

CENTERS FOR MEDICARE & MEDICAID SERVICES
Boston Regional Office
JFK Federal Building
Room 2350
Boston, MA 02203



Consortium for Quality Improvement and Survey & Certification Operations
Division of Survey & Certification

April 16, 2013

Dr. John Brumsted, President & CEO
Fletcher Allen Hospital of Vermont
111 Colchester Avenue
Burlington, VT 05401

Re: CMS Certification Number (CCN) : 470003
Survey ID: OYBD11, 04/03/2013

Dear Dr. Brumsted:

I am pleased to inform you that as a result of the substantial allegation survey conducted on April 3, 2013 by the Division of Licensing and Protection (State Survey Agency), Fletcher Allen Hospital of Vermont was found in compliance with the Medicare Conditions of Participation for Hospitals at 42 CFR Part 482 and will continue to be "deemed" to meet applicable Medicare requirements based upon accreditation by The Joint Commission.

The State Survey Agency advised you of the Medicare deficiencies noted during the substantial allegation survey of your hospital, and we are enclosing a complete listing of all deficiencies found by the State. We have forwarded a copy of this letter to the Joint Commission and to the State.

Since your hospital has been found to be "in compliance," you do not have to submit a plan for correcting any of the Medicare deficiencies cited by the State Survey Agency. However, under Federal disclosure rules, a copy of the findings of this Medicare survey must be publicly disclosed upon request within 90 days of the completion. You may therefore wish to submit for public disclosure, if you have not already done so, your comments on the survey findings, and any plans you may have for correcting the cited deficiencies.

We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program.

Sincerely,

A handwritten signature in black ink that reads "Kathy Mackin". The signature is written in a cursive style.

Kathy Mackin, Health Insurance Specialist
Certification & Enforcement Branch

Enclosure: CMS-2567

cc: Division Of Licensing And Protection
The Joint Commission

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

PRINTED: 04/18/2013
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401
--	---

(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	<p>INITIAL COMMENTS</p> <p>An onsite complaint investigation was completed on 4/3/13 by the Division of Licensing and Protection as authorized by the Centers for Medicare and Medicaid. The following regulatory violations were identified related to the complaint:</p> <p>A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to assure care was provided in a safe setting during the provision and management of care for a prisoner patient. (Patient #1) Findings include:</p> <p>The potential for an unsafe environment for patients recovering from anesthesia and surgical procedures was evident due to the hospital's failure to assure Security policy and procedures were followed.</p> <p>On 11/7/12, Security Staff failed to adhere to Policy "Sec00016/Prisoner Patient" last updated 3/11/11 which states hospital staff or outside police departments or correctional facilities are to notify the Security Shift supervisor whenever a prisoner is brought to the hospital for inpatient or outpatient treatment. Upon notification, the prisoner patient's level of security would be determined, assessing the level of restraints being used. Communication would be made to other Security officers, alerting them of any special precautions. The policy further states: "If a correction officer, private security officer, or other law enforcement official will be supervising</p>	A 000	<p>SEE PLAN OF CORRECTION PP Bonni Martin, BS, RN Carol Muzzy</p> <p>SEE PLAN OF CORRECTION PP Bonni Martin, BS, RN Carol Muzzy</p> <p>SEE PLAN OF CORRECTION PP Bonni Martin, BS, RN Carol Muzzy</p>	<p>8/1/13</p> <p>8/1/13</p> <p>8/1/13</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: PP Bonni Martin, BS, RN / Carol Muzzy Director of Regulatory TITLE: Director of Regulatory (X6) DATE: 7/1/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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.

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

PRINTED: 04/16/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401
--	---

(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 144	<p>Continued From page 1 or sitting with the inmate, the Security shift supervisor will issue him/her a Security radio and inservice him/her on their radio call number, and the information sheet..."</p> <p>Per review on 4/3/13, Patient #1, age 17, was brought to the Emergency Department (ED) on 11/7/12 at 1242 after ingesting a foreign body with complaints of mid to esophageal and upper epigastric discomfort. The patient had a past history of self injurious behaviors with previous ingestion of foreign objects including pencils and a toothbrush. Patient #1 arrived wearing leg shackles and handcuffs and was accompanied by staff from a State Juvenile rehabilitation center (a center used for short-term detention for youths and also operates a secure treatment program for youths). ED note written by EMT states at 12:42 "Coming from XXXXX for vomiting blood after swallowing object. Hx. of same. Will be in handcuffs and restrained. ED security aware".</p> <p>As a result of the medical screening exam conducted in the ED for Patient #1, a consult was requested and completed by a pediatric gastroenterologist. It was determined Patient #1 required an emergent endoscopy procedure for the possible removal of plastic in Patient #1's stomach. At 14:49 Patient #1 was brought to Endoscopy where shortly after a Esophagogastroduodenoscopy (EGD) was performed. Patient #1 was then transferred to Post Anesthesia Care Unit (PACU) arriving at approximately 1555 with only leg shackles and no handcuffs. Although ED Security staff were aware of Patient #1, there was a failure to notify the Security shift supervisor of Patient #1's arrival and circumstance as per policy. As a result,</p>	A 144	<p>See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzey</p> <p>See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzey</p> <p>See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzey</p>	8/1/13 8/1/13 8/1/13
-------	--	-------	--	------------------------------------

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

PRINTED: 04/16/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C. 04/03/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401
--	---

