

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

August 12, 2016

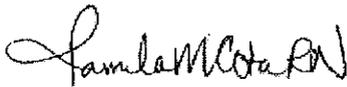
Mr. Louis Josephson, Administrator  
Brattleboro Retreat  
Anna Marsh Lane  
Po Box 803  
Brattleboro, VT 05301-0803

Dear Mr. Josephson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 13, 2016**. Please post this document in a prominent place in your facility.

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

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

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

PRINTED: 07/21/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>474001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/13/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRATTLEBORO RETREAT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A 000 INITIAL COMMENTS

A 000 See attached Corrective Action Plan  
Survey Completion Date: July 13, 2016  
Pages 1-18

An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection from 7/11/16 - 7/13/16 as authorized by the Centers for Medicare and Medicaid to determine compliance with Conditions of Participation: Patient Rights, Outpatient Services, QA/PI and Discharge Planning for complaint # 14670. The following regulatory violations were identified:

A 131 482.13(b)(2) PATIENT RIGHTS, INFORMED CONSENT

A 131

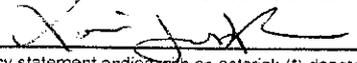
The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care

The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

This STANDARD is not met as evidenced by:  
Based on staff interviews and record review, the hospital failed to ensure a patient's representative (Court appointed Guardian) was informed and included in the decision involving an unplanned discharge for 1 applicable patient. (Patient #3)  
Findings include:

On 5/28/16 there was a failure of the Psychiatrist, Social Worker and RN to inform Patient #3's Guardian and also the patient's case manager for Pathways Vermont regarding the intentions and subsequent discharge of Patient #3. The lack of

*A-131-  
P.O.C.  
Accepted  
D. DeIntosh, RN  
8/11/16*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>CEO</b>	(X5) DATE <b>8/3/16</b>
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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 131 Continued From page 1 A 131

notification prior to discharge prevented the Guardian in collaborating with hospital staff and the patient in making an informed decision regarding a safe discharge and also ensuring housing and community support availability.

Patient #3, was admitted voluntarily to the hospital on 5/25/16 for increased mood instability and thoughts of suicide. Prior to admission, and according to community resources to include Patient #3's Public Guardian, the patient had been decompensating over the previous several weeks and sought hospitalization after receiving an emergency crisis screening. Per initial MD Assessment completed on 5/26/16, Patient #3 had a past history of attempted suicide by hanging and intentional heroin overdose. Patient #3 was assessed to have auditory hallucinations was disorganized and paranoid. For the first 48 hours after admission Patient #3 was assigned to ALSA (a low stimulation area) due to disruptive and agitated behaviors which were upsetting the milieu of the unit. On 5/27/16 a Multidisciplinary Treatment Plan was developed which stated under Patient Objectives: "Patient will consider aftercare possibilities as recommended to ensure adequate support after discharge". Multidisciplinary Interventions state: "SW (Social Worker) will meet with patient 1-2 times per week to discuss aftercare needs, will collaborate with current outpatient providers and schedule aftercare appointments as needed. SW will collaborate with Pathways case manager and guardian and provide additional recommendations as needed." Time frames for the Treatment Plan was 7 days. Per interview on the morning of 6/11/16, Social Worker #1, (identified as the supervisor for other social service staff on Tyler-2) helped develop Patient

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*8/11/16*  
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A 131 Continued From page 2 A 131

#3's Treatment Plan, confirmed after Patient #3's admission s/he had a conversation with the Public Guardian for Patient #3 and confirmed no formal plans for discharge had been created, using the tentative 7 day admission to prepare for discharge. In addition, Patient #3 was hospitalized over Memorial Day weekend, resulting in further plans for discharge to be reviewed by Social Worker #1 in collaboration with the patient's Guardian upon return on 5/31/16

However, on 5/28/16 Patient #3 approached nursing staff and requested to be discharged. Per interview on 7/12/16 at 9:05 AM, Nurse #1 confirmed Patient #3 came to her/him at lunch time stating "...he could handle things on the outside..." and "...wanted to go home to clean his room". As per hospital policy, RN #1 contacted the Doctor On Call informing the physician Patient #3 was requesting an unplanned discharge. Hospital policy: Discharges: Unplanned/Against Medical Advice (AMA) last approved 06/2014 states: "The physician or designee is responsible for informing the patient about specific concerns and/or potential negative outcomes of leaving the hospital prior to accomplishing the objectives outlined in the patient's treatment plan." It further states after the physician has evaluated the request for unplanned discharge: "S/he will discharge the patient with a full (regular) discharge. All requirements of the discharge including adequate follow-up care...will be provided to the patient to the extent of staff's ability to provide these services on short notice." A consultation was conducted between Nurse #1 and the Doctor on Call. Nurse #1 stated s/he saw "No red flags" and although Patient #3 told Nurse #1 s/he was still

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A 131 Continued From page 3 A 131

feeling depressed and mood was low, the patient remained calm but continued to make paranoid comments.

