

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

PRINTED: 07/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/02/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PORTER HOSPITAL, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>115 PORTER DRIVE</b> <b>MIDDLEBURY, VT 05753</b>
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C 000	INITIAL COMMENTS	C 000		
C 150	<p>485.608 COMPLIANCE WITH FEDERAL, STATE, &amp; LOCAL LAWS</p> <p>The CAH and its staff are in compliance with applicable Federal, State and local laws and regulations.</p> <p>This CONDITION is not met as evidenced by: Based on interview and record review conducted at the time of a complaint investigation, the CAH failed to assure compliance with State and Local laws and regulations relative to Title 18, Chapter 42; Bill of Rights for Hospital Patients, § 1852. 1) The patient has the right to considerate and respectful care at all times and under all circumstances with recognition of his or her personal dignity.</p>	C 150		
C 152	<p>Refer to C-0152</p> <p>485.608(b) COMPLIANCE WITH STATE &amp; LOCAL LAWS</p> <p>All patient care services are furnished in accordance with applicable State and local laws and regulations.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, during the provision of care and services in the Emergency Department (ED) staff failed to maintain patient rights in accordance with State</p>	C 152		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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C 152	<p>Continued From page 1</p> <p>statute, Title 18, Chapter 42; Bill of Rights for Hospital Patients; § 1852. 1) The patient has the right to considerate and respectful care at all times and under all circumstances with recognition of his or her personal dignity, for 3 of 4 applicable patients. (Patients #2, #5 and #11). Findings include:</p> <p>Per review the policy, titled Physical and Chemical Restraints, approved 12/2010, and identified by staff as the currently established facility policy, stated, under Safety Policy Statement: "Patients and staff have the right to be treated with respect and dignity in a safe environment....., the use of restraint is undertaken as a last resort in the management of the patient's behavior..... the patient should be engaged (if not clinically contraindicated) in identifying alternative safety interventions to minimize and possibly avoid the use of restraints. The policy further states; "The restraints are to be removed as soon as the violent/assaultive behavior has resolved AND the patient is able to contract for his/her safety and the safety of others."</p> <p>Per record review staff failed to provide care in a respectful and dignified manner by failing to adhere to the facility's policy for restraint use for Patients #2, #5 and #11, all of whom were physically restrained during the course of their respective individual treatment in the ED (Emergency Department). Each of the patients had an extended length of stay in the ED, exceeding 24 hours, while awaiting available bed placement for involuntary admission to an inpatient psychiatric unit. During the course of stay each of the respective patients was</p>	C 152		

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C 152	Continued From page 2 physically restrained, with use of hand cuffs, and/or leg shackles and/or soft restraints for extended periods of time, without evidence of consistent ongoing re-assessments by nursing or physicians to determine the need for initiation and/or ongoing use of the restraints. In addition there was no evidence of consistent use of less restrictive interventions utilized prior to initiation of the restraints and lack of evidence that patients were consistently engaged in an effort to determine their ability to contract for safe behavior.  During interview, on the afternoon of 10/2/12, the ED Nurse Manager confirmed the lack of evidence to: consistently warrant the need for continued use of restraints; to attempt to engage patients in an effort to determine ability to contract for safe behavior and to employ less restrictive interventions to affect a change in behavior prior to initiating the restraints.	C 152		
C 200	Refer to C-0271 485.618 EMERGENCY SERVICES  The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.  This CONDITION is not met as evidenced by: Based on staff interview and record review, the CAH Emergency Services failed to provide qualified and sufficient personnel necessary to furnish all services offered in a safe manner in accordance with hospital policies and procedures, compliance with State law and acceptable standards of practice, for 3 of 4 applicable patients. (Patients #2, #5 and #11). Findings	C 200		

