

PRINTED: 03/21/2011  
FORM APPROVED  
OMB NO. 0938-0391

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

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 02/23/2011
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NAME OF PROVIDER OR SUPPLIER  FLETCHER ALLEN HOSPITAL OF VERMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 111 COLCHESTER AVE BURLINGTON, VT 05401
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A 000	INITIAL COMMENTS	A 000		
A 144	<p>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 staff interview and record review the hospital failed to provide ongoing supervision and accountability for 1 applicable patient and failed to ensure the safety and well being for all patients. (Patient #1) Findings include:</p> <p>During the initial weeks of hospitalization from 6/23/10 through 7/22/10, Patient #1 had left their hospital room, exited the nursing unit, wandered the hospital and walked off the hospital campus to smoke without the provision of an escort for supervision. During hospitalization, the patient demonstrated challenging behaviors to include belligerence, agitation, intimidating verbal and physical threats towards staff on several occasions and was often non compliant with medication administration. Nursing note dated 7/19/10 at 1300 states "Per attending.....Patient is not allowed to leave the unit without assistance d/t high safety risk--patient insists to go outside to smoke.....". However, before and after this note, the patient frequently left the hospital and as noted in nursing note from 7/16/10 at 2045 "RN informed pt. s/he is not allowed to smoke on hospital grounds, and s/he would have to leave campus.....Will call security if pt does not return</p>	A 144	<p>SEE ATTACHED Plan of Correction Response</p>	<p>6/1/2011</p> <p>7/1/2011</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Amie L. Notica</i>	TITLE VP Quality	(X6) DATE 4-5-11
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 144	Continued From page 1 within 30 minutes". Despite the patient's behavioral issues and threats, the hospital did not provide a security escort for this individual as h/she wandered the hospital and patient units. Per interview on 2/22/11 at 10:28 AM, the Director of Patient Safety stated "We cannot have 1:1 security escorts for every patient that wants to walk around". On 7/22/10 during one of the patient's unescorted walks within the facility, the patient sustained a fall with injury. Per the Director of Patient Safety the hospital was unable to identify direct cause for the fall, but it was confirmed the patient was not provided a security escort and/or supervision at the time of the incident. In addition, there was no definitive plan in place to ensure the patient's safety or the safety of others when Patient #1 wandered in and out of the hospital and exited the hospital campus to smoke.	A 144	1144 4/20/11 POC Accepted. D. Detosh	
A 165	482.13(e)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION  The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient or others from harm.  This STANDARD is not met as evidenced by: Based on staff interview and record review, physical restraints were implemented on Patient #1 with no indication for their use or evidence of prior attempts at less restrictive measures to meet the patient's clinical needs or to protect the safety of the patient. Findings include:  1. Per review on 2/23/11, Patient #1 was admitted to the Medical Intensive Care Unit (MICU) on 6/24/10. The patient arrived to MICU intubated, requiring the assistance of a respirator for	A 165	SEE ATTACHED Plan of Correction	5/1/2011

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A 165	Continued From page 2 breathing. The patient was placed in a bed with 4 siderails up and soft wrist restraints were applied to prevent the patient from interfering with the enforceable tube (breathing tube). Per nursing progress note dated 6/24/10 at 1145 Patient #1 was extubated, breathing sufficiently on their own. Soft restraints were removed, but side rails remained up. At 0200 on 6/26/10 a nursing progress note states: "loud bang heard from room, upon entering Pt. found on floor, all 4 side rails remain up in bed. Confused conversation, oriented to person only, MAE (moving all extremities) on command, without sensorimotor deficits. Needed assistance of 4 to get back to bed, legs weak and unable to bear weight. Repositioned back to bed, vital signs stable, physical assessment done; vest posey applied.....". Per review of the Fall Prevention Policy - Adult Inpatient (published 03/21/2008), states: "Consider using two upper siderails to assist with bed mobility and safe egress. Note that four side rails up does not prevent falls and is a restraint if patient can initiate bed exit." Although the patient had demonstrated s/he was able to exit the bed, the 4 side rails continued to be used. There was no evidence of reassessment to determine justifications for the continued use of 4 side rails.  The hospital's policy "Restraints Medical, Surgical and Behavioral Health Indications on Non-Psychiatric Units" (published 04/08/2010) states "the choice of restraints should always be the least restrictive method possible and based on the patient's assessed needs." Record review revealed there was no assessment or documentation by nursing staff that described the need for, or implementation of, physical restraints as the least restrictive measure to assure the	A 165	SEE ATTACHED Plan of Correction	5/1/11