Upon exam of Patient #3 on 5/28/16 at 1:32 PM the Doctor On Call writes in a Physician Progress Note: "States on interview 'I feel better. I feel safe. I don't need to be here anymore.'...States s/he has an apartment . would like to be discharged and go home...". The physician also documents upon review of records and staff interviews Patient #3's behavior had improved and was described as " .calm and in good behavioral control > 24 hours.. No thought/plan or intent to harm self or others." The physician's final assessment states: " .distress, paranoia and cognitive disorganization have improved. S/he is not willing to remain in the inpt. context for further stabilization and does not meet criteria for involuntary treatment." There was no written indication or acknowledgement by the physician the patient was receiving Guardianship services.

After being examined by the Doctor On Call, Patient #3 eventually met with Social Worker #2 who was assigned on 5/28/16 to conduct, throughout the hospital, admission assessments, oversee group therapy meetings and create Aftercare Plans. Upon arrival to Tyler-2 on the afternoon of 5/28/16 Social Worker #1 met briefly with Patient #3 Per review of Social Work Progress Note created on 5/28/16 at 2:53 PM, Social Worker #2 states: "Pt. is requesting discharge on this date and was cleared for discharge by the physician. S/he presents with anxiety voicing various delusions ..S/he plans to continue his/her methadone maintenance therapy and is unsure about whether or not s/he will see a therapist, or consider other aftercare options such

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A 131 Continued From page 4 A 131

as psychotherapy and peer support". Per interview on 7/13/16 at 8:00 AM, Social Worker #2 stated s/he was told by RN #1 Patient #3 "...was good to go". Social Worker #2 stated the patient did not want to talk and wanted "...to go"

Although both the Initial Psychosocial History and Assessment identifies the "Community Support/ Agencies" contact to be Patient #3's court appointed Guardian and the Multidisciplinary Treatment Plan incorporates both the patient's Guardian and PathwaysVermont (housing and support services for individuals with chronic homelessness and psychiatric disabilities/with on-call team available 24/7), neither the Case Manager for PathwaysVermont or the Guardian were contacted and/or consulted by the On Call Physician, Nurse #1 or Social Worker #2 prior to the patient's unplanned discharge.

Further interview with RN #1 confirmed s/he had not reviewed the treatment plan or court ordered Guardianship documents for Patient #3 because s/he was unfamiliar where the documents were filed within the patient's medical record. The nurse further acknowledged had s/he been aware of the community resources and responsibility of notification to the Guardian prior to facilitating the discharge process, it "...probably may have changed discharged plans...". Social Worker #2 also acknowledged s/he failed to review the patient's record, noting "...there was pressure by the patient to get out" S/he had assumed the RN and Doctor On Call had assessed the patient for safety and stated "It was my fault" I failed to review the record. Social Worker #2 stated s/he was influenced by the discharge assessment presented when s/he arrived on Tyler 2 on the afternoon of 5/28/16. As a result, the staff

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A 131	Continued From page 5 involved with the unplanned discharge failed to notify and consult with Patient #3's Guardian or the Pathways Vermont case manager prior to the patient's discharge. Subsequently, within approximately 24 hours following discharge from the hospital, Patient #3 committed suicide	A 131		
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A 821	482.43(c)(4) REASSESSMENT OF A DISCHARGE PLAN	A 821		
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The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan

This STANDARD is not met as evidenced by:  
Based on interview and record review, there was a failure of hospital staff to appropriately reassess the discharge plan for a patient identified with developmentally disabilities, opioid dependence and psychotic disorder who was under public guardianship and receiving community support services prior to the patient's unplanned discharge. (Patient #3) Findings include:

On 5/28/16 there was a failure of the Psychiatrist, Social Worker and RN to reassess the discharge plan for Patient #3, admitted voluntarily to the hospital on 5/25/16 for increased mood instability and thoughts of suicide. Prior to admission, and according to community resources to include Patient #3's Public Guardian, the patient had been decompensating over the previous several weeks and sought hospitalization after receiving an emergency crisis screening. Per initial MD Assessment completed on 5/26/16. Patient #3 had a past history of attempted suicide by hanging and intentional heroin overdose. Patient #3 was assessed to have auditory hallucinations was disorganized and paranoid. For the first 48

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P.O.C. Accepted  
J. DeBartolich  
8/10/16*

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A 821 Continued From page 6 A 821

hours after admission Patient #3 was assigned to ALSA (a low stimulation area) due to disruptive and agitated behaviors which were upsetting the milieu of the unit. On 5/27/16 a Multidisciplinary Treatment Plan was developed which stated under Patient Objectives: "Patient will consider aftercare possibilities as recommended to ensure adequate support after discharge"  
Multidisciplinary Interventions state: "SW will meet with patient 1-2 times per week to discuss aftercare needs, will collaborate with current outpatient providers and schedule aftercare appointments as needed. SW will collaborate with Pathways case manager and Guardian and provide additional recommendations as needed."  
Time frames for the Treatment Plan was 7 days. Per interview on the morning of 6/11/16, Social Worker #1, (identified as the supervisor for other social service staff on Tyler-2) who helped develop Patient #3's Treatment Plan confirmed after Patient #3's admission s/he had a conversation with the Public Guardian for Patient #3 and confirmed no formal plans for discharge had been created, using the tentative 7 day admission to prepare for discharge. In addition, Patient #3 was hospitalized over Memorial Day weekend, resulting in further plans for discharge to be reviewed by Social Worker #1 in collaboration with the patient's Guardian upon return on 5/31/16

However, on 5/28/16 Patient #3 approached nursing staff and requested to be discharged. Per interview on 7/12/16 at 9:05 AM, Nurse #1 confirmed Patient #3 came to her/him at lunch time stating "S/he could handle things on the outside" and "wanted to go home to clean his room". As per hospital policy, RN #1 contacted the Doctor On Call informing the Physician

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A 821 Continued From page 7 A 821

Patient #3 was requesting an unplanned discharge. Hospital policy: Discharges: Unplanned/Against Medical Advice (AMA) last approved 06/2014 states: " The physician or designee is responsible for informing the patient about specific concerns and/or potential negative outcomes of leaving the hospital prior to accomplishing the objectives outlined in the patient's treatment plan." It further states after the physician has evaluated the request for unplanned discharge: "S/he will discharge the patient with a full (regular) discharge. All requirements of the discharge including adequate follow-up care...will be provided to the patient to the extent of staff's ability to provide these services on short notice." A consultation was conducted between Nurse #1 and the physician. Nurse #1 stated s/he saw "No red flags" and although Patient #3 told Nurse #1 s/he was still feeling depressed and mood was low, the patient remained calm but continued to make paranoid comments.

Upon exam of Patient #3 on 5/28/16 at 1:32 PM the Doctor On Call writes in Physician Progress Note: "States on interview 'I feel better. I feel safe. I don't need to be here anymore.'...States s/he has an apartment. .would like to be discharged and go home. " The physician also documents upon review of records and staff interviews Patient #3's behavior had improved and was described as " .calm and in good behavioral control > 24 hours...No thought/plan or intent to harm self or others." The physician's final assessment states: " ....distress, paranoia and cognitive disorganization have improved. S/he is not willing to remain in the inpt context for further stabilization and does not meet criteria for involuntary treatment." The physician did not