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C 200	<p>Continued From page 3 include:</p> <p>Per record review staff failed to provide care in accordance with the facility's policy for restraint use for Patients #2, #5 and #11, all of whom were physically restrained during the course of their respective individual treatment in the ED (Emergency Department). Each of the patients had an extended length of stay in the ED, exceeding 24 hours, while awaiting available bed placement for involuntary admission to an inpatient psychiatric unit.</p> <p>Per record review the policy, titled Physical and Chemical Restraints, approved 12/2010, and identified by staff as the currently established facility policy, stated, under Safety Policy Statement: "Patients and staff have the right to be treated with respect and dignity in a safe environment....., the use of restraint is undertaken as a last resort in the management of the patient's behavior..... the patient should be engaged (if not clinically contraindicated) in identifying alternative safety interventions to minimize and possibly avoid the use of restraints....The restraint policy must be adhered to when restraints are used." And, under Restraint Use in the Violent/Assaultive Patient (Behavior); "B. Initiation of Restraint: 1....The need for restraints is based on patient's assessed needs and discussed with the patient and/or family (as appropriate) around the time of use or as soon as practical; C. Orders: PRN (as necessary) orders are not acceptable. 1. The use of restraint requires an order from a Physician.....The physician must be notified, perform a face to face assessment of the patient and document a written order for restraint on the</p>	C 200		
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C 200	<p>Continued From page 4</p> <p>restraint order form within 1 hour of the application; 2. Order Content: c. Continuation of Restraints: i. A collaborative decision to continue restraints will necessitate a verbal or written order....ii. To continue restraint beyond 8 hrs adult.....requires the physician to perform a face to face evaluation of the patient and personally write a restraint order....E. Re assessment of the Patient; 1. The patient is re assessed by a RN at least every 15 minutes for the need for continued restraint...a. Re assessment addresses the: ii. patient's rights, dignity and safety, iii. use of least restrictive methods of restraint, iv. changes in the patient's behavior or clinical condition warranting a trial removal of restraints...b. Re assessment includes: iii. need for continued restraint." The policy further states; "The restraints are to be removed as soon as the violent/assaultive behavior has resolved AND the patient is able to contract for his/her safety and the safety of others."</p> <p>1. Per record review Patient #2 was brought to the ED, by law enforcement escort, at 1:05 AM on the morning of 4/29/12, for evaluation of paranoid ideation with homicidal ideation. The patient's behavior over the next several hours was described as anxious, hyper-verbal, and in "no apparent distress". The record indicated that law enforcement remained in the patient's presence throughout this period. A nurse's note, at 10:00 AM, stated "Pt escalating, attempts to calm without affect. Pt made for exit, sheriff intervene, onto floor. With assist from ED staff was restrained with cuffs, hands behind back." Although a subsequent note 48 minutes later, at 10:48 AM, stated the patient was calmer, indicating a change in behavior that may have</p>	C 200			

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C 200	Continued From page 5 warranted a trial removal of the restraints, there was no evidence that an attempt was made, in accordance with the facility's policy, to re-assess the patient for the continued need for restraint, or to engage the patient to determine ability to contract for safety of self and others at that time. Instead, the note further stated that soft restraints were applied to both hands and lower legs. Nurses's notes throughout the day indicated that a sitter as well as law enforcement remained with the patient, and the patient remained calm and cooperative. A note, at 3:00 PM, stated that the patient was awake and alert and handcuffed to a chair. A note at 3:35 PM stated; "restraints and handcuffs remain." It was not until 5:06 PM, 7 hours after the initiation of the restraint, that a nurse's note indicated that 3 of 4 restraints had been removed leaving the left arm handcuffed to the left side rail. However, and although there was still no evidence that the patient was a danger to self or others, a nurse's note at 7:15 PM stated that the patient was stable, the right arm was free of restraint and the left arm handcuffed to the left side rail, feet remain shackled with cuffs. Despite the evidence that Patient #2 was calm and cooperative and was not posing a danger to self/others, and although law enforcement personnel and a sitter remained with the patient throughout the patient's stay, there was no evidence of ongoing assessments by nursing or physicians, in accordance with facility policy, for the need to continue use of restraints, and the patient remained in physical restraints for a period of over 24 hours. A nurse's note, at 11:50 AM on 4/30/12 indicated that although wrist restraints were removed, the patient continued to have his/her legs shackled together. A psych consult note, dated 4/30/12, stated the patient	C 200			

