

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

PRINTED: 07/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  470001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/06/2012
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NAME OF PROVIDER OR SUPPLIER  CENTRAL VERMONT MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE BOX 547 BARRE, VT 05641
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A 000	INITIAL COMMENTS  An unannounced on-site complaint survey was completed by staff from the VT Division of Licensing & Protection on 7/6/12, as authorized by the Centers for Medicare and Medicaid Services. The following regulatory violations were found.	A 000	We are aware that Patient #3 was not treated correctly and we have initiated the following measures to preserve the Patient' Rights. The patient was admitted from the ED to the special care unit. The staff on the special care unit used the incorrect set of restraint orders. The orders used were for Non-Behavioral Health patients.	
A 154	482.13(e) USE OF RESTRAINT OR SECLUSION  Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.  This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that 1 of 4 applicable patients restrained for emergency situations was treated in accordance with the hospital's policies/procedures regarding behavioral restraints. The patient' rights were violated when staff failed to discontinue the physical restraints at the earliest possible time and failed to obtain new orders for restraints after discontinuing restraints. (Patient #3) Findings include:  Per review of the medical record for Patient #3 on 7/5/12 and 7/6/12, the hospital failed to protect the rights of Patient #3 during the utilization of behavioral restraints, initiated for protection from self injurious and threatening behaviors during the period from 2215 hours on 1/14/12 until	A 154	Order Set was developed and implemented for Non-Behavioral Restraints and a separate Order set was developed and implemented for Behavioral Restraints.  In-services for ICU staff on involuntary procedures were held covering the following topics:  - Policy /procedures on non-behavioral and behavioral restraints restraints/seclusion/medications.	4/20/12  5/29/12 0730 and 1700 5/30/12 0730 6/1/12 1700

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 8.12.12
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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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NAME OF PROVIDER OR SUPPLIER  CENTRAL VERMONT MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE BOX 547 BARRE, VT 05641	
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A 154	Continued From page 1 discontinuation of the restraints on 1/15/12 at 0800. Per review of the nursing documentation, there were no documented behaviors necessitating physical restraints after 2230 hours on 1/14/12. The patient was removed from 4 point locked restraints for toileting at 0000 - 0015 hours and then returned to 3 point locked restraints thereafter. The patient was released from the 3 point restraints for toileting at 0200 and returned to the restraints. Per the CON (Certificate of Need) flow sheets for Involuntary Treatment of the Violent/Assaultive Patient, commencing at 2215 on 1/14/12 and ending at 0800 on 1/15/12, nurses did not document any agitated behaviors after 2230 on 1/14/12. Nurses documented under the every hour assessment findings the following comments: "2300, Per nursing supervisor....., keep pt. restrained for the night due to physical threats." (none described) "1215 Pt. up to void in hat with 2 assist, cooperative - back in bed and compliant." "0200 Pt up to void with 2 assist for unsteadiness and dizziness." "0800 Off restraints - Took PO medications....accepted some care...to chair" Other hourly documentation during the night stated "continues to need restraints" even though nurses documented behaviors as "cooperative, calm and asleep/awake" from 2230 until 0800 the following morning. During interview on 7/5/12 at 12:45 PM, the Nurse Director of Critical Care stated that staff on the Critical Care Unit, including the physician provider, were not familiar with the hospital's 2 types of restraint policies/procedures, including different order sets for medical restraints and orders for behavioral restraints/seclusion. The	A 154	<ul style="list-style-type: none"> <li>- Reviewed Certificate of Need and required documentation</li> <li>- Reviewed CMS guidelines for involuntary procedure.</li> <li>- Reviewed clinical algorithm for non-behavioral and behavioral involuntary procedures.</li> <li>- Reviewed clinical criteria for use of involuntary procedures and criteria for discontinuation.</li> <li>- Discussed clinical scenarios.</li> </ul> <p>An ICU nurse team is working to standardize when restraints are to be reassessed and ordered.</p> <p>An In-service for hospitalist and physicians on non-behavioral and behavioral involuntary procedures was held covering the following topics:</p>	<p><i>In Process</i></p> <p><i>6/6/12</i></p>

