

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

October 24, 2014

By Facsimile and Overnight Mail

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

**Re: CMS Certification Number: 474001
Plan of Correction**

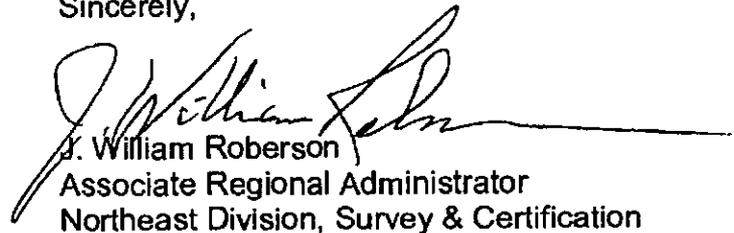
Dear Dr. Simpson:

I am pleased to inform you that the Brattleboro Retreat's plan of correction for its Medicare deficiencies, dated October 16, 2014, and the time schedule for completion of the plan, has been found acceptable by the Centers for Medicare and Medicaid Services (CMS) and the Vermont Division of Licensing and Protection (State Survey Agency). The agreed upon revisions to the Plan of Correction will be incorporated into the Systems Improvement Agreement (the Agreement).

The Centers for Medicare and Medicaid Services (CMS) Regional Office will contact you regarding the remaining requirements and the Systems Improvement Agreement (the Agreement).

If you have any questions regarding this notice, please contact Paul Miller at (617) 565-9160.

Sincerely,


J. William Roberson
Associate Regional Administrator
Northeast Division, Survey & Certification

cc: State Survey Agency
CMS-CO
Region I, OGC

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

PRINTED: 10/08/2014
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 R-C 10/01/2014
NAME OF PROVIDER OR SUPPLIER BRATTLEBORO RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE ANNA MARSH LANE PO BOX 003 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)

{A 000} INITIAL COMMENTS

{A 000}

An unannounced onsite follow-up survey for surveys completed on 8/18/14 and 8/18/14 was conducted on 9/29/14 - 10/1/14 by the Division of Licensing and Protection.

Based on information obtained through staff interviews and record reviews, an Immediate Jeopardy situation was determined to exist as the result of the hospital's failure to protect 2 patients from the potential for actual harm and failure to assure that appropriate and consistent monitoring was maintained.

Based on information gathered at the time of the follow-up survey, the hospital was determined not to be in compliance with Conditions of Participation: Governing Body, Patient Rights, and Quality Assurance/Performance Improvement.

A 043 482.12 GOVERNING BODY

A 043

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...

This CONDITION is not met as evidenced by: Based on observations, staff interviews and record review conducted through out the days of follow-up survey, and 2 previous complaint surveys completed on 6/18/14 and 8/18/14, the Governing Body failed to ensure protection and promotion of patient rights based on the hospital's

Please see attached Plan of Correction

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert E. Simpson, DSW, MPH TITLE: President & CEO (X8) DATE: 10/16/14

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 043	Continued From page 1 failure to ensure the safety of all patients. The Governing Body failed to ensure the hospital's Quality Assurance and Performance Improvement was effective and responsive when identifying, analyzing, and initiating action plans to ensure patient safety and patient rights. There was a failure to also ensure that corrective actions, as a result of significant adverse patient events, were sustained and regulatory compliance was maintained.	A 043			
(A 115)	Refer to: A-144, A-286, A-396 482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on staff interviews and record reviews, the Condition of Participation: Patient Rights was not met as evidenced by the hospital's failure to protect and promote the rights of each patient to receive care in a safe setting. Based on information obtained, an immediate jeopardy situation was determined to exist as the result of hospital staff's failure to take immediate action to reduce or eliminate potentially lethal harm to patients after the discovery and review of 2 separate incidents involving 2 patients who had attempted to self-harm. The hospital was also found not in compliance with a 3rd patient adverse event resulting in additional regulatory findings. Hospital staff failed to recognize the potential harm to all patients and failed to implement an immediate plan to assure the safety of all patients. Findings include: Refer also to A-144 and A-287.	(A 115)			

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(A 144)	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING	(A 144)			
	<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 observations, interviews and record review, the hospital failed to provide sufficient interventions to assure each patient's rights were protected by maintaining care in a safe setting as evidenced by the failure to recognize and implement immediate action to reduce or eliminate the potential lethal harm for all patients after the discovery and review of 3 separate incidents involving 3 patients. (Patients #4, #5 and #6). Findings include:</p> <p>1. Patient #6, age 16, was admitted involuntarily on 9/11/14 to the hospital with a diagnosis of Bipolar with acute mania. Upon admission, hospital staff determined Patient #5 would benefit from the environment and low census on Osgood I (child inpatient unit) where s/he remained until transfer to Tyler 3 (adolescent inpatient unit). Prior to transfer, the patient's attending psychiatrist states in a progress note for 9/16/14 "...his/her mental status has declined since yesterday with prominent paranoia, euphoric mood, rapid, tangential speech and religious preoccupation.". On 9/17/14 the psychiatrist further states "S/he continues to decompensate off meds and is increasingly psychotic...". When accepting medication, Patient #5's mood would improve slightly. On 9/19/14 Patient #5 was transferred to Tyler 3 and was placed on Continuous Visual Observation (CVO) with 1:1 (one staff member assigned to continuously monitor patient). Hospital policy Safety Checks/Special Observations (last approved</p>				

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(A 144)	Continued From page 3 4/2014) states: "Continuous Visual Observation: requires that staff must keep this patient within continuous visual observation and be ready to intervene immediately if the patient's behavior requires it." The nurse manager for Tyler 3 stated on 9/30/14 at 12:21 PM that staff assigned to CVO/1:1 "are expected to be only an arms length away from the patient." The psychiatrist's progress note for 9/22/14 states "Treatment Team reports this morning is the patient remains in ALSA (Low Stimulation Area) due to her/his high risk for safety... The patient's psychotic symptoms are not resolving despite the patient's compliance with the medication". Patient #5 was to remain on CVO/1:1. However at 11:15 AM on 9/22/14 Patient #5 was permitted to use the ALSA tub/shower. Since admission this was an actively Patient #5 enjoyed, spending extended time bathing and often singing while in the bathtub and/or shower. Mental Health Worker (MHW) #1 assigned to Patient #5 remained with the patient in the bathroom. At approximately 11:45 AM MHW #1 was due to be relieved of his/her duties by MHW #2 who would take over the monitoring of Patient #5 while s/he continued to bathe. Per interview on 9/30/14 at 1:44 PM MHW #2 stated upon arrival to relieve MHW #1 s/he observed the staff member standing outside the bathroom door and "I thought that was what I was suppose to do." S/he stated Patient #5 continued to sing and talk while bathing. "I knocked on the door every 10 minutes... to check on the patient..." who would reply s/he was "Ok" and was not ready to get out of the tub. At approximately 12:15 PM MHW #2 stated the patient was quiet. "I knocked and opened the door...s/he was face down in the water ...laying on left side with face half	(A 144)	

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{A 144}	<p>Continued From page 4</p> <p>submerged in water....went outside bathroom door to press the emergency button on wall...came back in and lifted her/his upper body and laid head on side of tub...". Staff quickly arrived; the patient was removed from the tub. MHW #2 further stated "...s/he was not responding". A sternal rub was performed and Patient #5 began coughing up water. Eventually Patient #5 was returned to her/his room and was seen by medical staff. The psychiatrist progress note for 9/22/14 states: "Later during the morning, called to see the patient after s/he was found 'submerged underwater in the tub'. The staff reported the patient was 'unresponsive' and becoming responsive 'after the sternal rub'...no functional limitations noted".</p> <p>Per interview on 9/30/14 at 2:19 PM MHW #1 did confirm, s/he had left the bathroom and Patient #5 unattended while s/he sought her/his replacement. MHW #1 stated a report is generally conducted at the time of the "switchover". "I am afraid I left pretty quick....I guess the door to the bathroom shut when I left...I was exiting because it was time for switch over." A report was not provided to MHW#2 by MHW #1 prior to resuming responsibilities of keeping Patient #5 safe. Despite Patient #5's significant psychiatric illness requiring the need for continuous observations for the purpose of keeping the patient safe, staff failed to follow hospital policy and physician orders resulting in a near drowning of the patient.</p> <p>2. Patient #4 was admitted to the hospital on 9/18/14 with depression with suicidal ideation. The patient had previous admissions to the hospital during April and May, 2013, for suicidal</p>	{A 144}	

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(A 144) Continued From page 5 (A 144)

Ideation, self-harming behaviors (cutting, scratching self) and a suicide attempt. During the current stay, when feeling anxious and depressed, the patient made multiple statements that he/she would harm him/herself. On 9/23/14, a nursing progress note stated (will tie something aroundneck). Staff continued to document the patient's intention to harm themselves on a daily basis. The patient alternated between 1:1 monitoring, constant observations and CAA, (Community Area Assignment). A progress note dated 9/25/14 documented, 'the patient attempted self harm by ripping apart bedding'.

On 9/29/14, the patient was found to have a length of spandage (a tubular, elastic dressing material) in his/her possession which he/she showed to a staff member and, per the nursing progress notes of 9/29/14, "patient.... quickly put this around his/her neck. MHW #3 (mental health worker) was assisted by the LPN in removing this from his/her neck (patient was attempting to tighten). Despite having security staff and nursing staff on hand, patient again tried to put spandage around the neck." The RN author of this progress note (RN #1) documented "admonished nursing staff to give out only short lengths of spandage to '(Patient #4)' or any patient." A physician progress note (9/29/14) about the same incident documented the patient slipped an elastic mesh material for bandages over his/her neck... "eventually required security and staff to wrestle to remove it from his/her neck. ---- repeated the act right after the first attempt." During a tour of the Tyler 3 Unit on 9/30/14 at 2:30 PM (when the survey team became aware of the event), the surveyor requested a 2 inch piece of the spandage to demonstrate the risk posed by ANY length of this type of material, which could

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{A 144} Continued From page 6 (A 144)

be used as a ligature device. RN #2 cut the spandage and pulled it open and was able to put the open tube of mesh over his/her head and place it around their neck. It was observed to be snug around their neck. RN #2 concurred that the spandage was dangerous and should not be continued to be used for patient needs. The Director of Social Services was also present for the demonstration.

During interview with the Clinical Nurse Manager of the Tyler 3 Unit on the afternoon of 9/30/14 and at 1 PM on 10/1/14, the manager confirmed that s/he had thought that the patient had wrapped a length of the material around the neck, lengthwise, not by opening the tubular material and looping it over the head. Although multiple hospital staff were aware of this incident, there was no evidence of a thorough investigation to review the facts of the incident and determine what course of action was necessary to protect the safety of all hospitalized patients in the future. No staff identified that the spandage was a potential ligature device, no matter what length the material was cut into. No staff identified that the continued use of this type of dressing material represented an extreme danger to patients at risk of suicide/self-harm. The only action recommended by the hospital after reviewing the incident was to "educate nursing staff to give out only short lengths of spandage to (Patient #4) or any patient". It was noted that many patients have cutting, self-harming behaviors on the units and the material was available for use on all units of the hospital.