(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 144	<p>Continued From page 2</p> <p>hospital wide Security staff were not made aware of Patient #1's presence within the hospital nor had Security been given the opportunity to assess the safety needs for Patient #1 or the safety concern for other patients who may be receiving care and services within the vicinity of Patient #1. There was no documented evidence of communication between staff from the juvenile rehabilitation center who accompanied Patient #1 and hospital staff to determine their authority, the degree of Patient #1's elopement risk or the severity of the patient's behaviors.</p> <p>Per interview on 4/2/13 at 2:01 PM, PACU Nurse #1 assigned to provide care to Patient #1 after the EGD on 11/7/12 stated s/he received only a brief notice from Endoscopy staff regarding the patient's previous history of ingestion and behavioral circumstances prior to Patient #1's admission to PACU. The nurse stated s/he attempted to strip "bay" area #49 in the PACU unit of dangerous material and/or equipment leaving what was needed to monitor the patient for post anesthesia recovery. Shortly after Patient #1's PACU admission, staff from the juvenile rehabilitation center, who had accompanied Patient #1 since admission to the hospital, requested to see the patient with the intent of reapplying handcuffs on Patient #1. PACU Nurse #1 stated Patient #1 began to cry and complained s/he did not want to return to the juvenile rehabilitation center. The nurse stated s/he objected to having Patient #1 handcuffed stating the patient was being "...good". S/he was informed by one of the staff from the juvenile rehabilitation center it was "protocol", however the PACU nurse further stated "I did not know where I stood wanting to be sure my patients</p>	A 144	<p>See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzzy</p> <p>See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzzy</p>	8/1/13 8/1/13
-------	---	-------	---	----------------------

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

PRINTED: 04/16/2011
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401
--	---

(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 144	<p>Continued From page 4</p> <p>approached the patient and the patient's refusal to be returned to the juvenile facility.</p> <p>During the process for arranging Patient #1's discharge there was a failure to assure patient safety when both the PACU Nurse #1 briefly left Patient #1 alone at the bedside and Security Officer #1 also then left Patient #1 when notified by radio and told by the Security office to find members of the Sheriff's Department who had arrived to transport the patient back to the juvenile rehabilitation center. Per PACU Nurse #1 "I came back and s/he (Patient #1) was on the floor beating his/her head (on the floor).....I don't remember specifically asking how s/he got to the floor." The nurse stated s/he straddled the patient and attempted to prevent Patient #1 from hitting her head on the floor. A second Code 8 was called, resulting again with additional Security Officers responding. Eventually, staff from the Sheriff's Department and hospital Security Officers were able to get Patient #1 into a wheelchair, additional restraints were applied and the patient was escorted from the hospital in custody of the Sheriff's Department accompanied by the staff from the juvenile rehabilitation center.</p> <p>Per interview on 4/2/13 at 3:02 PM, Security Officer #1 stated s/he was not made aware of Patient #1's outpatient admission prior to the first Code 8 being called on 11/7/12 or that the patient was in the custody of 2 staff members from the juvenile rehabilitation center. S/he did confirm a request was made from the juvenile rehabilitation center staff to unclasp, remove and reapply the handcuffs on Patient #1. Although handcuffs are prohibited for use by hospital staff to restrain patients, the cuffs were removed and then</p>	A 144	<p>See Plan of Correction PP Bonni Martin, BS RN Carol Muzzzy</p> <p>See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzzy</p> <p>See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzzy</p>	<p>8/1/11</p> <p>8/1/11</p> <p>8/1/11</p>

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

PRINTED: 04/18/201
FORM APPROVE
OMB NO. 0938-038

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401
--	---

(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 144	<p>Continued From page 5</p> <p>reapplied by the Security staff. Per interview on 4/2/13 at 12:48 PM, the Director of Security, Safety and Parking confirmed there was a lack of communication regarding notification to all Security Officers and hospital departments of Patient #1's arrival and circumstances on 11/7/12. When asked if s/he was aware of what authority staff from the juvenile rehabilitation center had in regards to the oversight of Patient #1, the Director stated the patient was in some sort of "custody". Both Security Officer #1 and the Director acknowledged most staff accompanying patients in custody arrive in a uniform, with a badge and identification. However, staff from the juvenile rehabilitation center were not in uniform and there was a failure by hospital Security to confirm the role of staff accompanying Patient #1 during the outpatient treatment provided. Within documentation reviewed, staff from the juvenile detention center were described in Patient #1's record by hospital staff as "counselors, guards and guardian". Per review of "Consent to Treat" signed by one of the staff members from the juvenile rehabilitation center identifies himself/herself as a "youth counselor", during the provision of authorization for the hospital to conduct treatment/procedures for Patient #1. The Director for Security, Safety and Parking initially described the staff from the juvenile rehabilitation center as "guards", but when informed juvenile rehabilitation center staff identified themselves in writing as a "youth counselor", the Director acknowledged s/he did not know if that was the same thing as a guard.</p> <p>On 4/2/13 at 1:30 PM accompanied by the PACU Nurse Manager and PACU Nurse #1 the "bays" in PACU where patients recover from anesthesia</p>	A 144	<p>See Plan of Correction pp Bonnie Martin, BS, RN Carol Muzzy</p> <p>See Plan of Correction pp Bonnie Martin BSRN Carol Muzzy</p>	<p>8/11/13</p> <p>8/11/13</p>

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

PRINTED: 04/16/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/03/2013
NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401		
(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) COMPLETE DATE	
A 144	Continued From page 6 were in close proximity of each other. It was confirmed during interview on 4/2/13 at 10:43 AM by the PACU Nurse Manager, due to the limited notification from Endoscopy prior to Patient #1's arrival, PACU staff had limited time to prepare for a safe environment, allowing for consideration where Patient #1 would be able to recover without being out among other recovering patients, allowing for a quiet more isolated and controlled location. However, the availability of the one isolation room was unknown, Patient #1 was placed in bay #49. Patients were at times opposite and beside Patient #1 during which time they were subjected to two Code 8 episodes, physical altercations by the patient on security, Patient #1's attempts at self injurious behavior along with screaming, yelling and the appearance of the Sheriff's Department. PACU nursing staff lacked a full awareness of precautions required when providing care to patients in custody especially individuals with violent and self destructive behaviors. Individuals from the juvenile rehabilitation center were not appraised of their responsibilities upon arrival to the hospital, or assigned a radio as they accompanied Patient #1 in the ED, Endoscopy and PACU and hospital staff failed to verify the authority of these individuals dictating use of handcuffs and leg shackles.	A 144	See Plan of Correction PP Bonnie Martin, BS, RN Carol Muzzzy	8/1/13	
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure staff, identified as	A 145	See Plan of Correction PP Bonnie Martin, BS, RN Carol Muzzzy	8/1/13	