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A 821	<p>Continued From page 8</p> <p>acknowledge the patient had a Guardian or suggest a consultation with the Guardian prior to the unplanned discharge.</p> <p>After being examined by the Doctor On Call, Patient #3 eventually met with Social Worker #2 who was assigned on 5/28/16 to conduct, throughout the hospital, admission assessments, oversee group therapy meetings and create Aftercare Plans. Upon arrival to Tyler-2 on the afternoon of 5/28/16 Social Worker #1 met briefly with Patient #3. Per review of Social Work Progress Note created on 5/28/16 at 2:53 PM, Social Worker #2 states: "Pt. is requesting discharge on this date and was cleared for discharge by the physician. S/he presents with anxiety voicing various delusions . S/he plans to continue his/her methadone maintenance therapy and is unsure about whether or not s/he will see a therapist, or consider other aftercare options such as psychotherapy and peer support". Per interview on 7/13/16 at 8:00 AM, Social Worker #2 stated s/he was told by RN #1 Patient #3 "...was good to go" Social Worker #2 stated the patient did not want to talk and wanted "...to go".</p> <p>Although both the Initial Psychosocial History and Assessment written by Social Worker #1 identifies the "Community Support/ Agencies" contact to be Patient #3's court appointed Guardian and the Multidisciplinary Treatment Plan incorporates both the patient's Guardian and PathwaysVermont (housing and support services for individuals with chronic homelessness and psychiatric disabilities/with on-call team available 24/7), neither the Case Manager for PathwaysVermont or the Guardian were contacted and/or consulted by the On Call Physician, Nurse #1 or Social Worker #2 prior to</p>	A 821	<p><i>A-821 P.O.C Accepted J. DeJongh</i></p>

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A 821	<p>Continued From page 9</p> <p>the patient's unplanned discharge</p> <p>Further interview with RN #1 confirmed s/he had not reviewed the treatment plan or court ordered Guardianship documents for Patient #3 because s/he was unfamiliar where the documents were filed within the patient's medical record. The nurse further acknowledged had s/he been aware of the community resources and responsibility of notification to the Guardian prior to facilitating the discharge process, it "...probably... may have changed discharged plans...". Social Worker #2 also acknowledged s/he failed to review the patient's record, noting "...there was pressure by the patient to get out" S/he had assumed the RN and Doctor On Call had assessed the patient for safety and stated "It was my fault" I failed to review the record.</p> <p>As a result, the unplanned discharge did not include notification and consultation with Patient #3's Guardian and also failed to notify PathwaysVermont, who provided the patient housing and case management along with community support. Subsequently, within approximately 24 hours following discharge from the hospital, Patient #3 committed suicide.</p>	A 821	<p>8/11/16 P.O.C. - Accepted A-821 Orseti</p>

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/Goal
A-000	<b>INITIAL COMMENTS</b> An unannounced on-site complaint investigation was conducted on 07/11-07/13/2016 by the Division of Licensing as authorized by the Centers for Medicare & Medicaid Services (CMS) to determine compliance with the Conditions of Participation: Patient Rights, Outpatient Services, QA/PI and Discharge Planning for complaint #14670. The following regulatory violations were identified:	The Brattleboro Retreat is fully committed as an organization to continually strive to improve the quality and safety of patient care. Though not required by regulation to respond in writing, the following represents our plan of correction for the regulatory standard level opportunities for improvement identified during the on-site complaint investigation.	1 Case review 6.8.16	1. CMO	
A 131	§482.13(b)(2) Condition of Participation: Patient's Rights : Informed Consent §482.13(b)(2) The patient or his or her representative(as allowed under state law) has the right to make informed decisions regarding his or her care.	1. A task force convened to determine current process for all unplanned discharges, to identify communication gaps and to recommend solutions to insure streamlined communication of the existence of any legal hard copy documentation such as guardianship paperwork. 2. Task force recommended the creation of a folder in the patient's Electronic Medical Record (EMR) where these types of legal paper documents would be housed. 3. Admissions staff identified to scan	1. Task force convened 6.10.16	1. Director of Quality and Risk Management	1. Task force completed its charge  2. Folder created  3. 100% A&E staff educated
	The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.		2. EMR folder created 6.23.16 3. Process developed and education	2. Director of Informatics	

A-131  
 Accepted 8/11/16  
 M. J. [Signature]

The Brattleboro Retreat  
 Corrective Action Plan  
 Survey Completion Date: July 13, 2016  
 Provider ID # 474001  
 Event ID WZETT1