The hospital's failure to identify the immediate risk to the patients and to take immediate hospital wide corrective action to prevent any future

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(A 144)	Continued From page 7 harmful incidents resulted in the determination of the immediate jeopardy situation. 3. Per record review Patient #6 was involuntarily admitted to the hospital on 8/26/14. S/he had reportedly been exhibiting paranoid, angry and aggressive behaviors, had threatened members of the group home where s/he had resided, and had been taken to the Emergency Department (ED) by the local police. The patient had remained delusional while in the ED and had made several attempts to elope from there. The patient presented to the hospital with paranoid delusions that involved a fear of imminent assault by others. The record revealed that s/he was delusional and schizophrenic by diagnosis, and, although s/he had not attempted to self-harm during this current episode, s/he had a history of acting on hallucinations which had previously resulted in serious self-harm. A nursing progress note, dated 9/9/14 stated: "Pt remains delusional and suspicious of staff ... Pt went for walk with MHW (Mental Health Worker) and attempted to elope today....Pt relates wanting to leave. "I don't feel safe here" A Physician progress note, on 9/10/14, stated that the patient reported "....that [s/he] tried to elope yesterday because [s/he] was hearing voices and they were scaring [him/her]." The patient was placed on unit restricted privileges following the elopement attempt and a subsequent Physician progress note on 9/22/14 indicated that there had been a discussion, on that date, regarding a change in privilege levels, to which the patient had responded: "I could handle some...staff would check in with me first...I could tell them if I was ok, I'd admit it if I wasn't." The patient was allowed off unit privileges in accordance with an Enhanced Safety Plan (ESP) which stated:	(A 144)	

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	(A 144) Continued From page 8		(A 144)

"Heightened vigilance when going on/off unit - be alert to pt's impulsivity, changes in thought process.....nursing will perform a safety check-in with pt. prior to leaving unit..." A nursing progress note, at 8:37 PM on 9/23/14, revealed that Patient #6 had been escorted to the off unit patient cafeteria by 2 staff members and eloped from the door in the unsecured staff dining room while walking through at 4:54 PM. A Code Green was called and Mental Health Workers (MHW) followed the patient off facility grounds. The local police department (PD) was notified and the patient eventually agreed to return to the hospital with Security department staff in one of their vehicles. Upon arrival at the hospital, Patient #6 again attempted to elope, tripped and fell to the ground. Although staff were in the process of implementing a therapeutic hold to control the patient, and despite the lack of evidence of criminal activity involving the patient, a police officer, who had followed staff back to the facility, applied handcuffs, which were not removed until the patient was inside the facility. The patient was immediately placed on unit restricted privileges and remained on that privilege level at the time of survey.

During interview, at 8:52 AM on 10/1/14, the RN (Registered Nurse) Unit Manager confirmed that the Charge Nurse on duty at the time of Patient #6's elopement on 9/23/14 admitted that s/he had not conducted a safety check-in with Patient #6 prior to his/her departure from the unit, in accordance with the patient's ESP. S/he stated that on the evening of 9/23/14 two MHWs had taken Patient #6, along with 4 other patients, off unit to the secure patient cafeteria via an unsecured hallway and staff dining area, in accordance with the hospital policy. MHW #4 was leading and MHW #5 was at the rear of the

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(A 144)	Continued From page 8 group. MHW #5 reportedly turned his/her head at one point to look at another MHW, and heard a patient ask where Patient #8 was going. When MHW #5 turned back Patient #8 was going out the door of the unsecured staff dining area, onto facility grounds. A Code Green was called, staff followed the patient off grounds, and the patient was eventually returned to the unit. The Unit Manager further stated that Patient #8 had been handcuffed by police, while staff were attempting to apply a therapeutic hold on the patient, that staff reportedly did not know why they had been applied and that the cuffs were not removed until the patient was inside the hospital building.	(A 144)			
(A 283)	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview and record review, the Condition of Participation: Quality Assessment and Performance Improvement (QA/PI) was not	(A 283)			

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{A 263} Continued From page 10 (A 263)

met due to the hospital's repeated failure to analyze and initiate action plans to ensure patient safety, based on 2 event reports related to patient self-harming attempts/incidents on the Tyler 3 Unit of the hospital. The information obtained during the investigation evidenced a problem with the Safety and Quality Committee's lack of a thorough investigative review of all patient incidents to identify, analyze and take immediate corrective action to prevent similar patient incidents from occurring in the future and on other units of the hospital. The issues identified lead to the determination that an immediate Jeopardy situation existed.

Refer to A-286 and A-114
{A 286} 482.21(a), (c)(2), (e)(3) PATIENT SAFETY (A 286)

(a) Standard: Program Scope
(1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors.
(2) The hospital must measure, analyze, and track ...adverse patient events ...

(c) Program Activities
(2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.

(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 474001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/01/2014
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)

(A 286) Continued From page 11 (A 286)
administrative officials are responsible and accountable for ensuring the following: ...
(3) That clear expectations for safety are established.

This STANDARD is not met as evidenced by:
Based on staff interview and record review, the hospital's Quality Assurance/Performance Improvement failed to assure that it's program activities included a thorough review and analysis of all adverse events and their causes, and failed to develop and implement hospital wide preventive actions to assure that adverse events will not recur and that learning and feedback is on-going throughout the hospital. The findings relate to 2 separate patient incidents involving self-harming/suicidal actions on the Tyler 3 Unit. (Patients #4 #5) and a 3rd incident involving a patient elopement from Osgood 3. (Patient #6)
Findings include:

1. On 9/22/14 Patient #6, identified to be a "high safety risk" experienced a near drowning after staff left the patient unattended in a bathtub. Patient #6 was admitted to the hospital on 9/11/14 with a diagnosis of Bipolar and acute mania. On 9/19/14 Patient #6 was transferred from Osgood 1 to Tyler 3 and was placed on Continuous Visual Observation (CVO) with 1:1 (one staff member assigned to continuously monitor patient). Hospital policy Safety Checks/Special Observations (last approved 4/2014) states: "Continuous Visual Observation: requires that staff must keep this patient within continuous visual observation and be ready to intervene immediately if the patient's behavior requires it."

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(A 286) Continued From page 12

(A 286)

Per Interview on 9/30/14 the nurse manager for Tyler 3 stated staff assigned to CVO/1:1 are expected to be only an arms length away from the patient while maintaining constant "eyes on".

On 11:15 AM 9/22/14 Patient #5 was permitted to use the ALSA tub/shower. Since admission this was an activity Patient #5 enjoyed, spending extended time bathing and often singing while in the bathtub and/or shower. Mental Health Worker (MHW) #1 assigned to Patient #5 remained with the patient in the bathroom. At approximately 11:45 AM MHW #1 was due to be relieved of his/her duties by MHW #2 who would take over the monitoring of Patient #5 while s/he bathed. Per Interview with MHW #2 on 9/30/14 at 1:44 PM stated upon arrival to relieve MHW #1 s/he observed the staff member standing outside the bathroom door and "I thought that was what I was suppose to do." S/he further stated Patient #5 continued to sing and talk while bathing. "I knocked on the door every 10 minutes." to check on the patient who would reply s/he was "Ok" and was not ready to get out of the tub. At approximately 12:15 PM MHW #2 stated the patient was quiet, "I knocked and opened the door...s/he was face down in the water...laying on left side with face half submerged in water...I went outside bathroom door to press the emergency button on wall...came back in and lifted her/his upper body and laid head on side of tub..." Staff quickly arrived and the patient was removed from the tub. MHW #2 further stated "...s/he was not responding". A sternal rub was performed and Patient #5 began coughing up water. Eventually Patient #5 was returned to his/her room and was examined by medical staff. Psychiatry progress note for 9/22/14 further states: "Later during the morning, called to see

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	<p>(A288) Continued From page 13</p> <p>the patient after s/he was found 'submerged underwater in the tub'. The staff reported the patient was 'unresponsive' and becoming responsive 'after the sternal rub'...no functional limitations noted".</p> <p>Per interview on 9/30/14 at 2:10 PM MHW #1 did confirm, s/he had left the bathroom and Patient #5 unattended while s/he sought her/his replacement. MHW #1 stated a report is generally conducted at the time of the "switchover". "I am afraid I left pretty quick....I guess the door to the bathroom shut when I left...I was exiting because it was time for switch over". A report was not provided between MHW#2 and MHW #1 at the time of the "switchover" prior to resuming responsibilities of keeping Patient #5 safe.</p> <p>An adverse event report was completed and the Tyler 3 nurse manager conducted an investigation. Actions taken included communication with family and appropriate authorities and only Tyler 3 Staff. There was a failure to identify the potential opportunity for staff on other units responsible for providing similar CVO/1:1 to lack the understanding or commitment to assure policies were followed. At the time of survey it was also identified by surveyors that staff were not affectively communicating with each other to maintain consistent awareness of each patient 's needs and confirmation of required observations. Despite the significance of the event QA/PI staff failed to identify the need to expand awareness and confirm all staff on all the units had a full understanding of their responsibilities pertaining to the observations of patients assuring patient safety is maintained by all staff at all times.</p>	(A288)	

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	(A 286) Continued From page 14	(A 286)	(X6) COMPLETION DATE

2. Patient #4 was admitted to the hospital on 9/16/14 with depression with suicidal ideation. The patient had previous admissions to the hospital during April and May, 2013, for suicidal ideation, self-harming behaviors (cutting, scratching self) and a suicide attempt. During the current stay, when feeling anxious and depressed, the patient made multiple statements that he/she would harm him/herself. On 9/23/14, a nursing progress note stated (will tie something aroundneck). Staff continued to document the patient's intention to harm themselves on a daily basis. The patient alternated between 1:1 monitoring, constant observations and CAA, (Community Area Assignment).

On 9/29/14, the patient was found to have a length of spandage (a tubular, elastic dressing material) in his/her possession which he/she showed to a staff member and, per the nursing progress notes of 9/29/14, "patient.... quickly put this around his/her neck. MHW #3 (mental health worker) was assisted by the LPN in removing this from his/her neck (patient was attempting to tighten). Despite having security staff and nursing staff on hand, patient again tried to put spandage around the neck." The RN author of this progress note (RN #1) documented "...admonished nursing staff to give out only short lengths of spandage to '(Patient #4)' or any patient." A physician progress note (9/29/14) about the same incident documented the patient slipped an elastic mesh material for bandages over his/her neck..."eventually required security and staff to wrestle to remove it from his/her neck. (Patient #4) repeated the act right after the first attempt." During a tour of the Tyler 3 Unit on 9/30/14 at 2:30 PM (when the survey team became aware of

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{A 286}	Continued From page 15 the event), the surveyor requested a 2 inch piece of the spandega to demonstrate the risk posed by ANY length of this type of material, which could be used as a ligature device. RN #2 cut a 2 inch piece of the spandega and pulled it open and was able to put the open tube of mesh over his/her head and place it around their neck. It was observed to be snug around their neck. RN #2 concurred that the spandega was dangerous and should not be continued to be used for patient needs. The Director of Social Services was also present for the demonstration. During interview with the Clinical Nurse Manager of the Tyler 3 Unit on the afternoon of 9/30/14 and at 1 PM on 10/1/14, the Manager confirmed that s/he had thought that the patient had wrapped a length of the material around the neck, lengthwise, not by opening the tubular material and looping it over the head. Although multiple hospital staff were aware of this incident, there was no evidence of a thorough investigation to review all the facts of the incident and determine what course of action was necessary to protect the safety of all hospitalized patients in the future. No staff identified that the spandega was a potential ligature device, no matter what length the material was cut into. No staff identified that the continued use of this type of dressing material represented an extreme danger to patients at risk of suicide/self-harm. The only action recommended by the hospital after reviewing the incident on 9/29/14 was to "admonish nursing staff to give out only short lengths of spandega to --- or any patient". It was noted that many patients have cutting, self-harming behaviors on the units and the material was available for use on all units of the hospital.	{A 286}			

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(A 286) Continued From page 16 (A 286)

3. Per record review Patient #6 was involuntarily admitted to the hospital on 8/26/14, S/he had reportedly been exhibiting paranoid, angry and aggressive behaviors, had threatened members of the group home where s/he had resided, and had been taken to the Emergency Department (ED) by the local police. S/he had remained delusional while in the ED and had made several attempts to elope from there. The patient presented with paranoid delusions that involved a fear of imminent assault by others. The record revealed that the patient was delusional and schizophrenic by diagnosis, and, although s/he had not attempted to self-harm during this current episode, s/he had a history of acting on hallucinations which had previously resulted in serious self-harm.

