A 020 482.11 COMPLIANCE WITH LAWS Continued</p> <p>Protective Services. She reviews all APS reports with clinical managers and the CNO to ensure regulatory compliance and quality assurance.</p> <p>PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Staff Education and Training regarding reporting requirements. Implemented system for review of APS Reporting.</p> <p>MONITORING/TRACKING: (method, frequency and responsible person) Daily Incident reporting review by PI/Risk Manager, CNO with focused attention on any reportable incident to ensure timely investigation and reporting. All reports to Adult Protective Services are sent to Performance Improvement/Risk Manager for quality review and tracking.</p> <p>PROCEDURES FOR INCORPORATING SYSTEMATIC IMPROVEMENT ACTIONS INTO QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) PROGRAM: 100 % of incident reports are reviewed and analyzed daily by Performance Improvement and Risk Manager and Nursing Supervisor on off hours and further analyzed by the Senior Director of Quality and Regulatory Compliance for trends and to identify performance improvement initiatives. The data is reported to the executive team (or administrator on call) on a daily basis and is presented monthly to the Safety Committee and Quarterly to the Board Quality Committee and to the Organization Wide Performance Improvement Committee.</p> <p>TITLE OF RESPONSIBLE PERSONS: Chief Nursing Officer and Vice President of Patient Care Senior Director of Quality and Regulatory Compliance Performance Improvement/Risk Manager</p>	

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A 144	Continued From page 10 the early morning hours of 4/10/13: at approximately 5:00 AM Patient #5 had requested a specific amount of Seroquel, was informed the only available dose was a larger dose and s/he agreed to take it. When Nurse #1 brought the medication the patient bit the pill in half, swallowed half and put the remaining piece back in the plastic med cup. Each MHW stated that Nurse #1 then started to speak to Patient #5 in a loud voice telling the patient s/he was tired of the patient manipulating his/her meds. The patient, who was sitting in a chair, became angry and threw the remaining water from the cup at Nurse #1 who immediately grabbed the patient by the arm, pulled him/her from the chair in which s/he was sitting, and placed him/her in locked door seclusion. Both MHWs stated there had been no attempt to verbally de-escalate the patient, no discussion at all prior to hands on by Nurse #1. Nurse #1 then left the ALSA unit and returned with Nurse #2 who brought medication for the patient to take by mouth..Nurse #1 made a statement that the patient had spit the medication out and then both Nurse #1 and Nurse #2 left and returned, within several minutes, to the seclusion room where Patient #5 was sitting quietly on the floor. The patient was placed in a face down position on the floor and restrained in that position by 3 staff members while Nurse #2 gave the patient an injection. All staff then left the room. MHW #1 stated that Nurse #1 continued to check on the patient every 10 to 15 minutes and discussed the conditions of release from seclusion. S/he stated that in addition to asking the patient if s/he could contract for safety and not be assaultive, Nurse #1 also asked the patient if s/he was going to continue to make allegations against staff.	A 144	A 115 482. 13 PATIENT RIGHTS  PLAN OF CORRECTION FOR CITED DEFICIENCY On 4/15/13, during the survey, executive leadership team (comprised of the Chief Medical Officer, Chief Nursing Officer and Vice President of Operations) immediately conducted training sessions with inpatient clinical teams to address: • Emergency procedures including seclusion and restraint. • Compliance with federal, state and local laws including reporting of suspected abuse, neglect and exploitation. • Requirements for treatment planning. • Legal aspects of care. • Documentation standards. Immediately following survey, on 4/18/13, the governing body consisting of the CEO, CMO, CNO and other executive team members conducted a comprehensive review of all policies and procedures that govern restraint and seclusion and requirements for reporting allegations of mistreatment and determined that existing policies meet regulatory requirements. On 5/3/13 the CNO received authorization for a redesign of clinical education department in order to enhance staff training and skill level and to promote a robust culture of learning. The redesign calls for the addition of two master prepared clinicians to work with the unit based staff post orientation. The first position for a clinical nurse specialist was posted on 5/28/13 and will be dedicated to the Adult Intensive Unit.  EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: Efforts to address deficiencies noted are outlined below in under standard citations.  PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Policy review. Education and Training.	5/3/13

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A 144	Continued From page 11  Nurse #1 confirmed, during interview at 9:13 AM on 4/18/13, that the patient had been given Seroquel, broke the pill in half and returned half to the med cup. S/he stated that Patient #5 refused to allow a mouth check and became... angry and threw the water (in which Nurse #1 felt the patient had spit oral secretions), into Nurse #1's face and the nurse responded by telling the patient, in a loud voice, "seclusion room now." Nurse #1 confirmed that there had been no attempt to employ less restrictive measures to de-escalate the patient's behavior. S/he also agreed that in hind sight s/he could have stepped away from the patient to give time to de-escalate but felt, based on past experience with the patient that the patient might attempt to assault staff. Nurse #1 stated that after being placed in LDS (Locked Door Seclusion) Patient #5 was given the option of taking Zyprexa (an antipsychotic drug) by mouth or injection. Nurse #1 stated the patient took the oral Zyprexa and spit it out. Nurse #1 stated s/he left the LDS and contacted the physician by phone and explained that s/he was not certain how much, if any, of the Zyprexa the patient had received orally. S/he stated that the physician ordered Zyprexa IM. The nurse confirmed that upon return to the LDS, despite the fact that Patient #5 was sitting quietly on the floor, s/he was placed in a face down position on the floor, and restrained by 3 staff members while Nurse #2 administered the IM Zyprexa. Nurse #1 further confirmed that s/he returned every 10 to 15 minutes to determine the patient's readiness to be released from LDS. S/he confirmed that s/he asked the patient if s/he was going to continue to assault staff and also asked the patient if s/he was going to continue to make	A 144	A 115 482. 13 PATIENT RIGHTS Continued  MONITORING/TRACKING: (method, frequency and responsible person) Specific monitoring and tracking noted below for each citation.  TITLE OF RESPONSIBLE PERSONS: President and Chief Executive Officer Chief Medical Officer Chief Nursing Officer and Vice President of Patient Care Vice President of Operations  A144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING  PLAN OF CORRECTION FOR CITED DEFICIENCY 1.) In order to ensure that care is provided in a safe setting, on 4/25/13 the executive team, comprised of the Chief Medical Officer, Chief Nursing Officer and Vice President of Operation increased formal supervision and oversight of the adult Intensive unit (AIU) from monthly to weekly scheduled meetings and increased on unit presence to provide clinical supervision modeling and support. 2.) In addition, The triad/leadership team held follow up training and educational sessions with the all staff on the Adult Intensive Unit on Tyler 4 (location of primary citations) on 4/23/13, 5/8/13 and 5/10/13 to ensure that care is provided in an environment that promotes the physical and emotional wellbeing of patients. Educational sessions covered the following: • Patient rights. • Regulatory and legal review of what constitutes an emergency involuntary procedures including restraint and seclusion. • Clinical rationale for emergency procedures. • Documentation requirements for emergency procedures. • Use of alternative less restrictive interventions. • Role of patient and staff debriefing.	5/13/13

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A 144	Continued From page 12 false allegations against staff.  b). A Nurse's Note, dated 4/14/13 at 6:53 PM, stated that Patient #5 had been challenging staff on every request. "Pt didn't like redirection and threw red Gatorade on staff person wearing white shirt. Cold jarred staff badly, and jostled pt against wall." A CON (Certificate of Need), dated 4/14/13 at 10:15, indicated a therapeutic hold had been implemented for a period of 1 minute and stated the reason the emergency procedure had been employed; "pt had been challenging staff all day shift, attempting to get out of ALSA (Adult Low Stimulation Area), threatening to throw items. At 10:15 pt threw drink at staff, threats of physical harm." Although the documentation indicated the patient had been challenging staff all day, the only less restrictive interventions employed prior to the therapeutic hold were reported as "pt has had negative responses to redirection by staff." Per review of the formal grievance, filed by Patient #5 and provided to the surveyor by the patient, MHW #3 had treated the patient in a non-therapeutic and disrespectful manner when, in response to the patient throwing Gatorade at MHW #3, the MHW grabbed him/her by the arms and held him/her against the wall and, in reaction to the patient stating "F--- You" to the MHW, MHW #3 responded by saying "F--- You" to the patient. Per review, statements documented by MHWs #4 & #5, both of whom witnessed the event, identified that MHW #3 had grabbed onto Patient #5's upper arms while facing him/her and pushed him/her against the wall. Both MHWs #4 & #5 also confirmed the above response by MHW #3 to Patient #5. MHW #5 further indicated that MHW #3 had stated to Patient #5 "I'm going to take you down" (meaning to the floor). During	A 144	A144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING Continued  • Use of the therapeutic inventory tool in treatment planning. • Role of formal case consultation. • Staff education and guidance on how to deal w/ patient and issues of transference and countertransference. • Identification of staff needs for ongoing forums for education, training and support.  3.) On 4/18/13 and 5/2/13 and 5/16/13 the Chief Medical Officer and Medical Director reviewed the CMS findings with the Medical Executive Committee. The CMO provided an in-service on emergency procedures, patient rights and documentation requirements. 4.) On 4/4/13 the CMO and Senior Medical Director implemented a formal case consultation seminar/series, meeting twice per month to provide opportunity for comprehensive case review for patients with who pose significant treatment challenges. The consultation forum is designed to promote a collaborative problem solving non-blaming culture of patient care and professional development. Patient # 5 was the first patient reviewed. In attendance were six board certified psychiatrists, several nursing staff and mental health workers, several social work/clinicians, quality and risk personnel and several executive team members including the CEO. Topics discussed during this consultation included: • What constitutes an emergency procedure (restraint/seclusion)? • Balancing of Patient Rights and Safety. • Challenges of caring for a patient with a significant mental illness and a traumatic brain injury that refuses pharmacological interventions. • Patient # 5's behavior and its impact on other patients' treatment. • Staff responses to patient # 5 and "compassion fatigue."	