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A 154	Continued From page 2 orders for behavioral restraints were incorrectly implemented and documented. Based on interviews throughout 7/5/12 and 7/6/12 with leadership staff from Quality and Risk Management, the Medical Affairs Director, the Vice President of Nursing and Quality, the Nurse Director of Critical Care and the Nurse Director of Inpatient Psychiatry and review of the hospitals written response to the patient grievance dated 4/12/12 and 5/30/12, the hospital concluded that the patient's right were violated regarding the use of restraints by failure to obtain restraint orders consistent with policy and regulatory requirements and failing to release from restraints at the earliest possible time, based on staff's assessments and documentation of behaviors from 1/14/12 to 1/15/12 at 0800.	A 154	<ul style="list-style-type: none"> <li>- Reviewed policy and procedures on non-behavioral and behavioral restraints/seclusion/medications.</li> <li>- Reviewed physician's role in completing Certificate of Need.</li> <li>- Reviewed CMS guidelines.</li> <li>- Reviewed clinical algorithm for non-behavioral and behavioral involuntary procedures.</li> </ul>	
A 168	<p>(Refer also to A -168, A-169, A-171 and A-174). 482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that staff complied with physician orders for physical restraint and hospital policy/procedures for behavioral restraints for 1 applicable patient in the sample. (Patient #3) Findings include:</p>	A 168	<ul style="list-style-type: none"> <li>- Reviewed clinical criteria for use of involuntary procedures and criteria for discontinuation.</li> <li>- Discussed clinical scenarios.</li> </ul> <p>In-service with Nursing Supervisors to review policy and procedures on involuntary procedures.</p>	<p>6/6/12</p> <p>6/14/12</p>

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A 168	Continued From page 3 Per record review on 7/5/12, Patient #3 was placed in physical restraints for behavioral reasons at 2315 hours on 1/14/12, and although staff removed the restraints at least 2 times to toilet the patient, staff re-applied the restraints each time until 0800 hours on 1/15/12, when a nurse documented that restraints were released. Nurses restrained the patient without physician orders after ending the orders when the patient was removed from restraints at 000 - 0015 hours and 0200 hours on 1/15/12. Per review of the hospital's policy titled "Restraint and Seclusion for Behavioral Health Patients, II A, #9 "If restraints or seclusion are discontinued prior to the expiration of the original order, a new order must be obtained prior to re-initiating restraint..". The failure to comply with the restraint policy by re-initiating restraints without a new order was confirmed during interview with the Vice President of Medical Affairs on 7/5/12 at 2:25 PM.	A 168	Reviewed all criteria noted in the inservice for the Special Care staff. all nursing supervisors are required to sign off on restraints during their shift as a means of tracking accountability  In-service with Medical-Surgical Unit to review policy and practice on non-behavioral use of restraints. Three more in-services to be scheduled for night shift. Staff requested a decision Algorithm. Developed a decision algorithm for staff and educated staff.	5/30/12 5/31/12 6/1/12	
A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION  Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).  This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that physician orders for use of behavioral restraint/seclusion were written in accordance with hospital policy and regulatory requirements for 1 of 4 applicable patients in the sample. (Patient #3). Findings include:  Per record review on 7/5/12 and confirmed by interview with the V.P. of Nursing and Quality, the RN Director of Inpatient Psychiatry and the	A 169	ED staff was required to attend a mandatory in-service regarding medical vs. behavioral restraint. Reviewed and discussed Order Sets, CON with staff at ED Staff Meetings. All ED and ICU staff required to review behavior and medical restraint policies and paperwork. Binders have been placed in	5/30/12	