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/Goal
	<p>This STANDARD is not met as evidenced by: Based on staff interviews and record review, the hospital failed to ensure a patient's representative (Court appointed guardian) was informed and included in the decision involving an unplanned discharge for one (1) applicable patient (Patient #3)</p> <p>Findings include:</p> <p>On 5/28/16 there was a failure of the Psychiatrist, Social Worker and RN to inform Patient #3's Guardian and also the patient's case manager for Pathways Vermont regarding the intentions and subsequent discharge of Patient #3. The lack of notification prior to discharge prevented the Guardian in collaborating with hospital staff and the patient in making an informed decision regarding a safe discharge and also ensuring housing and community support availability</p> <p>Patient #3, was admitted voluntarily to the hospital on 5/25/16 for increased mood instability and thoughts of</p>	<p>the hard copy papers into the designated folder in the EMR.</p> <p>4. Staff educated on the folder and its content</p>	<p>completed. Email communication 7.5.16</p> <p>4. Redbook memo distributed on availability of a folder in the EMR for the scanned legal documents which include guardianship legal hard copy paperwork 7.13.16</p>	<p>3. Director of Quality and Risk Management</p> <p>4. Director Health Information Management</p>	<p>on process</p> <p>Medical Records to audit for four months the availability of scanned legal papers in the designated folder in the EMR on finalizing discharged patients medical Records. Comparing paper copies in the hybrid Medical Record and the EMR. Goal 92%</p>

*Dr. J. G. [Signature]*

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>suicide. Prior to admission, and according to community resources to include Patient #3's Public Guardian, the patient had been decompensating over the previous several weeks and sought hospitalization after receiving an emergency crisis screening. Per initial MD Assessment completed on 5/26/16, Patient #3 had a past history of attempted suicide by hanging and intentional heroin overdose. Patient#3 was assessed to have auditory hallucinations was disorganized and paranoid. For the first 48 hours after admission Patient #3 was assigned to ALSA (a low stimulation area) due to disruptive and agitated behaviors which were upsetting the milieu of the unit. On 5/27/16 a Multidisciplinary Treatment Plan was developed which stated under Patient Objectives: "Patient will consider aftercare possibilities as recommended to ensure adequate support after discharge".</p>				

QAD  
 8/11/16 ✓

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>Multidisciplinary Interventions state: "SW (Social Worker) will meet with patient 1-2 times per week to discuss aftercare needs, will collaborate with current outpatient providers and schedule aftercare appointments as needed. SW will collaborate with Pathways case manager and guardian and provide additional recommendations as needed." Time frames for the Treatment Plan was 7 days. Per interview on the morning of 6/11/16, Social Worker #1, (identified as the supervisor for other social service staff on Tyler-2) helped develop Patient #3's Treatment Plan, confirmed after Patient #3's admission s/he had a conversation with the Public Guardian for Patient #3 and confirmed no formal plans for discharge had been created, using the tentative 7 day admission to prepare for discharge. In addition, Patient #3 was hospitalized over Memorial Day weekend, resulting in further plans for</p>				

8/11/16  
 O'Donoghue

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>discharge to be reviewed by Social Worker #1 in collaboration with the patient's Guardian upon return on 5/31/16.</p> <p>However, on 5/28/16 Patient #3 approached nursing staff and requested to be discharged. Per interview on 7/12/16 at 9:05 AM, Nurse #1 confirmed Patient #3 came to her/him at lunch time stating "...he could handle things on the outside..." and "...wanted to go home to clean his room". As per hospital policy, RN #1 contacted the Doctor On Call informing the physician Patient #3 was requesting an unplanned discharge. Hospital policy: Discharges: Unplanned/Against Medical Advice (AMA) last approved 06/2014 states: "The physician or designee is responsible for informing the patient about specific concerns and/or potential negative outcomes of leaving the hospital prior to accomplishing the objectives outlined in the</p>				

8/11/16  
 QAR ✓

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/Goal
	<p>patient's treatment plan." It further states after the physician has evaluated the request for unplanned discharge: "S/he will discharge the patient with a full (regular) discharge. All requirements of the discharge including adequate follow-up care... will be provided to the patient to the extent of staff's ability to provide these services on short notice." A consultation was conducted between Nurse #1 and the Doctor on Call. Nurse #1 stated s/he saw "No red flags" and although Patient #3 told Nurse #1 s/he was still feeling depressed and mood was low, the patient remained calm but continued to make paranoid comments.</p> <p>Upon exam of Patient #3 on 5/28/16 at 1:32 PM the Doctor On Call writes in a Physician Progress Note: "States on interview 'I feel better. I feel safe. I don't need to be here anymore'... States s/he has an apartment ... would like to be</p>				

8/11/16  
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The Brantleboro Retreat  
 Corrective Action Plan  
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 Provider ID # 474001  
 Event ID WZETT11