A nursing progress note, on 9/9/14, stated that the patient "...went for walk with MHW (Mental Health Worker) and attempted to elope today....Pt relates wanting to leave. "I don't feel safe here...." A Physician progress note, on 9/10/14, stated that the patient reported "...that [s/he] tried to elope yesterday because [s/he] was hearing voices and they were scaring [him/her]." The patient was placed on unit restricted privileges following the elopement attempt and a physician progress note, on 9/22/14, indicated that there had been a discussion, on that date, regarding a change in privilege level, to allow Patient #6 staff supervised off unit activity in accordance with an established Enhanced Safety Plan (ESP) for Elopement which stated: "Heightened vigilance when going on/off unit - be alert to pt.'s impulsivity, changes in thought process....nursing will perform a safety check-in with pt. prior to leaving unit..." During a staff supervised escort, through unsecured areas of the hospital, to the off unit patient cafeteria, on the evening of 9/23/14, the patient eloped from

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(A 286) Continued From page 17

(A 286)

the hospital and grounds. A Code Green was called, the local police were notified and Mental Health Workers (MHW) followed the patient. The patient eventually agreed to return to the hospital with Security department staff in one of their vehicles, and when arriving on hospital grounds the patient again attempted elopement. While staff were placing the patient in a therapeutic hold, and despite the lack of evidence of criminal activity involving the patient, a police officer, who had followed staff back to the facility, applied handcuffs, which were not removed until the patient was inside the facility. The patient was immediately placed on unit restricted privileges and remained on that privilege level at the time of survey.

s/he was handcuffed by police who had followed staff back to the hospital and the cuffs were not removed until the patient was inside the hospital. During interview, at 8:52 AM on 10/1/14, the RN (Registered Nurse) Unit Manager confirmed that the Charge Nurse on duty at the time of Patient #6's elopement admitted that s/he had not conducted a safety check-in with Patient #6 prior to his/her departure from the unit. In accordance with the patient's ESP, The Unit Manager stated that on the evening of 9/23/14 two MHWs had taken Patient #6, along with 4 other patients, off unit to the secure patient cafeteria via an unsecured hallway and staff dining area, in accordance with the hospital policy. MHW #4 was leading and MHW #5 was at the rear of the group to view all patients. MHW #5 reportedly turned his/her head at one point to look at another MHW, and heard a patient ask where Patient #6 was going. When MHW #5 turned back Patient #6 was going out the door of the unsecured staff dining area, onto facility grounds, a Code Green was called, staff followed the patient off grounds,

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(A 286) Continued From page 18

(A 286)

and the patient was eventually returned to the unit. The Unit Manager further stated that Patient #6 had been handcuffed by police, while staff were attempting to apply a therapeutic hold on the patient, that staff reportedly did not know why they had been applied and that the cuffs were not removed until the patient was inside the hospital building. S/he also stated that although some form of disciplinary action would be initiated against the Charge Nurse and MHWs #4 and #5 no action had occurred to date. S/he stated that the Charge Nurse had begun a vacation the day after the incident and had not yet returned, but both MHWs had continued to work on the unit. The Unit Manager further stated that although Patient #6 was immediately placed on unit restricted privileges and had remained on that privilege level to date, no other action had been taken to reduce the risk of elopement by patients from that unit while being escorted through unsecured areas of the hospital. The Quality Manager confirmed, during interview at 10:45 AM on 10/1/14, that although Patient #6 had been restricted to the unit and a Root Cause Analysis had been conducted following the elopement, no other action had been taken to reduce the risk of elopement by any patient on that unit or any other units from which patients could not be assured secure escort/transfer through the hospital. The hospital's Quality/Risk Management Committee has repeatedly failed to conduct thorough investigations of all patient incidents/events to assure that a complete analysis of all of the confounding facts is considered and to assure appropriate, hospital wide action plans are put into place in a timely manner to prevent further incidents with potential for significant patient harm.

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A 395	Continued From page 19	A 395
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE	A 395

A registered nurse must supervise and evaluate the nursing care for each patient.

This STANDARD is not met as evidenced by:
Based on staff interviews and record review nursing staff failed to conduct an assessment to determine appropriateness for supervised off unit activity for one of 5 applicable patients. Nursing staff also failed to evaluate the safety of the use of a type of elastic dressing material which presented a safety hazard to 1 applicable patient in the targeted sample, as well as any future patients utilizing the dressing who are identified as at risk for self-harming behaviors. (Patients #6 and #4). Findings include:

1. Per record review Patient #6 was involuntarily admitted to the hospital on 8/26/14. The patient, had reportedly been exhibiting paranoid, angry and aggressive behaviors and had threatened members of the group home where s/he had resided. S/he was transported to the Emergency Department (ED) by the local police, had remained delusional while in the ED and had made several attempts to elope from there. The patient, who presented to the hospital with paranoid delusions that involved a fear of imminent assault by others, had a history of Schizophrenia and PTSD and, although there had been no self harm during this episode, s/he had a history of previous serious self harm. A nursing progress note, dated 9/9/14 stated: 'Pt remains delusional and suspicious of staff ... Pt went for walk with MHW (Mental Health Worker) and attempted to elope today....Pt relates wanting to leave. "I don't feel safe here" A Physician progress note, on 9/10/14, stated that the patient

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A 396 Continued From page 20

A 395

reported ".....reported that [s/he] tried to elope yesterday because [s/he] was hearing voices and they were scaring [hlm/her]." The patient was placed on unit restricted privileges following the elopement attempt and a subsequent Physician progress note on 9/22/14 indicated that there had been a discussion, on that date, regarding privilege levels to which the patient had responded: "I could handle some...staff would check in with me first...I could tell them if I was ok, I'd admit it if I wasn't." The patient was allowed off unit privileges in accordance with an Enhanced Safety Plan (ESP) which stated: "Heightened vigilance when going on/off unit - be alert to pt's impulsivity, changes in thought processnursing will perform a safety check-in with pt. prior to leaving unit ..." A nursing progress note, at 8:37 PM on 9/23/14, revealed that Patient #8 had been escorted to the off unit patient cafeteria by 2 staff members and eloped from the door in the unsecured staff dining room while walking through at 4:54 PM. A Code Green was called and Mental Health Workers (MHW) followed the patient off facility grounds. The local police department (PD) was notified and the patient eventually agreed to return to the hospital with Security department staff in one of their vehicles.

During interview, at 8:52 AM on 10/1/14, the RN (Registered Nurse) Unit Manager confirmed that the Charge Nurse on duty at the time of Patient #8's elopement admitted that s/he had not conducted a safety check-in or any assessment of Patient #8 prior to his/her departure from the unit, in accordance with the patient's ESP.

2. Per record review on 9/30/14, Patient #4, was admitted to the hospital for self-harming behaviors and suicidal ideation on 9/18/14. An

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A 395	Continued From page 21 Incident report dated 9/29/14 stated that the patient (#4) had "pulled a long piece of gauze...and wrapped it around his/her neck. Myself and another coworker successfully cut it from his/her neck." Per review of the RN Charge Nurse progress note concerning this event, dated 9/29/14 at 5:44 PM, the RN response to the potentially lethal act by Patient #4 was to report the event to the evening shift and to "admonish nursing staff to give out only short lengths of spandage to (Patient #4) and any patient". A demonstration of the use of a 2.5 Inch length of spandage, per surveyor request, by RN #2 on 9/30/14 at 2:30 PM on the Tyler 3 Unit, revealed that any length of the spandage could be utilized as a ligature device by stretching it over the head to the neck and thus, was unsafe for use by any patients at risk for self-harm. RN #2 confirmed this finding as well. During interview on 9/30/14 at 12:20 PM, the Director of Quality and the Clinical Nurse Manager of the Tyler 3 Unit confirmed that nurses failed to evaluate the extreme safety risk posed by use of the spandage for Patient #4, who had engaged in self-harming behaviors and voiced suicidal ideation since admission on 9/18/14.	A 395	

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/Goal
A 000	<p>INITIAL COMMENTS</p> <p>An unannounced onsite follow-up survey for surveys completed on 6/18/14 and 8/18/14 was conducted on 9/29/14 - 10/1/14 by the Division of Licensing and Protection.</p> <p>Based on information obtained through staff interviews and record reviews, an Immediate Jeopardy situation was determined to exist as the result of the hospital's failure to protect 2 patients from the potential for actual harm and failure to assure that appropriate and consistent monitoring was maintained.</p> <p>Based on information gathered at the time of the follow-up survey, the hospital was determined not to be in compliance with Conditions of Participation: Governing Body, Patient Rights, and Quality Assurance/Performance Improvement.</p>	<p>Summary Statement</p> <p>A 000: Subsequent to an onsite follow-up survey completed on October 1, 2014 by the Division of Licensing and Protection, the Brattleboro Retreat has undertaken a series of targeted actions that address areas of identified regulatory noncompliance in the Conditions of Participation 42 CFR 482.13-Governing Body, Patient Rights, and Quality Assurance/Performance Improvement. We are fully committed as an organization to correct identified deficiencies and to achieve and sustain a high level of safe quality patient care. This plan of correction constitutes the organization's credible allegation of compliance.</p> <p>The Brattleboro Retreat's executive team reviewed CMS-2567 Statement of Deficiencies on 9/30/14; 10/6/14 and 10/13/14 and agreed upon the following plan of correction:</p>			

