
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

November 15, 2013

Mr. Robert Simpson, Administrator
Brattleboro Retreat
Anna Marsh Lane Po Box 803
Brattleboro, VT 05301

Dear Mr. Simpson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 22, 2013**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl

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

PRINTED: 11/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 474001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/22/2013
NAME OF PROVIDER OR SUPPLIER BRATTLEBORO RETREAT			STREET ADDRESS, CITY, STATE, ZIP CODE ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS An onsite complaint investigation was conducted by the Division of Licensing and Protection on 10/21/13 and 10/22/13. The following regulatory violations were identified.	A 000	See Attached Plan	
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure each patient's individual rights were maintained by staff during random contraband searches identified by the hospital to be necessary in preventing unsafe articles from entering a patient unit. Findings include: The hospital policies and procedures pertaining to the Disposition of Unsafe Items, last approved 12/2012, was developed for the purpose of assuring patients are receiving treatment "...in an environment that is free of any items or substances that are potentially harmful or actually harmful" and that subjects of patient searches "...will have his/her dignity and privacy and confidentiality maintained..." and "...will demonstrate the utmost sensitivity and respect..." during the search process. However, per interview on 10/22/13 at 11:23 AM a nurse on Tyler 3 confirmed the unit does their own specific searches which includes random contraband searches of adolescents whenever they have been off the unit. Prior to being allowed to return to the unit each patient is required to empty their pockets while being detained in the elevator alcove. When a group of patients return to the unit, in addition to the pocket search a random	A 143	<i>A-143</i> <i>10/14/13</i> <i>P.O.C. Accepted</i> <i>Dr. DeIntosh</i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Robert J. ...* TITLE *President + CEO* (X6) DATE *11/13/13*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 143 Continued From page 1
safety check is also conducted. Patients are directed by Tyler 3 staff to pick from a covered container one piece of colored paper. Depending on the color chosen, patients who had unknowingly choose the color red are then subjected to a search by staff. Despite the fact that a randomly chosen patient did not attempt to hide contraband or have a history of such behavior they would still be subjected to the search. A "search" for body contraband can include checking shoes and socks, removing a sweatshirt and rolling down waistbands and shaking out their hair. Although this protocol has been utilized as an attempt to prevent self injurious behaviors by discouraging patients from bringing sharp objects or other unsafe articles back on the unit, it does not preserve each patient's right to not be subjected to unwarranted search without just cause, clinical need or as directed per each patient's individualized behavioral/treatment plan.

A 143

A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING

The patient has the right to receive care in a safe setting.

This STANDARD is not met as evidenced by:
Based on observations and interviews, the hospital failed to assure each patient's right to receive care in a safe setting by failing to identify a potential safety hazard on Tyler 3. Findings include:

On 10/22/13 at 2:00 PM a tour was conducted of Tyler 3 to observe environmental changes made by the hospital in an effort to maintain a safe environment for the adolescent population.

A 144

11/14/13
A-144
P.O.C.
Accepted
Q. De Intosh

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A 144	Continued From page 2 Observation of the phone booth noted the door window to the phone booth was replaced with wood. This obstruction prevented staff ability to visualize patients during safety checks when a patient was utilizing the phone when the door to the booth is closed. Further observation noted, upon standing on the bench in the phone booth, a patient had easy access to a fire sprinkler head which had sharp edges and protrusions. The observation was confirmed by the unit nurse manager and a member of the maintenance department.	A 144			
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure staff, identified as mandated reporters, who became aware of an allegation of abuse, reported the allegation to the appropriate State Agency, as required, for 1 applicable patient. (Patient #2) Findings include: Per record review of Nursing Notes for Patient #2 from 9/4/13 "Patient had both verbal and physical altercation (tried to choke) male peer", and Mental Health Worker notes for the same day record Patient #2 as "mostly disruptive, disrespectful, noncompliant and assaultive towards peer ...trying to choke peer". Per record review of Physician Notes from 9/5/13, Patient #2 "engaged in a physical altercation with peer last evening ...responded by placing h/her hands around peer's neck. Staff intervened and patient	A 145			