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>discharged and go home...". The physician also documents upon review of records and staff interviews Patient #3's behavior had improved and was described as "...calm and in good behavioral control &gt; 24 hours.. No thought/plan or intent to harm self or others." The physician's final assessment states: "...distress, paranoia and cognitive disorganization have improved S/he is not willing to remain in the inpt. context for further stabilization and does not meet criteria for involuntary treatment." There was no written indication or acknowledgement by the physician the patient was receiving Guardianship services.</p>				
	<p>After being examined by the Doctor On Call, Patient #3 eventually met with Social Worker #2 who was assigned on 5/28/16 to conduct, throughout the hospital, admission assessments, oversee group therapy meetings and create Aftercare</p>				

8/11/16  


The Brattleboro Retreat  
 Corrective Action Plan  
 Survey Completion Date: July 13, 2016  
 Provider ID # 474001  
 Event ID WZET11

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>Plans. Upon arrival to Tyler-2 on the afternoon of 5/28/16 Social Worker #1 met briefly with Patient #3. Per review of Social WorkProgress Note created on 5/28/16 at 2:53 PM, Social Worker #2 states: "Pt. is requesting discharge on this date and was cleared for discharge by the physician. S/he presents with anxiety voicing various delusions ...S/he plans to continue his/her methadone maintenance therapy and is unsure about whether or not s/he will see a therapist, or consider other aftercare options such as psychotherapy and peer support". Per interview on 7/13/16 at 8:00 AM, Social Worker #2 stated s/he was told by RN #1 Patient #3"...was good to go". Social Worker #2 stated the patient did not want to talk and wanted "...to go".</p> <p>Although both the Initial Psychosocial History and Assessment identifies the "Community Support/ Agencies"</p>				

8/11/16  
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ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/Goal
	<p>contact to be Patient #3's court appointed Guardian and the Multidisciplinary Treatment Plan incorporates both the patient's Guardian and Pathways Vermont (housing and support services for individuals with chronic homelessness and psychiatric disabilities/with on-call team available 24/7), neither the Case Manager for Pathways Vermont or the Guardian were contacted and/or consulted by the On Call Physician, Nurse #1 or Social Worker #2 prior to the patient's unplanned discharge.</p> <p>Further interview with RN #1 confirmed s/he had not reviewed the treatment plan or court ordered Guardianship documents for Patient #3 because s/he was unfamiliar where the documents were filed within the patient's medical record. The nurse further acknowledged had s/he been aware of the community resources and responsibility of notification to the Guardian</p>				<p>8/11/16  </p>

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>prior to facilitating the discharge process, it "...probably...may havechanged discharged plans...". Social Worker #2 also acknowledged s/he failed to review the patient's record, noting "...there was pressure by the patient to get out". S/he had assumed the RN and Doctor On Call had assessed the patient for safety and stated "It was my fault" I failed to review the record. Social Worker #2 stated s/he was influenced by the discharge assessment presented when s/he arrived on Tyler 2 on the afternoon of 5/28/16. As a result, the staff involved with the unplanned discharge failed to notify and consult with Patient #3's Guardian or the Pathways Vermont case manager prior to the patient's discharge. Subsequently, within approximately 24 hours following discharge from the hospital, Patient #3 committed suicide.</p>				

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/Goal
	<p>§482.43 Condition of Participation: Discharge Planning</p>				
A-0821	<p>§482.43(c)(4) – Reassessment of a Discharge Plan</p> <p>The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, there was a failure of hospital staff to appropriately reassess the discharge plan for a patient identified with developmentally disabilities, opioid dependence and psychotic disorder who was under public guardianship and receiving community support services prior to the patient's unplanned discharge. (Patient #3)</p> <p>Findings include:          On 5/28/16 there was a failure of the Psychiatrist, Social Worker and RN to reassess the discharge plan for Patient #3, admitted voluntarily to the hospital on 5/25/16 for increased mood instability and thoughts of</p>	<ol style="list-style-type: none"> <li>Task force convened to formulate checklist of the interventions needed for an unplanned discharge. Checklist drafted, reviewed, discussed and finalized.</li> <li>Redbook memo distributed on the checklist worksheet for the interventions needed for an unplanned discharge.</li> <li>All affected staff educated on the checklist</li> </ol>	<ol style="list-style-type: none"> <li>Task force convened 6.9.16 and developed draft</li> <li>All triad team recommended a final version on 7.6.16</li> <li>Medical Executive Committee approved 7.8.16</li> <li>Posted to the shared folder with other clinical forms for easy access. 7.8.16</li> <li>Redbook memo distributed on the availability of checklist. 7.13.16</li> <li>Staff educated on the</li> </ol>	<ol style="list-style-type: none"> <li>Director of Quality and Risk Management</li> <li>VP Clinical Services Chief Clinical Officer</li> <li>CMO</li> <li>Director of Quality and Risk Management</li> <li>Director of Quality and Risk</li> </ol>	<p>100% of all unplanned discharges to be audited for 4 months for evidence of checklist.          Goal 92%</p>