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A 144	Continued From page 13 interview, at 1:11 PM on 4/17/13, the RN Unit Manager of AIU confirmed that MHW #4 had held onto the arms of Patient #5, placed the patient against the wall and had made the statement, "F--You" to the patient. In addition to the above, the RN Unit Manager further stated that a separate, previous incident had occurred on 3/22/13 in which Patient #5 had stated "F...You" to another MHW #6 and that MHW had also admitted that s/he had responded "F--You" back to the patient.	A 144	A144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING Continued  The expertise provided in this case consultation identified the need for increased case discussion with staff of all disciplines and on each shift and the need for expedited legal/medical counsel. In the days following this consultation the unit and executive triad leadership teams met with unit staff (overlapping shifts) to disseminate relevant case information and treatment strategies; to engage staff in dialogue; and to provide direction and support. The treatment team developed a behavior plan for patient # 5 that included identified coping strategies garnered from the case consultation and from the patient's own therapeutic inventory assessment.		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT  The patient has the right to be free from all forms of abuse or harassment.  This STANDARD is not met as evidenced by: Based on record review and staff interview, the hospital failed to report to the appropriate State Agency allegations of alleged abuse and financial exploitation in 1 of 30 records reviewed. ( Patient # 3 ) Findings include:  1. Per record review, Patient #3 has been hospitalized since December 5, 2012 with Schizophrenia - Paranoid Type. Physician notes on 3/14/13 stated the patient spoke "at length" about past sexual assaults "while in this facility as well as other hospitals. Doesn't think these beliefs are delusional or the result of hallucinated experiences".  On 3/21/13, the physician documented that Patient #3 believed that an outside agency stole \$106.00 from h/her. On 3/22/13, the physician documented that Patient #3 "repeats [h/her]request to have [h/her] treatment team	A 145	5.) On 4/24/13 CNO provided an educational session to nursing leadership and clinical educators regarding patient rights and emergency procedures. 6.) On 5/13/13 the CNO approved an enhanced on line educational module focused upon criteria for emergency procedures and requirements for one hour assessment. The on line module was implemented on 5/25/13 on MyLearningPointe.com and will be used for RN orientation and as annual competency to ensure that nursing staff follow policies and regulatory guidelines for restraint and/or seclusion procedures. On 4/4/13 the executive team implemented a system for formal review of all emergency procedures, including restraint and seclusion and associated documentation (Certificate of Need, CON). 100% of CONs are reviewed by Clinical Managers, Performance Improvement/Risk Manager and Nursing Supervisor for off hours to assess: a. That the emergency procedure (restraint or seclusion) was indicated. b. That less restrictive interventions were attempted prior the procedure, c. That all documentation requirements, including physician orders and assessment within one hour, are met.		

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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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A 145	Continued From page 14 Investigate [h/her] report that \$106.00 is missing from [h/her] possessions.  Based on interview on 4/17/13 at 10:10 AM, the physician confirmed that these allegations were not reported to Adult Protective Services in accordance with Vermont State Statute Title 33 Chapter 69 "Reports of abuse, Neglect and Exploitation of Vulnerable Adults" and facility policy.	A 145	A144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING Continued  Clinical Managers and Nursing Supervisor will respond to behavioral codes (restraint and/or seclusion) whenever possible to offer additional clinical supervision, guidance and training and to ensure that staff conduct a debriefing following the event. 7.) For any patient who has five or more episodes of restraint and/or seclusion in one week the treatment team will conduct a comprehensive review of the patient's care plan to identify potential patterns, trends, clusters of behaviors that make be contributing factors. Based upon this analysis the team will make modifications to the patient's treatment plan and communicate modifications to all staff. 8.) Immediately following the survey the Chief Executive Officer and Chief Medical Officer obtained legal and regulatory consultation from the Department of Mental Health regarding the expedition of non-emergent involuntary medication to ensure that patient # 5 receives needed treatment. 9.) The Chief Nursing Office and Clinical Manager addressed performance issues named in the citation as noted in citation response A 20.	
A 154	482.13(e) USE OF RESTRAINT OR SECLUSION  Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.  This STANDARD is not met as evidenced by: Based on staff interviews and record review there was no indication of threat to the immediate physical safety of self or others warranting the need for restraint and/or seclusion for 1 of 12 applicable patients. (Patient #5). Findings include:  1. Per record review Patient #5, who had been admitted to the AIU (Adult Intensive Unit) on an involuntary basis on 3/10/13, was subjected to hands on restraint and/or LDS (Locked Door Seclusion), on 4/10/13 and 4/14/13, respectively, without indication to warrant the need for the procedures. A nurse's note, dated 4/10/13 at 7:54	A 154	PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Comprehensive staff education and training. Increased supervision for the Adult Intensive Unit. Expedited review of 100% of Certificate of Needs (CON) and incidents that require external reporting (Adult Protective Services). Increased resources approved for clinical education. Implementation of enhanced review of all emergency procedures and associated documentation. Approval for additional resources in clinical education. New training module for emergency procedures with competency. Legal/regulatory consultation.	

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A 154	<p>Continued From page 15</p> <p>AM, stated Patient #5 had requested Seroquel 100 mg at 5:30 AM and when provided the patient bit the pill in half, "spit out, refused to comply with medication mouth check. When taught to regarding this safety issue threw dirty water (that [s/he] had been drinking when taking meds and allowing fluids from mouth back into cup). Instructed to QR (Quiet Room), refused, immediately escorted to QR - began kneeling and kicking staff....Refused to redirect - secluded for immediate risk of harm to others due to assaultive behavior." The note further indicated that the patient was grabbing at staff, attempting to exit the QR, and subsequently received an injection of zyprexa, at 5:50 AM. The note stated there had been an attempt to process the events leading to seclusion with the patient who reportedly stated his/her intent to continue to attempt to assault staff, engage in disruptive behavior with goal of expediting discharge and "stated, as well, intent of lodging allegations against staff/hospital..." The patient reportedly refused to contract for safe behavior and remained in seclusion at the end of the shift.</p> <p>Per interview, at 7:38 AM on 4/16/13 and at 7:50 AM on 4/17/13, both MHW (Mental Health Worker) #1 and MHW #2 stated, during each of their respective individual interviews, that they had been witness to the following events during the early morning hours of 4/10/13: at approximately 5:00 AM Patient #5 had requested a specific amount of Seroquel, was informed the only available dose was a larger dose and s/he agreed to take it. When Nurse #1 brought the medication the patient bit the pill in half, swallowed half and put the remaining piece back in the plastic med cup. Each MHW stated that</p>	A 154	<p>A144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING Continued</p> <p>Progressive disciplinary action taken for staff involved in citations.</p> <p>MONITORING/TRACKING: (method, frequency and responsible person) The Executive Leadership Triad Team will meet weekly and as needed with the adult intensive unit. The team will record progress related to regulatory compliance, issues pertaining to teamwork and the building of a culture of learning and safety. The meeting minutes will be shared with the executive team on a weekly basis for a minimum of four months. Review of all emergency procedures, including restraint and seclusion will remain an ongoing practice. Results of any deficiency noted will be immediately reported to the CMO, CNO. CNO will conduct quarterly audits of nursing personnel files to ensure that competencies regarding restraint and seclusion are complete and assess needs for additional training.</p> <p>PROCEDURES FOR INCORPORATING SYSTEMATIC IMPROVEMENT ACTIONS INTO QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) PROGRAM: As directed by the Chief Nursing Officer the Performance Improvement and Risk Manager will analyze and trend Certificate of Need (CON) and APS data for quality review and to identify performance improvement opportunities. The data is reported to the executive team (or administrator on call) including the Senior Director of Quality and Regulatory Compliance on a daily basis. This data is presented monthly to the Safety Committee and Quarterly to the Board Quality Committee and to the Organization Wide Performance Improvement Committee.</p>	

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A 154	Continued From page 16 Nurse #1 then started to speak to Patient #5 in a loud voice telling the patient s/he was tired of the patient manipulating his/her meds. The patient became angry and threw the remaining water from the cup at Nurse #1 who immediately grabbed the patient by the right arm, pulled him/her from the chair in which s/he was sitting, and propelled him/her forward. At that point MHW #2 used a CPI (Crisis Prevention Intervention) technique to hold the patient's left arm and s/he was placed in locked door seclusion. Both MHWs stated there had been no attempt to verbally de-escalate the patient prior to the hands on procedure and there was no evidence of self-harming behaviors or intent to harm others by Patient #5, until Nurse #1 put hands on the patient, at which point s/he began to kick and struggle. Nurse #1 then left the ALSA unit and returned with Nurse #2 who brought medication for the patient to take by mouth. Nurse #1 made a statement that the patient had spit the medication out and Nurse #1 and Nurse #2 then left and returned, within several minutes, to the seclusion room where Patient #5 was at that point sitting quietly on the floor. The patient was placed in a face down position on the floor and restrained in that position by 3 staff members while Nurse #2 gave the patient an injection. All staff then left the room. MHW #1 stated that Nurse #1 continued to check on the patient every 10 to 15 minutes and discussed the conditions of release from seclusion. S/he stated that in addition to asking the patient if s/he could contract for safety and not be assaultive, Nurse #1 also asked the patient if s/he was going to continue to make allegations against staff.  Nurse #1 confirmed, during interview at 9:13 AM	A 154	A144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING Continued  TITLE OF RESPONSIBLE PERSONS: Executive Triad Leadership Team (CMO, CNO, Vice President of Operations) Senior Director of Quality and Regulatory Compliance Performance Improvement/Risk Manager  A145 482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT  PLAN OF CORRECTION FOR CITED DEFICIENCY In response to deficiencies noted during the February 2013 survey, on 3/28/13 an external expert provided the inpatient unit leadership teams, consisting of unit medical director, clinical manager, and social work supervisor, an educational session in regards to the Vermont Statute for mandating reporting of abuse, neglect and exploitation. This education emphasized that the allegations do not have to be substantiated via an internal investigation in order to be reported to Adult Protective Services (APS).  EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: Following this education session on external requirements specific to the state of Vermont, on 4/19/13 the PI/Risk manager, during her review of all incidents in the previous 24 hours, conducts a comprehensive review of any incident that has been reported to Adult Protective Services or those incidents that might require such report. She then reviews all APS reports with clinical managers and CNO to ensure regulatory compliance and quality assurance and tracks and sends her findings. Each inpatient clinical manager trains staff on incident reporting. As part of the training module for incident reporting staff is provided with literature on managing risk and building a staff culture by Joseph Pepe, MD and Peter Cataldo, Ph.D.	4/19/13