A-145
11/14/13 POC - Accepted
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A 145	<p>Continued From page 3</p> <p>was placed on assaultive behavior protocol". Per interview on 10/22/13 at 9:30 A.M. Patient #2's Social Worker confirmed placing Patient #2 on assaultive behavior protocol indicated that the patient choking his/her peer was a serious incident and confirmed it should have been reported to the appropriate state agency.</p> <p>Per interview with the Director of Social Services on 10/22/13 at 9:30 A.M., if there is an assault or incident on Patient #2's unit, a report would be made to the Department of Children and Families (DCF) during the shift the incident occurred, in order to comply with DCF requirements that allegations of abuse be reported within 24 hours. (<http://dcf.vermont.gov/fsd/reporting_child_abuse>)</p> <p>Per interview on 10/22/13 at 12:55 P.M. the Manager of Performance Improvement and Risk Management stated it was his/her expectation that this incident would be reported to DCF and the reporting would be documented. The Manager confirmed s/he had not found any evidence or documentation that this specific assault by Patient #2 on 9/4/13 had been reported to the appropriate State Agency.</p>	A 145	

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>An onsite complaint investigation was conducted by the Division of Licensing and Protection on 10/21/13 AND 10/22/13. The following regulatory violations were identified.</p>				
A 143	<p>482.13 (c) (1) Patient Rights: Personal Privacy The patient has the right to personal privacy.</p> <p>This standard is not met as evidenced by: hospital failed to ensure each patient's individual rights were maintained by staff during random contraband searches identified by the hospital to be necessary in preventing unsafe articles from entering a patient unit. Findings include:</p> <p>The hospital policies and procedures pertaining to the Disposition of Unsafe Items, last approved 12/2012, was developed for the purpose of assuring patients are receiving treatment "...in an environment that is free of any items or substances that are potentially harmful or actually harmful" and that subjects of patient searches "...will have his/her dignity and privacy and confidentiality maintained...." and "...will demonstrate the utmost sensitivity and respect..." during the search process. However, per interview on 10/22/13 at 11:23 AM a nurse on Tyler 3 confirmed the</p>	<ol style="list-style-type: none"> 1. The random searches on Tyler 3 were immediately stopped. 2. The "Disposition of Unsafe Items" policy was sent to the Policy Committee for review and revision. This review includes insuring compliance with applicable laws and regulation while supporting practice and the delivery of safe quality patient centered care. 3. The adolescent division has a retreat planned to review protocols and treatment planning. 4. The patient Bill of Rights revised to include language which more strongly delineates the patient's right to personal privacy during physical examination, treatment, or procedures. 	<ol style="list-style-type: none"> 1. 10.22.13 2. 12.9.13 3. 11.11.13 4. 12.22.13 	<ol style="list-style-type: none"> 1..Clinical Manger Tyler 3 2.Policy Committee 3.Adolescent Services members 4.Patient Advocate 	<ol style="list-style-type: none"> 1. Audit of T3 charts, interview with patients. Goal: no random searches conducted

A-143
 11/14/13
 P.O.C.
 Accepted
 Dr. [Signature]

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>unit does their own specific searches which includes random contraband searches of adolescents whenever they have been off the unit. Prior to being allowed to return to the unit each patient is required to empty their pockets while being detained in the elevator alcove. When a group of patients return to the unit, in addition to the pocket search a random safety check is also conducted. Patients are directed by Tyler 3 staff to pick from a covered container one piece of colored paper. Depending on the color chosen, patients who had unknowingly choose the color red are then subjected to a search by staff. Despite the fact that a randomly chosen patient did not attempt to hide contraband or have a history of such behavior they would still be subjected to the search. A "search" for body contraband can include checking shoes and socks, removing a sweatshirt and rolling down waistbands and shaking out their hair. Although this protocol has been utilized as an attempt to prevent self injurious behaviors by discouraging patients from bringing sharp objects or other unsafe articles back on the unit, it does not preserve each patient's right to not be subjected to unwarranted search without just cause, clinical need or as directed per each patient's individualized behavioral/treatment plan.</p>				