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A 043	<p>482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body...</p> <p>This CONDITION is not met as evidenced by: Based on observations, staff interviews and record review conducted throughout the days of follow-up survey, and 2 previous complaint surveys completed on 6/18/14 and 8/18/14, the Governing Body failed to ensure protection and promotion of patient rights based on the hospital's failure to ensure the safety of all patients. The Governing Body failed to ensure the hospital's Quality Assurance and Performance Improvement was effective and responsive when identifying, analyzing, and initiating action plans to ensure patient safety and patient rights. There was a failure to also ensure that corrective actions, as a result of significant adverse patient events, were sustained and regulatory compliance was maintained.</p> <p>Refer to: A-144, A-286, A-395</p>	<p>In order to ensure that the hospital's Quality Assurance and Performance Improvement is effective and responsive when identifying, analyzing, and initiating action plans to ensure patient safety and patient rights and to ensure that regulatory compliance is maintained the Board of Trustees has approved the following action items.</p> <ul style="list-style-type: none"> ➤ The Board of Trustees has approved the CEO's request to expand and reorganize Quality Department as follows: <ul style="list-style-type: none"> ○ Creation of a position of Vice President (VP) of Quality and Clinical Services. ○ The VP of Quality will report to the CEO and be a member of the Executive Team. ○ The VP will review all current practices and determine a course of improvement which provides oversight, enhanced organization, data collection and analysis. ○ Increased allocation of administrative support including data analysis. ➤ Ad hoc Board Quality meetings are called by the CEO with Board members for review of all critical incidences including actual events and near misses. VP Quality (Director of Quality Interim) will attend. 	11/5/14	CEO	As evidenced by Board minutes
			Ongoing	CEO	VP Quality position hired
			11/30/14	VP of Quality	As evidenced by Executive membership proposal submitted
			11/15/14	VP of Quality	Staff assuming role
			Start 10/20/14 and ongoing	CEO	Minutes of meetings

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		<ul style="list-style-type: none"> ➤ Provide quarterly educational opportunities for Board members on Quality within Hospitals/Leadership. ➤ Quality continues as Standing Item on Board of Trustees Meetings. ➤ Recommending the addition of two Board members to Board of Trustees Quality Committee. ➤ Director of Quality (interim until VP Quality in the role), Board Quality Chair and the CEO will meet Bi-monthly (and ad hoc if need warrants) to review incident reports and completed action steps to ensure that data is analyzed and that systemic issues are identified and resolved. 	<p>Ongoing</p> <p>ongoing</p> <p>10/15/14</p> <p>10/16/14 and ongoing</p>	<p>CEO</p> <p>Board Chair</p> <p>CEO/Board Chair</p> <p>CEO</p>	<p>Board agenda: 100%</p> <p>Board agenda: 100%</p> <p>Membership of Board of Trustee Quality Committee</p> <p>Minutes of Meeting</p>
A 115	<p>482.13 PATIENT RIGHTS</p> <p>A hospital must protect and promote each patient's rights.</p> <p>This CONDITION is not met as evidenced by: Based on staff interviews and record reviews, the Condition of Participation: Patient Rights was not met as evidenced by the hospital's failure to protect and promote the rights of each patient to receive care in a safe setting. Based on information obtained, an Immediate Jeopardy situation was determined to exist as the result of hospital staff's failure to take immediate action to reduce or eliminate potentially</p>	<p>In order to protect and promote the rights of each patient to receive care in a safe setting the hospital took the following immediate steps to eliminate potentially lethal harm to patients:</p> <ul style="list-style-type: none"> ➤ All "Spandage" type dressing was removed from the units including the clinic and Admission and Evaluation (A&E). ➤ Director of Materials Management was notified to remove from all "Spandage" type bandages from inventories. 	<p>9/30/14</p> <p>9/30/14</p>	<p>VP Pt Care Services/VP of Operations</p> <p>VP of Pt Care Services</p>	<p>Spandage removed from all units and inventory 9/30/14</p> <p>Goal: 0 Spandage</p>

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	<p>lethal harm to patients after the discovery and review of 2 separate incidents involving 2 patients who had attempted to self-harm. The hospital was also found not in compliance with a 3rd patient adverse event resulting in additional regulatory findings. Hospital staff failed to recognize the potential harm to all patients and failed to implement an immediate plan to assure the safety of all patients. Findings include:</p> <p>Refer also to A-144 and A-287.</p>	<ul style="list-style-type: none"> ➤ The Chief Medical officer informed all medical staff via e-mail that "Spandage" has been removed from the facility. ➤ Clinical Managers phoned all their charge nurses on each respective unit on 9/30 and informed them of the removal of all Spandage type dressing. ➤ The VP of Operations informed the LIP'S in Admissions and in the Medical clinic of the removal of Spandage type dressing. ➤ Orders for 1:1 and Continuous Visual Observation (CVO) defined to clearly be with no exception. 1:1 is defined as within arm's reach at all times no exceptions. Continuous Visual Observation (CVO) defined as maintain continuous visual observation at all times no exception. ➤ Managers educated all staff on duty 3-11 and 11-7 (9/30/14) and 7-3 (10/1/14) on the removal of "Spandage" type dressings from clinical use. Staff were also educated on the definitions of 1:1 and CVO and the expectation for indication on the Nursing Observation Flow sheet of verifying awareness of patient's status when they assume care and the requirement for staff on handoff to both initial the Observation Flow Sheet at time of handoff. 	<p>9/30/14</p> <p>9/30/14</p> <p>9/30/14</p> <p>9/30/14</p> <p>9/30/14 & 10/1/14</p>	<p>Chief Medical Officer</p> <p>VP of Pt Care Services</p> <p>VP of Operations</p> <p>Chief Medical Officer</p> <p>VP of Pt Care Services</p>	<p>Completion of Monthly audits of all 1:1/CVO orders for correct language at 100% level for 3 months</p> <p>Process Audit: 20 observations across units/shifts of handoff for 1:1 CVO at 100% level monthly X 3 months</p> <p>Completion of Obs flow sheets for 1:1 CVO with initials indicating handoff 100% by 11/15/14</p>

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		<ul style="list-style-type: none"> > Staff assignment sheet and Nursing Observation sheet revised to reflect the modifications. (attachment) > CMO emailed all medical staff of the changes in definition of 1:1 and Continuous Visual Observation (CVO). > All active 1:1 and CVO orders on current patients reviewed by CMO discontinued and re-ordered as clinically indicated to include the definitions in the EMR with the specific order. > 1:1 and Continuous Visual Observation orders enhanced in the EMR for CPOE to include the special instructions for 1:1 within arm's reach at all times no exceptions and for Continuous Visual Observation maintain continuous visual observation at all times no exceptions. > Clinical Managers (CMs) will continue to meet with all staff on duty prior to their shift to educate and communicate changes to the 1:1 and CVO orders. > Staff education sign off sheet signed by staff receiving education. Data Base of staff acknowledging education maintained. > Provide reinforcement education about key parameters of care through posters/screensavers on the units in an 	<p>9/30/14</p> <p>9/30/14</p> <p>9/30/14</p> <p>10/1/14</p> <p>10/31/14</p> <p>10/31/14</p> <p>10/31/14</p>	<p>VP of Pt Care Services</p> <p>Chief Medical Officer</p> <p>Chief Medical Officer</p> <p>Director of Informatics</p> <p>VP of Pt Care Services</p> <p>Director of Clinical Education</p> <p>Director of Clinical Education/Director of Clinical</p>	<p>Attached</p> <p>Email</p> <p>Completed</p> <p>Evidenced by Client Profile of orders in AVATAR Instructions included in active orders for 1:1 and CVO in EMR</p> <p>Audit at 100% of all active staff assigned 1:1/CVO</p> <p>Posters evident on units</p>

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A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting.	<ul style="list-style-type: none"> > ongoing basis. > Inclusion of the definition of 1:1 order and Continuous Visual Observation (CVO) orders and expectations of staff fulfilling orders included in orientation for new staff and skills day for existing staff. > Develop a multidisciplinary Product review committee to review all material to be purchased or permitted on the unit for any patient safety concerns. 	10/7/14 11/15/14	Informatics Director of Clinical Education Senior Director of Finance	Included on the agenda for orientation/skills day Minutes of meeting
A 144	This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the hospital failed to provide sufficient interventions to assure each patient's rights were protected by maintaining care in a safe setting as evidenced by the failure to recognize and implement immediate action to reduce or eliminate the potential lethal harm for all patients after the discovery and review of 3 separate incidents involving 3 patients. (Patients #4, #5 and #6). Findings include: 1. Patient #5, age 16, was admitted involuntarily on 9/11/14 to the hospital with a diagnosis of Bipolar with acute	<ul style="list-style-type: none"> > Immediately all "Spandage" type dressing was removed from the units including the clinic and Admission and Evaluation. (A&E) > Director of Materials Management was notified to remove from all "Spandage" type bandages from inventories. > E mail notification to all medical staff of the removal of all "Spandage" type dressing by Chief Medical Officer. > Clinical Managers phoned their respective units to inform charge staff of the removal of all Spandage type dressing. > The LIP's notified via email by the VP of Operations of the removal of Spandage type dressing. 	9/30/14 9/30/14 9/30/14	VP of Pt Care Services/VP of Operations VP of Operations Chief Medical Officer VP Pt Care Services VP of Operations	Spandage removed from all units and inventory 9/30/14 Goal: 0 Spandage Completed Completion of Monthly audits of all 1:1/CVO orders for correct language at 100% level for 3 months Process Audit: 20 observations

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	<p>mania. Upon admission, hospital staff determined Patient #5 would benefit from the environment and low census on Osgood 1 (child inpatient unit) where s/he remained until transfer to Tyler 3 (adolescent inpatient unit). Prior to transfer, the patient's attending psychiatrist states in a progress note for 9/16/14 "...his/her mental status has declined since yesterday with prominent paranoia, euphoric mood, rapid, tangential speech and religious preoccupation." On 9/17/14 the psychiatrist further states "S/he continues to decompensate off meds and is increasingly psychotic..." When accepting medication, Patient #5's mood would improve slightly. On 9/19/14 Patient #5 was transferred to Tyler 3 and was placed on Continuous Visual Observation (CVO) with 1:1 (one staff member assigned to continuously monitor patient). Hospital policy Safety Checks/Special Observations (last approved 4/2014) states: "Continuous Visual Observation: requires that staff must keep this patient within continuous visual observation and be ready to intervene immediately if the patient's behavior requires it." The nurse manager for Tyler 3 stated on 9/30/14 at 12:21 PM that staff assigned to CV0/1:1 "are expected to be only an arm's length away from the patient." The psychiatrist's progress note for 9/22/14 states "Treatment Team reports this morning is</p>	<p>> Orders for 1:1 and Continuous Visual Observation (CVO) defined to clearly be with no exception. 1:1 is defined as within arm's reach at all times no exceptions. Continuous Visual Observation (CVO) defined as maintain continuous visual observation at all times no exceptions.</p> <p>> Managers educated all staff on duty 3-11 and 11-7 (9/30/14) and 7-3 (10/1/14) on the removal of "Spandage" type dressings from clinical use. Staff were also educated on the definitions of 1:1 and CVO and the expectation for indication on the Nursing Observation Flow sheet of verifying awareness of patient's status when they assume care and the requirement for staff on handoff to both initial the Observation Flow Sheet at time of handoff.</p> <p>> Staff assignment sheet and Nursing Observation sheet revised to reflect the modifications. (attachment)</p> <p>> CMO emailed all medical staff of the changes in definition of 1:1 and Continuous Visual Observation (CVO).</p> <p>> All active 1:1 and CVO orders on current patients reviewed by CMO discontinued and re-ordered as clinically indicated to include the definitions in the EMR with the specific</p>	<p>9/30/14</p> <p>9/30/14</p> <p>9/30/14</p> <p>9/30/14</p>	<p>Chief Medical Officer</p> <p>VP of Pt Care Services</p> <p>Chief Medical Officer</p> <p>Chief Medical Officer</p>	<p>across units/sifts of handoff for 1:1/ CVO at 100% level monthly X 3 months</p> <p>Completion of Obs flow sheets for 1:1/ CVO with initials indicating handoff 100% by 11/15/14</p> <p>Sign sheet</p> <p>Attached</p> <p>Email</p> <p>Completed</p>