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

PRINTED: 04/16/2013
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/03/2013
NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401		
(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 145	<p>Continued From page 7</p> <p>mandated reporters, who became aware of an allegation of abuse made by a child, reported the allegation to Child Welfare Services, as required. (Patient #1) Findings include:</p> <p>Per interview on 4/3/13 at 3:12 PM, the Director of Social Services stated "...our practice/our policy is that everyone should be on the look out for concerns related to abuse whether children or adults". The Director further stated Social Service staff are available 24/7 to assist staff or convince staff they may want to report allegations directly. However, on 11/7/12 when Patient #1, age 17, arrived in PACU to recover from an endoscopic procedure and alleged s/he had been abused by staff from a State juvenile detention center, nursing staff failed to report as required. Patient #1 had a past history of self injurious behaviors and was brought to the ED after ingesting an unknown foreign object. Upon presentation to the ED, s/he arrived in shackles and handcuffs in the custody of staff from the juvenile rehabilitation center.</p> <p>Shortly after Patient #1's PACU admission, staff from the juvenile rehabilitation center, who had accompanied Patient #1 since admission to the hospital, requested to see the patient with the intent of reapplying handcuffs on Patient #1. Per interview on 4/2/13 at 2:00 PM PACU Nurse #1 stated Patient #1 began to cry and complained s/he did not want to return to the juvenile rehabilitation center. The PACU nurse stated s/he objected to having Patient #1 handcuffed stating the patient was being "...good". S/he was informed by one of the staff from the juvenile rehabilitation center it was "protocol". During the process of handcuffing the patient and a later</p>	A 145	<p>See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzey</p> <p>See Plan of Correction PP Bonni Martin, BSRN Carol Muzzey</p>	8/1/13 8/1/13	

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

PRINTED: 04/18/201
FORM APPROVE
OMB NO. 0938-036

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/03/2013
NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401		
(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 145	Continued From page 8 episode when the handcuffs were moved, Patient #1 reacted violently when a staff member from the juvenile rehabilitation center approached or attempted to place hands on the patient. PACU Nurse #1 stated the patient was yelling "...get away from me, s/he hurt me..." and further alleging staff had hurt her/him at the juvenile rehabilitation center. On 4/2/13 at 10:43 AM , when asked if there was any consideration by herself/himself to report allegations of physical abuse to Child Welfare Services, the PACU Nurse Manager stated "we didn't feel we needed to report". Although s/he is a mandated reporter, the Nurse Manager's justification was other staff were also aware of Patient #1's allegations. In regards to this patient, the Director of Social Services further acknowledged a report should have been made by the PACU staff to the Department of Children's and Families.	A 145	See Plan of Correction PP Bonnie Martin BSN Carol Muzzey	8/1/13	
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 interview and record review, handcuffs, which are prohibited for use by hospital staff to restrain patients, were utilized by	A 154	See Plan of Correction PP Bonnie Martin BSN Carol Muzzey	8/1/13	

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

PRINTED: 04/16/2013
FORM APPROVE
OMB NO. 0938-038

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401
--	---

(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 154	<p>Continued From page 9</p> <p>Security Staff on 1 applicable patient. (Patient #1) Findings include:</p> <p>Per review on 4/3/13, Patient #1, age 17, was brought to the Emergency Department (ED) on 11/7/12 at 1242 after ingesting a foreign body. The patient had a past history of self injurious behaviors with previous ingestion of foreign objects including pencils and a toothbrush. Patient #1 arrived wearing leg shackles and handcuffs and was accompanied by staff from a State juvenile rehabilitation center (a center used for short-term detention for youths and also operates a secure treatment program for youths). ED note written by EMT states at 12:42 "Coming from X for vomiting blood after swallowing object. Hx. of same. Will be in handcuffs and restrained. ED security aware". Patient required Endoscopy and was transferred after the Endoscopic procedure to PACU to recover from anesthesia and to return to the juvenile rehabilitation center</p> <p>Shortly after Patient #1's PACU admission, staff from the juvenile rehabilitation center, who had accompanied Patient #1 since admission to the hospital, requested to see the patient with the intent of reapplying handcuffs, the leg shackles had remained on the patient. When the handcuffs were applied by staff from the juvenile rehabilitation center, Patient #1 began yelling and kicking and attempted to ingest a plastic allergy bracelet applied earlier by hospital staff. A Code 8 was called, security and support staff responded and assisted nursing staff in removing the bracelet from Patient #1's mouth. As a result of this incident, it was determined by staff from the juvenile detention center to remove the handcuffs, place Patient #1's hands behind</p>	A 154	<p>See Plan of Correction PP Bonnie Martin BS RN Carol Muzzey</p> <p>See Plan of Correction PP Bonnie Martin BS, RN Carol Muzzey</p>	<p>8/1/13</p> <p>8/1/13</p>
-------	--	-------	--	-----------------------------

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

PRINTED: 04/16/2013
FORM APPROVE
OMB NO. 0938-036

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/03/2013
NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401		
(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 154	Continued From page 10 his/her back and then reapply the handcuffs. Due to Patient #1's agitated behavior whenever staff from the juvenile rehabilitation center approached Patient #1, they requested the hospital Security officers unclasp and remove the left handcuff and reapply it behind Patient #1's back. The Security officers complied despite the fact they are prohibited from using handcuffs as a restraint. Per interview on 4/2/13 at 3:02 PM Security Officer #1 stated "We are not supposed to assist law enforcement with whatever restraint they are attempting to place....our role would just be to assist if person became violent. Yes, we did cuff her/him.....they asked us to and s/he (Patient #1) was completely out of control when s/he (staff from the juvenile rehabilitation center) came near her/him".	A 154	See Plan of Correction pp Bonno Martin BS, RN Carol Muzzey	8/1/13	
A 273	482.21(a), (b) PROGRAM SCOPE, PROGRAM DATA (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b) Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to—	A 273	See Plan of Correction pp Bonno Martin BS, RN Carol Muzzey	8/1/13	

