

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

PRINTED: 02/06/2012
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 01/26/2012
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 000 INITIAL COMMENTS

An unannounced on-site investigation was conducted by the Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services, on 1/24/12 through 1/26/12. The following regulatory deficiencies were identified.

Based on information gathered the facility was determined not to be in compliance with the Conditions of Participation for Nursing Services and Pharmacy Services.

A.385 482.23 NURSING SERVICES

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

This CONDITION is not met as evidenced by: Based on staff interviews and record review the Condition of Nursing Services was not met as evidenced by staff failure to provide patient care in accordance with the facility's policy and protocols and to conduct ongoing health status assessments when there is an identified change in patient condition.

Refer to A-0395 and A-0405

A.395 482.23(b)(3) RN SUPERVISION OF NURSING CARE

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

This STANDARD is not met as evidenced by:

A 000

A 385 482.23 NURSING SERVICES

Staff Failure to provide care in accordance with the facility's policy and protocols and to conduct on-going health status assessments when there is an identified change in patient condition.

The policy and procedure process for implementation and staff education has been addressed by the following methods:

A) All policies and procedures that have a critical impact on patient care, safety and well-being will be implemented with a process that requires staff to attend educational sessions and/or read the policy, sign that they understand the policy, and to direct questions to their respective managers. Any staff not on-site for educational sessions will be mailed the policy, included any educational hand-outs as needed and return receipt will be requested. Staff who do not follow the hospital's policies and procedures will receive performance counseling by their respective managers in concert with the existing HR policies for disciplinary action.

A 385

B) Additionally, the Executive Coordinator will make a CD for each unit of current policies and procedures and each unit/program Manager will be required to update as new or revised policies are sent out by the Executive Coordinator. This CD will assist direct care staff with easy retrieval of policies in addition to having the policies located on the hospital's S drive.

C) The Quality department will request that each Manager provide copies of the staff signatures for policies and will retain the postal receipts.

Identification by nursing staff of changes in a patient's condition and the provision of on-going health status assessment has been addressed by the following methods:

We have identified a global issue with fragmentation in nursing assessment and reassessment particularly as it relates to medical issues. We have addressed these systems issues with the following action plans:

RA accepted 1/19/12 [Signature]

A 395

A) NURSING: GLOBAL FRAGMENTATION IN NURSING ASSESSMENT AND REASSESSMENT-

On February 2nd, 2012 Varen O'Keefe Domaleski stepped down as The VP of Patient Care Services. Debra Lucey, RN, MSN took over the role effective that date. Debra was working at the Brattleboro Retreat as the Director of Education and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature] DSW, MPP

TITLE

President & CEO

(X6) DATE

3/6/12

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 395 Continued From page 1

Based on staff interview and record review nursing staff failed to follow the facility's policies and protocol for medication administration and safety searches, and failed to assure the ongoing evaluation and assessment of patient care needs and health status for 2 patients. (Patient's #1 and #2). Findings Include:

1. Per record review staff failed to follow the facility's policy titled Administration and Scheduled Time of Medication, last revised and approved in July of 2011, which stated: III. Verifications, Education and Discussion: "Before administering medication staff will: Verify that there is no contraindication for administering the medication." In addition the facility's protocol for responding to missing medication, titled Safety Searches - Unit Look-down for Contraband, dated June 2006, which stated; "All medication passes are to be halted and no medication may be given until cleared with the Unit Manager or Supervisor", was not followed.

Per record review Patient #1, who was admitted to the Tyler 2 Unit on 1/18/12 for treatment of suicidal ideation and alcohol detox., was able to obtain and ingest the Melhadone (opiata) prescribed for Patient #2 during a medication (med) pass on the morning of 1/19/12. Per interview, at 3:20 PM on 1/24/12, Nurse #1 who was responsible for med pass for all patients on Tyler 2 on 1/19/12, stated that s/he was inside the med room that morning with the bottom half of the Dutch style door to the room closed. S/he stated s/he had prepared medications for several patients and placed the meds in individual plastic med cups, identified by patient name, on the top of the med cart which was located next to the

A 395 she seamlessly stepped into the role of Interim Director of Nursing. Debra brings over 25 years experience in Nursing and Administrative Nursing roles.

New Care Delivery Model- Team/Modified Primary Model-

1. Initial nursing assessment to be done on the units by unit RN's in order to provide for consistent identification of medical and psychiatric problems and follow up re-assessment of patients.

2. Tyler 1, 2, 4, O2- LGBT: Each Nurse will be assigned to a team with a Social Worker, MD, and MHW. The Nurse will have a case-load of 6-8 patients- do their own admissions, assessments/reassessments, treatment plans and documentation, own medication passes, patient education, and attend treatment team of assigned MD/SW team. Meetings scheduled with PI team of Unit RN's -next step is to involve MD and SW stakeholders. The hiring of a 4th RN on the day and evening shifts for Tyler 1 and Tyler 2 is required to implement this major change in the care delivery model. A PI study had been undertaken by the Quality department in December 2011 at the request of the quality department with approval by the CEO. This study looked at data from 2007-2011 and indicated the volume of medications administered, and other Nursing workload data were substantially greater on these 2 adult units. The study also identified an increase in active Axis 3 Medical acuity, numbers of admissions and discharges, rapid cycling of admissions on Tyler 1, and the trending of admissions on the evening shift. The positions were verbally approved by the CEO in mid-January and formally approved for fast tracking on January 23rd, 2012.