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A 154	Continued From page 17 on 4/18/13, that the patient had been given Seroquel, broke the pill in half and returned half to the med cup. S/he stated that because Patient #5 had previously been manipulating his/her medications, the nurse asked the patient to do a mouth check which s/he refused to allow. The nurse stated the patient then became angry and threw the water (in which Nurse #1 felt the patient had spit oral secretions), into Nurse #1's face and the nurse responded by telling the patient, in a loud voice, "seclusion room now." Nurse #1 confirmed that there had been no attempt to employ less restrictive measures to de-escalate the patient's behavior. S/he also agreed that in hind sight s/he could have stepped away from the patient to give time to de-escalate but felt, based on past experience with the patient, that the patient might attempt to assault staff. Nurse #1 stated that after being placed in LDS (Locked Door Seclusion) Patient #5 was given the option of taking Zyprexa (an antipsychotic drug) by mouth or injection. The patient took the oral Zyprexa which Nurse #1 stated s/he felt the patient spit out. Nurse #1 stated s/he left the LDS and contacted the physician by phone and explained that s/he was not certain how much, if any, of the Zyprexa the patient had received orally. S/he stated that the physician ordered Zyprexa IM. The nurse confirmed that upon return to the LDS, despite the fact that Patient #5 was sitting quietly on the floor, s/he was placed in a face down position on the floor, and restrained by 3 staff members while Nurse #2 administered the IM Zyprexa. Nurse #1 further confirmed that s/he returned every 10 to 15 minutes to determine the patient's readiness to be released from LDS. S/he confirmed that s/he asked the patient if s/he was going to continue to assault	A 154	A145 482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT Continued  PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Staff Education and Training regarding reporting requirements. Implemented system for expediting a daily review of any incident or allegation that is reported to Adult Protective Services.  MONITORING/TRACKING: (method, frequency and responsible person) PI/Risk Manager reviews incident reports on a daily basis with expedited review of any report to APS to ensure timely investigation and reporting procedures.  PROCEDURES FOR INCORPORATING SYSTEMATIC IMPROVEMENT ACTIONS INTO QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) PROGRAM: As directed by the Chief Nursing Officer the Performance Improvement and Risk Manager will analyze and trend Certificate of Need (CON) and APS data for quality review and to identify performance improvement opportunities. The data is reported to the executive team (or administrator on call) including the Senior Director of Quality and Regulatory Compliance on a daily basis. This quality data is presented monthly to the Safety Committee and Quarterly to the Board Quality Committee and to the Organization Wide Performance Improvement Committee.  TITLE OF RESPONSIBLE PERSONS: Chief Nursing Officer and Vice President of Patient Care Senior Director of Quality and Regulatory Compliance Performance Improvement/Risk Manager	

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A 154	Continued From page 18 staff and the patient said yes. S/he also asked the patient if s/he was going to continue to make false allegations against staff and the patient responded yes.  Despite the lack of evidence of risk of immediate harm to self or others the patient was subjected to a restraint in the form of a hands on utilized to escort him/her to LDS where, despite sitting quietly on the floor s/he was further subjected to physical restraint for the purpose of a chemical restraint in the form of IM injection of Zyprexa.  2. A Nurse's Note, dated 4/14/13 at 6:53 PM, stated that Patient #5 had been challenging staff on every request. "Pt didn't like redirection and threw red Gatorade on staff person wearing white shirt. Cold Jarred staff badly, and jostled pt against wall." A CON (Certificate of Need), dated 4/14/13 at 10:15, indicated a therapeutic hold had been implemented for a period of 1 minute and stated the reason the emergency procedure had been employed; "pt had been challenging staff all day shift, attempting to get out of ALSA, threatening to throw items. At 10:15 pt threw drink at staff, threats of physical harm." Although the documentation indicated the patient had been challenging staff all day, the only less restrictive interventions employed prior to the therapeutic hold were reported as "pt has had negative responses to redirection by staff." Per review of the formal grievance, filed by Patient #5 and provided to the surveyor by the patient, MHW #3 had treated the patient in a non-therapeutic and disrespectful manner when, in response to the patient throwing Gatorade at MHW #3, the MHW	A 154	A154 482.13(e) USE OF RESTRAINT OR SECLUSION  PLAN OF CORRECTION FOR CITED DEFICIENCY & EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: 1.) In order to ensure that all patients are free from physical or mental abuse and corporal punishment, on 4/25/13 the executive team, comprised of the Chief Medical Officer, Chief Nursing Officer and Vice President of Operation increased formal supervision and oversight of the adult intensive unit (AIU) (location of primary citations) from monthly to weekly scheduled meetings and increased on unit presence to provide clinical supervision, modeling and support. 2.) In addition, the leadership team held follow up training and educational sessions with the all staff on the Adult Intensive Unit on 4/23/13, 5/8/13 and 5/10/13 to ensure that care is provided in an environment that promotes the physical and emotional wellbeing of patients. Educational sessions covered the following: a. Patient rights. b. Regulatory and legal review of what constitutes an emergency involuntary procedures including restraint and seclusion. c. Clinical rationale for emergency procedures. d. Documentation requirements for emergency procedures. e. Use of alternative less restrictive interventions. f. Role of patient and staff debriefing. g. Use of the therapeutic inventory tool in treatment planning. h. Role of formal case consultation. i. Staff education and guidance on how to deal w/ patient and issues of transference and countertransference. j. Identification of staff needs for ongoing forums for education, training and support. 3.) On 4/18/13 and 5/2/13 and 5/16/13 the Chief Medical Officer and Medical Director reviewed the CMS findings with the Medical Executive Committee.	4/25/13
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A 154	Continued From page 19 grabbed him/her by the arms and held him/her against the wall. Per review, statements documented by MHWs #4 & #5, both of whom witnessed the event, identified that MHW #3 had grabbed onto Patient #5's upper arms while facing him/her and pushed him/her against the wall. MHW #5 further indicated that MHW #3 had stated to Patient #5 "I'm going to take you down" (meaning to the floor). During interview, at 1:11 PM on 4/17/13, the RN Unit Manager of AIU confirmed that MHW #4 had held onto the arms of Patient #5 and had placed him/her against the wall.	A 154	A154 482.13(e) USE OF RESTRAINT OR SECLUSION Continued  The CMO provided an in-service on emergency procedures, patient rights and documentation requirements. 4.) On 4/4/13 the CMO and Senior Medical Director implemented a formal case consultation seminar/series, meeting twice per month to provide opportunity for comprehensive case review for patients with who pose significant treatment challenges. The consultation forum is designed to promote a collaborative problem solving non-blaming culture of patient care and professional development. Patient # 5 was the first patient reviewed. In attendance were six board certified psychiatrists, several nursing staff and mental health workers, several social work/clinicians, quality and risk personnel and several executive team members including the CEO. Topics discussed during this consultation included: • What constitutes an emergency procedure (restraint/seclusion)? • Balancing of Patient Rights and Safety. • Challenges of caring for a patient with a significant mental illness and a traumatic brain injury that refuses pharmacological interventions. • Patient # 5's behavior and its impact on other patients' treatment. • Staff responses to patient # 5 and "compassion fatigue."	
A 162	482.13(e)(1)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION  Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.  This STANDARD is not met as evidenced by: Based on record review and staff interview, there was no evidence of violent or self-destructive behaviors that resulted in use of seclusion in 1 of 12 applicable patients reviewed. (Patient #4) Findings include:  1. Per record review Patient #4 was placed in seclusion on 4/9/13 for approximately one hour without evidence of violence or self-destructive behavior. Nursing progress notes dated 4/9/13 during the evening shift stated " .. pt yelled and refused to be redirected or quieted for a long time ... Pt yelled about peer having visitors. Pt yelling about peer yelling and " you never tell HIM to be quiet! " Pt put in quiet room with door open from	A 162	The expertise provided in this case consultation identified the need for increased case discussion with staff of all disciplines and on each shift and the need for expedited legal/medical counsel. In the days following this consultation the unit and executive triad leadership teams met with unit staff (overlapping shifts) to disseminate relevant case information and treatment strategies; to engage staff in dialogue; and to provide direction and support. The treatment team developed a behavior plan for patient # 5 that included identified coping strategies garnered from the case consultation and from the patient's own therapeutic inventory assessment.	