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A 144	<p>482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews, the hospital failed to assure each patient's right to receive care in a safe setting by failing to identify a potential safety hazard on Tyler 3. Findings include:</p> <p>On 10/22/13 at 2:00 PM a tour was conducted of Tyler 3 to observe environmental changes made by the hospital in an effort to maintain a safe environment for the adolescent population.</p> <p>Observation of the phone booth noted the door window to the phone booth was replaced with wood. This obstruction prevented staff ability to visualize patients during safety checks when a patient was utilizing the phone when the door to the booth is closed. Further observation noted, upon standing on the bench in the phone booth, a patient had easy access to a fire sprinkler head which had sharp edges and protrusions. The observation was confirmed by the unit nurse manager and a member of the maintenance department.</p>	<ol style="list-style-type: none"> 1. When discovered and prior to the survey team leaving, the door on the phone booth as well as the bench in the phone booth was removed by facilities. 2. The environmental findings were reviewed at the morning manager meeting 10.23.13 3. Tip to report any safety concerns to quality or their manager e-mailed to all staff. 4. The environmental findings were reviewed at the Regulatory meeting 10.24.13 and again on 11.7.13. <p style="text-align: center;"><i>11/14/13 A.144. P.O.C. Accepted Dr. DeWitt</i></p>	<ol style="list-style-type: none"> 1. 10.22.13 2. 10.23. 13 3. 10.30.13 4. 10.24.13 and 11.7.13 	<ol style="list-style-type: none"> 1. Director of Facilities 2. Clinical Managers 3. Chair of Regulatory Committee 4. Chair of Regulatory Committee 	<ol style="list-style-type: none"> 1. Environment of Care Rounding results conducted quarterly reviewed at Safety Committee Goal: identified safety variances have corrective action plan developed. 4. Tracer rounds conducted monthly and results reviewed at Regulatory Committee. Goal: identified safety variances have corrective action plan developed.

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
A145	<p>482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT</p> <p>The patient has the right to be free from all forms of abuse or harassment.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure staff, identified as mandated reporters, who became aware of an allegation of abuse, reported the allegation to the appropriate State Agency, as required, for 1 applicable patient. (Patient #2)</p> <p>Findings include:</p> <p>Per record review of Nursing Notes for Patient #2 from 9/4/13 "Patient had both verbal and physical altercation (tried to choke) male peer", and Mental Health Worker notes for the same day record Patient #2 as "mostly disruptive, disrespectful, noncompliant and assaultive towards peer ... trying to choke peer". Per record review of Physician Notes from 9/5/13, Patient #2 "engaged in a physical altercation with peer last evening</p>	<ol style="list-style-type: none"> 1. Educational guidelines regarding DCF reporting were sent again to Triad leader's managers to review with Staff. 2. Inclusion in on-line mandatory training module for employees at hire and annually. 3. The Local DCF office has been scheduled to provide face to face training regarding mandated reporting requirements. 4. Treatment teams will review and discussion during daily rounds patient episodes to identify those which meet reporting requirements and verification of reporting to appropriate agency. 	<ol style="list-style-type: none"> 1. 10.29.13 2. 12.2.13 3. 11.13.13 4. ongoing 	<ol style="list-style-type: none"> 1 Director Quality/Risk Management 2. Director clinical education 3.. Director Quality/Risk Management 4. Treatment team leader 	<ol style="list-style-type: none"> 2.audit of mandatory training for inclusion: goal 95% active staff completing 3. Random chart audits/ incident report review to validate required reporting. 100% episodes meeting requirements for reporting are reported.

A-145
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 Accepted
 QCC
 11/14/13

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>...responded by placing h/her hands around peer's neck. Staff intervened and patient was placed on assaultive behavior protocol". Per interview on 10/22/13 at 9:30A.M. Patient #2's Social Worker confirmed placing Patient #2 on assaultive behavior protocol indicated that the patient choking his/her peer was a serious incident and confirmed it should have been reported to the appropriate state agency.</p> <p>Per interview with the Director of Social Services on 10/22/13 at 9:30 AM., if there is an assault or incident on Patient #2's unit, a report would be made to the Department of Children and Families (DCF) during the shift the incident occurred, in order to comply with DCF requirements that allegations of abuse be reported within 24 hours. (<http://dcf.vermont.gov/fsd/reporting child abuse>)</p> <p>Per interview on 10/22/13 at 12:55 P. M. the Manager of Performance Improvement and Risk Management stated it was his/her expectation that this incident would be reported to DCF and the reporting would be documented. The Manager confirmed s/he had not found any</p>				

The Brattleboro Retreat
Corrective Action Plan
Survey Completion Date: October 22, 2013
Provider ID # 474001

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	evidence or documentation that this specific assault by Patient #2 on 9/4/13 had been reported to the appropriate State Agency.				