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C 200	<p>Continued From page 6</p> <p>had requested to keep his/her ankles restrained so s/he would not be tempted to run. However the consult note did not include the time the entry was made and a separate psych consult, also dated 4/30/12, indicated there had been a question regarding the need for the continued restraints, since the patient was calm. The note indicated that per discussion with the sheriff, who was present at the time of the consult, there was a concern "about flight and safety so determined restraints needed." Despite this, there was no evidence that any re-assessment had ever been completed by nursing or physicians to determine continued need for use of ankle restraints, and the record indicated that the patient's legs remained shackled until s/he was transferred to another facility at 12:54 PM on 5/1/12. In addition there were no physician orders, in accordance with the policy, for the initiation or ongoing use of restraints.</p> <p>The ED Nurse Manager stated, during interview on the afternoon of 10/2/12, that metal hand cuffs and/or leg shackles should not have been used on Patient #2. S/he stated that although law enforcement remained in the presence of Patient #2 throughout his/her ED stay, the determination for the use and/or continued use of physical restraints, as well as the determination of type of restraint utilized, was the responsibility of the physician only.</p> <p>2. Per record review Patient #5 was transported by ambulance to the ED at 2:49 AM on 7/22/12 for evaluation and treatment of anxiety, psychosis and delusions. Records indicated that the patient, who arrived in the ED with arms hand cuffed behind his/her back, was agitated, yelling and verbally threatening staff and police with violence.</p>	C 200		

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C 200	<p>Continued From page 7</p> <p>A nurse's note at 5:06 AM stated that Patient #5 became more agitated and aggressive towards a staff member from the community Crisis Center, resulting in the decision to apply soft restraints to all 4 extremities. Although the record indicated that the patient remained angry and threatening towards staff at 5:34 AM a subsequent nurse's note, at 6:09 AM stated the patient appeared to be sleeping. During the subsequent 6 hour period between 6:30 AM and 12:30 PM there was no evidence of ongoing assessments by nursing or physicians that determined the need for the continued use of 4 point restraints, in accordance with the facility's policy. In addition there was no evidence that an attempt had been made to engage the patient to determine his/her ability to contract for safety of self/others. A note at 1:06 PM identified that the patient was again combative and verbally threatening towards staff and remained in 4 point restraints. At 7:58 PM a note stated the patient was more cooperative and, although a subsequent note, at 8:45 PM, revealed that both ankle restraints and the right wrist restraint had been removed for "a trial", allowing the patient to ambulate some, the restraints were re-applied, without evidence that warranted the continued need for them. In addition, although a note, dated 7/23/12 at 5:00 AM, indicated the patient was awake and appropriate wrist restraints were not discontinued until 5:45 AM and, despite the ongoing presence of law enforcement and a sitter with the patient, there was no evidence that the ankle restraints were ever removed throughout the remainder of the patient's stay.</p> <p>3. Review of records for Patient #11 revealed that the patient arrived in the ED at 9:58 AM on</p>	C 200		
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C 200	Continued From page 8 6/21/12, with law enforcement escort, for evaluation and treatment of a psychiatric disorder after being found "wandering on the street.....not answering questions approp.". Although there was no previous evidence of restraint use, a nurse's note, at 10:08 AM, stated; "cuffs removed by mpd (law enforcement agency) at request of md and nurse manager", indicating that the patient had been restrained for a period of time. A subsequent note, at 11:53 AM, stated; "pt placed in restraint-attempted to elope emergency department". The next nursing note, at 1:57 PM, stated; "pt attempted to stand and remove restraints, 4th restraint reapplied." There was no indication that the patient had posed a threat of harm to self or others nor any evidence that less restrictive interventions had been attempted, in accordance with the facility policy, prior to the use of physical restraints. Although there was no evidence of nursing or physician assessment that warranted use of restraints, and no physician order for their use, a physician note, at 3:01 PM, stated; "Restraining this patient who has been at risk of harming self and desires to flee the department was initiated. Continuos re assessment and visualization. Respite required re restraint." Despite the fact that staff had utilized the facility's Suicide Risk Flowsheet and Restraint Flowsheet for Violent/Assaultive Patient forms(many of which lacked dates) to document observations of patient status, there was no evidence of ongoing re-assessment by nursing or physicians of the need to continue the use of restraints for the greater than 24 hour period between 1:57 PM on 6/21/12 and 3:00 PM on 6/22/12. And although a nurse's note, at 3:00 PM on 6/22/12 stated Patient #11 was "resting in restraints with one leg out of restraints per MD",	C 200			

