

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

PRINTED: 12/07/2015  
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  11/19/2015
NAME OF PROVIDER OR SUPPLIER  BRATTLEBORO RETREAT			STREET ADDRESS, CITY, STATE, ZIP CODE ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 000	INITIAL COMMENTS  An unannounced recertification survey to review the Conditions of Participation, including the Acute Hospital and Psychiatric Hospital Regulations was conducted on 11/16/15 - 11/19/15 by the Division of Licensing and Protection and the Boston survey branch for the Centers for Medicare & Medicaid Services (CMS). The following Acute Hospital regulatory violations were identified:	A 000	See attached Corrective Action Plan Pages 1 - 7 <i>POC complete</i> <i>12-21-15 mclntosh/LHA</i>		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING  The patient has the right to receive care in a safe setting.  This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure each patient's right to receive care in a safe setting by failing to initiate advanced mouth checks when indicated and by not appropriately assessing the potential safety precautions for the use of a heat wrap for 1 applicable patient. (Patient #12) Findings include:  Per record review, when Patient #12 was admitted on 11/10/15, the hospital was informed of the patient's previous attempts of self harm to include self strangulation, toxic ingestion of lethal amounts of medications and chemical ingestion to include flea spray, hand sanitizer and burn relief cream. Patient #12 also reported "cheeking" medications and confirmed upon admission s/he remained suicidal. Per review of hospital policy Administration and Scheduled Time of Medication, last reviewed 01/2015, states: IV. Mouth Checks--Standard & Advanced : "Mouth check - the act of visually inspecting the inside of	A 144			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Paul E. Simpson Jr. DSW, MPH President & CEO* TITLE (X6) DATE *12/17/15*

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 144	Continued From page 1 the patient's mouth after a medication has been administered". The Treatment Team and assigned physician have the option of maintaining Standard Mouth Checks or Advanced Mouth Checks. With Advanced Mouth Checks the patient is monitored more closely by nursing staff and is initiated "For patients considered at high risk for cheeking/ palming/not taking meds according to policy". A Nursing Progress note states on 11/13/15 during the evening shift Patient #12 reported s/he "...planned to overdose. Pt handed staff a cup with dissolved pills in it with some water. Pt. stated that this was three nights worth of medication. Pt stated s/he took pills and spit them into water as s/he took them". Despite Patient's #12 previous history of cheeking medications, Advanced Mouth Checks were not ordered by the physician until after this incident had occurred. Per interview on 11/18/15 at 2:40 PM, the attending physician confirmed s/he should have placed Patient #12 on Advanced Mouth Checks at the time of admission.  In addition, there was also a failure of the Treatment team to assess if Patient #12 met criteria for the safe use of a ThermaCare heat wrap (a disposable over-the-counter wrap used for treatment associated with muscle & joint pain). Despite Patient #12's recent history of toxic ingestion, on 11/14/15 a ThermaCare wrap was ordered to treat the patient's complaints of back pain. Upon being informed on the evening of 11/14/15 s/he would continue to be assigned to ALSA (low stimulation area) due to the patient's ongoing expressions of depression and thoughts of wanting to die, Patient #12 went into her/his bedroom and broke open the ThremaCare wrap and ingested part of the contents which contains	A 144			

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A 144	Continued From page 2 iron. Hospital staff followed up with Poison Control, and the ingestion was not lethal. Per interview on the afternoon of 11/17/15, the Chief Medical Officer confirmed the use of ThermoCare wraps requires a more comprehensive safety assessment for each individual patient prior to application.	A 144			
A 396	482.23(b)(4) NURSING CARE PLAN  The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan  This STANDARD is not met as evidenced by: Based on staff interview and record review nursing failed to revise the care plan to reflect goals and interventions identified to meet the needs of 1 patient who was diagnosed with a new medical condition. (Patient #32). Findings include:  Per record review Patient #32 was admitted on 10/9/15 for evaluation and treatment of a psychiatric disorder. On 11/10/15 the patient, who was preparing for upcoming discharge, was identified with an elevated fasting blood sugar level requiring use of insulin by injection to help lower the level. Although the patient's discharge was delayed and s/he remained hospitalized for an additional 6 days to stabilize the newly diagnosed diabetes, his/her care plan had not been revised to reflect goals and interventions to address this identified issue. The Nurse Manager of the unit on which the patient resided confirmed, during interview on the morning of 11/19/15, that the care plan had not been revised to reflect the	A 396			

