

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

PRINTED: 08/24/2012
RECEIVED FORM APPROVED
Division of Licensing and Protection
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	NOV 28 12 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 08/23/2012
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NAME OF PROVIDER OR SUPPLIER NORTHWESTERN MEDICAL CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 133 FAIRFIELD STREET SAINT ALBANS, VT 05478
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(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
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A 000 INITIAL COMMENTS

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An unannounced on-site complaint investigation was conducted on 7/24/12 - 7/26/12 by the Division of Licensing and Protection as authorized by the Centers for Medicare and Medicaid Services. The investigation concluded on 8/23/12 and the following regulatory deficiencies were identified.

A 154 482.13(e) USE OF RESTRAINT OR SECLUSION

A 154 A154 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.

Restraint policy to be revised to include changes to require that the indication for the need of chemical or physical restraint is documented in MediTech (Electronic Medical Record)
The MediTech documentation screens to be changed to reflect the above required documentation.

This STANDARD is not met as evidenced by: Based on staff interviews and medical record review there was no indication to warrant the use of chemical and physical restraints to ensure the immediate safety of Patient #1, staff or others. (Patients #1). Findings include:

Also, ICU/MedSurg Nurse Manager re-educated nursing staff on the need to have careful, complete and accurate documentation according to policy.

Per record review, Patient #1 was admitted on 1/5/12, under observation status for monitoring of personal safety while awaiting involuntary placement to an available inpatient psychiatric bed. A Physician Orders: Restraint form, signed by LIP (Licensed Independent Practitioner) #1 on 1/6/12 at 3:45 PM, indicated administration of a chemical restraint had occurred, at 3:45 PM, in the form of 5 mg Haldol IM (Intramuscularly), and directed the use of physical restraints to bilateral

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE _____

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 154 Continued From page 1
upper and lower extremities. Although the restraint order form identified Patient #1 with unsafe behaviors including; "Violent/aggressive/combatative to self or others", there was no documentation that described specific behaviors that indicated the patient had posed an immediate threat of harm to self or others warranting the use of restraints.

Per interview, at 11:17 AM on 7/25/12, LIP #1, who had been responsible for ordering the restraints on 1/6/12, stated that Patient #1 had become very upset when law enforcement personnel arrived to escort the patient to an inpatient psychiatric unit in another facility. LIP #1 stated that s/he had administered the medication to Patient #1 and, although Patient #1 was emotionally distraught and crying, s/he had agreed to willingly accept the medication, had not become aggressive and there was no need for the patient to be restrained. The LIP further stated that s/he had not offered the medication to Patient #1 by mouth, and, "in hind sight I should have" offered the medication orally before giving it IM. The LIP stated that s/he did not believe chemical or physical restraints had been needed, and s/he had completed the Restraint Order form in anticipation that restraints might be needed and because the nurse told him/her to do so. The LIP stated that the patient was observed for a period of approximately 30-45 minutes after receiving the Haldol, to assure medical stability and then willingly left the facility with the law enforcement escort.

Although LIP #1 stated that Patient #1 did not need to be restrained, Nurse #1, who was present at the time the Haldol had been

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A 154	Continued From page 2 administered on 1/6/12 stated during interview, at 2:30 PM on 7/25/12, that s/he had heard Patient #1 yelling, and went into the patient's room to offer assistance. The nurse stated the patient was refusing to go with the law enforcement escort, refused to allow administration of medication and was very clear that s/he was going to fight. Nurse #1 stated s/he held the patient's arm while another nurse held the patient's legs so LIP #1 could administer the IM medication. Nurse #1 further stated that the physical hold of the patient lasted just long enough to administer the medication and that Patient #1 was observed by staff for a period of approximately 30-45 minutes after receiving the Haldol and then left the facility willingly with law enforcement escort.	A 154		
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to ensure that less restrictive interventions had been attempted and determined to be unsuccessful to protect the patient and/or others from harm, prior to the initiation of chemical and physical restraints for Patient #1. Findings include: 1. Per record review, Patient #1 was admitted on 1/5/12, under observation status for monitoring of personal safety while awaiting involuntary placement to an available inpatient psychiatric	A 164	A164 PATIENT RIGHTS RESTRAINT OR SECLUSION Restraint policy to be revised to include changes to add the documentation that less restrictive interventions have been attempted. The MediTech documentation screens to be revised to reflect the above required documentation.	12-2012

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A 164 Continued From page 3
bed. A Physician Orders: Restraint form, signed LIP #1 on 1/6/12 at 3:45 PM, indicated administration of a chemical restraint, at 3:45 PM, in the form of 5 mg Haldol IM, as well as use of physical restraints to bilateral upper and lower extremities. Although the order form identified Patient #1 with unsafe behaviors which included; "Violent/aggressive/combatative to self or others", there was no evidence that alternative or less restrictive interventions had been attempted and determined to be unsuccessful to protect the patient and/or others from harm, prior to the use of the chemical and physical restraints.