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C 200	<p>Continued From page 9</p> <p>and a subsequent note at 4:25 PM indicated the patient was kicking the free leg at the sheriff necessitating the need for reapplication of the 4th restraint, the only physician order for the restraints, dated 6/22/12 at 1:20 PM, stated; "Restraint - PRN - per protocol", a violation of the policy which stated PRN orders are not acceptable. The record further indicated that the patient remained in 4 point restraints for the subsequent 8 and a half hours, until 12:59 AM on 6/23/12, when the wrist restraints were removed to allow the patient to stretch his/her arms before the restraints were reapplied. In addition, although there continued to be no evidence to warrant the ongoing need for restraints, a subsequent note, at 1:29 AM, stated that the physician had recommended "patient continues on 4 point restraints due to violence this afternoon, after 2 restraints had been removed even after patient had agreed to stay safe" and Patient #11 remained in restraints from until 4:30 AM.</p> <p>During interview, on the afternoon of 10/2/12, the ED Nurse Manager confirmed the failure of staff to follow the facility's restraint policy, in all the aforementioned examples, regarding: lack of evidence of ongoing assessments by nursing staff, for the continued need for physical restraints; lack of evidence that less restrictive interventions were consistently employed by staff prior to the use of restraints; lack of consistently engaging the patient to determine ability to contract for safe behavior and lack of physician orders for use of restraints. The Nurse Manager further stated that annual competency in the use of chemical and physical restraints was conducted by the Staff Educator, and confirmed</p>	C 200			

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C 200	Continued From page 10 that it had last been completed approximately 1 and a half years ago. The Nurse Manager also stated that s/he felt that it was difficult to assure safe care to all patients at all times in the ED related to a lack of physical space to place patients, lack of staffing, and lack of appropriate education and training for staff who care for patients with violent/assaultive behaviors. S/he further stated that normal staffing patterns included 2 RNs from 11 PM to 11 AM and 3 RNs from 11 AM to 11 PM, and that, although average number of patients seen has increased recently, as has the number of patients with behavior issues, there has been no increase in the staffing patterns to accommodate that change. Per interview, at 3:51 PM on 10/2/12, the Staff Educator confirmed that s/he had not completed the annual restraint competency for the ED staff since mid year of 2011. S/he stated that although s/he had become aware, soon after the fact, that ED staff had completed their 2012 competency day, s/he did not reschedule a time to assure training in restraint competency was completed.  References: Agency for Healthcare Research and Quality (AHRQ) publication No. 11 (12) -0094 Improving PT Flow and Reducing Emergency Department Crowding. A Guide for Hospitals AHRQ: Ann Emerg Med. 2009 Jun;53(6):715-23.e1. Epub 2008 Dec 3. The safety of emergency care systems: Results of a survey of clinicians in 65 US emergency departments. Lippincott Manual of Nursing Practice, Eight Edition: "National League of Nursing Statement on Patient Rights" ; Chapter II; Page 13.	C 200			
C 271	485.635(a)(1) PATIENT CARE POLICIES	C 271			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/02/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PORTER HOSPITAL, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>115 PORTER DRIVE</b> <b>MIDDLEBURY, VT 05753</b>
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C 271	<p>Continued From page 11</p> <p>The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.</p> <p>This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interviews the facility failed to provide care and services in accordance with established policies for 3 of 4 applicable patients. (Patients #2, #5 and #11). Findings include:</p> <p>Per record review staff failed to provide care in accordance with the facility's policy for restraint use for Patients #2, #5 and #11, all of whom were physically restrained during the course of their respective individual treatment in the ED (Emergency Department). Each of the patients had an extended length of stay in the ED, exceeding 24 hours, while awaiting available bed placement for involuntary admission to an inpatient psychiatric unit.</p> <p>Per record review the policy, titled Physical and Chemical Restraints, approved 12/2010, and identified by staff as the currently established facility policy, stated, under Safety Policy Statement: "Patients and staff have the right to be treated with respect and dignity in a safe environment....., the use of restraint is undertaken as a last resort in the management of the patient's behavior..... the patient should be engaged (if not clinically contraindicated) in identifying alternative safety interventions to minimize and possibly avoid the use of restraints....The restraint policy must be adhered to when restraints are used." And, under</p>	C 271		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