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A 165	Continued From page 3 physical safety of the patient nor was a specific behavior demonstrated and/or documented that warranted both a vest posey and 4 side rails. Alternatives such as a bed alarm or sitter were not attempted. The patient remained restrained in a vest posey until 1400 on 6/25/10 even while up in a chair during a physical therapy evaluation.  In addition, although the hospital policy allows an RN to initiate the use of a restraint when an MD/LIP (Licensed Independent Practitioner) is not immediately available, the record does not specifically reflect notification of an MD/LIP for the initiation of the vest posey and 4 side rails at 0200 on 6/25/10. A signed order for the use of the restraints was not documented until 0703 on 6/25/10. The noncompliance by the MICU nurse with hospital policy related to restraint use was confirmed by the Director of Nursing Education on the morning of 2/23/11.	A 165	SEE ATTACHED Plan of Correction  4/20/11 A165 Joe Intosh POC Accepted.	5/1/11
A 267	482.21(a)(2) OAPI QUALITY INDICATORS  The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations.  This STANDARD is not met as evidenced by: Based on staff interview and record review, after a patient experienced a fall, an adverse patient event report was not completed, as per hospital policy, to ensure such events are measured, analyzed and monitored for patient safety and quality of care for 1 applicable patient. (Patient #1) Findings include:  The opportunity to improve patient safety outcomes specific to the use of restraints and fall	A 267	SEE ATTACHED Plan of Correction	4/26/11

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A 267	Continued From page 4 prevention did not occur as a result of nursing staff's failure to file a SAFE report (an adverse event report). On 6/25/10 in MICU at 0200 Patient #1 exited their bed while 4 side rails were in use and was found lying on the floor in their room. After the fall, the patient was placed back to bed, the 4 side rails remained up and a vest posey was then applied without any evidence of attempting a least restrictive intervention to prevent further falls or restraint use. The hospital's "Fall Prevention Policy - Adult Inpatient" requires staff to complete specific documentation and reporting after a patient experiences a fall. In addition to completing a "Post Fall Evaluation", the nurse who had found Patient #1 after the fall was also required to complete a SAFE report. The nurse failed to file the SAFE report or complete the process associated with the "Post Fall Evaluation". Per interview on 2/22/11 at 10:30 AM, the Director of Patient Safety confirmed all SAFE reports are sent to the Patient Safety office where events are reviewed. During this process the event is investigated to determine "...if there is anything we could have done differently.....any environmental factors that lead to a fall...human factors, any physical factors". The Director of Patient Safety stated a report of patient event investigations are reported monthly to the Quality Council. However, due to the omission of the SAFE report specific to Patient #1's fall on 6/25/10, a quality compliance review related to the use of 4 side rails, the use of a vest restraint and the circumstances associated with the fall were not investigated to explore opportunities for improvement.	A 267	See ATTACHED Plan of Correction	4/26/11
A 395	Refer to Tag: 154 482.23(b)(3) RN SUPERVISION OF NURSING	A 395	4/26/11 POC Accepted A267	