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A 396	Continued From page 3	A 396			
A 620	patient's current status and needs. 482.28(a)(1) DIRECTOR OF DIETARY SERVICES  The hospital must have a full-time employee who-  (i) Serves as director of the food and dietetic services;  (ii) Is responsible for daily management of the dietary services; and  (iii) Is qualified by experience or training.  This STANDARD is not met as evidenced by: Based on observation, and staff interview, the Director of Food Services failed to assure the hospital food services were effectively managed in regards to kitchen sanitation and infection control measures. Findings include:  Per observation during an initial tour of the kitchen accompanied by the Director of Food Services on 11/16/2015 at 10:30 AM, a bag of cooked bacon was stored unlabeled and undated in the freezer and a vat of yellow foodstuff was stored undated and unlabeled in the refrigerator. Per interview, The Director of Food Services confirmed that open containers of food should be labeled and dated when stored.  Per observation at 3:45 PM on 11/18/15, accompanied by the Director of Infection Control, a Dietary Aide was observed assembling a sandwich wrap without wearing gloves. When asked if s/he should be wearing gloves, the staff person state that s/he knew that s/he should be wearing gloves and usually does wear gloves.	A 620			

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A 620	Continued From page 4 Per interview, the Director of Infection Control and a Registered Dietitian who was present confirmed all staff should wear gloves when preparing food.	A 620		
B 000	INITIAL COMMENTS  In conjunction with the unannounced recertification survey of Brattleboro Retreat conducted by the Vermont State Agency and the CMS (Center for Medicare and Medicaid) Boston Regional Office, the Boston Regional Office assessed the Hospital's compliance with the special conditions of participation for Psychiatric Hospitals. The census at the time of survey was 113 patients. The sample of active patients was 10.  Brattleboro Retreat was found to be in compliance with 42 CFR 482.60, Special provisions applying to psychiatric hospitals and the special Conditions of Participation for psychiatric hospitals at 42 CFR 482.61 and 42 CFR 482.62.	B 000		

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A-000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced recertification survey to review the Conditions of Participation, including the Acute Hospital and Psychiatric Hospital Regulations was conducted on 11/16/15- 11/19/15 by the Division of Licensing and Protection and the Boston survey branch for the Centers for Medicare &amp; Medicaid Services (CMS). The following Acute Hospital regulatory violations were identified</p>	<p>The Brattleboro Retreat is fully committed as an organization to continually strive to improve the quality and safety of patient care as evidenced by the CMS full recertification survey and the re-instatement of Medicare deemed status. 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 full survey as well as comments on one particular finding.</p>			
A 144	<p><b>482.13 (c ) 2 ) PATIENT SAFETY: CARE IN A SAFE SETTING</b></p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure each patient's right to receive care in a safe setting by failing to initiate advanced mouth checks when indicated and by appropriately assessing the potential safety precautions for the use of a heat wrap for I applicable patient. (Patient #12) Findings include:          Per record review, when Patient #12 was admitted on 11/16/15 the hospital was informed</p>	<p>The following are comments on the finding reported under the CoP 482.13 A tag 144 Patient Safety : Care in a Safe Setting based on a physician ordering a ThermoCare Patch for a patient, not initially ordering advanced mouth checks, and the subsequent report that the patient ingested the ThermoCare patch and reported checking meds.</p> <p>In reviewing the pharmacology of ThermoCare, and calculating the severity of reaction with ingestion (which was a known risk factor for the patient), ThermoCare represented the lowest severity reaction based on the patient's weight/ height. It is noted that Ben Gay or other similar analgesic creams are more toxic than ThermoCare if ingested, and is not included in the Retreat's formulary for this reason.</p>			12-21-15 m/lc