Per interview, at 11:17 AM on 7/25/12, LIP #1, who had been responsible for ordering the restraints on 1/6/12, stated that the patient had become very upset when law enforcement personnel arrived to escort the patient to an inpatient psychiatric unit in another facility. LIP #1 stated that although s/he did not feel the use of Haldol IM had constituted a restraint, because Patient #1 had agreed to accept the medication, the LIP had not offered the medication to Patient #1 by mouth, and, "in hind sight I should have" offered the medication orally before giving it IM.

During interview, at 2:30 PM on 7/25/12, Nurse #1, who was present at the time the restraints were initiated, stated that s/he heard the patient yelling and went into the patient's room to offer assistance. The nurse stated the patient was refusing to go with the law enforcement escort, refused to allow administration of medication and Patient #1 was very clear that s/he was going to fight. Nurse #1 stated s/he held the patient's arm while another nurse held the patient's legs so LIP #1 could administer the IM medication. Nurse #1

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A 164 Continued From page 4
further stated that the physical hold of the patient lasted just long enough to administer the medication. The nurse further stated that s/he was not aware of any less restrictive measures that may have been attempted prior to the use of the restraints.

A 164

A 176 482.13(e)(11) PATIENT RIGHTS: RESTRAINT OR SECLUSION

A 176

A176 PATIENT RIGHTS RESTRAINT OR SECLUSION

To assure that all physicians/providers are knowledgeable, the Hospitalists were re-educated regarding restraints and restraint documentation

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Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

This STANDARD is not met as evidenced by:
Based on staff interviews and record review the facility failed to assure that all physicians and other LIPs authorized to order restraints and seclusion were knowledgeable of the facility's policy regarding use of restraints and seclusion. In addition the Restraint policy did not specify training requirements for physicians and other Lips authorized to order restraints and seclusion. Findings include:

Per record review, Patient #1 was admitted on 1/5/12, under observation status for monitoring of personal safety while awaiting involuntary placement to an available inpatient psychiatric bed. A Physician Orders: Restraint form, signed by LIP (Licensed Independent Practitioner) #1 on 1/6/12 at 3:45 PM, indicated administration of a chemical restraint had occurred, at 3:45 PM, in

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A 176	<p>Continued From page 5</p> <p>the form of 5 mg Haldol IM (Intramuscularly), and directed the use of physical restraints to bilateral upper and lower extremities. Although the restraint order form identified Patient #1 with unsafe behaviors including; "Violent/aggressive/combative to self or others", there was no documentation that described specific behaviors that indicated the patient had posed an immediate threat of harm to self or others warranting the use of restraints.</p> <p>Per interview, at 11:17 AM on 7/25/12, LIP #1, who had been responsible for ordering the restraints on 1/6/12, stated that Patient #1 had become very upset when law enforcement personnel arrived to escort the patient to an inpatient psychiatric unit in another facility. LIP #1 stated that s/he had administered the medication to Patient #1 and, although Patient #1 was emotionally distraught and crying, s/he had agreed to willingly accept the medication, had not become aggressive and there was no need for the patient to be restrained. The LIP further stated that s/he had not offered the medication to Patient #1 by mouth, and, "in hind sight I should have" offered the medication orally before giving it IM. The LIP stated that s/he did not believe chemical or physical restraints had been needed, and s/he had only completed the Restraint Order form in anticipation that restraints might be needed and because the nurse told him/her to do so. The LIP stated that the patient was observed for a period of approximately 30-45 minutes after receiving the Haldol, to assure medical stability and then willingly left the facility with the law enforcement escort.</p> <p>Per review, the facility's Restraint policy,</p>	A 176		
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A 176	Continued From page 6 provided by staff, last revised in October 2009, did not specify any training requirements for those physicians and other LIPs authorized by the policy to order restraint or seclusion. The Medical Surgical Unit Nurse Manager stated during interview at 1:04 PM on 7/24/12, that there had been challenges with some of the providers, in understanding the facility policy regarding use of restraints and seclusion, particularly regarding use of chemical restraints. S/he further stated that restraint use was one of the agenda topics scheduled for discussion at the next Hospitality physician/LIP group meeting. During interview, at 2:30 PM on 7/25/12, Nurse #1, a Nurse Educator, stated that there was no formal training process in place to assure that all physicians and other LIPs with the authority to order use of chemical and physical restraints or seclusion have a working knowledge of hospital policy regarding the use of restraints or seclusion. Nurse #1 further stated that all cases of restraint and/or seclusion use are reviewed for appropriateness, and if concerns arise regarding the orders for restraints or seclusions attempts are made to discuss the policy with the ordering physician or other LIPs, but some of the practitioners were resistant to receiving the education.	A 176	
A 184	482.13(e)(16)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION When restraint or seclusion is used, there must be documentation in the patient's medical record of the following: The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to	A 184	