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A 395	Continued From page 5 CARE  A registered nurse must supervise and evaluate the nursing care for each patient.  This STANDARD is not met as evidenced by: Based on staff interview and record review, nursing staff failed to conduct a post fall assessment and a adverse event report, as per hospital policy, for 1 applicable patient who had sustained a fall while hospitalized. (Patient #1) Findings include:  Per record review on 2/22/11 and 2/23/11 a nurse assigned to care for Patient #1 on 6/26/10 in the Medical Intensive Care Unit (MICU) failed to complete a "Post Fall Evaluation" assessment after Patient #1 sustained a fall from their bed at 0200 while 4 side rails remained in the upright position. The hospital's "Fall Prevention Policy - Adult (last reviewed 3/21/08) requires several actions to be initiated by the nurse to include an initial clinical evaluation of the patient after the fall and documenting findings and outcomes using the "Post Fall Algorithms". By not completing the assessment, actions and interventions in response to Patient #1's fall were not initiated, in accordance with hospital policy, notifications to nurse managers was not documented as completed; identification of immediate interventions needed to prevent another fall was not documented as implemented, and the MD section of the Post Fall Algorithm was also not completed. In addition, to not completing the "Post Fall Assessment" the nurse also failed to complete a SAFE report (adverse event report) as required per hospital policy. By not completing the SAFE report, the fall incident was not reviewed as per hospital protocol to include	A 395	See ATTACHED Plan of Correction	4/26/11	

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A 395	Continued From page 6 an investigation of the event by the nurse manager and a Patient Safety review was not triggered for Quality Improvement for an evaluation of risk factors. The omission of the Post Fall Assessment and the failure of the nurse to file the SAFE report was confirmed on 2/23/11 at 10:45 AM by the Director of Nursing Education.	A 395	4/20/11 A 395 Quality Intosh POC Accepted	
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.  This STANDARD is not met as evidenced by: Based on staff interviews and record review, nursing staff failed to develop a timely care plan for a patient who was assessed to be at risk for falls and who experienced a fall while hospitalized. (Patient #1) Findings include:  1. Despite being identified to be at high risk for falls upon admission on 6/24/10, Patient #1 experienced a fall on 6/25/10 and it was not until 6/30/10 that a care plan was developed by nursing to incorporate specific fall risk factors and interventions for Patient #1. Per record review, on 6/23/10 Patient #1 was brought to the Emergency Department after being found on the street experiencing multiple seizures. S/he was admitted to the MICU on 6/24/10 and per hospital policy, an assessment for fall risk was conducted using the Hendrich II Fall Risk Assessment tool as per the "Fall Prevention Policy - Adult Inpatient". Due to risk factors including a neurological injury with changes in mental status, generalized weakness and use of antiepileptic medications, Patient #1's high fall risk score from 6/25/10 through 6/30/10 were assessed to be 8 through 12 depending on the patient's daily	A 396	SEE ATTACHED Plan of CORRECTION	5/1/11

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A 395	Continued From page 7 clinical status. (A score of 6 or above designates a patient as a Level II/higher fall risk requiring additional fall prevention interventions). When admitted to MICU on 6/24/10, Patient #1 was placed in a bed with all 4 side rails up. On 6/25/10 at 0200 while all 4 side rails remained up, Patient #1 exited their bed and was found on the floor in their MICU room. The "Fall Prevention Policy" Post Fall Assessment process includes nurse managers or their designee assuring a plan of care exists to address the risk factors and fall precautions are initiated. On the morning of 2/23/11 the Director of Nursing Education confirmed that nursing staff failed to develop and implement a fall risk care plan until 6 days after Patient #1 was identified to be a fall risk.	A 396	See ATTACHED Plan of Correction P.O.C Accepted 4/20/11 Odetosh	5/1/11

A 133 482.13(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 provide ongoing supervision and accountability for 1 applicable patient and failed to ensure the safety and well being for all patients. (Patient #1).*