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	<p>of the patient's previous attempts of self-harm to include self-strangulation, toxic ingestion of lethal amounts of medications and chemical ingestion to include flea spray, hand sanitizer and burn relief cream. Patient #12 also reported "cheeking" medications and confirmed upon admission s/he remained suicidal. Per review of hospital policy Administration and Scheduled Time of Medication, last reviewed 01/2015, states: IV. Mouth Checks-Standard &amp; Advanced : "Mouth check - the act of visually inspecting the inside of the patient's mouth after a medication has been administered", The Treatment Team and assigned physician have the option of maintaining . Standard Mouth Checks or Advanced Mouth Checks. With Advanced Mouth Checks the patient is monitored more closely by nursing staff and is initiated "For patients considered at high risk for cheeking/ palming/not taking meds, according to policy". A Nursing Progress note . states on 11/13/15 during the evening shift Patient #12 reported s/he "....planned to overdose. Pt handed staff a cup with dissolved pills in it with some water.. Pt. stated that this was three nights</p>	<p>Although the patient ingested a portion of the patch, the patient reported no nausea or vomiting, and poison control, who was immediately contacted, stated that this would be the only reaction expected for this patient.</p> <p>The ordering physician's clinical rationale for ordering this medication took into careful consideration the fact that the patient was engaged in care during this admission and the physician clinically decided to encourage this engagement while recognizing the patient's complaint of pain. The physician was also addressing and assessing the patient's ability to establish a trusting relationship which was a significant part of the genesis of her ingestion history related to her attachment dynamic with others. The physician, in ordering ThernaCare for the patient's complaint of back pain, considered the presenting behavior, patient history, known risk factors, and then balanced providing care in a safe setting with the patient's right to appropriate pain management utilizing the least intrusive manner that would also address her attachment and trust issues.</p> <p>The physician considered available formulary options and treatment modalities. The ThernaCare Patch had previously been approved by both Medical Staff and the Pharmacy and Therapeutics Committee as an appropriate low risk pain management intervention. In this instance, the physician</p>			

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	<p>worth of medication. Pt stated s/he took pills and spit them into water as s/he took them. Despite Patient's #12-previous history of checking medications, Advanced Mouth Checks were not ordered by the physician until after this incident had occurred. Per interview on 11/18/15 at 2:40 PM, the attending physician confirmed s/he should have placed Patient#12 on Advanced Mouth Checks at the time of admission.</p> <p>In addition, there was also a failure of the Treatment team to assess if Patient #12 met criteria for the safe use of a ThermaCare heat wrap (a disposable over-the-counter wrap used for treatment associated with muscle &amp; joint pain). Despite Patient #12's recent history of toxic ingestion, on 11/14/15 a ThermaCare wrap was ordered to treat the patient's complaints of back pain. Upon being informed on the evening of 11/14/15 s/he would continue to be assigned to ALSA (low stimulation area) due to the patient's ongoing expressions of depression and thoughts of wanting to die, Patient #12 went into her/his bedroom and broke open the ThermaCare wrap and ingested part of the contents which contains iron. Hospital staff</p>	<p>with the data available at that point in time, clinically decided the Patient's Right to appropriate pain management took priority over a low risk to Patient Safety.</p> <p>All patients at the Brattleboro Retreat currently have a mouth check with medication administration, at the time of admission, the clinical decision to encourage the patient's engagement in treatment, was a factor in not immediately ordering more advanced mouth checks.</p> <p>The Brattleboro Retreat is always striving to improve the safety and quality of care it provides to its patients. As a result of this event, the first instance of any patient ingesting a Therma Care patch, several actions have occurred:</p> <ul style="list-style-type: none"> <li>We have reached out to other Psychiatric facilities to determine what noninvasive treatment modalities they use for muscle type pain.</li> <li>The Pharmacy and Therapeutic Committee will include both ThermaCare and mouth checks as agenda items to determine what if any additional factors should be considered prior to ordering and any other recommendations on their use.</li> <li>The CMO informed the medical staff of this patient ingesting the Therma Care with a reminder for</li> </ul>	<p>11.24.15</p> <p>12.10.15</p>	<p>Dir. Regulatory Affairs</p> <p>Chair of P &amp; T</p> <p>Chief Medical Officer (CMO)</p>	