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A 144	<p>the patient remains in ALISA (Low Stimulation Area) due to her/his high risk for safety... The patient's psychotropic symptoms are not resolving despite the patient's compliance with the medication". Patient #5 was to remain on CV0/1:1.</p> <p>However at 11:15 AM on 9/22/14 Patient #5 was permitted to use the ALISA tub/shower. Since admission this was an activity Patient #5 enjoyed, spending extended time bathing and often singing while in the bathtub and/or shower. Mental Health Worker (MHW) #1 assigned to Patient #5 remained with the patient in the bathroom. At approximately 11:45 AM MHW #1 was due to be relieved of his/her duties by MHW #2 who would take over the monitoring of Patient #5 while s/he continued to bathe. Per interview on 9/30/14 at 1:44PM MHW #2 stated upon arrival to relieve MHW #1 s/he observed the staff member standing outside the bathroom door and "I thought that was what I was supposed to do." S/he stated Patient #5 continued to sing and talk while bathing. "I knocked on the door every 10 minutes... to check on the patient... " who would reply s/he was "Ok" and was not ready to get out of the tub. At approximately 12:15 PM MHW #2 stated the patient was quiet. "I knocked and opened the door...s/he was face down in the water...laying on left side with face half submerged in water ...went outside bathroom door to press</p>	<p>order.</p> <ul style="list-style-type: none"> ➤ 1:1 and Continuous Visual Observation orders enhanced in the EMR for CPOE to include the special instructions for 1:1 within staff's reach at all times no exceptions and for Continuous Visual Observation maintain continuous visual observation at all times no exceptions. ➤ Clinical Managers (CMs) to continue to meet with all staff on duty prior to their shift to educate and communicate changes to the 1:1 and CVO orders. Per diems meet with the Nursing Supervisors for the education. ➤ Staff education sign off sheet signed by staff receiving education, CMs send a copy to VP Patient Services, Data Base of staff acknowledging education maintained. ➤ Provide reinforcement education about key parameters of care through posters/screensavers on the units in an ongoing basis. ➤ Inclusion of the definition of 1:1 order and Continuous Visual Observation (CVO) orders and expectations of staff fulfilling orders included in orientation for new staff and skills day for existing staff. 	<p>10/7/14</p> <p>10/31/14</p> <p>10/31/14</p> <p>10/31/14</p>	<p>Director of Informatics</p> <p>Clinical Managers</p> <p>Director of Clinical Education</p> <p>Director of Clinical Education/Clinical Informatics</p> <p>Director of Clinical Education</p>	<p>Evidenced by Client Profile of orders in AVATAR</p> <p>Instructions included in active orders for 1:1 and CVO in EMR</p> <p>Sign sheet</p> <p>Audit at 100% of all active staff assigned 1:1/ CVO</p> <p>Posters on units</p> <p>agenda for orientation/ skills day</p>

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A 144	<p>the emergency button on wall... came back in and lifted her/his upper body and laid head on side of tub ...". Staff quickly arrived, the patient was removed from the tub. MHTW #2 further stated "...she was not responding". A sternal rub was performed and Patient #5 began coughing up water. Eventually Patient #5 was returned to her/his room and was seen by medical staff. The psychiatrist progress note for 9/22/14 states: "Later during the morning, called to see the patient after she was found submerged underwater in the tub. The staff reported the patient was 'unresponsive and becoming responsive after the sternal rub'...no functional limitations noted".</p> <p>Per interview on 9/30/14 at 2:19PM MHTW #1 did confirm, s/he had left the bathroom and Patient #5 unattended while s/he sought her/his replacement. MHTW #1 stated a report is generally conducted at the time of the "switchover". "I am afraid I left pretty quick...! guess the door to the bathroom shut when I left... I was exiting because it was time for switch over." A report was not provided to MHTW#2 by MHTW #1, prior to resuming responsibilities of keeping Patient #5 safe. Despite Patient #5's significant psychiatric illness requiring the need for continuous observations for the purpose of keeping the patient safe, staff failed to follow hospital policy and physician orders resulting in a near drowning of the</p>	<ul style="list-style-type: none"> > Explore educational opportunities re better investigative techniques to improve Quality department and Clinical Managers' knowledge base. (Board member will recommend opportunities.) > Add more time to the daily (M-F) morning meeting that includes Clinical Managers, Quality, Risk and Executive Team members for review of incident reports, to identify a severity level to prioritize investigations of quality incidences and the progress of investigations/ action steps, system risk assessment. (Incidents are reviewed by the Nursing Supervisor with the Administrator-on-Call (AOC) on weekends and they are also reported at Monday meeting.) > Establish a standing weekly meeting time for Critical Incident Reviews in order to increase efficiency of getting required members' together and to increase timeliness of review and analysis (if a specific review is not necessary, use the time for education). > Develop a multidisciplinary Product review committee to review all material to be purchased or permitted on the unit for any patient safety concerns. 	<p>11/15/14</p> <p>10/6/14</p> <p>10/31/14</p> <p>11/15/14</p>	<p>Director of Quality</p> <p>VP Operations</p> <p>Director of Quality</p> <p>Senior Director of Finance</p>	<p>Proposal submitted</p> <p>Reflected in daily minutes</p> <p>Meeting Minutes</p> <p>Minutes of meeting</p>

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A 144	<p>patient.</p> <p>2. Patient #4 was admitted to the hospital on 9/16/14 with depression with suicidal ideation. The patient had previous admissions to the hospital during April and May, 2013, for suicidal ideation, self-harming behaviors (cutting, scratching self) and a suicide attempt. During the current stay, when feeling anxious and depressed, the patient made multiple statements that he/she would harm him/herself. On 9/23/14, a nursing progress note stated (will tie something aroundneck). Staff continued to document the patient's intention to harm themselves on a daily basis. The patient alternated between 1:1 monitoring, constant observations and CAA, (Community Area Assignment). A progress note dated 9/25/14 documented, 'the patient attempted self-harm by ripping apart bedding'.</p> <p>On 9/29/14, the patient was found to have a length of spandage (a tubular, elastic dressing material) in his/her possession which he/she showed to a staff member and, per the nursing progress notes of 9/29/14, "patient... quickly put this around his/her neck. MHW #3 (mental health worker) was assisted by the LPN in removing this from his/her neck (patient was attempting to tighten). Despite having security staff and nursing staff on hand, patient again tried to put spandage around the neck." The RN author of this</p>	<p>➤ Reinforcing the "See Something, Say Something Campaign" with posters on the units.</p> <p>Building on the foundation of staff recognizing they are the professionals for behavioral health emergencies and no longer calling the police for instances of behavioral emergencies at the Brattleboro Retreat. (No instances for more than year):</p> <p>With the Early Responder team, Security and the Nursing Supervisors:</p> <p>➤ Review Management Policy and role to team members with the Early Responder team, Security and the Nursing Supervisors, including parameters for police involvement on-ground events for patients currently in our care, and communication/ directional instructions to police to prevent hands-on by police.</p> <p>➤ CEO contacted Brattleboro Chief of Police regarding this incident with police involvement, and request to re-train officers in a no hands-on response (including use of handcuffs) for on-grounds inpatient elopements.</p>	<p>10/31/14</p> <p>11/5/14</p>	<p>Director of Regulatory/Clinical Informatics</p> <p>Interventionist Lead, Security Manager, VP of Pt Care Services</p> <p>CEO</p>	<p>Posters evident on units</p> <p>90% active staff</p> <p>Phone conversation</p>

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A 144	<p>progress note (RN #1) documented "admonished nursing staff to give out only short lengths of spandage to ('Patient #4') or any patient." A physician progress note (9/29/14) about the same incident documented the patient slipped an elastic mesh material for bandages over his/her neck. "eventually required security and staff to wrestle to remove it from his/her neck ---- repeated the act right after the first attempt." During a tour of the Tyler 3 Unit on 9/30/14 at 2:30 PM (when the survey team became aware of the event), the surveyor requested a 2 inch piece of the spandage to demonstrate the risk posed by ANY length of this type of material, which could be used as a ligature device. RN #2 cut the spandage and pulled it open and was able to put the open tube of mesh over his/her head and place it around their neck. It was observed to be snug around their neck. RN #2 concurred that the spandage was dangerous and should not be continued to be used for patient needs. The Director of Social Services was also present for the demonstration.</p> <p>During interview with the Clinical Nurse Manager of the Tyler 3 Unit on the afternoon of 9/30/14 and at 1 PM on 10/1/14, the manager confirmed that s/he had thought that the patient had wrapped a length of the material around the neck, lengthwise, not by opening the tubular material and looping it over the head. Although multiple hospital staff were</p>	<p>> CM's to review this specific situation in staff meetings, posters on unit, email, memos to staff mailboxes to clarify role of staff with police present in management of the patient, and role in communicating such with police.</p>	11/5/14	Clinical Managers	Meeting Agendas, e-mails, memos distributed, signage on units

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A 144	<p>aware of this incident, there was no evidence of a thorough investigation to review the facts of the incident and determine what course of action was necessary to protect the safety of all hospitalized patients in the future. No staff identified that the spandage was a potential ligature device, no matter what length the material was cut into. No staff identified that the continued use of this type of dressing material represented an extreme danger to patients at risk of suicide/self-harm. The only action recommended by the hospital after reviewing the incident was to "admonish nursing staff to give out only short lengths of spandage to (Patient #4) or any patient". It was noted that many patients have cutting, self-harming behaviors on the units and the material was available for use on all units of the hospital.</p> <p>The hospital's failure to identify the immediate risk to the patients and to take immediate hospital wide corrective action to prevent any future harmful incidents resulted in the determination of the Immediate Jeopardy situation.</p> <p>3. Per record review Patient #6 was involuntarily admitted to the hospital on 8/25/14. S/he had reportedly been exhibiting paranoid, angry and aggressive behaviors, had threatened members of the group home where s/he had resided, and had been taken to the Emergency Department (ED) by the local police. The patient had remained delusional while in</p>				

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A 144	<p>the BID and had made several attempts to elope from there. The patient presented to the hospital with paranoid delusions that involved a fear of imminent assault by others. The record revealed that s/he was delusional and schizophrenic by diagnosis, and, although s/he had not attempted to self-harm during this current episode, s/he had a history of acting on hallucinations which had previously resulted in serious self-harm.</p> <p>A nursing progress note, dated 9/9/14 stated: "Pt remains delusional and suspicious of staff Pt went for walk with MHW (Mental Health Worker) and attempted to elope today Pt relates wanting to leave. "I don't feel safe here"</p> <p>" A Physician progress note, on 9/10/14, stated that the patient reported ".....that [s/he] tried to elope yesterday because [s/he] was hearing voices and they were scaring [him/her]". The patient was placed on unit restricted privileges following the elopement attempt and a subsequent Physician progress note on 9/22/14 indicated that there had been a discussion, on that date, regarding a change in privilege levels, to which the patient had responded: "I could handle some ... staff would check in with me first.. I could tell them if I was ok, I'd admit it if I wasn't." The patient was allowed off unit privileges in accordance with an Enhanced Safety Plan (ESP) which stated: "Heightened vigilance when going on/off unit - be alert to pts</p>				