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C 271	<p>Continued From page 12</p> <p>Restraint Use in the Violent/Assaultive Patient (Behavior); "B. Initiation of Restraint: 1....The need for restraints is based on patient's assessed needs and discussed with the patient and/or family (as appropriate) around the time of use or as soon as practical; C. Orders: PRN (as necessary) orders are not acceptable. 1. The use of restraint requires an order from a Physician.....The physician must be notified, perform a face to face assessment of the patient and document a written order for restraint on the restraint order form within 1 hour of the application; 2. Order Content: c. Continuation of Restraints: i. A collaborative decision to continue restraints will necessitate a verbal or written order....ii. To continue restraint beyond 8 hrs adult.....requires the physician to perform a face to face evaluation of the patient and personally write a restraint order....E. Re assessment of the Patient; 1. The patient is re assessed by a RN at least every 15 minutes for the need for continued restraint...a. Re assessment addresses the: ii. patient's rights, dignity and safety, iii. use of least restrictive methods of restraint, iv. changes in the patient's behavior or clinical condition warranting a trial removal of restraints...b. Re assessment includes: iii. need for continued restraint." The policy further states; "The restraints are to be removed as soon as the violent/assaultive behavior has resolved AND the patient is able to contract for his/her safety and the safety of others."</p> <p>1. Per record review Patient #2 was brought to the ED, by law enforcement escort, at 1:05 AM on the morning of 4/29/12, for evaluation of paranoid ideation with homicidal ideation. The patient's behavior over the next several hours was</p>	C 271		

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

PRINTED: 07/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

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C 271	Continued From page 13 described as anxious, hyper-verbal, and in "no apparent distress". The record indicated that law enforcement remained in the patient's presence throughout this period. A nurse's note, at 10:00 AM, stated "Pt escalating, attempts to calm without affect. Pt made for exit, sheriff intervene, onto floor. With assist from ED staff was restrained with cuffs, hands behind back." Although a subsequent note 48 minutes later, at 10:48 AM, stated the patient was calmer, indicating a change in behavior that may have warranted a trial removal of the restraints, there was no evidence that an attempt was made, in accordance with the facility's policy, to re-assess the patient for the continued need for restraint, or to engage the patient to determine ability to contract for safety of self and others at that time. Instead, the note further stated that soft restraints were applied to both hands and lower legs. Nurses's notes throughout the day indicated that a sitter as well as law enforcement remained with the patient, and the patient remained calm and cooperative. A note, at 3:00 PM, stated that the patient was awake and alert and handcuffed to a chair. A note at 3:35 PM stated; "restraints and handcuffs remain." It was not until 5:06 PM, 7 hours after the initiation of the restraint, that a nurse's note indicated that 3 of 4 restraints had been removed leaving the left arm handcuffed to the left side rail. However, and although there was still no evidence that the patient was a danger to self or others, a nurse's note at 7:15 PM stated that the patient was stable, the right arm was free of restraint and the left arm handcuffed to the left side rail, feet remain shackled with cuffs. Despite the evidence that Patient #2 was calm and cooperative and was not posing a danger to self/others, and although law	C 271			

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

PRINTED: 07/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/02/2012</b>
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C 271	<p>Continued From page 14</p> <p>enforcement personnel and a sitter remained with the patient throughout the patient's stay, there was no evidence of ongoing assessments by nursing or physicians, in accordance with facility policy, for the need to continue use of restraints, and the patient remained in physical restraints for a period of over 24 hours. A nurse's note, at 11:50 AM on 4/30/12 indicated that although wrist restraints were removed, the patient continued to have his/her legs shackled together. A psych consult note, dated 4/30/12, stated the patient had requested to keep his/her ankles restrained so s/he would not be tempted to run. However the consult note did not include the time the entry was made and a separate psych consult, also dated 4/30/12, indicated there had been a question regarding the need for the continued restraints, since the patient was calm. The note indicated that per discussion with the sheriff, who was present at the time of the consult, there was a concern "about flight and safety so determined restraints needed." Despite this, there was no evidence that any re-assessment had ever been completed by nursing or physicians to determine continued need for use of ankle restraints, and the record indicated that the patient's legs remained shackled until s/he was transferred to another facility at 12:54 PM on 5/1/12. In addition there were no physician orders, in accordance with the policy, for the initiation or ongoing use of restraints.</p> <p>The ED Nurse Manager stated, during interview on the afternoon of 10/2/12, that metal hand cuffs and/or leg shackles should not have been used on Patient #2. S/he stated that although law enforcement remained in the presence of Patient #2 throughout his/her ED stay, the determination for the use and/or continued use of physical</p>	C 271		