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

PRINTED: 04/16/2011
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/03/2013
NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401	
(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 273	Continued From page 11 (1) Monitor the effectiveness and safety of services and quality of care; and (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to identify a quality deficient practice involving staff compliance with Security policies and procedures and the impact on patient safety during the provision of care of a prisoner patient brought for hospital treatment. Findings include: For the purpose of assuring the safety of hospital staff and patients the hospital has a policy outlining the procedures Security staff are to follow when a prisoner patient is brought for treatment, however on 11/7/12, Security Staff failed to adhere to Policy "Sec00016/Prisoner Patient" last updated 3/11/11. Per policy, hospital staff or outside police departments or correctional facilities are to notify the Security Shift supervisor whenever a prisoner is brought to the hospital for inpatient or outpatient treatment. The prisoner patient's level of security would be determined, assessing the level of restraints being used. Communication would be made to other Security officers, alerting them of any special precautions. The policy further states: "If a correction officer, private security officer, or other law enforcement official will be supervising or sitting with the inmate, the Security shift supervisor will issue him/her a Security radio and Inservice him/her on	A 273	See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzzy See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzzy See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzzy	8/1/11 8/1/11 8/1/11

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

PRINTED: 04/16/201
FORM APPROVE
OMB NO. 0938-0399

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/03/2013
NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401		
(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 273	<p>Continued From page 12 their radio call number, and the information sheet...".</p> <p>Per review on 4/3/13, Patient #1, age 17, was brought to the Emergency Department (ED) on 11/7/12 at 1242 after ingesting a foreign body. The patient had a past history of self injurious behaviors with previous ingestion of foreign objects. Patient #1 arrived wearing leg shackles and handcuffs and was accompanied by staff from a State juvenile rehabilitation center (a center used for short-term detention for youths and also operates a secure treatment program for youths). ED note written by EMT states at 12:42 "Coming from XXXX for vomiting blood after swallowing object. Hx. of same. Will be in handcuffs and restrained. ED security aware". Patient required Endoscopy and was transferred after the Endoscopic procedure to PACU to recover from anesthesia with the plan to return Patient #1 to the juvenile rehabilitation center.</p> <p>During the course of recovery in PACU, two Code 8's were initiated when Patient #1's behavior was endangering the physical well being of himself/herself and other patients. At the completion of a Code 8, staff involved conduct a debriefing. This process was confirmed with the Director of Regulatory Readiness who confirmed on 4/2/13 at 1:12 PM a "....debriefing is a huddle between people involved in Code 8....to discuss the incident and any opportunities for improvement....One of the questions is: was it safe". It was also confirmed staff within the QA/PI program were not aware of the hospital policy associated with prisoner patients and the required notification of the Security department when a prisoner patient is either</p>	A 273	<p>See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzzy</p> <p>See Plan of Correction PP Bonni Martin, BS, RN Carol Muzzzy</p>	8/1/13	

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

PRINTED: 04/16/2013
FORM APPROVE
OMB NO. 0998-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/03/2013
NAME OF PROVIDER OR SUPPLIER FLETCHER ALLEN HOSPITAL OF VERMONT			STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401		
(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 273	<p>Continued From page 13</p> <p>Inpatient/outpatient receiving care and services. As a result, when a review was conducted of the Code 8's and the Safe Report (a report of an adverse event) completed by the Nurse Manager of PACU, there was a failure to identify the lack of compliance with policy Sec00016/Prisoner Patients. In addition, it was also only brought to the attention of Regulatory staff during interview with Security Guard #1 on 4/2/13, that s/he had participated with the application of handcuffs applied to Patient #1 which are prohibited for use by hospital staff to restrain patients.</p> <p>It was also noted, despite the significance of events which had transpired on 11/7/12, the potential impact on patient safety, the injury to a Security guard, the lack of awareness of hospital policy regarding the management of prisoner patients, the PACU Nurse Manager confirmed on 4/2/13 at 2:15 PM, this event was not formerly shared with other PACU nursing staff as an opportunity for Improvement. Although s/he had completed a Safe Report, the only clinical outcome from which it was determined if Patient #1 returned for further treatment hospital staff should "...put wrist bands other than the wrist so s/he can't eat it".</p>	A 273	<p>See Plan of Correction PP Bonno Martin, BS, RN Carol mu 334</p> <p>See Plan of Correction PP Bonno Martin, BS, RN Carol mu 334</p>	8/1/13 8/1/13	

PLAN OF CORRECTION

A 000 INITIAL COMMENTS

An onsite complaint investigation was completed on 4/3/13 by the Division of Licensing and Protection as authorized by the Centers for Medicare and Medicaid. The following regulatory violations were identified related to the complaint:

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 interview and record review, the hospital failed to assure care was provided in a safe setting during the provision and management of care for a prisoner patient. (Patient #1) Findings include:

The potential for an unsafe environment for patients recovering from anesthesia and surgical procedures was evident due to the hospital's failure to assure Security policy and procedures were followed. On 11/7/12, Security Staff failed to adhere to Policy "Sec00016/Prisoner Patient" last updated 3/11/11 which states hospital staff or outside police departments or correctional facilities are to notify the Security Shift supervisor whenever a prisoner is brought to the hospital for inpatient or outpatient treatment. Upon notification, the prisoner patient's level of security would be determined, assessing the level of restraints being used. Communication would be made to other Security officers, alerting them of any special precautions. The policy further states: "If a correction officer, private security officer, or other law enforcement official will be supervising or sitting with the inmate, the Security shift supervisor will issue him/her a Security radio and in-service him/her on their radio call number, and the information sheet...".