A-0821 POC rec'd 8/11/16  
 O'Donnell

The Brattleboro Retreat  
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	<p>suicide. Prior to admission, and according to community resources to include Patient #3's Public Guardian, the patient had been decompensating over the previous several weeks and sought hospitalization after receiving an emergency crisis screening. Per initial MD Assessment completed on 5/26/16, Patient #3 had a past history of attempted suicide by hanging and intentional heroin overdose. Patient #3 was assessed to have auditory hallucinations was disorganized and paranoid. For the first 48 hours after admission Patient #3 was assigned to ALSA (a low stimulation area) due to disruptive and agitated behaviors which were upsetting the milieu of the unit. On 5/27/16 a Multidisciplinary Treatment Plan was developed which stated under Patient Objectives: "Patient will consider aftercare possibilities as recommended to ensure adequate support after discharge". Multidisciplinary</p>		<p>checklist, how to complete and where it is available.</p>	<p>Management  3. Director of Education</p>	

8/11/16  


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ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>Interventions state: "SW will meet with patient 1-2 times per week to discuss aftercare needs, will collaborate with current outpatient providers and schedule aftercare appointments as needed. SW will collaborate with Pathways case manager and Guardian and provide additional recommendations as needed."</p> <p>Time frames for the Treatment Plan were 7 days. Per interview on the morning of 6/11/16, Social</p> <p>Worker #1, (identified as the supervisor for other social service staff on Tyler-2) who helped develop Patient #3's Treatment Plan confirmed after Patient #3's admission s/he had a conversation with the Public Guardian for Patient #3 and confirmed no formal plans for discharge had been created, using the tentative 7 day admission to prepare for discharge. In addition, Patient #3 was hospitalized over Memorial Day weekend, resulting in further plans for discharge to be reviewed by Social Worker #1 in collaboration with the patient's Guardian upon return on 5/31/16.</p> <p>However, on 5/28/16 Patient #3 approached nursing staff and</p>				

6/11/16  
*[Signature]*

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ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>requested to be discharged. Per interview on 7/12/16 at 9:05 AM, Nurse #1 confirmed Patient #3 came to her/him at lunch time stating ".S/he could handle things on the outside" and "wanted to go home to clean his room". As per hospital policy, RN #1 contacted the Doctor On Call informing the Physician Patient #3 was requesting an unplanned discharge. Hospital policy: Discharges: Unplanned/Against Medical Advice (AMA) last approved 06/2014 states: " The physician or designee is responsible for informing the patient about specific concerns and/ or potential negative outcomes of leaving the hospital prior to accomplishing the objectives outlined in the patient's treatment plan." It further states after the physician has evaluated the request for unplanned discharge : "S/he will discharge the patient with a full (regular) discharge . All requirements of the discharge including adequate follow-up care...will be provided</p>				

8/11/16  
 [Signature]

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/Goal
	<p>to the patient to the extent of staff's ability to provide these services on short notice." A consultation was conducted between Nurse #1 and the physician. Nurse #1 stated s/he saw "No red flags" and although Patient #3 told Nurse #1 s/he was still feeling depressed and mood was low, the patient remained calm but continued to make paranoid comments.</p> <p>Upon exam of Patient #3 on 5/28/16 at 1:32 PM the Doctor On Call writes in Physician Progress Note: "States on interview 'I feel better. I feel safe. I don't need to be here anymore.'... States s/he has an apartment. ..would like to be discharged and go home...". The physician also documents upon review of records and staff interviews Patient #3's behavior had improved and was described as "...calm and in good behavioral control &gt; 24 hours...No thought/plan or intent to harm self or others." The physician's final assessment states: "...distress, paranoia and cognitive disorganization have improved. S/he is not willing to remain in the inpt context for further stabilization and does not meet criteria for involuntary treatment." The</p>				