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

PRINTED: 07/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

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C 271	<p>Continued From page 15</p> <p>restraints, as well as the determination of type of restraint utilized, was the responsibility of the physician only.</p> <p>2. Per record review Patient #5 was transported by ambulance to the ED at 2:49 AM on 7/22/12 for evaluation and treatment of anxiety, psychosis and delusions. Records indicated that the patient, who arrived in the ED with arms hand cuffed behind his/her back, was agitated, yelling and verbally threatening staff and police with violence. A nurse's note at 5:06 AM stated that Patient #5 became more agitated and aggressive towards a staff member from the community Crisis Center, resulting in the decision to apply soft restraints to all 4 extremities. Although the record indicated that the patient remained angry and threatening towards staff at 5:34 AM a subsequent nurse's note, at 6:09 AM stated the patient appeared to be sleeping. During the subsequent 6 hour period between 6:30 AM and 12:30 PM there was no evidence of ongoing assessments by nursing or physicians that determined the need for the continued use of 4 point restraints, in accordance with the facility's policy. In addition there was no evidence that an attempt had been made to engage the patient to determine his/her ability to contract for safety of self/others. A note at 1:06 PM identified that the patient was again combative and verbally threatening towards staff and remained in 4 point restraints. At 7:58 PM a note stated the patient was more cooperative and, although a subsequent note, at 8:45 PM, revealed that both ankle restraints and the right wrist restraint had been removed for "a trial", allowing the patient to ambulate some, the restraints were re-applied, without evidence that warranted the continued need for them. In</p>	C 271		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2013  
FORM APPROVED  
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C 271	<p>Continued From page 16</p> <p>addition, although a note, dated 7/23/12 at 5:00 AM, indicated the patient was awake and appropriate wrist restraints were not discontinued until 5:45 AM and, despite the ongoing presence of law enforcement and a sitter with the patient, there was no evidence that the ankle restraints were ever removed throughout the remainder of the patient's stay.</p> <p>3. Review of records for Patient #11 revealed that the patient arrived in the ED at 9:58 AM on 6/21/12, with law enforcement escort, for evaluation and treatment of a psychiatric disorder after being found "wandering on the street.....not answering questions approp.". Although there was no previous evidence of restraint use, a nurse's note, at 10:08 AM, stated; "cuffs removed by mpd (law enforcement agency) at request of md and nurse manager", indicating that the patient had been restrained for a period of time. A subsequent note, at 11:53 AM, stated; "pt placed in restraint-attempted to elope emergency department". The next nursing note, at 1:57 PM, stated; "pt attempted to stand and remove restraints, 4th restraint reapplied." There was no indication that the patient had posed a threat of harm to self or others nor any evidence that less restrictive interventions had been attempted, in accordance with the facility policy, prior to the use of physical restraints. Although there was no evidence of nursing or physician assessment that warranted use of restraints, and no physician order for their use, a physician note, at 3:01 PM, stated; "Restraining this patient who has been at risk of harming self and desires to flee the department was initiated. Continuos re assessment and visualization. Respite required re restraint." Despite the fact that staff had utilized</p>	C 271			

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

PRINTED: 07/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

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C 271	<p>Continued From page 17</p> <p>the facility's Suicide Risk Flowsheet and Restraint Flowsheet for Violent/Assaultive Patient forms(many of which lacked dates) to document observations of patient status, there was no evidence of ongoing re-assessment by nursing or physicians of the need to continue the use of restraints for the greater than 24 hour period between 1:57 PM on 6/21/12 and 3:00 PM on 6/22/12. And although a nurse's note, at 3:00 PM on 6/22/12 stated Patient #11 was "resting in restraints with one leg out of restraints per MD", and a subsequent note at 4:25 PM indicated the patient was kicking the free leg at the sheriff necessitating the need for reapplication of the 4th restraint, the only physician order for the restraints, dated 6/22/12 at 1:20 PM, stated; "Restraint - PRN - per protocol", a violation of the policy which stated PRN orders are not acceptable. The record further indicated that the patient remained in 4 point restraints for the subsequent 8 and a half hours, until 12:59 AM on 6/23/12, when the wrist restraints were removed to allow the patient to stretch his/her arms before the restraints were reapplied. In addition, although there continued to be no evidence to warrant the ongoing need for restraints, a subsequent note, at 1:29 AM, stated that the physician had recommended "patient continues on 4 point restraints due to violence this afternoon, after 2 restraints had been removed even after patient had agreed to stay safe" and Patient #11 remained in restraints until 4:30 AM.</p> <p>During interview, on the afternoon of 10/2/12, the ED Nurse Manager confirmed the failure of staff to follow the facility's restraint policy, in all the aforementioned examples, regarding: lack of evidence of ongoing assessments by nursing</p>	C 271		