Per review on 4/3/13, Patient #1, age 17, was brought to the Emergency Department (ED) on 11/7/12 at 1242 after ingesting a foreign body with complaints of mid to esophageal and upper epigastric discomfort. The patient had a past history of self injurious behaviors with previous ingestion of foreign objects including pencils and a toothbrush. Patient #1 arrived wearing leg shackles and handcuffs and was accompanied by staff from a State juvenile rehabilitation center (a center used for short-term detention for youths and also operates a secure treatment program for youths). ED note written by EMT states at 12:42 "Coming from XXXXX for vomiting blood after swallowing object. Hx. of same. Will be in handcuffs and restrained. ED security aware". As a result of the medical screening exam conducted in the ED for Patient #1, a consult was requested and completed by a pediatric gastroenterologist. It was determined Patient #1 required an emergent endoscopy procedure for the possible removal of plastic in Patient #1's stomach. At 14:49 Patient #1 was brought to Endoscopy where shortly after an Esophagogastroduodenoscopy (EGD) was performed. Patient #1 was then transferred to Post Anesthesia Care Unit (PACU) arriving at approximately 1555 with only leg shackles and no handcuffs. Although ED Security staff were aware of Patient #1, there was a failure to notify the Security shift supervisor of Patient #1's arrival and circumstance as per policy. As a result hospital wide Security staff were not made aware of Patient #1's presence within the hospital nor had Security been given the opportunity to assess the safety needs for Patient #1 or the safety concern for other patients who may be receiving care and services within the vicinity of Patient #1. There was no documented evidence of communication between staff from the juvenile rehabilitation center who accompanied Patient #1 and hospital staff to determine their authority, the degree of Patient #1's elopement risk or the severity of the patient's behaviors. Per interview on 4/2/13 at 2:01 PM, PACU Nurse #1 assigned to provide care to Patient #1 after the EGD on 11/7/12 stated s/he received only a brief notice from Endoscopy staff regarding the patient's previous history of ingestion and behavioral circumstances prior to Patient #1's admission to PACU. The nurse stated s/he attempted to strip "bay" area #49 in the PACU unit of dangerous material and/or equipment leaving what was needed to monitor the patient for post anesthesia recovery. Shortly after Patient #1's PACU admission, staff from the juvenile rehabilitation center, who had accompanied Patient #1 since admission to the hospital, requested to see the patient with the intent of reapplying handcuffs on Patient #1. PACU Nurse #1 stated Patient #1 began to cry and complained s/he did not want to return to the juvenile rehabilitation center. The nurse stated s/he objected to having Patient #1 handcuffed stating the patient was being "...good". S/he was

informed by one of the staff from the juvenile rehabilitation center it was "protocol", however the PACU nurse further stated "I did not know where I stood wanting to be sure my patients were safe". However, hospital policy Sec00016 states "The correctional facility or law enforcement agency sitting with the patient may determine the level of restraint and type of restraint necessary to restrain the patient". Upon application of the handcuffs by juvenile rehabilitation center staff, Patient #1 became immediately aggressive, yelling and screaming at staff, specifically the staff member who had applied the handcuffs. Patient #1 proceeded to roll on his/her side and began attempting to eat a plastic allergy wrist bracelet applied earlier in the day by hospital staff. PACU Nurse #1 stated a Code 8 was called (requesting assistance from the hospital's Security Officers and other support services). At 1600 a show of support arrived and staff was able to remove the plastic bracelet from Patient #1's mouth. Patient #1 continued kicking and screaming while in the leg shackles resulting in an injury to one of the Security Officers. As a result of this incident it was determined by staff from the juvenile rehabilitation center to remove the handcuffs and reapply them behind Patient #1's back. Due to Patient #1's agitated behavior whenever staff from the rehabilitation center approached Patient #1, they requested the hospital security officers unclasp and remove the left handcuff and reapply it behind Patient #1's back. The Security officers complied. Hospital staff eventually were able to calm the patient and a Crisis Screener from First Call came and stayed with Patient #1. The decision was made to have the Sheriff's Department transport Patient #1 back to the juvenile rehabilitation center due to Patient #1's violent and dangerous behaviors accelerating whenever staff from the juvenile rehabilitation center approached the patient and the patient's refusal to be returned to the juvenile facility.

During the process for arranging Patient #1's discharge there was a failure to assure patient safety when both the PACU Nurse #1 briefly left Patient #1 alone at the bedside and Security Officer #1 also then left Patient #1 when notified by radio and told by the Security office to find members of the Sheriff's Department who had arrived to transport the patient back to the juvenile rehabilitation center. Per PACU Nurse #1 "I came back and s/he (Patient #1) was on the floor beating his/her head (on the floor) I don't remember specifically asking how s/he got to the floor." The nurse stated s/he straddled the patient and attempted to prevent Patient #1 from hitting her head on the floor. A second Code 8 was called, resulting again with additional Security Officers responding. Eventually, staff from the Sheriff's Department and hospital Security Officers were able to get Patient #1 into a wheelchair, additional restraints were applied and the patient was escorted from the hospital in custody of the Sheriff's Department accompanied by the staff from the juvenile rehabilitation center.