POC accepted 1/19/12 [Signature]

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A 395	Continued From page 2 door and within arm's reach of someone standing outside the door. Nurse #1 stated that Patient #1 presented at the med room door for his/her medication at approximately 8:00 or 9:30 AM that day. S/he stated that the patient, who was on an alcohol detox program had an assessment conducted by his/her primary nurse, in accordance with the Alcohol Detox protocol, that identified a score which required administration of 75 mg of Librium (benzodiazepine used to relieve anxiety and control agitation caused by alcohol withdrawal). Nurse #1 stated that s/he administered the Librium and Patient #1 continued to stand leaning on the shelf of the half door repeatedly requesting Ritalin, for which there was no physician order, while other patients lined up in the hallway awaiting their turns for med administration. Nurse #1 stated that s/he had turned his/her head away from the patient for a short period just once during the exchange with Patient #1. Following the exchange, Patient #1 left the area of the med room and the nurse continued to administer meds to other patients. Nurse #1 stated it was within 15 minutes of the exchange with Patient #1 that Patient #2 presented to the med room door asking for their daily maintenance dose of 110 mg of Methadone and the nurse was not able to find the pre-poured medication. S/he stated s/he had previously prepared the (2) 40 mg wafers and (8) 5 mg tablets to total the 110 mg dose, placed them in a plastic med cup with another plastic med cup covering it and placed it on top of the med cart. Nurse #1 stated that s/he alerted other staff and the Pharmacy that the Methadone was missing. S/he stated that, with the assistance of a pharmacy technician, they searched, unsuccessfully, throughout the med room for the	A 395	The 8 new positions were posted on January 24th, and recruiting efforts immediately began, resulting in the hiring of 5 new staff as of 2/27/12. An extra orientation has been added in order to get newly hired staff in place sooner than the regular orientation. Projected implementation date is 4/31/12 for the new care delivery model. 3. Quality department chart audits had revealed that RN assessment and documentation needed to be improved in regards to on-going health assessment of medical problems. A PI team consisting of unit Nurses, Quality department staff, and led by the Director of Education was started in November 2011. Documentation flow sheets were revised to be specific to the patient population, include standardized mental status assessment, and standardized physical systems assessment and reassessment. Included are triggers to notify an LIP and abnormal and normal physical systems criteria as well as triggers when to document additional information in the progress notes. These new documentation flow sheets were developed with unit staff input and mandatory education sessions completed on 3/1/12 and 3/5/12. Staff who have not completed will be mailed educational hand-outs on 3/8/12 and told to check in with their Managers for questions. The Quality department will begin auditing 20 patient records weekly to monitor the new process for documentation, after implementation on 3/8/12. 4. Medical Systems education modules and protocols for Nursing Intervention education on Respiratory, Cardiovascular, Neurological, GI/GU and Integumentary systems to begin 3/6/12 to replicate new initial nursing assessment and new documentation flow sheets. The soonest the instructor could come for training is 3/6/12. 5. MD hired to supervise the Medical Clinic and Medical LIP's start date April 2012.	

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A 395 Continued From page 3
Methadone. The protocol for Safety Searches - Unit Lock down for Contraband was implemented immediately following the identification of missing Methadone; patients were gathered in the community area as individual room searches were conducted and the process of obtaining urine for drug screening was initiated on all patients. Nurse #1 stated that, during this time, although s/he had not consulted Patient #2's attending physician, s/he did speak with a Pharmacist about providing the maintenance dose of Methadone to Patient #2 who had still not received the medication. Despite the fact that administration of Methadone to Patient #2 was contraindicated because staff had not been able to account for the missing Methadone, it was not in accordance with the protocol that stated to halt all medication administration, and, finally, without consulting with the attending physician or Nurse Manager, Nurse #1 confirmed that s/he administered 110 mg of Methadone to Patient #2 (at 9:30 AM according to the Medication Administration Record). In addition Nurse #1 stated that s/he continued to administer medication to the 3 or 4 patients that had still not received their scheduled medications.

During interview, at 3:45 PM on 1/24/12, Nurse #2, the Charge Nurse on Tyler 2 on 1/18/12, confirmed that following the identification of the missing Methadone the Nurse Manager, Supervisor and Physicians on the unit were all notified; the patients were gathered in the community area and room searches were conducted on the individual patient rooms. Nurse #2 stated that during this period Patient #1 approached him/her and admitted that s/he had found a white pill (a 40 mg wafer of Methadone)

A 395 6. A medical LIP will be assigned a beeper for immediate availability for Nursing staff to contact regarding emergent medical issues, in addition to attending psychiatrist and DOC. -implement 3/31/12 or sooner.

7. Dr. Brad Reynolds-sleep specialist, agreed to come and present an educational conference for all staff on high risk patients with sleep apnea, in May 2012. He agreed to be videotaped for future staff education.

8. Executive team members have conducted investigation into what other free-standing Psychiatric Hospitals use for emergency life support response and equipment and have found all hospitals contacted use AED's and basic life support or BLS. A Juran PI has been assembled effective 3/6/12 to research the level of Code Response offered in Medical Acute Care Hospitals, other Psychiatric Hospitals not yet contacted and other levels of care. This research will include an equipment review, staff competency and training requirements, and additional advanced certifications required should we move beyond BLS.

9. Clinical Managers and Nursing House Supervisors instructed to immediately begin checking documentation after incidents, and for patients with high risk medical issues. Debra Lucey, RN, MSN, Interim VP of Patient Care services, follows up weekly with Nurse Manager's to ensure process is occurring.

10. The Quality department began conducting 20 chart audits weekly and charts sampled to be chosen based on medical issues noted in the Nursing Supervisor's report. 100% of code blue incidents are being reviewed by the Quality department. Feedback including inadequate documentation and patient name and medical record number are provided to Nurse Manager's for their review with respective staff.