8/11/16  
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ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/Frequency/Goal
	<p>physician did not After being examined by the Doctor On Call, Patient #3 eventually met with Social Worker #2 who was assigned on 5/28/16 to conduct, throughout the hospital, admission assessments, oversee group therapy meetings and create</p> <p>Aftercare Plans. Upon arrival to Tyler-2 on the afternoon of 5/28/16 Social Worker #1 met briefly with Patient #3. Per review of Social Work Progress Note created on 5/28/16 at 2:53 PM, Social Worker #2 states: "Pt. is requesting discharge on this date and was cleared for discharge by the physician. S/he presents with anxiety voicing various delusions...S/he plans to continue his/her methadone maintenance therapy and is unsure about whether or not s/he will see a therapist, or consider other aftercare options such as psychotherapy and peer support". Per interview on 7/13/16 at 8:00 AM, Social Worker #2 stated s/he was told by RN #1 Patient #3 "...was good to go". Social Worker #2 stated the patient did not want to talk and wanted "...to go".</p> <p>Although both the Initial Psychosocial History and Assessment written by</p>				

8/11/16  


ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>Social Worker #1 identifies the "Community Support/ Agencies" contact to be Patient #3's court appointed Guardian and the Multidisciplinary Treatment Plan incorporates both the patient's Guardian and Pathways Vermont (housing and support services for individuals with chronic homelessness and psychiatric disabilities/with on-call team available 24/7), neither the Case Manager for Pathways Vermont or the Guardian were contacted and/or consulted by the On Call Physician, Nurse #1 or Social Worker #2 prior to the patient's unplanned discharge</p> <p>Further interview with RN #1 confirmed s/he had not reviewed the treatment plan or court ordered Guardianship documents for Patient #3 because s/he was unfamiliar where the documents were filed within the patient's medical record. The nurse further acknowledged had s/he been aware of the community resources and responsibility of notification to the Guardian prior to facilitating the</p>				

2/14/16  


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 Event ID WZET11

ID Prefix Tag	Summary Statement	Plan of Correction	Completion Date	Responsible Party	QA/ Frequency/ Goal
	<p>discharge process. it            "...probably...may have            changed discharged plans...."            Social Worker #2 also            acknowledged s/he failed to            review the patient's record,            noting "...there was pressure by            the patient to get out" S/he had            assumed the RN and Doctor On            Call had assessed the patient for            safety and stated "It was            my fault" I failed to review            the record.</p> <p>As a result, the unplanned discharge            did not include notification and            consultation with Patient #3's Guardian            and also failed to notify Pathways            Vermont, who provided the patient            housing and case management along            with community support. Subsequently,            within approximately 24 hours            following discharge from the hospital,            Patient #3 committed suicide.</p>				

*8/11/16*  


AUG - 4 2016



Brattleboro Retreat  
MENTAL HEALTH AND ADDICTION CARE

August 3, 2016

Ms. Kathy Mackin, Health Insurance Specialist  
Survey Branch  
Department of Health and Human Services  
John F. Kennedy Federal Building, Room 2325  
Boston, MA 02203

Ms. Susan Leavitt  
Assistant Division Director  
Agency of Human Services, Department of Aging and Disabilities  
Division of Licensing and Protection  
HC 2 South, 280 State Drive  
Waterbury, Vermont 05671-2060

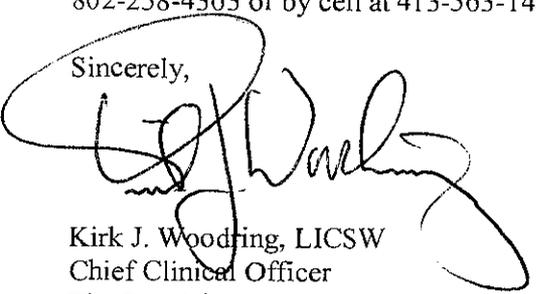
Re: Survey ID: WZET 11, 7/13/16  
CMS Certification Number (CCN): 474001

Dear Ms. Mackin and Ms. Leavitt:

I have enclosed the signed Statement of Deficiencies and Plan of Correction regarding the substantial allegation survey conducted on July 13, 2016 with representatives from the Vermont Department of Licensing and Protection.

If you have any questions or need additional information, please do not hesitate to contact me at 802-258-4363 or by cell at 413-563-1468.

Sincerely,



Kirk J. Woodring, LICSW  
Chief Clinical Officer  
The Brattleboro Retreat