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A 162	Continued From page 20 approximately 3:45 to 4:45. Pt had prn Ativan 1 mg at 2:00 PM, and Zyprexa at 3:40. Pt finally quieted down, ate dinner, used the phone and went to sleep. This nurse does not see pt using spoons or anything to self-harm". The charge nurse confirmed during interview on 4/16/13 at 3:05 PM, that Patient # 4 was placed in seclusion and "was not allowed to leave".  The " Certificate of Need For Emergency Involuntary Procedures " form used by the facility, which identifies how the use of restraint and seclusion meets emergency criteria, less restrictive measures attempted, the RN or LIP 1-Hour assessment release from seclusion and patient response could not be found by the Clinical Manager which was confirmed during interview on 4/18/13 at 9:25AM. In addition, the physician's order did not include the reason for seclusion or the behavioral objectives for release.	A 162	A154 482.13(e) USE OF RESTRAINT OR SECLUSION Continued  5.) On 4/24/13 CNO provided an educational session to nursing leadership and clinical educators regarding patient rights and emergency procedures. 6.) On 5/13/13 the CNO approved an enhanced on line educational module focused upon criteria for emergency procedures and requirements for one hour assessment. The on line module was implemented on 5/25/13 on MyLearningPointe.com and will be used for RN orientation and as annual competency to ensure that nursing staff follow policies and regulatory guidelines for restraint and/or seclusion procedures. 7.) On 4/4/13 the executive team implemented a system for formal review of all emergency procedures, including restraint and seclusion and associated documentation (Certificate of Need, CON). 100% of CONs are reviewed by Clinical and Risk Manager for appropriate use of emergency procedures, less restrictive interventions attempted prior the procedure, and that all documentation requirements are met. For any patient who has five or more episodes of restraint and/or seclusion in one week the treatment team will conduct a complete review of the patient's care plan and make modifications as appropriate. 8.) Immediately following survey the Chief Executive and Medical Officer obtained legal and regulatory consultation from the Department of Mental Health regarding the expedition of non-emergent involuntary medication to ensure that patient # 5 receives needed treatment. 9.) The Chief Nursing Office and Clinical Manager addressed performance issues named in the citation as noted in citation response A 20.		
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION  Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.  This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to show evidence of less restrictive interventions being utilized prior to implementation of seclusion in 2 of 12 applicable records reviewed. ( Patients # 4, 5) Findings include:  1. Per record review, Patient #4 was placed in seclusion on 4/9/13 for approximately one hour	A 164			

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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		
(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 164	<p>Continued From page 21</p> <p>without evidence of lesser restrictive interventions being attempted with the exception of prn medication. Nursing progress notes dated 4/9/13 during the evening shift stated " .. pt yelled and refused to be redirected or quieted for a long time ... Pt yelled about peer having visitors. Pt yelling about peer yelling and " you never tell HIM to be quiet! " Pt put in quiet room with door open from approximately 3:45 to 4:45. Pt had prn Ativan 1 mg at 2:00 PM, and Zyprexa at 3:40. Pt finally quieted down, ate dinner, used the phone and went to sleep. This writer does not see pt using spoons or anything to self-harm".</p> <p>The " Certificate of Need For Emergency Involuntary Procedures " form used by the facility, which identifies how the use of restraint and/or seclusion meets emergency criteria, less restrictive measures attempted, the RN or LIP 1-Hour assessment release from seclusion and patient response could not be found. The physician order did not include the reason for seclusion and the behavioral objectives for release. The charge nurse confirmed during interview on 4/16/13 at 3:05 PM, that Patient # 4 was placed in seclusion and "was not allowed to leave".</p> <p>2. Per record review Patient #5, who had been admitted to the AIU (Adult Intensive Unit) on an involuntary basis on 3/10/13, was subjected to the following procedures including hands on restraint and/or LDS (Locked Door Seclusion), on 4/10/13 and 4/14/13, respectively, without evidence that less restrictive interventions had been employed and determined to be unsuccessful prior to the individual procedures:</p>	A 164	<p>A154 482.13(e) USE OF RESTRAINT OR SECLUSION Continued</p> <p>PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION</p> <p>Comprehensive staff education and training. Increased supervision for the Adult Intensive Unit. Increased resources approved for clinical education. Implementation of enhanced review of all emergency procedures and associated documentation. Approval for additional resources in clinical education. New training module for emergency procedures with competency. Legal/regulatory consultation. Progressive disciplinary action taken for staff involved in citations.</p> <p>MONITORING/TRACKING: (method, frequency and responsible person The executive leadership team will meet weekly and as needed with the adult intensive unit and will document progress in meeting minutes for a minimum of four months. Review of all emergency procedures, including restraint and seclusion will remain an ongoing practice. Results of any deficiency noted will be immediately reported to the CMO, CNO, Quality and Risk Manager. The Performance Improvement/Risk Manager will monitor 100% of all incidents and APS reports on ongoing basis. CNO will conduct quarterly audits of nursing personnel files to ensure that competencies regarding restraint and seclusion are complete and assess needs for additional training.</p>		



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A 164	Continued From page 23 in the plastic med cup. Each MHW stated that Nurse #1 then started to speak to Patient #5 in a loud voice telling the patient s/he was tired of the patient manipulating his/her meds. The patient became angry and threw the remaining water from the cup at Nurse #1 who immediately grabbed the patient by the right arm, pulled him/her from the chair in which s/he was sitting, and propelled him/her forward. At that point MHW #2 used a CPI (Crisis Prevention Intervention) technique to hold the patient's left arm and s/he was placed in locked door seclusion. Both MHWs stated there had been no attempt to verbally de-escalate the patient prior to the hands on procedure and there was no evidence of self harming behaviors or intent to harm others by Patient #5, until Nurse #1 put hands on the patient, at which point s/he began to kick and struggle. Nurse #1 then left the ALSA unit and returned with Nurse #2 who brought medication for the patient to take by mouth. Nurse #1 made a statement that the patient had spit the medication out and Nurse #1 and Nurse #2 then left and returned, within several minutes, to the seclusion room where Patient #5 was at that point sitting quietly on the floor. The patient was placed in a face down position on the floor and restrained in that position by 3 staff members while Nurse #2 gave the patient an injection. All staff then left the room. MHW #1 stated that Nurse #1 continued to check on the patient every 10 to 15 minutes and discussed the conditions of release from seclusion. S/he stated that in addition to asking the patient if s/he could contract for safety and not be assaultive, Nurse #1 also asked the patient if s/he was going to continue to make allegations against staff.	A 164	A162 482.13(e)(1)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION Continued  associated documentation (Certificate of Need, CON). 3.) 100% of CONs are reviewed by Clinical and Risk Manager for appropriate use of emergency procedures to ensure that less restrictive interventions are attempted prior the procedure, and that all documentation requirements are met. 4.) For any patient who has five or more episodes of restraint and/or seclusion in one week the treatment team will conduct a comprehensive review of the patient's care plan to identify potential patterns, trends, clusters of behaviors that make be contributing factors. Based upon this analysis the team will make modifications to the patient's treatment plan and communicate modifications to all staff.  PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Education and Training. Formalized process for CON monitoring. Implemented a system for a comprehensive case review for any patient who has had five or more emergency procedures within one week.  MONITORING/TRACKING: (method, frequency and responsible person) All Certificate of Need documents (CONs) are reviewed daily by unit based leadership teams (Unit Chief, Clinical Manager, Charge RN and Senior Clinician) and Performance Improvement/Risk Manager. CONs reviewed for Completion of MD orders; Criteria met for emergency procedure, less restrictive alternatives attempted. PI/Risk Manager, Clinical Managers, and House Supervisor on off hours review 100% of all CONs to assess that the event met emergency criteria and that policies and procedures were followed. Clinical Managers will audit 5 charts weekly to review for completeness of treatment plans and nursing documentation including evidence that less restrictive interventions were attempted prior to emergency	

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A 164	Continued From page 24 Nurse #1 confirmed, during interview at 9:13 AM on 4/18/13, that the patient had been given Seroquel, broke the pill in half and returned half to the med cup. S/he stated that because Patient #5 had previously been manipulating his/her medications, the nurse asked the patient to do a mouth check which s/he refused to allow. The nurse stated the patient then became angry and threw the water (in which Nurse #1 felt the patient had spit oral secretions), into Nurse #1's face and the nurse responded by telling the patient, in a loud voice, "seclusion room now." Nurse #1 confirmed that there had been no attempt to employ less restrictive measures to de-escalate the patient's behavior. S/he also agreed that in hind sight s/he could have stepped away from the patient to give time to de-escalate but felt, based on past experience with the patient, that the patient might attempt to assault staff. Nurse #1 stated that after being placed in LDS (Locked Door Seclusion). Patient #5 was given the option of taking Zyprexa (an antipsychotic drug) by mouth or injection. The patient took the oral Zyprexa which Nurse #1 stated s/he felt the patient spit out. Nurse #1 stated s/he left the LDS and contacted the physician by phone and explained that s/he was not certain how much, if any, of the Zyprexa the patient had received orally. S/he stated that the physician ordered Zyprexa IM. The nurse confirmed that upon return to the LDS, despite the fact that Patient #5 was sitting quietly on the floor, s/he was placed in a face down position on the floor, and restrained by 3 staff members while Nurse #2 administered the IM Zyprexa. Nurse #1 further confirmed that s/he returned every 10 to 15 minutes to determine the patient's readiness to be released from LDS. S/he confirmed that s/he asked the	A 164	A162 482.13(e)(1)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION Continued procedures.  PROCEDURES FOR INCORPORATING SYSTEMATIC IMPROVEMENT ACTIONS INTO QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) PROGRAM: As directed by the Chief Nursing Officer the Performance Improvement and Risk Manager will analyze and trend Certificate of Need (CON) and APS data for quality review and to identify performance improvement opportunities. The data is reported to the executive team (or administrator on call) including Senior Director of Quality and Regulatory Compliance on a daily basis. This quality data is presented monthly to the Safety Committee and Quarterly to the Board Quality Committee and to the Organization Wide Performance Improvement Committee.  TITLE OF RESPONSIBLE PERSONS: Chief Nursing Officer and Vice President of Patient Care Senior Director of Quality and Regulatory Compliance Performance Improvement/Risk Manager  A164 482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION  PLAN OF CORRECTION FOR CITED DEFICIENCY & EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: 1.) In order to ensure that less restrictive interventions have been determined to be ineffective to protect the patient, a staff, or others from harm, the executive leadership team provided education and training regarding policies and procedures that govern restraint and seclusion to the full executive team, medical staff and unit based leadership. 2.) This education provided a focused review of the use of the patient's therapeutic inventory assessment and staff training on its use and efficacy in patient	4/19/13	