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A 395	Continued From page 4 on the floor of the bathroom that morning and had ingested it. A body search was then conducted on Patient #1 and during the contraband search of Patient #1's room s/he revealed a 5 mg tablet of Methadone that had been taped to the underside of a drawer. Patient #1 was placed on 1:1 observation status and after beginning to exhibit symptoms of Methadone overdose, including slurred speech, decreased respirations, increasing lethargy and constricted pupils, s/he was transferred, at 11:55 AM, to the ER (Emergency Room) for treatment. Patient #1 returned to the facility approximately 3 and a half hours later at 3:30 PM, was transferred to the Tyler I Unit and subsequently returned to the ER at approximately 5:00 PM that evening as a result of continuing to exhibit symptoms associated with Methadone overdose. Per interview, at 12:53 PM on 1/25/12, the Tyler II Nurse Manager confirmed that Nurse #1 had continued to administer meds to patients after Methadone had gone missing and further stated that s/he had told Nurse #1 and all staff that medication administration had to be halted because they could not account for the missing Methadone. 2. Per record review staff failed to provide ongoing assessments of health status for Patient #1 who was readmitted to the facility on the afternoon of 1/20/12, following an acute care stay in the ICU (Intensive Care Unit) for monitoring and treatment of Methadone overdose. Per review of documentation completed at the hospital during Patient #1's acute care stay from 1/19/12 through 1/20/12, a nurse's note, dated 1/20/12 at 8:15 AM stated the patient's O2	A.395	Debra Lucey, RN, MSN, Interim VP of Patient Care services, follows up weekly with Nurse Manager's to ensure they are meeting with staff who are not documenting adequately and providing education and expectations for documentation. Staff exhibiting trends in inadequate documentation will receive performance counseling via the hospital's disciplinary action policy. 11. Rob Simpson, CEO requiring that all action items are reviewed every week in Executive team to ensure Executive ownership and oversight, as well as ensuring any implementation issues resolved. B) POLICY AND PROCEDURES IMPLEMENTED SINCE 1/21/12 1. The hospital's Patient Safety Items and Contraband policy was revised on 1/25/12. The revision included the addition of a protocol that instructs staff on the actions to take when medication is missing or contraband is suspected to be on the unit. The protocol was well known to many staff however it was difficult to locate and there were some staff that were not aware of this protocol. This revised policy and educational material was implemented on 1/25/12, and was mailed to all staff who did not receive orientation on site with return receipt requested. All staff were required to sign that they received and understood the policy and were directed to their respective Manager's for questions. Additionally large posters were made for the medication rooms and unit staff's break areas that specify steps to take in these situations. 2. An O2 saturation and vital signs protocol for respiratory depression was initiated and implemented on 1/21/12 and reviewed with all RN/LPN staff. The protocol was formalized into a physician's ordered protocol on 2/16/12 and nursing may implement nursing interventions at any time at their discretion.

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A 395	<p>Continued From page 6</p> <p>(oxygen) saturation had dropped into the 80's when asleep requiring the use of oxygen to increase the saturation to a more normal level of 94-97%. The note also revealed that the patient had stated, "I have sleep apnea".</p> <p>Although a history and physical had been conducted by medical staff upon the Patient's return to the facility on the evening of 1/20/12, there was no evidence that facility staff were aware of the recent history of low O2 sats during sleep and the patient identified sleep apnea. The patient received 800 mg of Ibuprofen at 8:30 PM, (at which time his/her temperature was recorded as 100.1 degrees Fahrenheit), for complaints of a sore throat associated with a diagnosis of acute Uvullitis. Patient #1 was admitted to Tyler 1 at 8:40 PM and placed on observation status that included every 15 minute checks. The patient's temperature was taken on just two subsequent occasions and was recorded as 99.7 at 6:45 PM and 98.4 at 9:30 PM, respectively. Per review of the Nursing Observation Flow Sheet, dated 1/20/12, the patient was ambulating about the unit and talking with the nurse and other patients during the evening hours following admission, and was noted to be awake until approximately 12:30 AM. During the time period between 4:00 - 5:30 AM the patient was noted, every 15 minutes, to be yelling in sleep and snoring loudly. An Addendum for 1/21/12, documented by MHW (Mental Health Worker #2) on 1/24/12 at 2:20 AM, stated that, between 4:15 AM and 5:00 AM Patient #1 was doing "a lot of yelling in....sleep.. It sounded angry almost as if growling" and staff questioned if patient was having a nightmare. The record also stated that staff had attempted to awaken Patient #1 "numerous times as a means</p>	A 395	<p>This new protocol and educational material with return receipt requested, was mailed to all staff who did receive orientation on site. All staff were required to sign that they received and understood the policy and were directed to their respective Manager's for questions.</p> <p>3. A code blue recorder sheet was finalized and implemented on 1/25/12 and reviewed with all RN/LPN staff. This new protocol and educational material with return receipt requested, was mailed to all staff who did not receive orientation on site. All staff were required to sign that they received and understood the policy and were directed to their respective Manager's for questions.</p> <p>4. The code blue bag contents were revised on 1/18/12 for ease of access and to include only emergency equipment needed during a Code Blue for emergency resuscitation efforts. This new protocol and educational material was implemented on 1/24/12, was mailed to all staff who did receive orientation on site with return receipt requested. All staff were required to sign that they received and understood the policy and were directed to their respective Manager's for questions.</p> <p>5. Hospital Transportation policy was amended to encourage ED's to send patients back to the Brattleboro Retreat via ambulance. This new protocol and educational material was implemented on 1/24/12, was mailed to all staff who did receive orientation on site with return receipt requested. All staff were required to sign that they received and understood the policy and were directed to their respective Manager's for questions.</p> <p>C) HAND-OFF COMMUNICATION</p> <p>1. Hand-off communication forms were developed with the SBAR protocol for both the Brattleboro Retreat MD- Emergency Department LIP and Brattleboro Retreat RN- Emergency Department RN verbal contact for accepting a patient for admission or transfer back to the Brattleboro Retreat.</p>