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A 184 Continued From page 7
manage violent or self-destructive behavior.

This STANDARD is not met as evidenced by:
Based on staff interview and record review there was no documentation that a medical and behavioral evaluation was conducted within 1 hour of the initiation of chemical and/or physical restraints used to manage violent or self-destructive behavior for #4 of 10 patients. (Patients #1, #2, #5 and #8). Findings include:

Per review, although the following patient records indicated use of chemical and/or physical restraints for each of the respective patients, for "Violent/aggressive/combatative to self or others", there was no documentation that a face-to-face medical and behavioral evaluation had been completed by the provider within 1 hour of the initiation of restraints

1. Per record review, Patient #1 was admitted on 1/5/12, under observation status for monitoring of personal safety while awaiting involuntary placement to an available inpatient psychiatric bed. A Physician Orders: Restraint form, signed LIP #1 on 1/6/12 at 3:45 PM, indicated administration of a chemical restraint, at 3:45 PM, in the form of 5 mg Haldol IM, as well as use of physical restraints to bilateral upper and lower extremities. Although the order form identified Patient #1 with unsafe behaviors which included; "Violent/aggressive/combatative to self or others", there was no documentation of a face-to-face evaluation by the provider to evaluate the effectiveness of the intervention.

2. Per record review, Patient #2 had a Physician Orders: Restraint form, signed by LIP #1 on

A 184 A184 PATIENT RIGHTS RESTRAINT OR SECLUSION

A prompt was added to the Restraint Order Sheet to facilitate the process of documentation by physician/provider of the one hour face-to-face.

Restraint policy to be revised to include the need for documentation of the one hour face-to-face evaluation by the physician/provider in the medical record.

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A 184	<p>Continued From page 8</p> <p>5/3/12 at 3:30 PM that indicated the patient had exhibited unsafe behavior, including: "Violent/aggressive/combatative to self or others" and altered mental status. The orders directed use of a chemical restraint in the form of Haldol 5 mg IM which was administered at 3:31 PM and initiation of soft restraints on bilateral upper and lower extremities. A nursing note, dated 5/3/12 at 12:30 PM stated, "Pt sedated" and a subsequent note on 5/3/12 at 3:52 PM, stated, "Attempted to do hygiene care prior to placing pt. back in soft restraints. Pt. became aggressive and resistive to care, throwing toothbrush across room." There was no documentation of a face-to-face evaluation conducted by a provider within 1 hour of the initiation of the restraints</p> <p>3. Per record review, Patient #8 had a Physician Orders: Restraint form, that indicated the resident had received a chemical restraint, "Zyprexa 2.5 mg IM x 1 now for agitation", at 7:37 PM on 6/27/12. The order had also directed use of "Manual/physical restraints for chemical restraint administration", for unsafe behaviors described as "Violent/aggressive/combatative to self or others". Although the restraints had been implemented at that time, the order had not been signed by an authorizing physician or other LIP until more that 18 hours later, at 2:00 PM on 6/28/12, and there was no evidence that a face-to-face evaluation had been conducted by a provider to determine the effectiveness of the intervention.</p> <p>4. Per review 2 separate Physician Orders: Restraint forms signed by LIP #1, and dated 4/21/12 at 2:15 PM and 4/22/12 at 2:55 PM respectively, directed staff to administer a</p>	A 184		

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A 184 Continued From page 9
chemical restraint in the form of Haldol 5 mg IM, for each respective restraint episode for unsafe behavior described, on each occasion as "Violent/aggressive/combative to self or others". Despite nursing notes dated 4/21/12 at 3:03 PM that stated "Pt agitated at this time, IM Haldol given. Pt in bed. Security paged and standing outside the room", and a note, on 4/22/12 at 3:01 PM that stated "Pt agitated at this time. One time dose of IM haldol ordered. Pt is dressed, has pulled IV out and is threatening to leave. Security at door", there was no documentation of a face-to-face evaluation conducted by the provider within 1 hour of the initiation of the intervention.