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A 144	<p>impulsivity, changes in thought process....nursing will perform a safety check-in with pt. prior to leaving unit. "</p> <p>A nursing progress note, at 8:37 PM on 9/23/14, revealed that Patient #6 had been escorted to the off unit patient cafeteria by 2 staff members and eloped from the door in the unsecured staff dining room while walking through at 4:54 PM. A Code Green was called and Mental Health Workers (MHW) followed the patient off facility grounds. The local police department (PO) was notified and the patient eventually agreed to return to the hospital with Security department staff in one of their vehicles. Upon arrival at the hospital, Patient #6 again attempted to elope, tripped and fell to the ground. Although staff were in the process of implementing a therapeutic hold to control the patient, and despite the lack of evidence of criminal activity involving the patient, a police officer, who had followed staff back to the facility, applied handcuffs, which were not removed until the patient was inside the facility. The patient was immediately placed on unit restricted privileges and remained on that privilege level at the time of survey.</p> <p>During interview, at 8:52AM on 10/1/14, the RN (Registered Nurse) Unit Manager confirmed that the Charge Nurse on duty at the time of Patient #6's elopement on 9/23/14 admitted that s/he had not conducted a safety check-in with Patient #6 prior to his/her departure from the unit.</p>				

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A 144	<p>in accordance with the patient's ESP. S/he stated that on the evening of 9/23/14 two MHW's had taken Patient #6, along with 4 other patients; off unit to the secure patient cafeteria via an unsecured hallway and staff dining area, in accordance with the hospital policy. MHW #4 was leading and MHW #5 was at the rear of the group. MHW #5 reportedly turned his/her head at one point to look at another MHW, and heard a patient ask where Patient #6 was going. When MHW #5 turned back Patient #6 was going out the door of the unsecured staff dining area, onto facility grounds. A Code Green was called, staff followed the patient off grounds, and the patient was eventually returned to the unit. The Unit Manager further stated that Patient #6 had been handcuffed by police, while staff were attempting to apply a therapeutic hold on the patient, that staff reportedly did not know why they had been applied and that the cuffs were not removed until the patient was inside the hospital building.</p>	<p>In order to ensure that the hospital's Quality Assurance and Performance Improvement is effective and responsive when identifying, analyzing, and initiating action plans to ensure patient safety and patient rights and to ensure that regulatory compliance is maintained the Board of Trustees has approved the following action items.</p> <p>> The Board of Trustees has approved the CEO's request to expand and</p>	Ongoing	CEO	As evidenced by
A 263	<p>482.21 OAPI</p> <p>The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and</p>				

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A 263	<p>services (including those services furnished under contract or arrangements) and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>This CONDITION is not met as evidenced by: Based on interview and record review, the Condition of Participation: Quality Assessment and Performance Improvement (QA/PD) was not met due to the hospital's repeated failure to analyze and initiate action plans to ensure patient safety, based on 2 event reports related to patient self-harming attempts/incidents on the Tyler 3 Unit of the hospital. The information obtained during the investigation evidenced a problem with the Safety and Quality Committee's lack of a thorough investigative review of all patient incidents to identify, analyze and take immediate corrective action to prevent similar patient incidents from occurring in the future and on other units of the hospital. The issues identified lead to the determination that an Immediate Jeopardy situation existed.</p> <p>Refer to A-286 and A-114</p>	<p>reorganize Quality Department as follows:</p> <ul style="list-style-type: none"> o Creation of a position of Vice President (VP) of Quality and Clinical Services. o The VP of Quality will report to the CEO and be a member of the Executive Team. o The VP will review all current practices and determine a course of improvement which provides oversight, enhanced organization, data collection and analysis. o Increased allocation of administrative support including data analysis. <p>Quality continues as Standing Item on Board of Trustees Meetings with focus on managing safety.</p> <p>Recommendation: the addition of two Board members to Board of Trustees Quality Committee.</p> <p>Director of Quality (interim until VP Quality in the role), Board Quality Chair and the CEO will meet Bi-monthly (and ad hoc if need warrants) to review incident reports and completed action steps to ensure that data is analyzed and that systemic issues are identified and resolved.</p>	<p>11/5/14</p> <p>Ongoing</p> <p>Ongoing</p> <p>10/15/14</p> <p>10/16/14 and ongoing</p>	<p>CEO</p> <p>CEO</p> <p>VP of Quality</p> <p>VP of Quality</p> <p>Board Chair</p> <p>Board Chair</p> <p>CEO/Board Chair</p>	<p>Board minutes</p> <p>VP Quality position hired</p> <p>Membership on Executive Team</p> <p>Proposal submitted</p> <p>Staff assuming role</p> <p>Board agenda: 100%</p> <p>Membership of Board of Trustees Quality Committee</p> <p>Minutes of Meeting</p>

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/Goal
		<ul style="list-style-type: none"> > Ad hoc meetings are called by the CEO with Board members for review of all critical incidences including actual events and near misses. > Provide quarterly educational opportunities for Board members on Quality within Hospitals/Leadership. > Immediately all "Spandage" type dressing was removed from the units including the clinic and Admission and Evaluation. (A&E) > Director of Materials Management was notified to remove from all "Spandage" type bandages from inventories. > E mail notification to all medical staff of the removal of all "Spandage" type dressing by Chief Medical Officer. > Clinical Managers phoned their respective units to inform charge staff of the removal of all Spandage type dressing. > The LIP's notified via email by the VP of Operations of the removal of Spandage type dressing. > Orders for 1:1 and Continuous Visual Observation (CVO) defined to clearly be with no exception. 1:1 is defined as within arm's reach at all times no 	<p>Start 10/20/14 and ongoing</p> <p>Ongoing</p> <p>9/30/14</p> <p>9/30/14</p> <p>9/30/14</p> <p>9/30/14</p> <p>9/30/14</p>	<p>CEO/Board Chair</p> <p>CEO</p> <p>VP Pt Care Services/VP of Operations</p> <p>VP of Pt Care Services</p> <p>VP of Operations</p> <p>Chief Medical Officer</p>	<p>Minutes of Meeting</p> <p>Reflected on Board agenda</p> <p>Spandage removed from all units and inventory 9/30/14 Goal: 0 Spandage</p> <p>Completion of Monthly audits of all 1:1/CVO</p>

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		<p>exception. Continuous Visual Observation (CVO) defined as maintain continuous visual observation at all times no exception.</p> <p>> Managers educated all staff on duty 3-11 and 11-7 (9/30/14) and 7-3 (10/7/14) on the removal of "Spandage" type dressings from clinical use. Staff were also educated on the definitions of 1:1 and CVO and the expectation for indication on the Nursing Observation Flow sheet of verifying awareness of patient's status when they assume care and the requirement for staff on handoff to both initial the Observation Flow Sheet at time of handoff.</p> <p>> Staff assignment sheet and Nursing Observation sheet revised to reflect the modifications. (attachment)</p> <p>> CMO emailed all medical staff of the changes in definition of 1:1 and Continuous Visual Observation (CVO).</p> <p>> All active 1:1 and CVO orders on current patients reviewed by CMO discontinued and re-ordered as clinically indicated to include the definitions in the EMR with the specific order.</p> <p>> 1:1 and Continuous Visual Observation orders enhanced in the EMR for CPOE to include the special instructions for 1:1</p>	<p>9/30/14 & 10/7/14</p> <p>9/30/14</p> <p>9/30/14</p> <p>9/30/14</p> <p>10/7/14</p>	<p>VP of Pt Care Services</p> <p>VP of Pt Care Services</p> <p>Chief Medical Officer</p> <p>Chief Medical Officer</p> <p>Director of Informatics</p>	<p>orders for correct language at 100% level for 3 months</p> <p>Process Audit: 20 observations across units/shifts of handoff for 1:1/CVO at 100% level monthly X 3 months</p> <p>Completion of Obs flow sheets for 1:1/CVO with initials indicating handoff 100% by 11/15/14</p> <p>Attached</p> <p>Email</p> <p>Completed</p> <p>Evidenced by Client Profile of</p>

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		<p>within arm's reach at all times no exceptions and for Continuous Visual Observation maintain continuous visual observation at all times no exceptions.</p> <p>> Clinical Managers to continue to meet with all staff on duty prior to their shift to educate and communicate changes to the 1:1 and CVO orders. Per diems meet with the Nursing Supervisors for the education.</p> <p>> Staff education sign off sheet signed by staff receiving education, CMs send a copy to VP Patient Services. Data Base of staff acknowledging education maintained.</p> <p>> Provide reinforcement education about key parameters of care through posters/screensavers on the units in an ongoing basis.</p> <p>> Inclusion of the definition of 1:1 order and Continuous Visual Observation (CVO) orders and expectations of staff fulfilling orders included in orientation for new staff and skills day for existing staff.</p> <p>Develop a corrective action for demonstrating compliance with the QAPI based on the success of the EOC approach. Build on the foundation of success of staff consistently reporting incidents and submitting reports by:</p>	10/31/14	Clinical Managers	orders in AVATAR Instructions included in active orders for 1:1 and CVO in EMR
		<p>> Staff education sign off sheet signed by staff receiving education, CMs send a copy to VP Patient Services. Data Base of staff acknowledging education maintained.</p>	10/31/14	Director of Clinical Education	Audit at 100% of all active staff assigned 1:1/ CVO
		<p>> Provide reinforcement education about key parameters of care through posters/screensavers on the units in an ongoing basis.</p>	10/31/14	Director of Clinical Education	Posters evident on units
		<p>> Inclusion of the definition of 1:1 order and Continuous Visual Observation (CVO) orders and expectations of staff fulfilling orders included in orientation for new staff and skills day for existing staff.</p> <p>Develop a corrective action for demonstrating compliance with the QAPI based on the success of the EOC approach. Build on the foundation of success of staff consistently reporting incidents and submitting reports by:</p>	10/13/14	Director of Clinical Education/Director of Clinical Informatics	Included on agenda for orientation/ skills day

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		<ul style="list-style-type: none"> > Ad hoc meetings are called by the CEO with Board members for review of all critical incidences including actual events and near misses. > Evaluate what other Incident Reporting software are available that may offer more specific data entry, capture, analysis and reporting capability. > Seek education re better investigative techniques to improve Quality department and Clinical Managers' knowledge base. (Board member will recommend educational sources.) > Add more time to the daily (M-F) morning meeting that includes Clinical Managers, Quality, Risk and Executive Team members for review of incident reports, to identify a severity level to prioritize investigations of quality incidences and the progress of investigations/ action steps, system risk assessment. (Incidents are reviewed by the Nursing Supervisor with the Administrator-on-Call (AOC) on weekends and they are also reported at Monday meeting.) > Establish a standing weekly meeting time for Critical Incident Reviews in order to increase efficiency of getting required members' together and to increase timeliness of review and 	<p>Start 10/20/14 and ongoing</p> <p>11/15/14</p> <p>10/6/14</p> <p>10/31/14</p>	<p>CEO</p> <p>Director Clinical Informatics</p> <p>Director Quality</p> <p>VP Operations</p> <p>Director Quality</p>	<p>Meeting minutes</p> <p>Proposal submitted</p> <p>Proposal submitted</p> <p>Reflected in Minutes</p> <p>Meeting Minutes</p>