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A.395	<p>Continued From page 6</p> <p>to get (patient) out of the dream or whatever was going on. This was done by calling (patient) name repeatedly with 1 response of "huh". Despite the previous recent history of low O2-sats during sleep, the patient's statement that s/he had sleep apnea, as well as the diagnosis of acute Uvulitis and elevated temperature on admission, and the noted change in Patient #1's condition exhibited by symptoms of intermittent yelling during sleep for a prolonged period, with difficulty arousing the patient, there was no evidence that nursing staff had conducted any health status assessment of the patient after 9:30 PM. During a subsequent visual check at 5:43 AM the patient was found unresponsive and without respirations, a Code Blue was called, CPR (Cardiopulmonary Resuscitation) was initiated and Patient #1 was subsequently transferred to the ER where s/he expired.</p> <p>During separate interviews, conducted at 7:50 AM on 1/25/12 and 11:02 AM on 1/26/12, respectively, MHWs (Mental Health Workers) #1 and #2, both of whom had worked the Tyler I unit on the 11:00 PM - 7:00 AM shift on the night of 1/20/12 through 1/21/12 confirmed that Patient #1 had begun yelling in his/her sleep at approximately 4:00 AM and continued to do so until 5:35 AM. They stated that the night light was on in the patient's room providing enough light to determine that the patient's color remained good throughout the night. Patient #1 was described as yelling frequently and loud enough at times to awaken other patients. The MHWs stated that they had attempted to arouse the patient when s/he yelled and, although s/he would stop yelling the patient never awoke. MHW #2 stated that the patient "was obviously having a hard time." and</p>	A 395	<p>These forms were made a permanent part of the medical record.</p> <p>All Admissions and Evaluation staff have been in-serviced and documents in use since 2/9/12. The quality department will audit 20 medical records weekly to monitor compliance with this new process.</p> <p>2. A PI initiated to address nursing shift to shift report and hand-off communication. Unit Nursing representatives for each unit met on February 1st and 8th and process reviewed and standardized. Hand-off communication education done on SBAR, posters made and distributed to units, and recommendations made for an SBAR template for shift to shift report. SBAR education article published in the BR Connections newsletter. Implementation date for SBAR template scheduled for March 15th, 2012.</p> <p>3. Medical Staff bylaws were amended on 2/9/12, to ensure that the attending psychiatrist or doctor-on-call receives a verbal report from the ED LIP prior to accepting a patient back from an ED, after transferring for an emergent medical issue.</p> <p>4. The Brattleboro Retreat Medical Director has initiated a dialogue with Rascue, Inc. to work on improving the time it takes for an ambulance to arrive after a 911 call is made.</p> <p>D) PATIENT SAFETY SEARCHES - CONTRABAND</p> <p>Patients can hide contraband in body cavities-DMH, consumers and advocates already state our contraband process is very strict. If a patient refuses the skin assessment they are placed on 1-1. We do not do body cavity searches. Clothing and belongings contraband can be difficult when patients bring several bags of belongings. Some have brought up to 10 bags. The Brattleboro Retreat will implement a new process for patient safety/contraband searches as follows:</p> <p>PATIENT SAFETY SEARCHES (CONTRABAND)</p> <p>1. All patient clothing and personal belongings to be contrabanded off the unit in A and E</p> <p>2. All patient belongings will be labeled and placed in the security area upon arrival to the admissions area. Belongings include anything in bags, suitcases, pockets,</p>	

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A 395	<p>Continued From page 7</p> <p>s/he voiced concerns about Patient #1, to Nurse #3, the Charge Nurse on Tyler I during the 11:00 PM - 7:00 AM shift at the time. Nurse #3 told MHW #2 to just continue checking on the patient. At 5:35 AM Patient #1 was yelling again and was checked by both the MHWs. MHW #1 next conducted a visual check of Patient #1 approximately 8 minutes later at 5:43 AM and found the patient unresponsive.</p> <p>Nurse #3, stated during interview at 11:02 AM on 1/25/12, that, although s/he does not routinely perform visual checks of patients during the night, s/he had visually checked on Patient #1 at least 4 times during the shift because of the concerns by MHWs regarding the patient's prolonged intermittent yelling. Nurse #3 stated that, although the patient's color was good, and the patient was moving about in bed, s/he "was screaming and hollering at times", and even woke up other patients s/he "was so loud". S/he further stated that s/he did not attempt to awaken Patient #1. Nurse #3 stated that, although s/he had received report that Patient #1 had been readmitted to the unit following acute care treatment for Methadone overdose, s/he had not been aware of Patient #1's elevated temperature or diagnosis of Uvulitis, and confirmed that s/he had not conducted any assessment of the patient's health status. Nurse #3 stated that s/he was called to Patient #1's room at approximately 5:43 AM and found the patient unresponsive and without respirations or pulse. S/he stated that CPR was initiated and a Code Blue was called. Patient #1 was subsequently transferred to the ER by ambulance at approximately 6:20 AM. During interview, at 9:42 AM on the morning of 1/28/12, the Senior Vice President of Patient</p>	A 395	<p>3. Once the patient has their physical examination completed, they are given sweatpants and sweatshirt to wear and all clothing will be placed in a container, labeled and sent to the secure storage area.</p> <p>4. The security staff responsible for checking for patient contraband will go through the belongings with the patient, remove the amount clothing as specified below, and personal items acceptable to be used while on the unit/program.</p> <ul style="list-style-type: none"> - Inpatient Adult Units: Co-Occurring Unit, Adult Inpatient, LGBT unit-5 days' worth of clothing - Adolescent Inpatient Unit 2 weeks' worth of clothing - Osgood 1 Inpatient Unit 2 weeks' worth of clothing - DMH Inpatient Unit: 4 weeks' worth of clothing. <p>5. These items will be searched by security for contraband and then placed in a bag for patient use.</p> <p>6. Any illicit drugs found will be disposed of and any weapons found will be taken.</p> <p>7. Adult Patients will be given only their personal belongings that can be used on the unit.</p> <p>8. Adolescent patients will have an ADL bucket for personal items that can be used with staff supervision.</p> <p>9. These items given to the patient for use on the unit will be logged onto the patient's belongings sheet and signed by the patients and security staff person.</p> <p>10. The items going into storage will not be searched for contraband and will be inaccessible during the patient's treatment.</p> <p>11. Patients will sign that they have been informed of this policy and that the Brattleboro Retreat is not responsible for these items, and that these items will be returned to the patient on discharge.</p> <p>12. Patient's belongings will be stored in large impervious containers, labeled with patient identification information, and stored in the designated storage area.</p> <p>13. Upon discharge, the unit MHW or security staff will go to the storage area for patients to retrieve belongings as they are leaving the hospital.</p>