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A 164	<p>Continued From page 25</p> <p>patient if s/he was going to continue to assault staff and the patient said yes. S/he also asked the patient if s/he was going to continue to make false allegations against staff and the patient responded yes.</p> <p>A Nurse's Note, dated 4/14/13 at 6:53 PM, stated that Patient #5 had been challenging staff on every request. "Pt didn't like redirection and threw red Gatorade on staff person wearing white shirt. Cold jarred staff badly, and jostled pt against wall." A CON (Certificate of Need), dated 4/14/13 at 10:15, indicated a therapeutic hold had been implemented for a period of 1 minute and stated the reason the emergency procedure had been employed; "pt had been challenging staff all day shift, attempting to get out of ALSA, threatening to throw items. At 10:15 pt threw drink at staff, threats of physical harm." Although the documentation indicated the patient had been challenging staff all day, the only less restrictive interventions employed prior to the therapeutic hold were reported as "pt has had negative responses to redirection by staff." Per review of the formal grievance, filed by Patient #5 and provided to the surveyor by the patient, MHW #3 had treated the patient in a non-therapeutic and disrespectful manner when, in response to the patient throwing Gatorade at MHW #3, the MHW grabbed him/her by the arms and held him/her against the wall. Per review, statements documented by MHWs #4 &amp; #5, both of whom witnessed the event, identified that MHW #3 had grabbed onto Patient #5's upper arms while facing him/her and pushed him/her against the wall. MHW #5 further indicated that MHW #3 had stated to Patient #5 "I'm going to take you down" (meaning to the floor). During interview, at 1:11</p>	A 164	<p>A164 482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Continued</p> <p>care.</p> <p>3.) On 4/19/13 the executive team implemented a system for formal review of all emergency procedures, including restraint and seclusion and associated documentation (Certificate of Need, CON).</p> <p>4.) 100% of CONs are reviewed by Clinical and Risk Manager for appropriate use of emergency procedures to ensure that less restrictive interventions are attempted prior to the procedure, and that all documentation requirements are met.</p> <p>5.) For any patient who has five or more episodes of restraint and/or seclusion in one week the treatment team will conduct a complete review of the patient's care plan and make modifications as appropriate.</p> <p>PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION</p> <p>Education and Training. Formalized process for CON monitoring. Implemented a system for a comprehensive case review for any patient who has had five or more emergency procedures within one week.</p> <p>MONITORING/TRACKING: (method, frequency and responsible person) All Certificate of Need documents (CONs) are reviewed by Clinical managers, PI/Risk Manager and Nursing Supervisors on off shifts daily. The adult intensive team reviews all CONs daily as part of the treatment planning process. CONs are reviewed for completion of MD orders; to confirm that criteria are met for the emergency procedure, that less restrictive alternatives were attempted and that the nursing assessment within one hour was conducted. Clinical Managers will audit 5 charts weekly to review for completeness of treatment plans and nursing documentation including evidence that less restrictive interventions were attempted prior to emergency procedures.</p>	

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A 164	Continued From page 26 PM on 4/17/13, the RN Unit Manager of AIU confirmed that MHW #4 had held onto the arms of Patient #5 and had placed him/her against the wall.	A 164	A164 482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Continued		
A 166	482.13(e)(4)(I) PATIENT RIGHTS: RESTRAINT OR SECLUSION  The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care.  This STANDARD is not met as evidenced by: Based on record review and staff interview, the hospital failed to assure that the plan of care was modified to reflect the use of restraint or seclusion in 2 of 12 applicable records reviewed. (Patients #4 & #5 Findings include:  1. Per review of the 4/2/13 "Certificate of Need for Involuntary Procedures" (CON) and progress notes, Patient #4 was placed in open door seclusion from 7:57 PM to 8:30 PM when h/she refused to return a plastic utensil, refused redirection, began banging on the walls and attempted to wrap the cord of a blood pressure cuff around h/her neck. The CON stated that Patient #4 made a suicidal threat a day earlier (4/1/13) and had a history of using utensils for self-harming behavior. Per record review, the use of seclusion related to this incident was not incorporated into interdisciplinary treatment plan, which was updated on 4/3/13.  Patient # 4 was placed in open door seclusion on 4/9/13 from 3:45 PM to 4:45 PM. Nursing progress notes stated "...pt. yelled and refused to be redirected or quieted for a long time. Pt yelled about peer having visitors. Pt yelled and peer	A 166	PROCEDURES FOR INCORPORATING SYSTEMATIC IMPROVEMENT ACTIONS INTO QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI) PROGRAM: As directed by the Chief Nursing Officer the Performance Improvement and Risk Manager will analyze and trend Certificate of Need (CON) for quality review and to identify performance improvement opportunities. The data is reported to the executive team (or administrator on call) including Senior Director of Quality and Regulatory Compliance on a daily basis. This quality data is presented monthly to the Safety Committee and Quarterly to the Board Quality Committee and to the Organization Wide Performance Improvement Committee.  TITLE OF RESPONSIBLE PERSONS: Chief Nursing Officer and Vice President of Patient Care Senior Director of Quality and Regulatory Compliance Performance Improvement/Risk Manager Clinical Managers  A166 482.13(e)(4)(I) PATIENT RIGHTS: RESTRAINT OR SECLUSION  PLAN OF CORRECTION FOR CITED DEFICIENCY & EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: 1.) In order to ensure that all episodes of restraint and/or seclusion are reflected in the patient's plan of care, the executive leadership team provided education and training regarding documentation requirements for treatment planning that include the required modifications to the plan of care following incidents of restraint or seclusion. Training was given to the full executive team, medical staff and unit based leadership. 2.) On 4/19/13 the executive team implemented a system for formal review of all emergency procedures	4/19/13	

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A 166	<p>Continued From page 27</p> <p>yelling and "you never tell HIM to be quiet". Pt. had PRN Ativan 1 mg at 2PM and Zyprexa at 3:40 PM. Pt. finally quieted down, ate dinner, used the phone, and went to sleep."</p> <p>Per record review, the interdisciplinary treatment plan, updated on 4/10/13, stated "Superficial attempts to hurt self yesterday secondary to distressed re :slowness of aftercare"... "remains labile with emotional outbursts, continually needing attention or limit setting.." However, the treatment plan did not reflect of the use of seclusion on 4/9/13. This was confirmed during interview with the Clinical Manager on 4/18/13 at 9:25 AM.</p> <p>2. Per record review staff had utilized restraints and/or seclusion for Patient #5 on multiple occasions from his/her involuntary admission on 3/10/13 through 4/14/13. The use of restraints and/or seclusion occurred on at least 10 episodes between the dates of 4/8/13 - 4/14/13, including up to 3 episodes on some days, for behaviors that included attempts to assault staff and several incidents in which the patient threw liquid from a cup at staff. Despite the frequent use of restraints and/or seclusion the patient's care plan did not reflect their use. Although a specific Behavior Plan had been developed, dated 3/27/13 and revised on 4/15/13, which reflected patient specific unsafe behaviors, the plan only addressed the consequences of unsafe behavior and the benefits of changing that behavior. There was no plan of care that identified interventions to employ to assist in preventing unsafe behavior exhibited by the patient or prevent escalation of that unsafe. The Clinical Manger of the unit on</p>	A 166	<p>A166 482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION Continued</p> <p>including restraint and seclusion and associated documentation (Certificate of Need, CON). 3.) 100% of CONs are reviewed by Clinical and Risk Manager for appropriate use of emergency procedures to ensure that less restrictive interventions are attempted prior the procedure, and that all documentation requirements are met. 4.) The PI/Risk Manager provides data to clinical managers for any patient who has had 5 or more emergency procedures in one week. Those patients require a comprehensive full team review to assure that modifications including behavior plans are incorporated into the current treatment plans. 5.) The Director of Social Work provided training on treatment planning and incorporation of behavioral plans to all social work on 4/16/13, during survey, and again on 5/23/13.</p> <p>PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Education to staff regarding Emergency procedures and need for treatment plan updates that incorporate behavioral interventions and plans. CON documentation modification. CON reporting function added to Electronic Health Record. Implemented a systematic review of all CONs.</p> <p>MONITORING/TRACKING: (method, frequency and responsible person) Performance Improvement/Risk Manager reviews 100% of all CONs and reports trends for emergency procedures to Patient Safety, Quality and informs clinical education. Daily review of all CONs by Adult Intensive Team. Clinical Managers will audit 100% of all CONs for restraint and seclusion for four months to ensure that treatment plans are modified accordingly. In addition the Director of Social work will review 12 chart audits per month to ensure that treatment plans reflect current plans of care.</p>	