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

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C 271	Continued From page 18 staff, for the continued need for physical restraints; lack of evidence that less restrictive interventions were consistently employed by staff prior to the use of restraints; lack of consistently engaging the patient to determine ability to contract for safe behavior and lack of physician orders for use of restraints.	C 271		
C 302	485.638(a)(2) RECORDS SYSTEMS  The records are legible, complete, accurately documented, readily accessible, and systematically organized.  This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interview, the facility failed to assure that all records were complete and accurately documented for 3 of 11 records reviewed. (Patients #2, #5 and #11). Findings include:  Per record review Patients #2, #5 and #11, each had an extended length of stay in the ED, exceeding 24 hours, while awaiting available bed placement for involuntary admission to an inpatient psychiatric unit. During the course of stay each of the respective patients was physically restrained, with use of hand cuffs, and/or leg shackles and/or soft restraints for extended periods of time and the following was revealed during medical record review, conducted on 10/1/12 and 10/2/12:  1. Per record review Patient #2 was admitted to the ED on the morning of 4/29/12 and transferred to another facility on 5/1/12, and, during that stay the patient remained in physical restraints for a period of greater than 48 hours. Although the facility restraint policy stated that the use of	C 302		

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

PRINTED: 07/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

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C 302	<p>Continued From page 19</p> <p>restraint requires an order from a physician and written orders for restraint are time limited to 4 hours, there were no physician orders for use of restraints. In addition, although the facility's Restraint Flowsheet for Cognitively Impaired Med/Surg Patient forms were used to document patient assessments the forms were not completely filled out and lacked dates.</p> <p>2. Per review, Patient #5 was admitted to the ED at 2:49 AM on 7/22/12, and transferred to another facility on the afternoon of 7/23/12. Although the patient remained in physical restraints throughout his/her stay, there was no nursing or physician documentation of his/her status for a greater than 6 hour period between 12:52 PM and 7:06 PM on 7/22/12, and although information was documented on Restraint Flow Sheets only one of the 12 sheets utilized contained a date. In addition the Physician Documentation record inaccurately identified the patient's disposition on 7/23/12 as discharged to home when the patient was actually transferred to another facility.</p> <p>3. Per record review Patient #11, admitted at 9:58 AM and discharged on the morning of 6/23/12, was physically restrained for a period of greater than 24 hours. Despite the extended period of time in restraints there were only two physician orders for their use and there was no nursing or physician documentation of the patient's status between the hours of 3:03 PM on 6/21/12 and 3:00 PM on 6/22/12. Although staff utilized facility Suicide Risk Flow sheet and Restraint Flow sheet forms for documentation purposes, only 6 of the 18 forms used contained dates, 5 of which were dated 6/22/12.</p>	C 302			

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

PRINTED: 07/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/02/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PORTER HOSPITAL, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>115 PORTER DRIVE</b> <b>MIDDLEBURY, VT 05753</b>
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C 302	Continued From page 20 Per interview, on the afternoon of 10/2/12, the ED Nurse Manager confirmed the lack of documentation in all above medical records.	C 302		
C 330	485.641 PERIODIC EVALUATION & QA REVIEW  Periodic Evaluation and Quality Assurance Review	C 330		
	This CONDITION is not met as evidenced by: Based on staff interview and record review the facility failed to implement, in a timely manner, corrective actions developed as the result of a recognized deficient practice and failed to include in their quality assurance program all sources of information that could lead to potential opportunities for quality assessment and improvement.			
C 336	Refer to Tag C-0336 485.641(b) QUALITY ASSURANCE  The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that --  This STANDARD is not met as evidenced by: Based on record review and confirmed through staff interviews the facility failed to implement, in a timely manner, corrective actions developed as the result of a recognized deficient practice and	C 336		