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A 395	<p>Continued From page 8</p> <p>Care Services and CNO (Chief Nursing Officer) confirmed the lack of health status assessment for Patient #1 and stated that s/he would have expected nursing staff to conduct an assessment of the patient related to the patient's change in condition exhibited by prolonged yelling out and lack of response to staff attempts to arouse him/her during the night of 1/21/12.</p> <p>A 405 482.23(c)(1) ADMINISTRATION OF DRUGS</p> <p>All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review nursing staff failed to administer medications in accordance with established policies and protocols and resulting in the potential for and actual negative outcome for 2 patients. (Patients #1 and #2). Findings include:</p> <p>Per record review staff failed to follow the facility's policies which included: the policy for Medication Procurement, Distribution, Storage and Disposition, last revised in July 2011 and which stated: Medication Storage and Disposition: When a medication is delivered to a unit it shall be locked in the designated location in the medication room unless it is to be administered immediately.....All Controlled Substances stored on the unit shall be secured and locked inside the medication cart drawer or a cabinet; the policy titled Administration and Scheduled Time of</p>	A 395	<p>14. Family members, significant others and friends who visit patients will have items they plan on giving to patients, searched per current policy, "Visitor's and Patient Belongings", and any items not allowed on the units will be held behind the Nursing Station, and given back to visitors as they leave the unit.</p> <p>15. Patients admitted directly to a unit/program: All belongings will be brought to A and E for the contraband process OR security staff will go to the unit to complete contraband process of clothing and personal items allowed on the unit and bring non-contrabanded items to the secure storage area.</p> <p><i>A395 pd accepted 1/11/12 [Signature]</i></p> <p>A 405</p> <p>A 385 482.23 NURSING SERVICES, A 405: ADMINISTRATION OF DRUGS</p> <p>A 490 482.25 PHARMACEUTICAL SERVICES, A 502 SECURE STORAGE</p> <p>The condition is not met as evidenced by the failure to ensure safe and secure storage of all drugs in accordance with established policies and procedures, to prevent access by patients, resulting in a negative outcome. In addition, there was a failure to assure that pharmacy staff provided information to nursing staff in a manner that would promote safe medication use in accordance with established policies and protocols.</p> <p>(A) Immediately and again on 1/25/12, all RN's were informed via a memo that no medications were to be placed on top of the medication cart, and no medications were to be set up by the 11pm-7am RN. If the hospital policy was not followed and practice observed by Managers, Pharmacy staff or during quality spot checks/tracers, staff will be immediately suspended.</p> <p>(B) Disciplinary action was conducted for the RN who administered methadone on 1/19/12 during the unit lockdown.</p> <p>(C) Disciplinary action was conducted for the Pharmacist who authorized the RN to give methadone during the unit lockdown on 1/19/12.</p> <p>(D) All medication carts were moved to the back of each medication room out of reach of a patient.</p> <p>(E) "Zones of Safety" were created and bright colored tape used to delineate where patients are to wait for medication administration.</p>

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A 405	<p>Continued From page 9</p> <p>Medication; last revised and approved in July of 2011, which stated: III. Verifications, Education and Discussion: "Before administering medication staff will: Verify that there is no contraindication for administering the medication"; and the protocol for responding to missing medication, titled Safety Searches - Unit Lock-down for Contraband, dated June 2008, which stated; "All medication passes are to be halted and no medication may be given until cleared with the Unit Manager or Supervisor".</p> <p>Patient #1, who was admitted to the Tyler 2 Unit on 1/18/12 for treatment of suicidal ideation and alcohol detox., was able to obtain and ingest the Methadone (opiate) prescribed for Patient #2 during a medication (med) pass on the morning of 1/19/12. Per interview, at 3:20 PM on 1/24/12, Nurse #1, who was responsible for med pass for all patients on Tyler 2 on 1/19/12, stated that s/he was inside the med room that morning with the bottom half of the Dutch style door to the room closed. Although the facility's policy for storage of medication specifies that medication delivered to a unit shall be locked in the designated location in the med room unless it is to be administered immediately, and all Controlled Substances, like Methadone, stored on the unit shall be secured and locked inside the medication cart drawer or a cabinet, Nurse #1 stated that s/he had prepared medications for several patients, placed the meds in individual plastic med cups, identified by patient name, and lined the cups up on the top of the med cart which was located next to the door and reachable by someone standing outside the door. Nurse #1 stated that Patient #1 presented at the med room door for his/her medication at approximately 9:00 or 9:30 AM that day. S/he</p>	A 405	<p>F) Inside locks were installed in all medication rooms so that a patient would not be able to lean over the dutch- door and unlock the med room.</p> <p>G) An extra set of medication room keys were removed from all code blue bags.</p> <p>H) All code blue bags with emergency medications were immediately placed in locked medication rooms.</p> <p>I) Each unit was given 2 sets of medication room keys for Nurses and only 1 Nurse with a set of keys can leave the unit at a one time and implemented on 2/1/12. A set was given to the Nursing House Supervisors who respond to Code implemented on 2/1/12.</p> <p>J) A form was developed to sign in and out medication keys each shift and implemented on 2/1/12.</p> <p>K) A new policy was developed to reflect the changes titles "Emergency Cart Storage, and the policy titled Medication Procurement, Storage and Disposition was revised to reflect that no personnel other than unit nurse, pharmacist can access the medication room independently and all other staff will be directly supervised by the unit nurse. These policies were approved on 3/2/12 and will be sent to all staff to read and sign and mailed to staff who have not signed by 3/8/12, along with new documentation flow sheets, with return receipt requested.</p> <p>Responsible Person and Due Dates:</p> <p>Anthony Girard, Kirk Woodring, and Gerri Cole: by 2/29/12</p> <ol style="list-style-type: none"> 1. Identify A and E space for actual contraband process, 2. Identify storage area for non-contrabanded items <p>Jeff Corrigan- by 2/23/12</p> <ol style="list-style-type: none"> 1. Complete security job description- 2/20/12-completed 2. Post security positions-2/20/12-completed 3. Recruit 4th RN for Tyler 1 and 2- 5 positions filled, 3 positions remaining 4. Recruit two medical LIPS for 11-7am position - one position offer made, Locum Tenans agency contacted.