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A 166	Continued From page 28	A 166	A166 482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION Continued	
A 168	<p>which Patient #5 resided, confirmed that the care plan did not reflect the use of restraints/seclusion, during interview on the morning of 4/18/13.</p> <p>482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to assure staff obtained an order from a physician for the use of seclusion and/or physical restraint for 3 of 12 applicable patients. (Patients # 4, 5, 23) Findings include:</p> <p>1. Per review on 4/18/13, Patient #23 with a diagnosis of Schizoaffective Disorder and Depression, was admitted to the hospital involuntarily on 8/3/12. Over the course of several weeks, Patient #23 had several behavioral emergencies requiring both emergency medications and the use of seclusion. Both interventions require a physician order. On 10/22/12, the psychiatric progress note states "...remains quite psychotic, intrusive.....de-escalation techniques proved ineffective...." A nursing progress note states "...2 person hands escort to quiet room (seclusion)..." and further stating Patient #23 remained in quiet room for 20 minutes. Per review of physician orders for 10/22/12, no order was received or written for the use of seclusion during the</p>	A 168	<p>TITLE OF RESPONSIBLE PERSONS: Chief Medical Officer Chief Nursing Officer and Vice President of Patient Care Director of Social Work</p> <p>A168 482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: On 4/18/13 and 5/2/13 and 5/16/13 the Chief Medical Officer and Medical Director provided in-service to the medical staff on emergency procedures, including a review of policies and procedures that govern emergency procedures and quality oversight of patient care and documentation procedures. On 4/24/13 the CNO provided an in-service to clinical nurse managers reviewing policies, procedures and regulations that govern emergency procedures including the timeliness of medical orders for any any/all emergency procedures. She emphasized the importance of incident reporting to track medication and procedure errors and their role in promoting patient safety in a just culture. To enhance oversight and review of emergency procedures on the Adult Intensive unit, on 5/20/13 the executive team implemented a system to review 100% of all Certificate of Need documents (CONs) as part of the daily treatment team planning process. This procedure will be in place for 60 days and will be a pilot for hospital-wide implementation. CONs are reviewed for: 1.) Completion of MD orders. 2.) Documentation that criteria is met for emergency procedure. 3.) Documentation that less restrictive interventions were attempted.</p>	5/21/13

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

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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  04/18/2013
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	
A 168	Continued From page 29 morning intervention which occurred from 9:25 AM - 10:00 AM. This omission was confirmed on the afternoon of 4/18/13 with the nurse manager for the former Osgood 3 unit where Patient #23 was hospitalized.  2. Per record review, a stamped order dated 4/9/13 at 3:35 PM for the use of seclusion for Patient #4 was not signed by the physician in a timely manner. Per interview of 4/16/13 at 2:10 PM, the Clinical Manager and Charge Nurse confirmed that the telephone order had not been signed by the physician. The Clinical Manager and Charge Nurse said the expectation is for telephone orders to be signed within 24 hours and if the prescriber is not available, the covering physician would sign the order. The order was not signed until 4/17/13 at 9:00 AM.  3. Per record review Patient #5, who was admitted on 3/10/13, on involuntary admission status had a CON, dated 4/10/13, which indicated that at 5:40 AM the patient had been placed in seclusion and received involuntary medication (a chemical restraint) in response to: "Pt refused to comply with mouth check, assaulted staff throwing dirty (had been in Pt mouth) water in staff's face - escorted to QR - kneed and kicked writer - placed in QR & seclusion initiated secondary to assaultive 'bx' (behavior). Per separate, individual interviews, conducted on 4/17/13 and 4/18/13, respectively, two MHWs and the Unit Charge Nurse at the time of the incident, each confirmed that physical restraint in the form of hands on was utilized to escort Patient #5 to the seclusion room. In addition, the MHWs and the Charge Nurse also confirmed the use of physical restraint by 3 staff members who held	A 168	A168 482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION Continued.  On 5/21/13 the executive team approved the addition of an administrative assistant to assist the Clinical Manager on the AIU with chart audits.  PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Staff education. Daily review of all incidents of restraint and seclusion and associated Certificates of Need (CON). Implementation of system for daily review of CONs by treatment team piloted on the Adult Intensive Unit for 60 days. Provided additional administrative support for the AIU.  MONITORING/TRACKING: (method, frequency and responsible person) Clinical Managers, PI/ Risk Manager and Nursing Supervisor off shifts will review all CON's daily.  TITLE OF RESPONSIBLE PERSONS: Chief Nursing Officer and Vice President of Patient Care Clinical Manager		

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A 168	Continued From page 30 the patient face down on the floor during the administration of involuntary IM medication. The Unit Charge Nurse, who was responsible for obtaining physician orders, further confirmed there was no physician order for use of restraints during the escort nor during administration of involuntary medications.	A 168	A178 482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION  PLAN OF CORRECTION FOR CITED DEFICIENCY & EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: In order to assure that nursing staff conduct an accurate and comprehensive assessment of patents within one hour after the initiation of either a restraint or seclusion, 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. 100% of Clinical Managers and Clinical Educators attended the training.  The training included: 1.) 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. 2.) Elements of the one hour assessment include: a. Patient's immediate situation. b. Patient's reaction to the event. c. Behavioral and/or medical conditions that may have contributed to the event. d. The need to continue or terminate the restraint or seclusion.  On 5/13/13 CNO approved an on line educational module that clinical managers will incorporate into unit based training. On 5/25/13 the on line training was activated on MyLearningPointe.com. 100% of current nursing staff will receive this training and will and complete the required competency to ensure that nursing staff are trained in accordance with the one hour assessment requirement by 6/28/13. This training module will be included in orientation of new nurses and become an annual competency.	5/25/13
A 178	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION  When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention -- o By a-- - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section.  This STANDARD is not met as evidenced by: Based on record review, the hospital failed to assure nursing staff conducted an accurate and comprehensive assessment of patients 1 hour after the initiation of either a restraint or seclusion for 1 of 12 applicable patients. (Patient #23 ) Findings include:  1. Per review of the Certificate of Need for Emergency Involuntary Procedures (CON), staff failed to complete a 1 hour face-to-face assessment after the initiation of seclusion on 10/22/12 at 10:00 AM for Patient # 23. Patient #23's specific behaviors (physical threats to staff,	A 178		

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A 178	Continued From page 31 extreme agitation, not re-directable) resolved prior to the 1 hour face-to-face assessment evaluation with seclusion being discontinued at 10:50 AM. However, hospital staff identified to be qualified to complete the evaluation (nursing staff) are still required to conduct the patient face-to-face and assess if further evaluation is necessary regarding the medical or psychological affects of seclusion, factors that may have contributed to Patient #23's behaviors and whether the intervention was appropriate.	A 178	A178 482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION Continued  PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION 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.  MONITORING/TRACKING: (method, frequency and responsible person) CNO will ensure that all nursing staff completes the comprehensive training module for emergency procedures at orientation and on annual basis. Clinical Managers will review 100% of all CONs to ensure that nursing assessments are completed within one hour of an emergency procedure.	
A 179	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION  [the patient must be seen face-to-face within 1 hour after the initiation of the intervention -- ]  §482.13(e)(12)(ii) To evaluate - 1. The patient's immediate situation; 2. The patient's reaction to the intervention; 3. The patient's medical and behavioral condition; and 4. The need to continue or terminate the restraint or seclusion.  This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to assure that the face-to-face evaluations conducted within 1 hour after the initiation of restraints and/or seclusion included all elements of a medical and behavioral assessment, necessary to determine if other factors, such as drug or medication interactions, electrolyte imbalance, etc., could be contributing to the behavior that warranted the need for intervention for 1 of 12 patients. (Patients #5 ). Findings include:	A 179	A 179 482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION  TITLE OF RESPONSIBLE PERSONS: Chief Nursing Officer and Vice President of Patient Care Clinical Manager  A 179 482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION  PLAN OF CORRECTION FOR CITED DEFICIENCY & EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: On 4/22/13 the CNO and PI/Risk Manager met with the Clinical Education Department to review and revise the educational curriculum for dealing with emergency procedures and the requirement for an assessment within one hour. The revisions included: 1.) Clarification regarding the intent of the one hour assessment following an emergency procedure. The assessment must take place within 1 hr for all emergency procedures, even those whose duration is very short.	5/25/13

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A 179	<p>Continued From page 32</p> <p>1. Per record review, Patient #5, who was admitted involuntarily on 3/10/13; had multiple episodes of use of restraints and/or seclusion between the date of admission and 4/15/13. The CONs used by staff included a 1 Hour Assessment process that directed staff to: describe the patient's condition and circumstances leading up to the emergency procedure; identify if there was any patient injury; identify less restrictive measures tried; describe what interventions were authorized; document the patient's response to the intervention; and describe the nursing assessment of any physical problems as a result of the restraint, indicating the reason for the assessment is to determine any injuries or problems that resulted from the use of restraints/seclusion. The CON form did not include information regarding the patient's physical or medical condition. Per review of 9 separate CONs completed for use of restraints/seclusion for Patient #5 between the dates of 4/8/13 and 4/14/13 there was no evidence, in the 1 hour face-to-face evaluation, that an assessment of the patient's physical (including a complete review of systems) and medical condition had been conducted.</p> <p>During interview, at 9:33 AM on 4/17/13, the CNO (Chief Nursing Officer) confirmed that RN staff conduct the 1 hour face to face assessments of patients following initiation of restraints and/or seclusion. S/he further agreed that the CON form used for assessments did not direct staff to include all elements of the face to face assessment and stated that the assessments currently being conducted by RNs does not include assessment of the physical (including a complete review of systems) and medical</p>	A 179	<p>A 179 482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION Continued</p> <p>2.) Elements of the one hour assessment include:</p> <ul style="list-style-type: none"> <li>a. Patient's immediate situation.</li> <li>b. Patient's reaction to the event.</li> <li>c. Behavioral and/or medical conditions that may have contributed to the event.</li> <li>d. The need to continue or terminate the restraint or seclusion.</li> </ul> <p>On 5/13/13 CNO approved an on line educational module 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.</p> <p>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 comprehensive training module for emergency procedures at orientation and on annual basis. Clinical Managers will review 100% of all CONs to ensure that nursing assessments are completed within one hour of an emergency procedure.</p> <p>TITLE OF RESPONSIBLE PERSONS:</p> <p>Chief Nursing Officer and Vice President of Patient Care Clinical Managers</p>	
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A 179	Continued From page 33 conditions of the patient needed to make a determination of whether or not a physical or medical condition could be contributing to the patient behavior that warranted the use of restraints and/or seclusion.	A 179	A396 482.23(b)(4) NURSING CARE PLAN PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: To assure that the nursing staff develops and keeps current a nursing care plan, on 4/18/13 the CNO provided an in-service to the nursing leadership regarding standards and requirements for planning and the process for updating plans to incorporate treatment interventions and behavior plans when emergency procedures are used. A comprehensive reeducation on treatment planning for medical, nursing and social work staff will be completed by June 28, 2013. (B Tag action item). The training will include: • Individualized plans of care. • Role of patient and family in treatment planning. • Family therapy as a treatment modality as clinically indicated. • 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. On 5/21/13 CNO, CMO, Vice President of Operations and Director of Social Work made modifications to the current paper based treatment plans in preparation for a conversion to the electronic health record. Modifications made are described further in the POC for B Tag Survey date 4/17/13.	5/21/13
A 396	482.23(b)(4) NURSING CARE PLAN  The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient.  This STANDARD is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to assure that the nursing staff develops, and keeps current, a nursing care plan for 2 of 30 patients. (Patients #11,16) . Findings include:  1). Patient #11, whose diagnoses include Major Depressive Disorder with Psychotic Features and Attention Deficit Hyperactivity Disorder, has a Care Plan dated 3/21/13 for Risk of Harm to Others and/or Self resulting from Impaired Insight/Judgment. The Care Plan includes the intervention of 'Nursing will reinforce ...the "point system"'. Per interview with the Unit Manager for Patient #11 on 4/16/13 at 10:35 A.M. the 'point system' was "not working for (Patient #11) so we tried an Individual plan" and confirmed that the Treatment Plan Update dated 3/28/13 states Patient #11 has "a behavior plan to address negative behavior".  Per observation of Patient #11's Treatment Team Meeting on 4/16/13 at 9:40 A.M., the patient's Physician, a Licensed Social Worker, and the Unit Manager decided to place Patient #11 "back on the behavior plan" with regards to	A 396	PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Staff education. Modifications to treatment plan documents.	