*During the initial weeks of hospitalization from 6/23/10 through 7/22/10, Patient #1 had left their hospital room, exited the nursing unit, wandered the hospital and walked off the hospital campus to smoke without the provision of an escort for supervision. During hospitalization, the patient demonstrated challenging behaviors that include belligerence, agitation, intimidating verbal and physical threats towards staff on several occasions and was often non compliant with medication administration. Nursing note dated 7/19/10 at 1300 states "Per attending.....Patient is not allowed to leave unit without assistance to smoke...". However, before and after this note, the patient frequently left the hospital as noted in the note from 7/16/10 at 2045 "RN informed patient s/he is not allowed to smoke on hospital grounds, and s/he would have to leave campus.... Will call security if patient does not return within 30 minutes". Despite the patient's behavioral issues and threats, the hospital did not provide a security escort for this individual as h/she wandered the hospital and patients units. Per interview on 2/22/11 at 10:28 AM, the Director of Patient Safety stated: "We cannot have 1:1 security escorts for every patient that wants to walk around". On 7/22/10 during one of the patient's unescorted walks within the facility, the patient sustained a fall with injury. Per the Director of Patient Safety the hospital was unable to identify the direct cause for the fall, but it was confirmed the patient was not provided a security escort and/or supervision at the time of the incident. In addition, there was no definitive plan in place to ensure the patient's safety or the safety of others when Patient #1 wandered in and out of the hospital and exited the hospital campus to smoke.*

**Fletcher Allen Health Response to Survey Findings**

Fletcher Allen would like to take this opportunity to identify additional information that was contained in the patient's medical record and which the Division of Licensing and Protection surveyors failed to identify. Fletcher Allen believes that this additional information clearly demonstrates that its actions were not contrary to the Medicare regulation cited above. What the additional information *does* show is that, during the time in question, the patient: (a) had full capability to ambulate on his own, (b) did not exhibit any aggressive behavior, (c) experienced an *improved* mental state, and (d) possessed the ability to perform all independent activities of daily living. While Fletcher Allen regrets that the patient experienced a significant fall on 7/22/2010, a careful review of the records would lead an independent reviewer to conclude that the patient did not lack the capability to ambulate on his own and did not require a personal escort to accompany him each time he left the unit.

During the time period at issue (6/23/2010 to 7/22/2010), the following facts give a better overview of the patient's mental and physical condition and provide sufficient evidence that the patient did not require a personal escort:

- A review of the medical record shows that, during this time, the patient demonstrated a level of independence that he was fully capable of self-care and of ambulation.
- The patient did not exhibit any aggressive behavior during this time.
- The patient's mental status improved from oriented X1 to oriented X3 and his ability to ambulate and conduct independent activities of daily living returned to baseline levels.
- On 7/1/2010, the patient was identified as being ready for discharge to a Sub-Acute Rehabilitation Facility ("SAR"). However, despite multiple attempts for placement, a suitable SAR was not identified, because the patient *declined* transfer attempts each time a suitable SAR was identified that had agreed to accept his admission.
- The patient's status continued to improve as evidenced by a physician note on 7/20/2010 stating:  
"Pt feeling well. without complaints except that he is out of cigarettes. Is aware of hospital policy that he cannot go out to smoke, but has been doing so on his own anyway." "Pt asymptomatic and back to baseline. Ambulating independently and able to perform all ADL's (activities of daily living)."
- The discharge plan written by the physician at this time indicated:  
"Home or self care; discharge at anytime. Pt does not require SAR at this time as he does not have any skilled needs. Can be discharged to the shelter with f/u at Safe Harbor Medical

clinic at HMH.”

- During this time, the patient was assessed as being *independent*, able to care for himself, able to independently perform all activities of daily living, and able to competently make his own decisions.

While Fletcher Allen regrets that the patient experienced a significant fall, a careful review of the patient's medical record shows that the patient did not exhibit any characteristics of an individual who required a one-on-one escort each time he left the unit. In fact, during this time period, the patient was first ready for discharge to a Sub-Acute Rehabilitation Facility (which he refused), and was later determined, on 7/20/2010, to be ready for discharge home, *without* the need for skilled nursing-level care (again, the patient refused discharge). Fletcher Allen should also note that its staff repeatedly informed the patient that leaving the unit to smoke cigarettes was not permitted. Although Fletcher Allen wishes that the patient had followed the advice of its health care providers and not left the unit to smoke cigarettes, state and federal law affords competent patients the right to make their own decisions, which includes the right to disregard the advice provided by one's caregivers. Specifically, 42 CFR §482.13(b)(2) provides that: the patient "has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment." It is the patient's prerogative to choose or not choose to follow the advice of his or her health care providers and while Fletcher Allen would like for all of its patients to follow the recommendations of their health care providers, we could not prevent the patient, who was competent at the time, from leaving the unit.