Per interview on 4/2/13 at 3:02 PM, Security Officer #1 stated s/he was not made aware of Patient #1's outpatient admission prior to the first Code 8 being called on 11/7/12 or that the patient was in the custody of 2 staff members from the juvenile rehabilitation center. S/he did confirm a request was made from the juvenile rehabilitation center staff to unclasp, remove and reapply the handcuffs on Patient #1. Although handcuffs are prohibited for use by hospital staff to restrain patients, the cuffs were removed and then reapplied by the Security staff. Per interview on 4/2/13 at 12:48 PM, the Director of Security, Safety and Parking confirmed there was a lack of communication regarding notification to all Security Officers and hospital departments of Patient #1's arrival and circumstances on 11/7/12. When asked if s/he was aware of what authority staff from the juvenile rehabilitation center had in regards to the oversight of Patient #1, the Director stated the patient was in some sort of "custody". Both Security Officer #1 and the Director acknowledged most staff accompanying patients in custody arrived in a uniform, with a badge and identification. However, staff from the juvenile rehabilitation center were not in uniform and there was a failure by hospital Security to confirm the role of staff accompanying Patient #1 during the outpatient treatment provided. Within documentation reviewed, staff from the juvenile detention center were described in Patient #1's record by hospital staff as "counselors, guards and guardian". Per review of "Consent to Treat" signed by one of the staff members from the juvenile rehabilitation center identifies himself/herself as a "youth counselor", during the provision of authorization for the hospital to conduct treatment/procedures for Patient #1. The Director for Security, Safety and Parking initially described the staff from the juvenile rehabilitation center as "guards", but when informed juvenile rehabilitation center staff identified themselves in writing as a "youth counselor", the Director acknowledged s/he did not know if that was the same thing as a guard.

On 4/2/13 at 1:30 PM accompanied by the PACU Nurse Manager and PACU Nurse #1 the "bays" in PACU where patients recover from anesthesia were in close proximity of each other. It was confirmed during interview on 4/2/13 at 10:43 AM by the PACU Nurse Manager, due to the limited notification from Endoscopy prior to Patient #1's arrival, PACU staff had limited time to prepare for a safe environment, allowing for consideration where Patient #1 would be able to recover without being out among other recovering patients, allowing for a quiet more isolated and controlled location. However, the availability of the one isolation room was unknown; Patient #1 was placed in bay #49. Patients were at times opposite and beside Patient #1 during which time they were subjected to two Code 8 episodes, physical altercations by the patient on security, Patient #1's attempts at self injurious behavior along with screaming, yelling and the appearance of the Sheriff's Department. PACU nursing staff lacked a full awareness of precautions required especially individuals with violent and self destructive behaviors. Individuals from the juvenile rehabilitation center were not apprised of their responsibilities upon arrival to the hospital, or assigned a radio as they accompanied Patient #1 in the ED, Endoscopy and PACU and hospital staff failed to verify the authority of these individuals dictating use of handcuffs and leg shackles.

Action Plan

- Fletcher Allen Health Care Policy entitled: Prisoner Patients and Forensic Patients was revised on 4/19/2013 and published on 5/17/2013 by the Director of Security/ Safety and Parking in collaboration with the Directors of Patient Safety and Advocacy, Accreditation and Regulatory Affairs and Nursing. The referenced policy was moved from a department policy to an organization wide policy. The policy articulates requirements for validating corrections, staff identification, clarifying their roles and responsibilities, and ensuring proper notification within the facility as appropriate.
- To support the process outlined in the Prisoner Patients and Forensic Patient policy, an intake assessment form was created for a guard / police in-service guide titled Intake Assessment and In-service Guide for Corrections and Law Enforcement Officers. The referenced intake form is designed for patients who are transferred from the Emergency Department. It is designed to gather information about the patients visit (where they will be going), the guard/police officer (where they are from and their role), and the risk associated with the patient (potential for violence). The in-service section of the guide is intended to be reviewed with the guard/police officer by Fletcher Allen Security to educate them on communication paths, emergency procedures.
- All Security staff were initially educated on the Prisoner Patients and Forensic Patient policy and required documentation by the Director of Security/Safety and Parking on 4/18/2013 and received follow-up education at the 4/30/13 Security Department Meeting.
- The Vice Presidents communicated the expectations noted in the Fletcher Allen Health Care policy entitled: Prisoner Patients and Forensic Patients with their leadership teams. The referenced policies and staff accountabilities will be shared by leadership with staff via electronic communications and or staff meetings. This process will be completed by 8/1/2013.
- The Director of Security/Safety and Parking or designee will ensure review of the Fletcher Allen Intake Assessment and In-service Guide for Corrections and Law Enforcement Officers intake form for completeness and compliance with the Prisoner Patients and Forensics Patient policy. Performance data will be given on an individual basis and reported quarterly to the Environment of Care Committee by the Director of Security/ Safety and Parking. The performance data will also be

reported out at the Standards of Operation and Patient Safety Committees chaired by the Chief Medical Officer.

- The Fletcher Allen Health Care Code 8 debriefing process (a multidisciplinary quality review by the team members involved in the Code 8 for violent or aggressive behavior) was updated to include a documented team prompt to ensure that appropriate policies and procedures were followed and any suggestions for improvement in the process noted. The Director of Security/Safety and Parking educated the security staff on 4/28/2013 regarding the updated Code 8 Debriefing process and supporting incident form. The Director of Security/Safety and Parking or designee will ensure review of the Fletcher Allen Health Care Security Incident Services Form to assure elements of debriefing process were completed and documented. Negative findings will be given to the Managers of the involved departments. In addition, The Director of Accreditation and Regulatory Affairs will ensure review of the Code Forms for adherence to the process. Performance data on the debriefing process will be reported out by the Director of Security/Safety and Parking quarterly at the Security Subcommittee the Environment of Care Committee and the cross-organizational Standards of Operation Committee and the Patient Safety Committee chaired by the Chief Medical Officer.

A 145 482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT:

The patient has the right to be free from all forms of abuse or harassment.