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A 405	Continued From page 10 stated that the patient, who was on an alcohol detox program, received 75 mg of Librium (benzodiazepine used to relieve anxiety and control agitation caused by alcohol withdrawal) at that time but continued to stand at the door, leaning on the shelf of the half door and repeatedly asking for Ritalin, for which there was no physician order, while other patients lined up in the hallway awaiting their turns for medication administration. Nurse #1 stated that s/he had turned his/her head away from the Patient #1 for a short period just once during the exchange. Patient #1 left the area of the med room and the nurse continued to administer meds to other patients. Nurse #1 stated it was within 15 minutes of the exchange with Patient #1 that Patient #2 presented to the med room door asking for their daily maintenance dose of 110 mg of Methadone and the nurse was not able to find the pre-poured medication. S/he stated s/he had previously prepared the (2) 40 mg wafers and (6) 5 mg tablets totaling the 110 mg dose, placed them in a plastic med cup with another plastic med cup covering it and placed it on top of the med cart prior to the exchange with Patient #1. Nurse #1 stated that s/he alerted other staff and the Pharmacy that the Methadone was missing. S/he stated that, with the assistance of a pharmacy technician, they searched, unsuccessfully, throughout the med room for the Methadone. The protocol for Safety Searches - Unit Lock down for Contraband was implemented immediately following the identification of missing Methadone, and patients were gathered in the community area... Nurse #1 stated that, during this time, although s/he had not consulted Patient #2's attending physician, s/he did speak with Pharmacist #1 about providing the maintenance	A 405	Kirk Woodring 1. Hire security staff 3/16/12 2. Implement new process by 3/31/12 or sooner. 3. Assign a Medical LIP to a beeper for Nursing to have immediate verbal contact for an emergent medical issue. Deb Lucey 1. Develop and implement "safety zones" for medication administration on each unit. Area where patients are to stand is delineated with brightly colored tape. -completed 2. Immediately on 1/25/12 all RN's were informed via a memo that no medications were to be placed on top of the medication cart, and no medications were to be set up by the 11pm-7am RN. If practice observed by Managers, Pharmacy staff or during quality spot checks/tracers, staff would be immediately suspended. 3. Ensure disciplinary action conducted for RN who administered methadone on 1/19/12 during unit lockdown. -completed 4. Review contraband education, revise if needed, orient new staff- 3/23/12 5. Implement new documentation flow-sheets- completed 3/5/12 6. Education modules and policies for physical assessment -implement by 3/31/12. 7. Develop and implement new nursing assessment for unit RN's - 3/12/12 8. Implement new assessment and team nursing model by 4/31/12. Sharon Chaput 1. Develop action plans for CMS Nursing and Pharmaceutical CoP's.

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A 405	Continued From page 11 dose of Methadone to Patient #2 who had still not received the medication and the Pharmacist told Nurse #1 that Patient #2 needed the medication. Despite the fact that administration of Methadone to Patient #2 was contraindicated because staff had not been able to account for the missing Methadone, and it was a violation of the protocol that stated to halt all medication administration, and, finally, without consulting the attending physician, Nurse #1 confirmed that s/he administered 110 mg of Methadone to Patient #2 (at 9:30 AM according to the Medication Administration Record). In addition Nurse #1 stated that s/he continued to administer medication to the 3 or 4 patients that had still not received their scheduled medications. Nurse #2 stated during interview at 3:45 PM on 1/24/12, that while all patients were gathered in the community area of the unit, Patient #1 approached him/her and admitted that s/he had found a white pill (a 40 mg wafer of Methadone) on the floor of the bathroom that morning and had ingested it. A body search was then conducted on Patient #1 and during the contraband search of Patient #1's room s/he revealed a 5 mg tablet of Methadone that had been taped to the underside of a drawer. Patient #1 was placed on 1:1 observation status and after beginning to exhibit symptoms of Methadone overdose, including slurred speech, decreased respirations, increasing lethargy and constricted pupils, s/he was transferred, at 11:55 AM, to the ER (Emergency Room) for treatment. Patient #1 returned to the facility approximately 3 and a half hours later at 3:30 PM, was transferred to the Tyler I Unit and subsequently returned to the ER at approximately 5:00 PM that evening as a result	A 405	2. Provide weekly updates to the Executive Team and CEO. 3. Monitor medication administration compliance through tracer activities. 4. Develop new nursing assessment and policy by 3/12/12 and monitor 20 charts weekly for compliance. 5. Review current contraband policy/list with stakeholders-completed 6. Write new policy for process-2/28/12 7. Review policy with exec team-2/28/12 8. The Quality department will review 100% of contraband incident reports daily to monitor current and new process. 9. Spot check by directly observing process in A and E. 10. Identify action plans for process breakdowns with key stakeholders. 11. Review 100% of contraband incident reports in Patient Safety Committee monthly. 12. Continue tracking, trending and quarterly analysis of contraband incidents and report to Org Wide PI and Patient Safety Committee. Sen Pu, Pharmacy Director: 1. Revise medication storage and security policies with assist by Sharon Chaput by 2/28/12-completed 2. Educate all pharmacy staff on their responsibility to observe medication administration, medication security and storage and report policy non-compliance to the staff person and their respective Manager. 3. Educate all pharmacy staff on the unit lockdown procedure-completed 4. Conduct performance counseling with pharmacist who did not follow the procedure on 1/19/12-completed.	

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A 405 Continued From page 12
of continuing to exhibit symptoms associated with Methadone overdose.

Per interview, at 12:53 PM on 1/25/12, the Tyler II Nurse Manager confirmed that Nurse #1 had continued to administer meds to patients after Methadone had gone missing and further stated that s/he had told Nurse #1 and all staff that medication administration had to be halted because they could not account for the missing Methadone.

A 480 482.25 PHARMACEUTICAL SERVICES

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

This CONDITION is not met as evidenced by: Based on staff interviews and record review the Condition of Pharmacy Services is not met as evidenced by the failure to ensure safe and secure storage of all drugs in accordance with established policies and protocols, to prevent access by patients, and resulting in a negative patient outcome. In addition there was a failure to assure that pharmacy staff provided information to nursing staff in a manner that would promote safe medication use in accordance with established policies and protocols.

A 405 5. Remove all medication room keys from the Code Blue bags-
6. Store all Code Blue bags containing emergency medications in a locked area or medication room; completed.
7. Provide each unit with 2 sets of medication room keys for 2 unit Nurses- completed.
8. Implement sign off form on each unit for medication keys.

Immediate actions 1/19/12: (prior to patient coming back on 1/20/12)
A405 OK accepted 1/19/12

A 480 Unit lock-down procedure initiated upon noting methadone was missing from the top of the medication cart and after search of immediate area was conducted.
1. Medication RN called Pharmacy who arrived to assist with searching immediate area.
2. All patients gathered in day-room
3. Directive by NM to administer no medication until further notice
4. Urine DAS's done and collected on all patients
5. Unit and patient room contraband search conducted
6. As one patient's room search was being conducted he came forward and acknowledged "finding methadone" in bathroom, having ingested it, and hiding a tablet under a desk in his room.
7. This patient was placed on 1-1 in the ALSA area, had a complete skin assessment for contraband hidden or taped on his body.
8. The patient who was scheduled to receive the methadone was also placed on 1-1 and a body and room contraband conducted. He denied having stolen the methadone as the dose was meant for him.
9. The PI/Risk Manager was present and assisted with the unit lock down procedure.