#### Fletcher Allen Plan of Correction

A Complete literature/ best practice review on elopement risk and interventions will be completed by the Nursing Director and Nurse Manager by 5/1/2011. Based on the outcome of the literature/ best practice review the Nurse Director and Nurse Manger will review and update the Fletcher Allen Patient Elopement Policy with expanded content on prevention - comprehensive guidelines for identification of patients at risk for elopement, and specific interventions for patients identified to be an elopement risk by 6/1/2011. Incorporate assessment elements into electronic documentation by 6/15/2011. Staff education by the Nursing Directors will occur via Patient Safety Newsletter, Notes on Nursing, staff meetings, policy review to be completed by 7/1/2011. Report out on Patient Elopement Policy changes at the Patient Safety Committee in July 2011. Elopement events will be reviewed on a case by case basis by the unit manager and director, with identification of areas for improvement.

A-133 4/20/11 P.O.C. Accepted  
J. DeIntosh

#### *A 165 482.13(e)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION*

*The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient or others from harm.*

*This STANDARD is not met as evidenced by: Based on staff interview and record review, physical restraints were implemented on Patient #1 with no indication for their use or evidence of prior attempts at less restrictive measures to meet the patient's clinical needs or to protect the safety of the patient, Findings include:*

3. *Per review on 2/23/11, Patient #1 was admitted to the Medical Intensive Care Unit (MICU) on 6/24/10. The patient arrived to MICU intubated, requiring the assistance of a respirator for breathing. The patient was placed in a bed with 4 side rails up and soft wrist restraints were applied to prevent the patient from interfering with the enforceable tube (breathing tube). Per nursing progress noted dated 6/24/11 at 1145 Patient #1 was extubated, breathing sufficiently on their own. Soft restraints were removed, but side rails remained up. At 0200 on 6/25/10 a nursing progress note states: "loud banging heard from room, upon entering patient found on floor, all 4 side rails remain up in bed. Confused conversation, orient to person only MAE (moving all extremities) on command, without sensorimotor deficits. Needed assistance of 4 to get back to bed, legs weak and unable to bear weight. Repositioned back to bed, vital signs stable, physical assessment done, vest posey applied.....". Per review of the Fall Prevention Policy - Adult Inpatient (published 3/21/2008), states: "Consider using two upper side rails to assist with bed mobility and safe egress. Note that four side rails up does not prevent falls and is a restrain if patient can initiate bed exit." Although the patient had demonstrated s/he was able to exit the bed, the 4 side rails continued to be used. There was no evidence of reassessment to determine justifications for the continued use of 4 side rails.*

*The hospital's policy "Restraints Medical, Surgical and Behavioral Health Indications on Non-Psychiatric Units" (published 4/8/10) states "the choice of restraints should always be the least restrictive method possible and based on the patient's assessed needs." Record review revealed there was no assessment or documentation by nursing staff that described the need for, or implementation of, physical restraints as the least restrictive measure to assure the physical safety of the patient nor was a specific behavior demonstrated and/or documented that warranted both a vest posey and 4 side rails. Alternatives such as a bed alarm or sitter were not attempted. The patient remained restrained in a vest posey until 1400 on 6/25/10 even while up in a chair during a physical therapy evaluation.*

*In addition, although the hospital policy allows an RN to initiate the use of a restraint when an MD/IP (Licensed Independent Practitioner) is not immediately available, the record does not specifically reflect notification of an MD/LIP for the initiation of the vest posey and 4 side rails at 0200 on 6/25/10. A signed order for the use of the restraints was not documented until 0703 on 6/25/10. The noncompliance by the MICU nurse with hospital policy related to restraint use was confirmed by the Director of Nursing Education on the morning of 2/23/11.*