Nurse #1 confirmed the lack of documentation regarding face-to-face evaluations by the provider within 1 hour of the initiation of the intervention, for all above stated patients, during interview on 7/16/12 at 10:10 AM.

A 185 482.13(e)(16)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION

[there must be documentation in the patient's medical record of the following:]

A description of the patient's behavior and the intervention used.

This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview the medical records did not include descriptions of the patients' behavior indicating the need for restraint use for 4 of 10 patients. (Patients #1, #2, #5 and #8). Findings include:

Per record review, there was no description of the specific behaviors that warranted the use of

A 184

A 185 A185 PATIENT RIGHTS RESTRAINT OR SECLUSION

Restraint policy to be revised to include the need for documentation of patient behavior indicating the need for restraint.

The MediTech documentation screens to be revised to reflect the above required documentation.

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A 185	<p>Continued From page 10</p> <p>chemical and/or physical restraints for the following patients:</p> <p>a. Patient #1 was admitted on 1/5/12, under observation status for monitoring of personal safety while awaiting involuntary placement to an available inpatient psychiatric bed. A Physician Orders: Restraint form, signed by LIP #1, on 1/6/12 at 3:45 PM, indicated administration of a chemical restraint, at 3:45 PM, in the form of 5 mg Haldol IM, as well as use of physical restraints to bilateral upper and lower extremities. Although the order form identified Patient #1 with unsafe behaviors, which included; "Violent/aggressive/combatative to self or other" there was no documentation that identified the specific behaviors exhibited by the patient.</p> <p>b. Patient #2 had a Physician Orders: Restraint form, signed by LIP #1 on 5/3/12 at 3:30 PM that indicated the patient had exhibited unsafe behavior, including: "Violent/aggressive/combatative to self or others" and altered mental status. The orders directed use of a chemical restraint in the form of Haldol 5 mg IM which was administered at 3:31 PM and initiation of soft restraints on bilateral upper and lower extremities. A nursing note, dated 5/3/12 at 12:30 PM stated, "Pt sedated". Although a subsequent note on 5/3/12 at 3:52 PM, following administration of the Haldol, stated, "Attempted to do hygiene care prior to placing pt. back in soft restraints. Pt. became aggressive and resistive to care, throwing toothbrush across room", there was no documentation of specific behaviors exhibited by Patient #2 that warranted the use of the restraints.</p>	A 185		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/23/2012
NAME OF PROVIDER OR SUPPLIER NORTHWESTERN MEDICAL CENTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 133 FAIRFIELD STREET SAINT ALBANS, VT 05478	
(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 185	<p>Continued From page 11</p> <p>c. Patient #8 had a Physician Orders: Restraint form, signed by LIP #1, on 6/28/12 at 2:00 PM that directed use of "Manual/physical restraints for chemical restraint administration", on 6/27/12 at 7:37 PM, for unsafe behaviors described as "Violent/aggressive/combatative to self or others." The chemical restraint order, at 7:37 PM on 6/27/12, stated to give "Zyprexa 2.5 mg IM x 1 now for agitation". Although a nurse's note, dated 6/27/12 at 3:34 PM, indicated that the patient was restless and anxious and had received medication for anxiety as ordered, there was no documentation of specific behaviors that had warranted the use of the restraints.</p> <p>d. Per review of Patient #5's record, 2 separate Physician Orders: Restraint forms signed by LIP #1, and dated 4/21/12 at 2:15 PM and 4/22/12 at 2:55 PM respectively, directed staff to administer a chemical restraint, in the form of Haldol 5 mg IM, for each respective restraint episode, for unsafe behavior described, on each occasion as; "Violent/aggressive/combatative to self or others". Despite nursing notes dated 4/21/12 at 3:03 PM that stated "Pt agitated at this time, IM Haldol given. Pt in bed. Security paged and standing outside the room", and a note, on 4/22/12 at 3:01 PM that stated "Pt agitated at this time. One time dose of IM haldol ordered. Pt is dressed, has pulled IV out and is threatening to leave. Security at door", there is no documentation, for either of the respective restraint episodes, describing the patient's behavior that warranted use of the restraints.</p> <p>During interview, at 10:10 AM on 7/26/12, Nurse #1 confirmed the lack of documentation regarding descriptive behaviors that warranted the use of</p>	A 185	