This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure staff, identified as mandated reporters, who became aware of an allegation of abuse made by a child, reported the allegation to Child Welfare Services, as required. (Patient #1) Findings include:

Per interview on 4/3/13 at 3:12 PM, the Director of Social Services stated "...our practice/our policy is that everyone should be on the look out for concerns related to abuse whether children or adults". The Director further stated Social Service staff are available 24/7 to assist staff or convince staff they may want to report allegations directly. However, on 11/7/12 when Patient #1, age 17, arrived in PACU to recover from an endoscopic procedure and alleged s/he had been abused by staff from a State juvenile detention center, nursing staff failed to report as required. Patient #1 had a past history of self injurious behaviors and was brought to the ED after ingesting an unknown foreign object. Upon presentation to the ED, s/he arrived in shackles and handcuffs in the custody of staff from the juvenile rehabilitation center. Shortly after Patient #1's PACU admission, staff from the juvenile rehabilitation center, who had accompanied Patient #1 since admission to the hospital, requested to see the patient with the intent of reapplying handcuffs on Patient #1. Per interview on 4/2/13 at 2:00 PM PACU Nurse #1 stated Patient #1 began to cry and complained s/he did not want to return to the juvenile rehabilitation center. The PACU nurse stated s/he objected to having Patient #1 handcuffed stating the patient was being "...good". S/he was informed by one of the staff from the juvenile rehabilitation center it was "protocol". During the process of handcuffing the patient and a later episode when the handcuffs were moved, Patient #1 reacted violently when a staff member from the juvenile rehabilitation center approached or attempted to place hands on the patient. PACU Nurse #1 stated the patient was yelling "...get away from me, s/he hurt me..." and further alleging staff had hurt her/him at the juvenile rehabilitation center.

On 4/2/13 at 10:43 AM, when asked if there was any consideration by herself/himself to report allegations of physical abuse to Child Welfare Services, the PACU Nurse Manager stated "we didn't feel we needed to report". Although s/he is a mandated reporter, the Nurse Manager's justification was other staff were also aware of Patient #1's allegations. In regards to this patient the Director of Social Services further acknowledged a report should have been made by the PACU staff to the Department of Children's and Families.

Action Plan

- The Manager of the Post Anesthesia Care Unit reviewed the expectations noted in Fletcher Allen Health Care policies: Suspected Abuse, Neglect or Exploitation of Vulnerable Adults and Identifying and Reporting Child Abuse and Neglect on 5/18/13 staff meeting.
- The Vice Presidents communicated the expectations noted in the Fletcher Allen Health Care policies: Suspected Abuse, Neglect or Exploitation of Vulnerable Adults and Identifying and Reporting Child Abuse and Neglect with their leadership teams. The referenced policies will be shared with staff via electronic communications and/or staff meetings. This process will be completed 8/1/2013.
- The Director of Clinical Support Services assured the content review for The Fletcher Allen Health Care educational mandatory training module entitled Victims of Abuse. All staff is required to complete the mandatory on a yearly basis.

A 154 482.13c: USE OF RESTRAINTS 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 interview and record review, handcuffs, which are prohibited for use by hospital staff to restrain patients, were utilized by

Security Staff on 1 applicable patient. (Patient #1) Findings include:

Per review on 4/3/13, Patient #1, age 17, was brought to the Emergency Department (ED) on 11/7/12 at 1242 after ingesting a foreign body. The patient had a past history of self injurious behaviors with previous ingestion of foreign objects including pencils and a toothbrush. Patient #1 arrived wearing leg shackles and handcuffs and was accompanied by staff from a State juvenile rehabilitation center (a center used for short-term detention for youths and also operates a secure treatment program for youths). ED note written by EMT states at 12:42 "Coming from X for vomiting blood after swallowing object. Hx. of same. Will be in handcuffs and restrained. ED security aware". Patient required Endoscopy and was transferred after the Endoscopic procedure to PACU to recover from anesthesia and to return to the juvenile rehabilitation center. Shortly after Patient #1's PACU admission, staff from the juvenile rehabilitation center, who had accompanied Patient #1 since admission to the hospital, requested to see the patient with the intent of reapplying handcuffs, the leg shackles had remained on the patient. When the handcuffs were applied by staff from the juvenile rehabilitation center, Patient #1 began yelling and kicking and attempted to ingest a plastic allergy bracelet applied earlier by hospital staff. A Code 8 was called, security and support staff responded and assisted nursing staff in removing the bracelet from Patient #1's mouth. As a result of this incident, it was determined by staff from the juvenile detention center to remove the handcuffs, place Patient #1's hands behind his/her back and then reapply the handcuffs. Due to Patient #1's agitated behavior whenever staff from the juvenile rehabilitation center approached Patient #1, they requested the hospital Security officers unclasp and remove the left handcuff and reapply it behind Patient #1's back. The Security officers complied despite the fact they are prohibited from using handcuffs as a restraint.

Per interview on 4/2/13 at 3:02 PM Security Officer #1 stated "We are not supposed to assist law enforcement with whatever restraint they are attempting to place...our role would just be to assist if person became violent. Yes, we did cuff her/him they asked us to and s/he (Patient #1) was completely out of control when s/he (staff from the juvenile rehabilitation center) came near her/him".

Action Plan

- All Security staff was alerted by the Director of Security that Fletcher Allen Health Care Security will not provide assist with, apply, adjust, or remove handcuffs. This change in procedure was discussed with Security Supervisors at a supervisors meeting in 4/16/13, sent via email to all Security staff on 4/18/13, and discussed at two Department meetings on 4/30/13. In addition, all handcuff keys have been collected from Security staff.
- The Director of Accreditation and Regulatory Affairs will ensure review of the Security Code 8 Incident Reports to ensure adherence with handcuff procedure changes as outlined in the referenced action plan. Performance Feedback will be provided to the Director of Security.

A 273 482.21(a)(b) PROGRAM SCOPE, PROGRAM DATA

(a) Program Scope

- (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ..
- (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations.

(b) Program Data

- (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization.

The hospital must use the data collected to

- (1) Monitor the effectiveness and safety of services and quality of care; and (3). The frequency and detail of data collection must be specified by the hospital's governing body.

This STANDARD is not met as evidenced by:

Based on interview and record review, the hospital failed to identify a quality deficient practice involving staff compliance with Security policies and procedures and the impact on patient safety during the provision of care of a prisoner patient brought for hospital treatment. Findings include:

For the purpose of assuring the safety of hospital staff and patients the hospital has a policy outlining the procedures Security staff are to follow when a prisoner patient is brought for treatment, however on 11/7/12, Security Staff failed to adhere to Policy "Sec00016/Prisoner Patient" last updated 3/11/11.