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
A286	<p>482.21 (a), (c)(2), (e)(3) PATIENT SAFETY</p> <p>Standard: Program Scope The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will identify and reduce medical errors. The hospital must measure, analyze, and track ... adverse patient events ...</p> <p>(c) Program Activities ... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital</p> <p>(e) Executive Responsibilities: The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ...</p>	<p>Develop a corrective action for demonstrating compliance with Patient Safety based on the success of the EOC approach. Build on the foundation of success of staff consistently reporting incidents and submitting reports by:</p> <ul style="list-style-type: none"> > Explore options for resource enhancement in the Quality Department including: <ul style="list-style-type: none"> > VP Quality as a member of the executive team > Clinical Oversight > Clinical Audit Function > Data Analyst > Administrative Support > Evaluate what other Incident Reporting software are available that may offer more specific data entry, capture, analysis and reporting capability. 	<p>11/5/14</p>	<p>CEO</p>	<p>VP Quality position hired</p>
A 286	<p>482.21 (a), (c)(2), (e)(3) PATIENT SAFETY</p> <p>Standard: Program Scope The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will identify and reduce medical errors. The hospital must measure, analyze, and track ... adverse patient events ...</p> <p>(c) Program Activities ... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital</p> <p>(e) Executive Responsibilities: The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ...</p>	<p>Director of Quality (Interim until VP Quality in the role), Board Quality Chair and the CEO will meet Bi-monthly (and ad hoc if need warrants) to review incident reports and completed action steps to ensure that data is analyzed and that systemic issues are identified and resolved.</p>	<p>10/16/14 and ongoing</p>	<p>CEO</p>	<p>Meeting Minutes</p>

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A 286	<p>(3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital's Quality Assurance/Performance Improvement failed to assure that its program activities included a thorough review and analysis of all adverse events and their causes, and failed to develop and implement hospital wide preventive actions to assure that adverse events will not recur and that learning and feedback is on-going throughout the hospital. The findings relate to 2 separate patient incidents involving self-harming/suicidal actions on the Tyler 3 Unit. (Patient #4 #5) and a 3rd incident involving a patient elopement from Osgood 3. (Patient #6)</p> <p>Findings include: 1. On 9/22/14 Patient #5, identified to be a "high safety risk" experienced a near drowning after staff left the patient unattended in a bathtub. Patient #5 was admitted to the hospital on 9/11/14 with a diagnosis of Bipolar and acute mania. On 9/19/14 Patient #5 was transferred from Osgood 1 to Tyler 3 and was placed on Continuous Visual Observation (CVO) with 1:1 (one staff member assigned to continuously monitor patient). Hospital policy Safety Checks/Special Observations (last approved 4/2014) states: "Continuous Visual Observation: requires that staff must keep this patient within continuous visual observation and be ready to intervene immediately if the patient's behavior requires it"</p> <p>Per interview on 9/30/14 the nurse</p>	<p>> Seek education re investigative techniques to improve Quality department and Clinical Managers knowledge base.</p> <p>> Add more time into the daily (M-F) morning meeting that includes clinical managers, quality, risk and members of the executive team for review of incident reports to identify quality incidents and the progress of investigations/ action steps, system risk assessment. (Incidents are reviewed by the Nursing Supervisor with the Administrator-on-Call (AOC) on weekends and they are also reported at Monday meeting).</p> <p>> Establish a standing weekly meeting time for Critical Incident Reviews to increase efficiency and timeliness of review and analysis (if a specific review is not necessary, use the time for education).</p> <p>> Director of Quality (interim until VP Quality in the role), Board Quality and the CEO will meet Bi-monthly (and ad hoc if Director of Quality (interim until VP Quality in the role) recognizes need) to review incident reports and completed action steps to ensure that data is analyzed and that systemic issues</p>	<p>11/15/14</p> <p>10/6/14</p> <p>10/31/14</p> <p>10/16/14 and ongoing</p>	<p>Director Quality</p> <p>VP Operations</p> <p>Director Quality</p> <p>CEO</p>	<p>Proposal submitted</p> <p>Meeting minutes</p> <p>Meeting minutes</p> <p>Meeting minutes</p>

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A 286	<p>manager for Tyler J stated staff assigned to CV0/1:1 are expected to be only an arm's length away from the patient while maintaining constant "eyes on"</p> <p>On 11:15 AM 9/22/14 Patient #5 was permitted to use the ALSA tub/shower. Since admission this was an activity Patient #5 enjoyed, spending extended time bathing and often singing while in the bathtub and/or shower. Mental Health Worker (MHW) #1 assigned to Patient #5 remained with the patient in the bathroom.</p> <p>At approximately 11:45 AM MHW #1 was due to be relieved of his/her duties by MHW #2 who would take over the monitoring of Patient #5 while s/he bathed. Per interview with MHW #2 on 9/30/14 at 1:44 PM stated upon arrival to relieve MHW #1 s/he observed the staff member standing outside the bathroom door and "I thought that was what I was supposed to do." She further stated Patient #5 continued to sing and talk while bathing. "I knocked on the door every 10 minutes." to check on the patient who would reply s/he was "Ok" and was not ready to get out of the tub. At approximately 12:15 PM MHW #2 stated the patient was quiet. "I knocked and opened the door...she was face down in the water...laying on left side with face half submerged in water...I went outside bathroom door to press the emergency button on wall...came back in and lifted her/his upper body and laid head on side of tub..." Staff quickly arrived and the patient was removed from the tub. MHW #2 further stated "...she was not responding". A sternal rub was performed and Patient #5 began coughing up water. Eventually Patient #5 was returned to his/her room and was</p>	<p>are identified and resolved.</p> <ul style="list-style-type: none"> ➤ Implement Quarterly Reviews of PI projects with Executive Team members for prioritization of projects and systemic analysis of impact. ➤ Explore options for resource enhancement in the Clinical Informatics and/or IT Department including: <ul style="list-style-type: none"> • Review existing EMR, link data elements to report builds for easy auditing (eliminate as much hand audits as possible, e.g. chart audits, link with HBIPS data, reports for CM's re staff documentation elements). <p>Building on the foundation of staff recognizing they are the professionals for behavioral health emergencies and no longer calling the police for instances of behavioral emergencies at the Brattleboro Retreat. (No instances for more than year):</p> <ul style="list-style-type: none"> ➤ With the Early Responder team, Security and the Nursing Supervisors: <ul style="list-style-type: none"> • Review of elopement policy and role to team member to include parameters for police involvement 	<p>11/15/14</p> <p>11/5/14</p>	<p>CEO</p> <p>Director Chemical Informatics</p>	<p>Meeting minutes</p> <p>Proposal submitted</p> <p>90% of active staff</p>

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A 286	<p>examined by medical staff</p> <p>Psychiatry progress note for 9/22/14 further states: "Later during the patient after she was found submerged underwater in the tub". The staff reported the patient was 'unresponsive' and becoming responsive 'after the sternal rub'...no functional limitations noted".</p> <p>Per interview on 9/30/14 at 2:19 PM MHW #1 did confirm, she had left the bathroom and Patient #5 unattended while she sought her/his replacement. MHW #1 stated a report is generally conducted at the time of the "switchover". "I am afraid I left pretty quick...I guess the door to the bathroom shut when I left...I was exiting because it was time for switch over". A report was not provided between MHW#2 and MHW #1 at the time of the "switchover" prior to resuming responsibilities of keeping Patient #5 safe.</p> <p>An adverse event report was completed and the Tyler 3 nurse manager conducted an investigation. Actions taken included communication with family and appropriate authorities and only Tyler 3 Staff. There was a failure to identify the potential opportunity for staff on other units responsible for providing similar CV0/1:1 to lack the understanding or commitment to assure policies were followed. At the time of survey it was also identified by surveyors that staff were not effectively communicating with each other to maintain consistent awareness of each patient's needs and confirmation of required observations. Despite the significance of the event QAPI staff failed to identify the need to expand</p>	<p>> during outside the building but on-ground events for patients currently in our care, and communication/directional instructions to police to prevent hand-on by police.</p> <p>> CEO to contact Brattleboro Chief of Police regarding this incident with police involvement, and request to re-train officers in a no hands-on response (including use of handcuffs) for on-ground inpatient elopements.</p> <p>> CMA's to review this specific situation in staff meetings, posters on unit, email, memo in staff mailboxes to clarify role of staff with police present in management of the patient, and role in communicating such with police.</p>	<p>10/3/14</p> <p>11/5/14</p>	<p>of Pt Care Services</p> <p>CEO</p> <p>Clinical Managers</p>	<p>Phone conversation</p> <p>Meeting Agendas, e-mails, memos distributed, signage on units</p>

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A 286	<p>awareness and confirm all staff on all the units had a full understanding of their responsibilities pertaining to the observations of patients assuring patient safety is maintained by all staff at all times.</p> <p>2. Patient #4 was admitted to the hospital on 9/16/14 with depression with suicidal ideation. The patient had previous admissions to the hospital during April and May, 2013, for suicidal ideation, self-harming behaviors (cutting, scratching self) and a suicide attempt. During the current stay, when feeling anxious and depressed, the patient made multiple statements that he/she would harm him/herself. On 9/23/14, a nursing progress note stated (will tie something aroundneck). Staff continued to document the patient's intention to harm themselves on a daily basis. The patient alternated between 1:1 monitoring, constant observations and CAA, (Community Area Assignment).</p>	<p>On 9/29/14, the patient was found to have a length of spandage (a tubular, elastic dressing material) in his/her possession which he/she showed to a staff member and, per the nursing progress notes of 9/29/14, "patient.... quickly put this around his/her neck. MFTW #3 (mental health worker) was assisted by the LPN in removing this from his/her neck (patient was attempting to tighten). Despite having security staff and nursing staff on hand, patient again tried to put spandage around the neck." The RN author of this progress note (RN #1) documented "....admonished nursing staff to give out only short lengths of spandage to ('Patient #4)' or any patient". A physician progress note</p>			

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A 286	<p>(9/29/14) about the same incident documented the patient slipped an elastic mesh material for bandages over his/her neck... "eventually required security and staff to wrestle to remove it from his/her neck. (Patient #4) repeated the act right after the first attempt." During a tour of the Tyler 3 Unit on 9/30/14 at 2:30 PM (when the survey team became aware of the event), the surveyor requested a 2 inch piece of the spandage to demonstrate the risk posed by ANY length of this type of material, which could be used as a ligature device. RN #2 cut a 2 inch piece of the spandage and pulled it open and was able to put the open tube of mesh over his/her head and place it around their neck. It was observed to be snug around their neck. RN #2 concurred that the spandage was dangerous and should not be continued to be used for patient needs. The Director of Social Services was also present for the demonstration. During interview with the Clinical Nurse Manager of the Tyler 3 Unit on the afternoon of 9/30/14 and at 1 PM on 10/1/14, the Manager confirmed that s/he had thought that the patient had wrapped a length of the material around the neck, lengthwise, not by opening the tubular material and looping it over the head. Although multiple hospital staff were aware of this incident, there was no evidence of a thorough investigation to review all the facts of the incident and determine what course of action was necessary to protect the safety of all hospitalized patients in the future. No staff identified that the spandage was a potential ligature device, no matter what length the material was cut into. No staff identified that the continued use of this</p>				