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A 490	Continued From page 13 Refer to tag A-0502	A 480	o All medication carts on every unit were moved to the farthest point and not accessible by a patient reaching over the half door. o Senior Director of Standards and Quality and the Pharmacy Director conducted a critical incident review of the event in the CMS/TJC meeting at 1pm-all Managers present
A 502	482.25(b)(2)(i) SECURE STORAGE All drugs and biologicals must be kept in a secure area, and locked when appropriate. This STANDARD is not met as evidenced by: Based on staff interview and record review the Pharmacy Department failed to ensure that all Controlled drugs were securely stored in a manner that prevented unauthorized access by patients, and failed to assure that medications were administered in a manner consistent with facility Policies and Procedures. Findings include: Per record review staff failed to follow the facility's policies which included: the policy for Medication Procurement, Distribution, Storage and Disposition, last revised in July 2011 and which stated: Medication Storage and Disposition: When a medication is delivered to a unit it shall be locked in the designated location in the medication room unless it is to be administered immediately.....All Controlled Substances stored on the unit shall be secured and locked inside the medication cart drawer or a cabinet; the policy titled Administration and Scheduled Time of Medication, last revised and approved in July of 2011, which stated: III. Verifications, Education and Discussion: "Before administering medication staff will: Verify that there is no contraindication for administering the medication"; and the protocol for responding to missing medication, titled Safety Searches - Unit	A 502	o Anthony Girard, Director of Facilities had inside key locks for all medication rooms installed that day, so a patient would be prevented from leaning over and unlocking med room door. (Dutch door) o Deb Lucey, Director of Education requested that the Managers ensure that the Medication Administration policy was posted in all medication rooms, and have all RN's, particularly RN's administering medications review the policy, read and sign off on the policy. IMMEDIATE ACTIONS ON 1/21/12: (FOLLOWING PATIENT DEATH) 1. Admissions to Tyler 1 held 2. All patients placed on 15 minute checks 3. Dr. Engstrom reviewed chart, interviewed the medical staff, Dr. Kloster 4. Dr. Engstrom reviewed chart over the phone with Sharon Chaput 5. Sharon spoke with Deb Rivera night House Supervisor- AED secured with chart in medication room and replacement AED brought to the unit. 6. Sharon Chaput called Franktinus S. the Nursing Supervisor coming on for the day shift at 10:15 am on 1/21/12, (he arrives at 10am for shift) to give him a report on events of 1/19/12 through this morning at 5:45 am when patient J.F. found unresponsive. 7. Franktinus secured the Chart and AED in Sharon's office.

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A 502 Continued From page 14
Lock-down for Contraband, dated June 2006, which stated, "All medication passes are to be halted and no medication may be given until cleared with the Unit Manager or Supervisor".

Patient #1, who was admitted to the Tyler 2 Unit on 1/18/12 for treatment of suicidal ideation and alcohol detox., was able to obtain and ingest the Methadone (opiate) prescribed for Patient #2 during a medication (med) pass on the morning of 1/19/12. Per interview, at 3:20 PM on 1/24/12, Nurse #1, who was responsible for med pass for all patients on Tyler 2 on 1/19/12, stated that s/he was inside the med room that morning with the bottom half of the Dutch style door to the room closed. Although the facility's policy for storage of medication specifies that medication delivered to a unit shall be locked in the designated location in the med room unless it is to be administered immediately Nurse #1 stated that s/he had prepared medications for several patients, placed the meds in individual plastic med cups, identified by patient name, and lined the cups up on the top of the med cart which was located next to the door and reachable by someone standing outside the door. Nurse #1 stated that Patient #1 presented at the med room door for his/her medication at approximately 8:00 or 9:30 AM that day. S/he stated that the patient, who was on an alcohol detox program, received 75 mg of Librium (benzodiazepine used to relieve anxiety and control agitation caused by alcohol withdrawal) at that time but continued to stand at the door, leaning on the shelf of the half door and repeatedly asking for Ritalin, for which there was no physician order, while other patients lined up in the hallway awaiting their turns for medication administration. Nurse #1 stated that s/he had

A 502 8. Sharon Chaput developed and instituted an emergency protocol for O2 Sat's and VS for respiratory depression risk by 11am
9. Staff debriefing-Sherri French interviewed nursing staff
10. Patient community meeting held

On 1/21/12 at 11am an emergency O2/VS protocol for respiratory depression risk was implemented on all inpatient units as follows:

O2 SAT's every 15 minutes, and VS Q 2-4 hrs for the following:

- Suspicion of checking meds, suspicion of overdose,
- Having ingested illicit meds,
- For changes in mental status that indicate confusion, drowsiness, slurred speech, decreased respirations, decreasing O2 Sat's, VS changes
- Any patient sent to BMH for the above, upon return will be placed on 1-1, or 15 minute checks, and O2 SATs and VS every done 15 minutes

Onsite Executive Emergency meeting called by Rob Simpson:

- Chart review completed by Sharon Chaput, prior to meeting.
- Decision to continue to hold admissions.
- RCA scheduled already for Monday 1/23 due to 1/19/12 medication incident.
- Dr. Engstrom, Dr. Kloster and Sharon Chaput, reviewed the incidents on 1/19/12 and 1/21/12 for the team assembled.
- Sharon Chaput reviewed the timeline for both incidents.
- Reviewed our ability to respond to Code Blues and noted that Rescue Inc. took 17 minutes to arrive after the initial 911 call. Dr. Engstrom to contact Rescue Inc.

