

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

PRINTED: 10/31/2011
FORM APPROVED
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 _____	(X3) DATE SURVEY COMPLETED C 10/26/2011
--	--	--	---

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 000	INITIAL COMMENTS An unannounced on-site complaint investigation, authorized by the Centers for Medicare and Medicaid Services, was completed on 10/25/11 by staff from the Vermont Division of Licensing and Protection. The following regulatory violation was found.	A 000		
A 161	482.13(e)(1)(i)(c) PATIENT RIGHTS: RESTRAINT OR SECLUSION A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort) This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that patients were free from physical restraints during the administration of medication for 1 applicable patient in the sample. (Patient # 1) Findings Include: Per record review on 10/24/11 and 10/25/11, nursing staff physically restrained Patient #1 on 12/4/10 in order to administer a newly ordered anti-psychotic medication without evidence of an assessment to determine need and without a physician order for a physical and/or chemical restraint. A nursing progress note dated 12/4/10, 2201, stated "pt. continually talking to self and combative when touched, given IM Zyprexa (3 assist to help keep pt. still)". There was no	A 161	Policy revisions: The Restraint Policy updated to reflect the following additions: Under definition of Chemical Restraint: "The application of physical force to administer a medication acting as a chemical restraint is considered a physical restraint and requires an additional separate order." Under the section entitled "Procedure for Violent/Behavioral Management Restraint" the following: "If physical force is required to administer a chemical restraint, the nurse obtains an additional separate order for physical restraint." Electronic Health record revisions: Nov 2011 Both the Emergency Department and the Hospital electronic health record revised to reflect policy revisions	Nov, 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) 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.

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

PRINTED: 10/31/2011
FORM APPROVED
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 _____	(X3) DATE SURVEY COMPLETED C 10/26/2011
--	--	--	---

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 161	<p>Continued From page 1</p> <p>physician order to restrain the patient per review of the medical record.</p> <p>Nursing progress notes from another inpatient stay by the same patient on 6/29/11, 0640 stated "Pt. in hall attempting to leave unit. Yelling at staff. Charge RN received orders for IM (intramuscular) Zyprexa X 1. Given with 3 assist." Although the charge nurse obtained a telephone physician order to chemically restrain the patient at 0639 on 6/29/11, there was no evidence of a face to face assessment within 1 hour by the ordering physician, per policy for restraints used for violent behavior</p> <p>The CMS (Centers for Medicare and Medicaid Services) Interpretive guidelines for hospitals for A-0161 state that "the application of force to physically administer a medication against the patient's wishes, is considered restraint". During interview on 10/25/11 at 2 PM, the RN Clinical Resource Nurse confirmed that she had not considered 'holding a patient momentarily to give a medication a restraint'. The Director of Quality and the Director of Risk Management, who were also present at the time, agreed there was no physician order to restrain the patient for medication administration on 12/4/10 and there was no evidence of a physician 1 hour face to face with the patient after the chemical restraint was implemented on 6/29/11. They also agreed that a physician order for a restraint for violent behaviors written on 6/22/11 for this patient was inappropriate and included potential use of all physical restraints listed on the order sheet without evidence of need.</p>	A 161	<p>Education</p> <p>Clinical Nurse Managers and Clinical Resource Nurses educate staff at unit meetings to policy revisions.</p> <p>Audits</p> <p>One hundred percent (100%) of all restraint records (chemical, violent and non-violent restraint episodes) will be audited for compliance to revised policy for a period of four (4) months. Any issues of non compliance will be addressed with any and all staff involved.</p>	<p>Nov and Dec 2011</p> <p>Dec 2011</p> <p>Jan 2012</p> <p>Feb 2012</p> <p>Mar 2012</p>
-------	---	-------	--	---