### **Fletcher Allen Health Care Response to Survey Findings**

Before responding to the specific deficiencies raised by CMS above, Fletcher Allen would like to take this opportunity to provide additional information on the facts and circumstances affecting the patient's care. Fletcher Allen believes that a more comprehensive review of the patient's care would lead an independent reviewer to conclude that its use of medical restraints was appropriate and clinically indicated. The following information adequately summarizes the indication for restraint use and provides evidence of prior attempts at deploying less restrictive measures to meet the patient's clinical needs:

- On 6/24/2011 at 2247 the nursing notes indicate the patient was pulling at foley catheter and removing "Miami J" collar. The nurse consulted with the physician and the foley catheter was removed, eliminating the potential need for soft limb restraints. The use of a patient sitter was considered and not employed as less restrictive measures, including the removal of the foley catheter and modifications to use of equipment, achieved the goal of providing safe and effective care at the time in question.
- RN documentation on the restraint flow sheet shows that on at 0200 on 6/25/2011, less restrictive interventions including "Provide companionship/supervision; reality orientation/psychosocial interventions; modify environment" were implemented.
- Regarding the use of a vest restraint and side rails, a vest restraint was applied to the patient to prevent bed exit as its application is less restrictive than soft limb restraints and did not limit bed mobility or access to self. Once the vest was in place, per the manufacturer's instructions, it is recommended to employ means to minimize the risk of strangulation including preventing the patient from sliding their legs off the bed. For this reason, we train staff to consider the use of side rails when a patient is in a vest restraint. See attached manufacturers recommendations for use of "posey" device. Side rails were indicated in this situation as the patient had demonstrated the ability to move his legs off the mattress.

### **Fletcher Allen Plan of Correction**

Nurse Educators in the SICU and MICU will develop a formal plan for educating staff by 4/8/2011. The plan will include the review of the policy associated with the use side rails and the application of vest restraints. Review of policy statement with staff will be documented. The education will be completed by 5/1/2011. Key educational points will be summarized and distributed electronically to nursing staff in the March 2011 "Notes on Nursing" and in the April 2011 "Patient Safety Tips Newsletter." Nursing staff will complete the annual "Restraint Competency" which includes content on the need for clinical justification, documentation of continued need and documentation of alternatives attempted as part of the 2011 annual performance evaluation process. Compliance with the completion of the Restraint Competency will be monitored with results forwarded to nursing leadership by 8/30/2011. Audits regarding use of restraints and compliance with the established policies and standards will be completed by a Nurse

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Clinical Auditor from the Institute for Quality. Feedback on performance will be provided to nursing leadership on a monthly basis for action related to any identified performance improvement.

A165

4/20/11  
P.O.C. Accepted  
J. McIntosh, RN

*A 267 482.13(a)(2) QAPI QUALITY INDICATORS*

*The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations.*

*This STANDARD is not met as evidenced by: Based on staff interview and record review, after a patient experienced a fall, and adverse patient event report was not completed, as per hospital policy, to ensure such events are measured, analyzed and monitored for patient safety and quality care for 1 applicable patient. (Patient #1) Findings include:*

*The opportunity to improve patient safety outcomes specific to the use of restraints and fall prevention did not occur as a result of nursing staff's failure to file a SAFE report (an adverse event report). On 6/25/10 in MICU at 0200 Patient #1 exited their bed while 4 side rails were in use and was found lying on the floor in their room. After the fall, the patient was placed back to bed, the 4 side rails remained up and a vest posey was then applied without any evidence of attempting a least restrictive intervention to prevent further falls or restraint use. The hospital's "Fall Prevent Policy - Adult Inpatient" requires staff to complete specific documentation and reporting after a patient experiences a fall. In addition to completing a "Post Fall Evaluation", the nurse who had found Patient #1 after the fall was also required to complete a SAFE report. The nurse failed to file the SAFE report or completed the process associated with the "Post Fall Evaluation". Per interview on 2/22/11 at 10:30 AM, the Director of Patient Safety confirmed the SAFE reports are sent to the Patient Safety offices where events are reviewed. During this process the event is investigated to determine "....if there is anything we could have done differently....any environmental factors that lead to a fall....human factors, any physical factors". The Director of Patient Safety state a report of patient event investigations are reported monthly to the Quality Council... However, due to the omission of the SAFE report specific to Patient #1's fall on 6/25/10, a quality compliance review related to the use of 4 side rails, the use of a vest restraint and the circumstances associated with the fall were not investigated to explore opportunities for improvement.*