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A 396	<p>Continued From page 34</p> <p>a recent change in behavior .The Unit Manager then stated that the behavior plan was never written down. The Physician stated " We came up with it, it was working, and we didn't write it down " . Per interview with the Unit Manager for Patient #11 on 4/16/13 at 10:35 A.M.; h/she confirmed there was no documentation that Patient #11 ' s Plan of Care had been reviewed or revised since admission, that there was a recent change in Patient #11 ' s behavior, and a Behavior Plan that ' was working ' for the patient was never written down.</p> <p>2). Per record review Patient #16, whose diagnoses include suicide ideation and psychosis, had 3 incidents between 3/22 &amp; 3/23/13 for which a Physician ' s Order for restraint and seclusion was obtained, and a Care Plan regarding the behaviors was developed and dated 3/25/13. Per record review, another incident of restraint and seclusion for Patient #16 on 4/4/13 A Nursing Note one hour after the incident reports " a new plan for triggered and flashback management was developed with the patient " . Per interview with Patient #16 ' s Unit Manager on 4/18/13 at 12:05 P.M., the Unit Manager confirmed there was nothing in the patient ' s plan of care reflecting a new plan, and no documentation of any review or revision of Patient #16 ' s Care Plan since the initial implementation on 3/25/13. The Unit Manager confirmed that only the Nursing Notes dated 4/4/13 contained specific interventions that " probably " were part of the new plan. The Unit Manager stated the Nursing Notes would be read the next day during morning meeting, and passed on verbally shift to shift. The Unit Manager confirmed in order for the new treatment plan to be available for staff on the day</p>	A 396	<p>A396 482.23(b)(4) NURSING CARE PLAN Continued</p> <p>MONITORING/TRACKING: (method, frequency and responsible person) Clinical Manager chart audit – 5 per week for 4 months per plan of correction approved 4/24/13. Director of Social Work will conduct 12 chart audits per month for four months to ensure that behavior plans are incorporated into treatment plans:</p> <p>TITLE OF RESPONSIBLE PERSONS: Chief Medical Officer Chief Nursing Officer and Vice President of Patient Care Director of Social Work Clinical Managers</p> <p>A407 482.23(c)(2)(i) USE OF VERBAL ORDERS</p> <p>PLAN OF CORRECTION FOR CITED DEFICIENCY &amp; EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: On May 22, 2013 the Chief Medical Officer and the Chief Nursing Officer revised the policy for verbal/telephone orders to ensure that the licensed practitioner reads back all verbal/telephone orders. By 5/31/12 laminated posters providing visual cues that prompt the sequence and compliance of verbal/Telephone read back orders will be posted in medication room on each inpatient unit. 100 % of nursing and medical staff will be educated to the revised policy by June 14, 2013.</p> <p>PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION</p> <p>Policy revision Use of visual aide to prompt compliance Education of policy revision</p>	6/14/13
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A 396	Continued From page 35 of the interview (4/18/13), information would have had to be transferred verbally shift to shift for 14 days and to accomplish this would be "hard" and that some effective Interventions of the new plan developed could have been lost or altered along the way. The Unit Manager also confirmed an incident of restraint and seclusion of Patient #16 occurred later on 4/10/13 and there was no documentation that any new interventions had been developed or implemented in Patient #16's Plan of Care.	A 396	A407 482.23(c)(2)(i) USE OF VERBAL ORDERS Continued  MONITORING/TRACKING: (method, frequency and responsible person)  Indication that physician verbal/telephone orders were read back will be audited by the clinical manager during weekly chart audits for three months commencing June 17 2013.  Results of audits will be reported to patient safety committee.	
A 407	482.23(c)(2)(i) USE OF VERBAL ORDERS  If verbal orders are used, they are to be used infrequently.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to assure that telephone and verbal orders were being verified through a "read back" process. Findings include:  Per interview with the Unit Manager for Osgood 1 on 4/16/13 at 11:10 A.M. the Unit Manager stated "the only thing documented as read back is critical lab values". Per interview with the Unit Manager for Osgood 2 on 4/17/13 at 12:05 P.M. the Unit Manager stated "We do not mark that they (telephone and verbal orders) were read back. They are marked "TO" (Telephone Order). We used to mark them "TORB" (Telephone Order Read Back). I don't remember when we stopped that." Per record review, physician orders on 10 patient charts from both Osgood 1 and Osgood 2 were reviewed regarding verification of telephone and verbal orders having been read back. Both Unit Managers confirmed there was no documentation	A 407	TITLE OF RESPONSIBLE PERSONS(s): Chief Nursing Office and Vice President of Patient Care Clinical Nurse Managers  A 620 482.28(a)(1) DIRECTOR OF DIETARY SERVICES  PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: The Manager of Dietary Services held an in-service for all dietary personnel on 4/30/13. The focus of the in-service was on: • the importance of maintaining physical separation of clean & dirty dishes/ utensils; • monitoring fill levels for trash cans. • a review of policies and procedures for removal of foods by noted expiration date. On 4/19/13 temporary repairs to the floor tiles, baseboard molding and plaster were initiated and were on 5/22/13. Permanent repairs are part of a larger renovation and will be completed by 8/17/13. For any future work order in the dietary department that may have infection control ramifications, the Manager of Dietary Department will notify Manager of Infection Prevention & Control whenever an environmental repair is requisitioned. The needed repair will be completed within 24 hours.	6/17/13

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A 407	Continued From page 36 verifying whether or not telephone and verbal orders had been read back to the practitioner at the time when an order was received.	A 407	A 620 482.28(a)(1) DIRECTOR OF DIETARY SERVICES Continued	
A 620	482.28(a)(1) DIRECTOR OF DIETARY SERVICES  The hospital must have a full-time employee who-  (i) Serves as director of the food and dietetic services;  (ii) Is responsible for daily management of the dietary services; and  (iii) Is qualified by experience or training.  This STANDARD is not met as evidenced by: Based upon observation and interview, the Director of Food Services failed to assure the facility's food services were effectively managed in regards to kitchen sanitation and infection control measures. Findings include:  -1. Per observation in the facility's kitchen on 4/16/13 at 11:40 A.M. a food service worker in the dishwashing area moved a visibly soiled dish cart to abut a cart containing clean mugs and dishes. The Food Services Director [FSD] moved the dirty dish cart away from the cart containing the clean items. The food service worker then stated " I want it there " and moved the dirty cart back against the clean cart. Per interview with the facility's Infectious Disease Preventionist during a tour of the kitchen on 4/18/13 at 10:20 A.M. a dirty dish cart abutting a cart with clean dishes was " definitely " an infection control issue and the FSD moving the carts apart demonstrated that h/she recognized it as an issue.	A 620	MONITORING/TRACKING: (method, frequency and responsible person) On April 22, 2013 the Manager of Dietary Services implemented a monitoring system to ensure compliance with food disposal by expiration date; trash containers at appropriate fill levels, a separation of clean and dirty dishes and utensils and a visual inspection of flooring and baseboards in the kitchen. He will monitor all items for four months. On 5/24/13 the Manager of Infection Prevention and Control assured that she will conduct announced inspections of dietary/kitchen twice per month for four months.  TITLE OF RESPONSIBLE PERSONS(s): Manager of Dietary Services Manager of Infection Prevention and Control  A701 482.41 (a) MAINTENANCE OF PHYSICAL PLANT  PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: Temporary repairs to the floor tiles, baseboard molding and plaster were initiated on 4/19/13 and were completed on 5/22/13. Permanent repairs are part of a larger renovation and will be completed by 6/17/13. For any future work order in the dietary department that may have infection control ramifications, the Manager of Dietary Department will notify Manager of Infection Prevention & Control whenever an environmental repair is requisitioned.  For any repair that has infection control or other patient safety ramifications, the needed repair will be completed within 24 hours.	6/17/13