Per policy, hospital staff or outside police departments or correctional facilities are to notify the Security Shift supervisor whenever a prisoner is brought to the hospital for inpatient or outpatient treatment. The prisoner patient's level of security would be determined, assessing the level of restraints being used. Communication would be made to other Security officers, alerting them of any special precautions. The policy further states: "If a correction officer, private security officer, or other law enforcement official will be supervising or sitting with the inmate, the Security shift supervisor will issue him/her a Security radio and in-service him/her on their radio call number, and the Information sheet...".

Per review on 4/3/13, Patient #1, age 17, was brought to the Emergency Department (ED) on 11/7/12 at 1242 after ingesting a foreign body. The patient had a past history of self injurious behaviors with previous ingestion of foreign objects. Patient #1 arrived wearing leg shackles and handcuffs and was accompanied by staff from a State juvenile rehabilitation center (a center used for short-term detention for youths and also operates a secure treatment program for youths). ED note written by EMT states at 12:42 "Coming from XXXX for vomiting blood after swallowing object. Hx. of same. Will be in handcuffs and restrained. ED security aware". Patient required Endoscopy and was transferred after the Endoscopic procedure to PACU to recover from anesthesia with the plan to return Patient #1 to the juvenile rehabilitation center.

During the course of recovery in PACU, two Code 8's were initiated when Patient #1's behavior was endangering the physical well being of himself/herself and other patients. At the completion of a Code 8, staff involved conduct a debriefing. This process was confirmed with the Director of Regulatory Readiness who confirmed on 4/2/13 at 1:12 PM a "...debriefing is a huddle between people involved in Code 8....to discuss the incident and any opportunities for improvement One of the questions is: was it safe". It was also confirmed staff within the QA/PI program were not aware of the hospital policy associated with prisoner patients and the required notification of the Security department when a prisoner patient is either inpatient/outpatient receiving care and services. As a result, when a review was conducted of the Code 8's and the Safe Report (a report of an adverse event) completed by the Nurse Manager of PACU, there was a failure to identify the lack of compliance with policy Sec00016/Prisoner Patients. In addition, it was

also only brought to the attention of Regulatory staff during interview with Security Guard #1 on 4/2/13, that s/he had participated with the application of handcuffs applied to Patient #1 which are prohibited for use by hospital staff to restrain patients. It was also noted, despite the significance of events which had transpired on 11/7/12, the potential impact on patient safety, the injury to a Security guard, the lack of awareness of hospital policy regarding the management of prisoner patients, the PACU Nurse Manager confirmed on 4/2/13 at 2:15 PM, this event was not formerly shared with other PACU nursing staff as an opportunity for improvement. Although s/he had completed a Safe Report, the only clinical outcome from which it was determined if Patient #1 returned for further treatment hospital staff should "...put wrist bands other than the wrist so s/he can't eat it".

Action Plan

- On 4/10/13 an analysis was conducted by the Director of Advocacy and Patient Safety with the involved multidisciplinary team.
- Fletcher Allen Health Care Policy entitled: Prisoner Patients and Forensic Patients was revised on 4/19/2013 and published on 5/17/2013 by the Director of Security/Safety and Parking in collaboration with the Directors of Patient Safety and Advocacy, Accreditation and Regulatory Affairs and Nursing. The referenced policy was moved from a department policy to an organization wide policy. The policy articulates requirements for validating corrections, staff identification, clarifying their roles and responsibilities, and ensuring proper notification within the facility as appropriate.
- To support the process outlined in the Prisoner Patients and Forensic Patient policy, an intake assessment form was created for a guard / police in-service guide titled Intake Assessment and In-service Guide for Corrections and Law enforcement Officers. The referenced intake form is designed for patients who are transferred from the Emergency Department. It is designed to gather information about the patients visit (where they will be going), the guard/police officer (where they are from and their role), and the risk associated with the patient (potential for violence). The in-service section of the guide is intended to be reviewed with the guard/police officer by Fletcher Allen Security to educate them on communication paths, emergency procedures.
- All Security staff were initially educated on the Prisoner Patients and Forensic Patient policy and required documentation by the Director of Security/Safety and Parking on 4/18/2013 and received follow-up education at the 4/30/13 Security Department Meeting.
- The Vice Presidents communicated the expectations noted in the Fletcher Allen Health Care policy entitled: Prisoner Patients and Forensic Patients with their leadership teams. The referenced policies and staff accountabilities will be shared by leadership with staff via electronic communications and or staff meetings. This process will be completed by 8/1/2013.
- The Director of Security/Safety and Parking or designee will ensure review of the Fletcher Allen Intake Assessment and In-service Guide for Corrections and Law Enforcement Officers intake form for completeness and compliance with the Prisoner Patients and Forensics Patient policy. Performance data will be given on an individual basis and reported quarterly to the Environment of Care Committee by the Director of Security/Safety and Parking. The performance data will also be reported out at the Standards of Operation and Patient Safety Committees chaired by the Chief Medical Officer.
- The Fletcher Allen Health Care Code 8 debriefing process (a multidisciplinary quality review by the team members involved in the Code 8 for violent or aggressive behavior) was updated to include a

documented team prompt to ensure that appropriate policies and procedures were followed and any suggestions for improvement in the process noted. The Director of Security/ Safety and Parking educated the security staff on 4/28/2013 regarding the updated Code 8 Debriefing process and supporting incident form. The Director of Security/Safety and Parking or designee will ensure review of the Fletcher Allen Health Care Security Incident Services Form to assure elements of debriefing process were completed and documented. Negative findings will be given to the Managers of the involved departments. In addition, The Director of Accreditation and Regulatory Affairs will ensure review of the Code Forms for adherence to the process. Performance data on the debriefing process will be reported out by the Director of Security/ Safety and Parking quarterly at the Security Subcommittee the Environment of Care Committee and the Cross organizational Standards of Operation Committee and the Patient Safety Committee chaired by the Chief Medical Officer.