**Fletcher Allen Health Care Response to Survey Findings**

The Safety Alerts For Events system (the "SAFE system") is one tool that is used by Fletcher Allen to identify actual or potential safety concerns and is one of many ways in which Fletcher Allen promotes a culture of safety within the organization. Fletcher Allen should first note that the SAFE system is a voluntary, web-based event reporting system used to identify actual and potential events for the purposes of quality improvement. While the staff is strongly encouraged to fill out SAFE reports, as this is a voluntary event reporting system, not all events or potential events (i.e., near misses) will be reported using this system

Because Fletcher Allen's position on reporting incidents in the SAFE system is voluntary, Fletcher Allen does not believe that the absence of a report on this specific incident constitutes a deviation from hospital practice. Nor is the lack of a mandatory reporting requirement inconsistent with the Medicare Conditions of Participation in any way. Although Fletcher Allen does not believe that the absence of a report in the SAFE system on this particular incident was contrary to the Medicare regulations or Fletcher Allen practices, Fletcher Allen recognizes that encouraging all safety events to be reported through a centralized system helps to ensure consistent documentation, analysis, and improvement of safety concerns. As such, Fletcher Allen intends to reinforce to its staff the use of the SAFE system as outlined in the Plan of Correction below.

**Fletcher Allen Plan of Correction**

The Director of Patient Safety will reinforce the importance of "SAFE" event and near miss reporting as outlined in the "Fletcher Allen Health Care Adverse Event Reporting Policy". Key educational points will be summarized and published in the April 2011 edition of "Patient Safety Tips." The leadership team will reinforce the expectations related to event or near miss reporting to staff by 4/26/2011.

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As part of an integrated performance improvement process, cases reported through the SAFE System are reviewed at a weekly quality committee comprised of the Chief Medical Officer, Vice President of Institute for Quality, Director of Risk Management, Vice President of Nursing, Manager of Office of Patient and Family Advocacy, Director of Patient Safety, Patient Safety Coordinator and the Director of Regulatory Readiness. This Committee will continue to monitor the use of the SAFE system across the organization, and will appropriately advise hospital leadership and affected departments if it learns that specific departments or staff is not using the SAFE System in accordance with Fletcher Allen policies.

Refer to Tag: 154

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

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

*This STANDARD is not met as evidenced by: Based on staff interview and record review, nursing staff failed to conduct a post fall assessment and an adverse event report, as per hospital policy, for 1 applicable patient who had sustained a fall while hospitalized. (Patient #1) Findings include:*

*Per record review on 2/21/11 and 2/23/11 a nurse assigned to care for Patient #1 on 6/25/10 in the Medical Intensive Care Unit (MICU) failed to complete a "Post Fall Evaluation" assessment after Patient #1 sustained a fall from their bed a 0200 while 4 side rails remained in the upright position. The hospital's "Fall Prevention Policy-Adult (last reviewed on 3/21/08) requires several actions to be initiated by the nurse to include and initial clinical evaluation of the patient after the fall and documenting findings and outcomes using the "Post Fall Algorithms". By not completing the assessment and interventions in response to Patient #1's fall were not initiated. In accordance with hospital policy, notifications to nurse managers was not documented as completed, identification of immediate interventions needed to prevent another fall was not documented as implemented, and the MD section of the Post Fall Algorithm was also not completed. In addition, to not completing the "Post Fall Assessment" the nurse also failed to complete a SAFE report (adverse event report) as required per hospital policy. By not completing the SAFE report, the fall incident was not reviewed as per hospital protocol to include an investigation of the event by the nurse manager and a Patient Safety review was not triggered for Quality Improvement for an evaluation of risk factors. The omission of the Post Fall Assessment and the failure of the nurse to file the SAFE report was confirmed on 2/23/11 at 10:45 AM by the Director of Nursing Education,*