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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  04/18/2013	
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
A 620	<p>Continued From page 37</p> <p>2. Per observation on 11:40 A.M. on 4/16/13 the facility's kitchen contained an area approximately 8 ft. in length in the food prep area where tiles used for baseboard molding were missing, exposing the plaster wall. The plaster wall had areas which were cracked and crumbling, running behind an ice machine and a sink, where a hole in the plaster exposed pipes in the wall. Additionally, there was an approximate 1/2 inch gap between the floor tiles and the length of wall.</p> <p>Per interview with the FSD on 4/16/13 at 11:50 A.M. the Facilities staff had been " working on it for months " Per phone interview with the Facilities Manager [FM] on 4/17/13 at 1:30 P.M. the staff were working on replacing tile molding for ' a couple weeks ' and along with tile replacement the gaps between the floor and the wall were to be filled within ' a week ' .</p> <p>Per review of FDA guidelines (<a href="http://www.fda.gov/ICECI/EnforcementActions/.../ucm256413.htm">www.fda.gov/ICECI/EnforcementActions/.../ucm256413.htm</a> &lt;<a href="http://www.fda.gov/ICECI/EnforcementActions/.../ucm256413.htm">http://www.fda.gov/ICECI/EnforcementActions/.../ucm256413.htm</a>&gt;)</p> <p>The "FDA recommends all flooring in food preparation and storage areas be smooth, non-absorbent, easily cleanable and durable (e.g., no cracks) ". Per interview with the facility's Infectious Disease Preventionist during a tour of the kitchen on 4/18/13 at 10:20 A.M. the areas of missing tile, crumbling plaster, and the gap between the floor and wall " absolutely " demonstrated an infection control issue.</p> <p>3. Per observation on 11:40 A.M. on 4/16/13 the</p>	A 620	<p>A701 482.41 (a) MAINTENANCE OF PHYSICAL PLANT Continued</p> <p>Manager of Infection Prevention and Control will add flooring and baseboard inspection to her environment of care rounds findings to the patient safety committee.</p> <p>TITLE OF RESPONSIBLE PERSONS(s): Director of Facilities Manager of Dietary Manager of Infection Prevention and Control</p>	

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

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A 620	Continued From page 38 facility 's kitchen contained a visibly soiled trash container in a food prep area with the container 's lid raised due to overflowing trash. Per interview with the FSD on 4/16/13 at 11:50 A.M. it is the kitchen manager 's responsibility to empty the kitchen trash containers and h/she " usually does them but today is delivery day ". Per interview with the facility 's Infectious Disease Preventionist during a tour of the kitchen on 4/18/13 at 10:20 A.M. the overflowing trash can in the food prep area represented an infection control issue.  4. Per observation on 11:40 A.M. on 4/16/13 the facility 's walk-in refrigerator contained an approx. 12 oz. plastic container of tuna fish dated 4/15/13. Per interview with the Food Services Director [FSD] on 4/16/13 at 11:50 A.M. the facility 's policy regarding perishable foods is the food is labeled with a 'use by' date. At the end of the day on that date, the outdated items are disposed of by the kitchen manager. The FSD confirmed the tuna fish should have been thrown out previous day.	A 620		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT  The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.  This STANDARD is not met as evidenced by: Based upon observation and staff interview the facility failed to maintain the facility 's kitchen and food preparation areas in such a manner that the safety and well-being of patients is assured. Findings include:	A 701		

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A 701	Continued From page 39  Per review of FDA guidellnes ( <a href="http://www.fda.gov/ICECI/EnforcementActions/.../ucm256413.htm">www.fda.gov/ICECI/EnforcementActions/.../ucm256413.htm</a> ) < <a href="http://www.fda.gov/ICECI/EnforcementActions/.../ucm256413.htm">http://www.fda.gov/ICECI/EnforcementActions/.../ucm256413.htm</a> > The " FDA recommends all flooring in food preparation and storage areas be smooth, non-absorbent, easily cleanable and durable (e.g., no cracks) ". Per observation on 11:40 A.M. on 4/16/13 the facility ' s klitchen contained an area approximately 8 ft. in length in the food prep area where tiles used for baseboard molding were missing, exposing the plaster wall. The plaster wall had areas which were cracked and crumbling, running behind an ice machine and a sink, where a hole in the plaster exposed pipes in the wall. Additionally, there was an approximate 1/2 inch gap between the floor tiles and the length of wall.  Per interview with the Food Services Director on 4/16/13 at 11:50 A.M. the Facilities staff had been " working on it for months " . Per phone interview with the Facilities Manager on 4/17/13 at 1:30 P.M. the staff were working on replacing tile moldings for ' a couple weeks ' and along with tile replacement the gaps between the floor and the wall were to be filled within ' a week ' . Per interview with the facility ' s Infectious Disease Preventionist during a tour of the kitchen on 4/18/13 at 10:20 A.M. the areas of missing tile, crumbling plaster, and the gap between the floor and wall " absolutely " demonstrated an infection control issue.	A 701		



# BRATTLEBORO RETREAT BOARD OF TRUSTEES ORGANIZATIONAL CHART

**Board Chair**  
Jeffrey Morse

**Brattleboro Retreat Board of Trustees**  
Bette Abrams, Elizabeth Catlin, David Dunn, Mary Faucher,  
Daniel Normandeau, Patty O'Donnell, Tammy Richards,  
Michael Sarsynski, Robert E. Simpson, Jr., Tonia Wheeler

**Board Committees**

**Compensation (Meets Annually)**  
Jeffrey Morse, Chair, *ex officio*

**Executive Committee (Meets Bi-Monthly)**  
Jeffrey Morse, Chair, *ex officio*

**Finance Committee (Meets Bi-Monthly)**  
Tammy Richards, Chair

**Audit Committee (Meets Annually)**  
Tammy Richards, Chair

**Quality & Performance Improvement Committee (Meets Quarterly)**  
Bette Abrams, Chair

**Development Committee (Meets Monthly)**  
Bette Abrams, Chair

**Governance Committee (Meets as Needed)**  
Bette Abrams, Chair

**President and Chief Executive Officer**  
Robert E. Simpson, Jr., DSW, MPH

**Chief Financial Officer**  
John Blaha, MBA

**Sr. Vice President Government Public Relations**  
Peter Albert, LICSW

**Vice President Strategy and Development**  
Konstantin von Krusenstern

**Vice President Human Resources**  
Jeffrey Corrigan

**Chief Medical Officer**  
Frederick Engstrom, MD

**Vice President Operations**  
Gerri Cote, LICSW

**Chief Nursing Officer**  
Debra Lucey, RN, MSN

**Associate Medical Director**  
Robyn Ostrander, MD

**Senior Director of Quality and Regulatory Compliance**  
Sharon Chaput, RN, C, CSHA



Brattleboro Retreat  
MIND. BODY. AND BEHAVIORAL HEALTH

# Organizational Chart

Executive Coordinator/Patient Advocate  
Brenda Nichols

President and Chief Executive Officer  
Robert E. Simpson, Jr., DSW, MPH

Sr. Vice President  
Finance  
Chief Financial Officer  
John E. Blaha, MBA

Sr. Vice President  
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Peter Albert, LICSW

Vice President of Strategy and Development  
Konstantin van Krusenstern

Vice President  
Human Resources  
Jeffrey T. Corrigan

Chief Medical Officer  
Frederick Engstrom, MD

Sr. Medical Director  
Robyn Ostrander, MD

Vice President Operations  
Gerril Cole, LICSW

Vice President Patient Care  
Chief Nursing Officer  
Debra Lucey, RN, MSN

Finance  
Lisa Dixon, Controller

Accounts Payable  
General Accounting  
Payroll  
Budget & Reimbursement  
Materials Management

Director of Ambulatory Services  
Kurt White, LICSW, LADP, CDP

Associate Director of Development  
Maggie Foley

Physician Recruitment & Employment and Contract Medical Services

Adult Program Medical Directors  
Adult Inpatient - Tyler 1  
Jennifer Flier, MD (interim)  
Adult Services - Tyler 2  
Timothy Rowland, MD  
Adult Intensive Unit  
Geoffrey Sinner, MD  
Addiction Services  
Geoffrey Kane, MD

Child/Adolescent Residential  
Darrel Williams, Director

Child/Adolescent Inpatient Services  
Child Inpatient Services  
Osgood 1 Rachel Bergstrom, RN Clinical Manager  
Adolescent Inpatient Services - Tyler 3  
Jackie Chappell, RN Clinical Manager

Health Information Management  
Lorin Young, Director

Transcription

Continuing Education  
Gay Maxwell

Communication  
Jeff Kellner

Physician Recruitment & Employment and Contract Medical Services

Adolescent Program Medical Directors  
Child Inpatient - Osgood 1  
Paul Boutin, MD  
Adol Inpatient - Tyler 3  
William Knorr, MD

Environmental & Dietary Services  
Rick Krolick, Director

Child/Adolescent Inpatient Services  
Child Inpatient Services  
Osgood 1 Rachel Bergstrom, RN Clinical Manager  
Adolescent Inpatient Services - Tyler 3  
Jackie Chappell, RN Clinical Manager

Managed Care Contracts & Utilization Review Management  
Michele Noel, Director 2

AMBC, Jillia Snyder, Director  
Medical Services, Linda Moye, RN, MSN Clinical Manager  
Ripley  
Uniform Services Program (USP), Frank Gallo, Director

Outpatient Services and Uniformed Services Program  
Jennifer Flier, MD

Child/Adolescent Residential  
Darrel Williams, Director

Child/Adolescent Inpatient Services  
Child Inpatient Services  
Osgood 1 Rachel Bergstrom, RN Clinical Manager  
Adolescent Inpatient Services - Tyler 3  
Jackie Chappell, RN Clinical Manager

Facilities  
Power Plant, Anthony Girard, Interim Director

Information Services  
Don Blummann, Director

Telecommunications

Senior Director of Quality and Regulatory Compliance  
Sharon Chaput, RN, C, CMA

Medical Staff Credentialing  
John Murphy, DO Director

Legal Affairs

Compliance

Medical Staff Credentialing  
John Murphy, DO Director

Infection Control  
Mary Ann Hoyt

Security Services, Sam Epiceno

Effective February 27, 2013