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A 185	Continued From page 12 restraints for each of the above stated patients.	A 185		
A 186	<p>482.13(e)(16)(iii) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>[there must be documentation in the patient's medical record of]</p> <p>Alternatives or other less restrictive interventions attempted (as applicable);</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews the medical records lacked documentation of alternatives or other less restrictive interventions attempted prior to initiation of chemical and/or physical restraints for 3 of 10 patients. (Patients #1, #8 and #9). Findings include:</p> <p>1. Per record review, there was no documentation of less restrictive measures attempted for Patient #1 prior to using both chemical and physical restraints on the afternoon of 1/6/12. The patient was admitted on 1/5/12, under observation status for monitoring of personal safety while awaiting involuntary placement to an available inpatient psychiatric bed. A Physician Orders: Restraint form, signed LIP #1 on 1/6/12 at 3:45 PM, indicated administration of a chemical restraint, at 3:45 PM, in the form of 5 mg Haldol IM, as well as use of physical restraints to bilateral upper and lower extremities. Although the order form identified Patient #1 with unsafe behaviors which included: "Violent/aggressive/combatative to self or others", there was no evidence that less restrictive interventions had been determined to be ineffective prior to the use of the chemical and physical restraints.</p>	A 186	<p>A186 PATIENT RIGHTS RESTRAINT OR SECLUSION</p> <p>Audit process:</p> <p>100% of open records of patients with restraints will be reviewed for the months of September, October, November, and December 2012 using the Restraint Record Review Tool</p>	12/2012

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A 186	<p>Continued From page 13</p> <p>Per interview, at 11:17 AM on 7/25/12, LIP #1, who had been responsible for ordering the restraints on 1/6/12, stated that the patient had become very upset when law enforcement personnel arrived to escort the patient to an inpatient psychiatric unit in another facility. LIP #1 stated that although s/he did not feel the use of Haldol IM had constituted a restraint, because Patient #1 had agreed to accept the medication, the LIP had not offered the medication to Patient #1 by mouth, and, "in hind sight I should have" offered the medication orally before giving it IM.</p> <p>During interview, at 2:30 PM on 7/25/12, Nurse #1, who was present at the time the restraints were initiated, stated that s/he heard the patient yelling and went into the patient's room to offer assistance. The nurse stated the patient was refusing to go with the law enforcement escort, refused to allow administration of medication and Patient #1 was very clear that s/he was going to fight. Nurse #1 stated s/he held the patient's arm while another nurse held the patient's legs so LIP #1 could administer the IM medication. Nurse #1 further stated that the physical hold of the patient lasted just long enough to administer the medication and the nurse was not aware of any less restrictive efforts that may have been unsuccessfully attempted prior to the use of the restraints.</p> <p>2. Per record review, Patient #8 had a Physician Orders: Restraint form, signed by LIP #1, on 6/28/12 at 2:00 PM that directed use of "Manual/physical restraints for chemical restraint administration", on 6/27/12 at 7:37 PM, for unsafe behaviors described as "Violent/aggressive/combatative to self or others."</p>	A 186		
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A 186	<p>Continued From page 14</p> <p>The chemical restraint order, at 7:37 PM on 6/27/12, stated to give "Zyprexa 2.5 mg IM x 1 now for agitation". Although a nurse's note, dated 6/27/12 at 3:34 PM, indicated that the patient was restless and anxious and had received medication for anxiety as ordered, there was no documentation that staff attempted to implement any other less restrictive interventions prior to the use of the chemical and physical restraint. This was confirmed by Nurse #1, during interview at 10:10 AM on 7/26/12.</p> <p>3. Per review of Resident #9's record, 2 separate Physician Orders: Restraint forms signed by LIP #1, and dated 4/21/12 at 2:15 PM and 4/22/12 at 2:55 PM respectively, directed staff to administer a chemical restraint in the form of Haldol 5 mg IM, for each respective restraint episode for unsafe behavior described, on each occasion as "Violent/aggressive/combatative to self or others". Despite nursing notes dated 4/21/12 at 3:03 PM that stated "Pt agitated at this time, IM Haldol given. Pt in bed. Security paged and standing outside the room", and a note, on 4/22/12 at 3:01 PM that stated; "Pt agitated at this time. One time dose of IM haldol ordered. Pt is dressed, has pulled IV out and is threatening to leave. Security at door", there was no documentation, for either of the respective restraint episodes, that staff attempted to implement any less restrictive measures prior to the initiation of the chemical restraint. This was confirmed by Nurse #1 during interview on 7/16/12 at 10:10 AM.</p>	A 186		
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