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A 169	Continued From page 4 Nursing Director of Critical Care Services on 7/6/12 at 1 PM, Patient #3's physician wrote orders on 1/14/12 noted at 1440 hours, stating "#3. If PT becomes a danger to herself or others, restrain as needed." Another physician telephone order written on 1/15/12 at 0330 stated "continue restraints, release if & when safe for patient.... (restraints are 2 -4 pt depending on degree of agitation". During interview, the hospital staff confirmed that this physician had written orders that were not in accordance with the hospital's policies/procedures for Behavioral Restraint/Seclusion and were in violation of the patient's rights. The hospital's P/P stated under part II B, 8. "PRN orders for restraint or seclusion are prohibited".	A 169	ICU and ED with medical and behavioral policies and order sets. Staff must sign that they have reviewed.  A team is working with IS to determine if there is a way to create a certificate of need and all accompanying documentation electronically  Concurrent review of involuntary procedures is completed by nurse managers on respective units. Involuntary procedures data base maintained by VP of Nursing. Inpatient psychiatry mandatory meeting held to review policy and procedures and practice of involuntary procedures.	In progress	
A 171	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION  Unless superseded by State law that is more restrictive-- (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age;  This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that, for 2 of 4 patients in the applicable sample, orders for behavioral restraints were renewed every four hours for adults over 18 years of age, per hospital	A 171	A committee chaired by the RN Nursing Director for Inpatient Psychiatry is in the process of developing hospital-wide committee with	In process  7/10/12  In process	

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A 171	Continued From page 5 regulatory requirements regarding Patient Rights and per hospital policy for behavioral restraint use. (Patients # 1 & # 3). Findings include:  1. Per record review on 7/5/12 at 1:00 P.M., Patient #1 had a physician's order dated 1/2/12 for four point locked restraints written at 8:00 P.M. due to 'dangerous behavioral issues....assaultive behavior...auditory and visual hallucinations.. acting out.. yelling,'. Per record review, Patient #1 was restrained for 15 1/2 hours. There was no evidence in the clinical record of a subsequent physician order to continue the restraint every 4 hours as required by regulation and facility policy entitled "Restraint and Seclusion for Behavioral Health Patients", II, Section B, 4 a. This was confirmed during interview with the Nurse Director of Critical Care Services on 7/6/12 at 8:40 A.M..  2. Per record review and confirmed by interview with the Nurse Director of Critical Care Services on 7/5/12 at 12:45 PM and the Physician Vice President of Medical Affairs at 2:35 PM the same day, staff restrained Patient #3 for longer than 4 hours (from 1/14/12 at 2215 until 1/15/12 at 0800) and failed to renew the orders every 4 hours as required by hospital regulations and the hospital's policy as stated in example number 1 above. Nurses obtained a telephone order at 0330 on 1/15/12 to "continue restraints, release if and when safe for pt. , 1:1 obs. to continue (restraints are 2-4 point depending on degree of agitation). Refer also to A- 154.	A 171	purpose of reviewing all involuntary procedures and adherence to CMS guidelines and exploration of quality improvement opportunities.  Code Green Training Sessions (a three hours training session covering de-escalation and application of restraints) for all clinical staff are held monthly. These sessions are taught by the RN Director of Inpatient Psychiatry. Inpatient psychiatry maintains a quarterly report on all hospital-wide code greens yearly. Inpatient psychiatry maintains a quarterly report on all hospital-wide code greens yearly. This is reviewed by IPP nurse director, VP of Nursing and hospital Safety committee.  A DVD of in-services was created with accompanying	10/25/11 11/29/11 12/28/11 1/31/12 3/15/12 4/24/12 5/31/12 7/12	
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 174			

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A 174	<p>Continued From page 6</p> <p>Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, nurses failed to discontinue at the earliest possible time, 3 point locked physical restraints used for 1 of 4 applicable patients in the sample. (Patient #3) Findings include:</p> <p>Per record review on 7/5/12, Patient #3 was documented as being restrained in 3 - 4 point locked restraints from 2215 hours on 1/14/12 until 0800 hours on 1/15/12.</p> <p>Per the CON (Certificate of Need) flow sheets for involuntary Treatment of the Violent/Assaultive Patient, commencing at 2215 on 1/14/12 and ending at 0800 on 1/15/12, nurses did not document any agitated behaviors after 2230 on 1/14/12. Nurses documented under the every hour assessment findings the following comments:</p> <p>"2300, Per nursing supervisor....., keep pt. restrained for the night due to physical threats." "1215 Pt. up to void in hat with 2 assist, cooperative - back in bed and compliant." "0200 Pt up to void with 2 assist for unsteadiness and dizziness." "0800 Off restraints - Took PO medications....accepted some care...to chair"</p> <p>Other hourly documentation during the night stated "continues to need restraints" even though nurses documented behaviors as "cooperative, calm and asleep/awake" from 2230 until 0800 the following morning.</p>	A 174	<p>quiz for staff unable to attend. This is located on Root Directory for staff. The Nursing Education Committee is considering doing a nursing grand round on the regulations related to Behavioral and Non-Behavioral restraints as another educational moment.</p> <p>In-service with Nursing Supervisors to review policy and procedures on involuntary procedures. Reviewed all criteria noted in the inservice for the Special Care staff. All nursing supervisors are required to sign off on restraints during their shift as a means of tracking accountability</p>	6/14/12