The Brattleboro Retreat
 Corrective Action Plan
 Survey Completion Date: October 1, 2014
 Provider ID # 474001

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/ Goal
A 286	<p>Type of dressing material represented an extreme danger to patients at risk of suicide/self-harm. The only action recommended by the hospital after reviewing the incident on 9/29/14 was to "admonish nursing staff to give out only short lengths of spandex to --or any patient". It was noted that many patients have cutting, self-harming behaviors on the units and the material was available for use on all units of the hospital 3. Per record review Patient #6 was involuntarily admitted to the hospital on 8/25/14. S/he had reportedly been exhibiting paranoid, angry and aggressive behaviors, had threatened members of the group home where s/he had resided, and had been taken to the Emergency Department (ED) by the local police. S/he had remained delusional while in the ED and had made several attempts to elope from there. The patient presented with paranoid delusions that involved a fear of imminent assault by others. The record revealed that the patient was delusional and schizophrenic by diagnosis, and, although s/he had not attempted to self-harm during this current episode, s/he had a history of acting on hallucinations which had previously resulted in serious self-harm. A nursing progress note, on 9/9/14, stated that the patient "... went for walk with MHW (Mental Health Worker) and attempted to elope today Pt relates wanting to leave. "I don't feel safe here...." A Physician progress note, on 9/10/14, stated that the patient reported "... that [s/he] tried to elope yesterday because [s/he] was hearing voices and they were scaring [him/her]." The patient was placed on unit restricted privileges following the elopement attempt and a physician progress note, on 9/22/14,</p>				

The Braintreeboro Retreat
 Corrective Action Plan
 Survey Completion Date: October 1, 2014
 Provider ID # 474001

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/ Goal
A 286	<p>indicated that there had been a discussion, on that date, regarding a change in privilege level, to allow Patient #6 staff supervised off unit activity in accordance with an established Enhanced Safety Plan (ESP) for Elopement which stated: "Heightened vigilance when going on/off unit- be alert to pt's impulsivity, changes in thought process.... nursing will perform a safety check-in with pt. prior to leaving unit..." During a staff supervised escort, through unsecured areas of the hospital, to the off unit patient cafeteria, on the evening of 9/23/14, the patient eloped from the hospital and grounds. A Code Green was called, the local police were notified and Mental Health Workers (MHW) followed the patient. The patient eventually agreed to return to the hospital with Security department staff in one of their vehicles, and when arriving on hospital grounds the patient again attempted elopement. While staff were placing the patient in a therapeutic hold, and despite the lack of evidence of criminal activity involving the patient, a police officer, who had followed staff back to the facility, applied handcuffs, which were not removed until the patient was inside the facility. The patient was immediately placed on unit restricted privileges and remained on that privilege level at the time of survey. s/he was handcuffed by police who had followed staff back to the hospital and the cuffs were not removed until the patient was inside the hospital. During interview, at 8:52AM on 10/1/14, the RN (Registered Nurse) Unit Manager confirmed that the Charge Nurse on duty at the time of Patient #6's elopement admitted that s/he had not conducted a safety check-in with</p>				

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
A 286	<p>Patient #6 prior to his/her departure from the unit, in accordance with the patient's ESP. The Unit Manager stated that on the evening of 9/23/14 two MHWs had taken Patient #6, along with 4 other patients, off unit to the secure patient cafeteria via an unsecured hallway and staff dining area, in accordance with the hospital policy. MHW #4 was leading and MHW #5 was at the rear of the group to view all patients. MHW #5 reportedly turned his/her head at one point to look at another MHW, and heard a patient ask where Patient #6 was going. When MHW #5 turned back Patient #6 was going out the door of the unsecured staff dining area, onto facility grounds, a Code Green was called, staff followed the patient off grounds, and the patient was eventually returned to the unit. The Unit Manager further stated that Patient #6 had been handcuffed by police, while staff were attempting to apply a therapeutic hold on the patient, that staff reportedly did not know why they had been applied and that the cuffs were not removed until the patient was inside the hospital building. S/he also stated that although some form of disciplinary action would be initiated against the Charge Nurse and MHWs #4 and #5 no action had occurred to date. S/he stated that the Charge Nurse had begun a vacation the day after the incident and had not yet returned, but both MHWs had continued to work on the unit. The Unit Manager further stated that although Patient #6 was immediately placed on unit restricted privileges and had remained on that privilege level to date, no other action had been taken to reduce the risk of elopement by patients from that unit while being escorted through unsecured</p>				

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal	
A 395	<p>areas of the hospital. The Quality Manager confirmed, during interview at 10:45 AM on 10/1/14, that although Patient #6 had been restricted to the unit and a Root Cause Analysis had been conducted following the elopement, no other action had been taken to reduce the risk of elopement by any patient on that unit or any other units from which patients could not be assured secure escort/transfer through the hospital.</p> <p>The hospital's Quality/Risk Management Committee has repeatedly failed to conduct thorough investigations of all patient incidents/events to assure that a complete analysis of all of the confounding facts is considered and to assure appropriate, hospital wide action plans are put into place in a timely manner to prevent further incidents with potential for significant patient harm.</p>	<ul style="list-style-type: none"> ➤ Reinststate practice of RN nursing assessment/progress notes on days/even on all inpatient units. ➤ Provide re-training on psychiatric components of Nursing Assessment. ➤ Provide auditing of RN documentation for 3 months to assure completion/quality of documentation and to identify educational gaps. ➤ Evaluate opportunities for revision of documentation format in EMR. 	<p>10/20/14</p>	<p>482.23(b)(3) RN SUPERVISION OF NURSING CARE</p> <p>A registered nurse must supervise and evaluate the nursing care for each patient.</p> <p>This STANDARD is not met as evidenced by: Based on staff interviews and record review nursing staff failed to conduct an assessment to determine appropriateness for supervised off unit activity for one of 5 applicable patients. Nursing staff also failed to evaluate the safety of the use of a type of elastic dressing material which presented a safety hazard to 1 applicable patient in the targeted sample, as well as any future patients utilizing the dressing who are identified as at risk for self-harming behaviors. (Patients #6 and #4).</p>	<p>VP of Pt Care Services</p> <p>Director of Clinical Education</p> <p>VP of Pt Care services</p> <p>Director of Clinical Informatics</p>	<p>Nursing Assessments completed 100%: 8 charts/unit per month for 3 months</p> <p>90% all active nursing staff</p> <p>8 charts/unit per month for 3 months</p>

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/Goal
A 395	<p>Findings include:</p> <p>1. Per record review Patient #6 was involuntarily admitted to the hospital on 8/25/14. The patient had reportedly been exhibiting paranoid, angry and aggressive behaviors and had threatened members of the group home where s/he had resided. S/he was transported to the Emergency Department (ED) by the local police, had remained delusional while in the ED and had made several attempts to elope from there.</p> <p>The patient, who presented to the hospital with paranoid delusions that involved a fear of imminent assault by others, had a history of Schizophrenia and PTSD and although there had been no self-harm during this episode, s/he had a history of previous serious self-harm.</p> <p>A nursing progress note, dated 9/9/14 stated: Pt remains delusional and suspicious of staffPt went for walk with MHV (Mental Health Worker) and attempted to elope todayPt relates wanting to leave. "I don't feel safe here" A Physician progress note, on 9/10/14, stated that the patient reported ".....reported that [s/he] tried to elope yesterday because [s/he] was hearing voices and they were scaring [him/her]." The patient was placed on unit restricted privileges following the elopement attempt and a subsequent Physician progress note on 9/22/14 indicated that there had been a discussion, on that date, regarding privilege levels to which the patient had responded: "I could handle some... staff would check in with me first... I could</p>				

The Brantford Retreat
 Corrective Action Plan
 Survey Completion Date: October 1, 2014
 Provider ID # 474001

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QAI Frequency/ Goal
A 395	<p>tell them if I was ok, I'd admit it if I wasn't." The patient was allowed off unit privileges in accordance with an Enhanced Safety Plan (ESP) which stated: "Heightened vigilance when going on/off unit- be alert to pt's impulsivity, changes in thought process.... nursing will perform a safety check- in with pt. prior to leaving unit...." A nursing progress note, at 8:37 PM on 9/23/14, revealed that Patient #6 had been escorted to the off unit patient cafeteria by 2 staff members and eloped from the door in the unsecured staff dining room while walking through at 4:54PM. A Code Green was called and Mental Health Workers (MHW) followed the patient off facility grounds. The local police department (PO) was notified and the patient eventually agreed to return to the hospital with Security department staff in one of their vehicles.</p> <p>During interview, at 8:52AM on 10/1/14, the RN (Registered Nurse) Unit Manager confirmed that the Charge Nurse on duty at the time of Patient #6's elopement admitted that s/he had not conducted a safety check- in or any assessment of Patient #6 prior to his/her departure from the unit, in accordance with the patient's ESP.</p> <p>2. Per record review on 9/30/14, Patient #4, was admitted to the hospital for self-harming behaviors and suicidal ideation on 9/16/14. An incident report dated 9/29/14 stated that the patient (#4) had "pulled a long piece of gauze... and wrapped it around his/her neck."</p>				

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	<p>Myself and another coworker successfully cut it from his/her neck." Per review of the RN Charge Nurse progress note concerning this event, dated 9/29/14 at 5:44 PM, the RN response to the potentially lethal act by Patient #4 was to report the event to the evening shift and to "admonish nursing staff to give out only short lengths of spandage to (Patient #4) and any patient". A demonstration of the use of a 2.5 inch length of spandage, per surveyor request by RN #2 on 9/30/14 at 2:30 PM on the Tyler 3 Unit, revealed that any length of the spandage could be utilized as a ligature device by stretching it over the head to the neck and thus, was unsafe for use by any patients at risk for self-harm. RN #2 confirmed this finding as well. During interview on 9/30/14 at 12:20 PM, the Director of Quality and the Clinical Nurse Manager of the Tyler 3 Unit confirmed that nurses failed to evaluate the extreme safety risk posed by use of the spandage for Patient #4 who had engaged in self-harming behavior and voiced suicidal ideation since admission on 9/16/14.</p>				

Nursing Observation Flow Sheet

Date: _____ Time: _____
 Q 15 minutes checks OR (check one)
 Level of Observation:
 1:1 within arm's length at all times
 Continuous Visual Observation at all times
 Reason for Obs: _____
 Changed/DC: Date: _____ Time: _____
 Rationale: _____
 Initial: _____

For all Safety Checks/Special Observations, document every 15 minutes.

15 min. checks (initial)	Hand Off On/Off	Location (see key)	Personal Care/BR	Nutrition	O2 Protocol	P's behavioral concerns Nourishment/Exercise/Circulation
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Charge Nurse Signature

Directions for Handoff: Offgoing and Oncoming staff need to both review level of obs (1:1 or CVO) on changing staffing of patient and initial form.

Initials and Signatures	

Location Key: O=Off unit; R=RL Room; BR=Bathroom; A=ALSA QR=Quiet Room BR=Senior Room CA=Community Area GR=Group Area

Attachment A

ADDRESSOGRAPH Revised B/14