**Fletcher Allen Plan of Correction**

Fletcher Allen leadership will communicate to nursing staff and nursing leadership the expectation to complete post-fall evaluation assessments and event reporting, in accordance with Fletcher Allen policies, as outlined below:

The Directors of Nursing will review "Post Fall Evaluation" expectations outlined in the Fletcher Allen Health Care "Fall Prevention Policy" and SAFE system reporting as outlined in the Fletcher Allen Health Care "Adverse Event Reporting Policy" with Nurse Managers and the Administrative Nurse Coordinators and will use a case study methodology to reinforce expectations. The Nurse Managers will then communicate the expectations referenced in the two policies electronically or via staff meetings. This process will be completed by 4/26/2011. The Administrative Nurse Coordinators will reinforce the expectation referenced above with staff during their rounds. The Directors of Nursing will reinforce the key points in the March 2011 edition of "Notes on Nursing," which is distributed to all nursing staff. The Director of Patient Safety will reinforce the educational points regarding Post Fall Evaluation, Restraint Use, and Adverse Event reporting in the April 2011 edition of "Patient Safety Tips." This newsletter is sent to all leaders and is shared with staff. Each Nurse Manager's written plan for sharing this information with staff will be provided to their director by 4/8/2011. Audits regarding compliance with "Post Fall Evaluation" expectations, as outlined in the Fletcher Allen Health Care "Fall Prevention Policy," will be completed by a Nurse Clinical Auditor from the Institute for Quality. Feedback on performance will be provided to nursing leadership on a monthly basis for action related to any identified performance improvement.

A 395 POC Accepted 4/20/11  
De. [Signature]

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.

This STANDARD is not met as evidenced by: Based on staff interviews and record review, nursing staff failed to develop a timely care plan for a patient who was assessed to be at risk for falls and who experienced a fall while hospitalized. (Patient #1) Findings include:

1. Despite being identified to be at high risk for falls upon admission on 6/24/10, Patient #1 experiences a fall on 6/25/10 and it was not until 6/30/10 that a care plan was developed by nursing to incorporate specific fall risk factors and interventions for Patient #1. Per record review, on 6/23/10 Patient #1 was brought to the Emergency Department after being found on the street experiencing multiple seizures. S/he was admitted to MICU on 6/24/10 and per hospital policy, an assessment for fall risk was conducted using the Hendrich II Fall Risk Assessment tool as per the "Fall Prevention Policy-Adult Inpatient". Due to risk factors including a neurological injury with changes in mental status, generalized weakness and use of antiepileptic medications, Patient #1's high fall risk score from 6/25/10 through 6/30/10 were assessed to be 8 through 12 depending on the patient's daily clinical status. (A score of 5 or above designates a patient as a Level II/higher fall risk requiring additional fall prevention interventions). When admitted to MICU on 6/24/10, Patient #1 was placed in a bed with all 4 side rails remained up. On 6/25/10 at 0200 while all 4 side rails remained up Patient #1 exited their bed and was found on the floor in their MICU room. The "Fall Prevention Policy" Post Fall Assessment process includes nurse managers or their designee assuring plan of care exists to address the risk factors and fall precautions are initiated. On the morning of 2/23/11 the Director of Nursing Education confirmed that nursing staff failed to develop and implement a fall risk care plan until 6 days after Patient #1 was identified to be a fall risk....

Fletcher Allen Plan of Correction

Nurse educators in the MICU and SICU will develop and implement training that reinforces the use of electronic care plans. This training will be completed by 5/1/2011. Evidence of completion will be documented by the Nurse Educators and provided to the Nurse Managers and Directors. The current fall care plan content in PRISM is being reviewed by the Fall Prevention Committee. The Committee will make recommendations for improvements on 5/1/2011. Audits regarding compliance with care plan development will be completed by a Nurse Clinical Auditor from the Institute for Quality. Feedback on performance will be provided to nursing leadership on a monthly basis for action related to any identified performance improvement.

A 396 P.O.C. 4/20/11  
Accepted  
O. McIntosh