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A 396	<p>followed up with Poison Control, and the ingestion was not lethal. Per interview on the afternoon of 11/17/15, the Chief Medical Officer confirmed the use of ThermoCare, wraps requires a more comprehensive safety assessment for each individual patient prior to application.</p> <p>482.23(b)(4) NURSING CARE PLAN          The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review nursing failed to revise the care plan to reflect goals and interventions identified to meet the needs of 1 patient who was diagnosed with a new medical condition. (Patient #32). Findings 1</p> <p>1, include:          Per record review Patient #32 was admitted on 10/9/15 for evaluation and treatment of a psychiatric disorder. On 11/10/15 the patient, who was preparing for upcoming discharge, was identified with an</p>	<p>careful consideration in ordering Thermo Care for any patient specific treatment modality.</p> <p>1) a. Findings presented and discussed at meeting attended by Triad Teams. Attendees were reminded of need to insure medical problems are adequately addressed in TX plan.</p> <p>b. -Director of Medical Services contacted the national office of the ADA and forwarded via email their recommended educational resource for patients to all clinic LIPs          - Director of Medical Services arranged for additional training for LIPs on common psychiatric drugs and potential impact on common chronic medical conditions.</p> <p>c. Specific nurse re-educated one on one. Treatment plan including medical problems is included in the initial nursing training of new hires and is a component of ongoing training.</p>	<p>a. 11.19.15</p> <p>b. -11.19.15          -12.14.15</p> <p>c. 11.19.15</p>	<p>1) a. CEO</p> <p>b. Director of Medical Services</p> <p>c. Clinical Manager of specific unit.</p>	<p>Random monthly review of TX plans for 4 mos. to insure medical problems addressed.          Goal: 92%</p>

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A 620	<p>elevated fasting blood sugar level requiring use of insulin by injection to help lower the level, Although the patient's discharge , was delayed and s/he remained hospitalized for an additional 6 days to stabilize the newly diagnosed diabetes, His/her care plan had not been revised to reflect goals and interventions to address&amp; this identified issue. The Nurse Manager of the unit on which the patient resided confirmed, during interview on the morning of 11/19/15, that the care plan had not been revised to reflect the patient's current status and needs.</p>	<p>1) a. Just in time re-education performed by Director of Food Services to reinforce with all staff the need for all food to be labeled.          b. Line item that all open food in refrigerator has a legible label with date and time opened added to the daily dietary check list.</p>	<p>1) a. 11.17.15          b. 12.7.15</p>	<p>1. Director of Food Services</p>	<p>1. 4 month audit to monitor compliance goal:95%</p>
	<p>This STANDARD is not met as evidenced by: Based on observation, and staff interview, the Director of Food Services failed to assure the hospital food services were effectively managed in regards to kitchen sanitation and infection</p>	<p>2. a. Individual staff member counseled on need to wear gloves during food prep 100% of the time.          b. Just in time re-education performed by Director of Food Services to reinforce with all staff the need of wearing gloves in food preparation 100% of the time.</p>	<p>2) a. 11.18.15          b. 11.18.15</p>	<p>2. a. b Director of Food Services</p>	<p>2. 4 month audit to monitor compliance Goal 100%</p>

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B000	<p>control measures. Findings include: Per observation during an initial tour of the Services on 11/16/2015 at 10:30 AM, accompanied by the Director of Food cooked bacon was stored unlabeled and undated in the freezer and a vat of yellow foodstuff was stored undated and unlabeled in the refrigerator. Per interview, The Director of Food Services confirmed that open containers of food should be labeled and dated when stored. Per observation at 3:45 PM on 11/18/15, accompanied by the Director of Infection Control, a Dietary Aide was observed assembling a sandwich wrap without wearing gloves. When asked if s/he should be wearing gloves, the staff person state that s/he knew that s/he should be wearing gloves and usually does wear gloves. Per interview, the Director of Infection Control and a Registered Dietitian who was present confirmed all staff should wear gloves when preparing food.</p>	<p>c. Random unannounced monitoring for compliance.</p>	<p>c. initiated week 12.7 monitoring for 4 months</p>	<p>c. Manager of IC</p>	
	<p><b>Initial Comments:</b>          In conjunction with the unannounced recertification survey of Brattleboro Retreat CMS (Center for Medicare and Medicaid) Boston conducted by the Vermont State Agency and the Regional Office, the Boston Regional Office assessed the Hospital's compliance with the special</p>				

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The Brattleboro Retreat  
 Corrective Action Plan  
 Survey Completion Date: November 19, 2015  
 Provider ID # 474001

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	<p>conditions of participation for Psychiatric Hospitals. The census at the time of survey was 113 patients. The sample of active patients was 10.</p> <p>Brattleboro Retreat was found to be in compliance with 42 CFR 482.60, Special provisions applying to psychiatric hospitals and the special Conditions of Participation for Psychiatric hospitals at 42 CFR 482.61 and 42 CFR 482.62.</p>				

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