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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 C 01/26/2012
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 502	Continued From page 15 turned his/her head away from the Patient #1 for a short period just once during the exchange. Patient #1 left the area of the med room and the nurse continued to administer meds to other patients. Nurse #1 stated it was within 15 minutes of the exchange with Patient #1 that Patient #2 presented to the med room door asking for their daily maintenance dose of 110 mg of Methadone and the nurse was not able to find the pre-poured medication. S/he stated s/he had previously prepared the (2) 40 mg wafers and (8) 5 mg tablets totaling the 110 mg dose, placed them in a plastic med cup with another plastic med cup covering it and placed it on top of the med cart prior to the exchange with Patient #1. Nurse #1 stated that s/he alerted other staff and the Pharmacy that the Methadone was missing. S/he stated that, with the assistance of a pharmacy technician, they searched, unsuccessfully, throughout the med room for the Methadone. The protocol for Safety Searches - Unit Lock down for Contraband was implemented immediately following the identification of missing Methadone, and patients were gathered in the community area. Nurse #1 stated that, during this time, although s/he had not consulted Patient #2's attending physician, s/he did speak with Pharmacist #1 about providing the maintenance dose of Methadone to Patient #2 who had still not received the medication and the Pharmacist told Nurse #1 that Patient #2 needed the medication. Despite the fact that administration of Methadone to Patient #2 was contraindicated because staff had not been able to account for the missing Methadone, and it was a violation of the protocol that stated to halt all medication administration, and, finally, without consulting the attending physician, Nurse #1 confirmed that s/he	A 502	<ul style="list-style-type: none"> • Began benchmarking with other psychiatric hospitals to see if they have ACLS trained LIP's and RN's- all BLS only so far and none use airways. • Methadone 64 mg unaccounted for and RN had administered 110 mg to the patient who was scheduled to receive it, before we could finish the unit look-down procedure-no injury occurred to THIS patient however it could have. Serious near miss. Disciplinary action for RN and memo sent that no medications were to be left on top of the medication carts. • Discussed Pyxis/Omniceil having supervisor override capability-would have prevented the RN on T2 from administering methadone to the patient without a Supervisor sign-off. Rob Simpson CEO approved leasing option. • Contraband policy and process reviewed and to be reviewed during RCA with staff who did the admission and subsequent re-admissions. Concern was the possibility that the patient who had died had hidden the unaccounted for methadone on his person or in a body cavity. • Discussed need for medical LIP in addition to A and E admissions nurse. In order to provide same level of medical care 24/7. Rob Simpson CEO approved and recruitment to begin on Monday 1/23/12. • Extra House Nursing Supervisor to be added on 11pm-7am shift until a medical LIP can be recruited- Rob Simpson CEO approved.

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NAME OF PROVIDER OR SUPPLIER BRATTLEBORO RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301	
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A 502	<p>Continued From page 16</p> <p>administered 110 mg of Methadone to Patient #2 (at 9:30 AM according to the Medication Administration Record). In addition Nurse #1 stated that s/he continued to administer medication to the 3 or 4 patients that had still not received their scheduled medications.</p> <p>Nurse #2 stated, during interview at 3:45 PM on 1/24/12, that while all patients were gathered in the community area of the unit, Patient #1 approached him/her and admitted that s/he had found a white pill (a 40 mg wafer of Methadone) on the floor of the bathroom that morning and had ingested it. A body search was then conducted on Patient #1 and during the contraband search of Patient #1's room s/he revealed a 5 mg tablet of Methadone that had been taped to the underside of a drawer. Patient #1 was placed on 1:1 observation status and after beginning to exhibit symptoms of Methadone overdose, including slurred speech, decreased respirations, increasing lethargy and constricted pupils, s/he was transferred, at 11:55 AM, to the ER (Emergency Room) for treatment. Patient #1 returned to the facility approximately 3 and a half hours later at 3:30 PM, was transferred to the Tyler I Unit and subsequently returned to the ER at approximately 5:00 PM that evening as a result of continuing to exhibit symptoms associated with Methadone overdose.</p> <p>During interview, at 10:14 AM on 1/25/12, Pharmacist #1 confirmed that Nurse #1 had contacted him/her on the morning of 1/19/12 to report that Methadone was missing. The Pharmacist stated that during the conversation the question came up about giving Patient #2 their prescribed Methadone. S/he stated that</p>	A 502	<p>Nursing critical thinking/ assessment and reassessment discussed. Need to pull chain on RN assessment coming to unit RN's, medical response/assessment training, and critical thinking training - not happening quick enough and VP of Patient Care has been talking about it for too long. Rob Simpson CEO approved and Sharon Chaput to develop action plans.</p> <p>Staffing levels for units with high volume medication administration and high risk meds discussed. Model of care delivery also being discussed for too long-need to pull chain on this one.</p> <p>4th RN for T1, T2 already approved in December by Rob Simpson CEO - based on medication workload, high risk meds, detox protocols. He is asking VP of Patient Care to fast track hiring and explain why it was not in the budget.</p> <p>Sleep apnea, high risk long acting meds like methadone discussed and options for monitoring at night. Continue with current O2 sat machines. Dr. Kloster to contact a colleague, who is a sleep apnea specialist to come and do an educational workshop for all LIP's, RN's, MHW's and any other staff. In-service to be videotaped for staff who cannot come.</p> <p>Discussed need to have meetings with BMH ED again as no DOC-DOC verbal report done when patient returned on 1/19/12 and BMH faxed medical information directly to the unit on 1/20/12/10, not to A and E.</p> <p>Sharon Chaput wrote up action plans to address all items-added responsible person and due dates. Additional Action items added after RCA</p> <p>Action items reviewed weekly in Executive Team beginning 1/24/12.</p> <p><i>A 502 PRC accepted 4/19/12</i></p>

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A. 602 Continued From page 17

A 502

Nurse #1 had expressed that s/he was sure Patient #2 had not taken the Methadone and the Pharmacist told Nurse #1 that s/he would give the Methadone if positive Patient #2 hadn't had it.

The Director of Pharmacy Services agreed, during interview at 9:50 AM on 1/25/12, that there was a potential for Methadone overdose to occur if a patient receiving a daily maintenance dose of 110 mg were given more than the maintenance dose. During a subsequent interview, at 9:55 AM on 1/26/12, the Director of Pharmacy Services agreed that administration of medication should be halted, in accordance with the facility's established protocol for Safety Searches - Unit Lock-down for Contraband during any event when staff are not able to account for missing patient medications. S/he further agreed that response by pharmacy staff to questions posed regarding medication administration during an event requiring a unit lock-down should reflect the directives in the protocol.