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

PRINTED: 07/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>471307</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/02/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PORTER HOSPITAL, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>115 PORTER DRIVE</b> <b>MIDDLEBURY, VT 05753</b>
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C 336	<p>Continued From page 21</p> <p>failed to include in their quality assurance program all sources of information that could lead to potential opportunities for quality assessment and improvement. Findings include:</p> <p>1. Per record review staff failed to provide care in accordance with the facility's policy for restraint use for Patient #2, who was physically restrained during the course of his/her treatment in the ED (Emergency Department), on 4/29/12 through 5/1/12, while awaiting available bed placement for involuntary admission to an inpatient psychiatric unit. The patient was physically restrained for extended periods of time during his/her stay, without: evidence of ongoing reassessments to determine continued need for the restraints; evidence that less restrictive methods had been employed prior to the initiation/continued use of restraints; evidence of attempts to engage the patient to determine ability to contract for safe behavior or evidence of appropriate physician orders for the restraints. The ED Nurse Manager confirmed, during interview on the afternoon of 10/2/12, that deficient practice had been identified related to use of restraints for Patient #2, and as a result a memo directing nursing staff to review the restraint policy had been placed in each staff member's mailbox sometime in August of 2012. S/he further stated that annual competency in the use of chemical and physical restraints was conducted by the Staff Educator, and confirmed that it had last been completed approximately 1 and a half years ago. The Nurse Manager also stated that s/he felt that it was difficult to assure safe care to all patients at all times in the ED related to a lack of physical space to place patients, lack of staffing, and lack of appropriate</p>	C 336		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2013  
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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	
C 336	Continued From page 22 education and training for staff who care for patients with violent/assaultive behaviors. Per interview, at 3:51 PM on 10/2/12, the Staff Educator confirmed that s/he had not completed the annual restraint competency for the ED staff since mid year of 2011. S/he stated that although s/he had become aware, soon after the fact, that ED staff had completed their 2012 competency day (which did not include restraint training), s/he did not reschedule a time to assure training in restraint competency was completed. S/he further stated that although the restraint competency had recently been completed for staff caring for inpatients, despite the identification of deficient practice related to use of restraints in the ED, the competency had still not been completed for ED staff. During interview, on the afternoon of 10/2/12, the Quality and Risk Manager acknowledged that the issue of deficient practice regarding use of restraints had been identified through an investigation conducted as the result of a complaint filed with the facility on July 30, 2012. S/he stated that a plan to correct the deficient practice had been developed and included: quality review of all restraint use; the restraint policy was revised; implementation of use of paper forms for documentation of care of ED patients for whom restraints are used. In addition, s/she stated that regardless of whether or not patients present to the ED with metal handcuffs in place, it is the facility's requirement that the handcuffs will be removed and use of soft restraints employed if necessary. S/he stated that a plan had been made for the ED Medical Director and Nurse Manager to meet with law enforcement personnel to discuss the policy and the role of law enforcement in the ED. The	C 336			

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

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C 336	<p>Continued From page 23</p> <p>Quality Manager also stated that the issue of appropriate levels of staffing and physical space had also been discussed.</p> <p>Despite the action plan identified, the Quality and Risk Manager confirmed that, as of 10/2/12, the facility had not implemented the new restraint policy, the meeting between the ED clinical management staff and law enforcement had not occurred and no changes had been made to staffing levels or identification of appropriate physical placement of patients who exhibit violent/assaultive behavior.</p> <p>2. During afternoon interview on 10/2/12, the Quality and Risk Manager stated that s/he had become aware, following receipt of a formal complaint on 7/30/12, that a prior written request had been made to the Medical Records department for the same record on 5/29/12. S/he stated that, although it was not formally included in the facility quality program, s/he had asked the Director of Medical Records, sometime after 7/30/12, to notify him/her of any request for medical records so the records could be reviewed for quality and risk management purposes. Per review of medical records on 10/2/12, an outside request for the medical record of a patient was identified by the surveyor. The request was dated September, 2012. Despite the conversation and direction from the Quality Risk Manager to the Director of Medical Records for notification when a request for a medical record is made to the Medical Records department, the Quality Manager was not aware of the recent request until informed by the surveyor, thereby missing a potential opportunity to identify and correct potential quality deficient practice in a timely manner.</p>	C 336		