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A 174	Continued From page 7 Per review of the hospital's policy "Restraint and Seclusion for the Behavioral Health Patient", page 6, #9 and #10 a., a RN will assess the patient's clinical status and then collaborate with the treatment team to determine the patient's readiness for tapering and release of the restraints. During interview on the afternoon of 7/5/12, the Nurse Director of Critical Care Services confirmed that nurses continued to maintain the restraints even though there was no evidence of the continued need or a reassessment of the patient's status.	A 174	<p>An In-service for hospitalist and physicians on non-behavioral and behavioral involuntary procedures was held covering the following topics:</p> <ul style="list-style-type: none"> <li>- Reviewed policy and procedures on non-behavioral and behavioral restraints/seclusion/medications.</li> <li>- Reviewed physician's role in completing Certificate of Need.</li> <li>- Reviewed CMS guidelines.</li> <li>- Reviewed clinical algorithm for non-behavioral and behavioral involuntary procedures.</li> <li>- Reviewed clinical criteria for use of involuntary procedures and criteria for discontinuation.</li> </ul>	6/6/12
A 178	<p>482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention --</p> <p>o By a--</p> <ul style="list-style-type: none"> <li>- Physician or other licensed independent practitioner; or</li> <li>- Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section.</li> </ul> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to assure 2 of 4 applicable patients in the sample who were restrained for behavioral reasons were assessed by a physician or other LIP (licensed independent practitioner) as required by hospital policy/procedures. (Patients#1 &amp; #3). Findings include:</p>	A 178		

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A 178	<p>Continued From page 8</p> <p>1. Per record review on 7/5/12 at 1:00 P.M., Patient #1 was placed in 4 point locked restraints per a physician's order dated 1/2/12, 8:00 PM, due to dangerous behaviors including 'assaultive behavior with auditory and visual hallucinations' 'acting out, yelling'. Per record review, Patient #1 was restrained for 15 1/2 hours. There is no evidence in the clinical record that Patient #1 had an initial face to face physician assessment within one hour or a subsequent assessment after 8 hours as required by a facility policy entitled "Restraint and Seclusion for Behavioral Health Patients", section B,2. This was confirmed during interview with the Nurse Director of Critical Care Services on 7/6/12 at 8:40 AM.</p> <p>2. Per record review on 7/5/12, Patient #3 was restrained (and re-restrained after toileting) during the period from 2315 hours on 1/14/12 until 0800 on 1/15/12. Per review of the physician orders, the physician incorrectly wrote initial orders under "Physician Reassessment" at 11:38 PM on 1/14/12. At that time, the physician failed to describe the clinical condition of the patient including behaviors, thought process and affect/mood that required involuntary treatment. Additionally, there was no evidence of a face to face assessment every 8 hours for adults over 18 years of age, per the hospital's policy, (as referred to in example #1 above). The record stated that the physician saw the patient at 0830 hours on 1/15/12. The lack of required physician/LIP face to face assessment was confirmed during interview with the Nurse Director of Critical Care Services on 7/6/12 at 1 PM.</p>	A 178	<p>An In-service for hospitalist and physicians on non-behavioral and behavioral involuntary procedures was held covering the following topics:</p> <ul style="list-style-type: none"> <li>- Reviewed policy and procedures on non-behavioral and behavioral restraints/seclusion/medications.</li> <li>- Reviewed physician's role in completing Certificate of Need.</li> <li>- Reviewed CMS guidelines.</li> <li>- Reviewed clinical algorithm for non-behavioral and behavioral involuntary procedures.</li> <li>- Reviewed clinical criteria for use of involuntary procedures and criteria for discontinuation.</li> <li>- Discussed clinical scenarios.</li> </ul>	6/6/12	