

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 21, 2013

Tom Huebner, Administrator
Rutland Regional Medical Center
160 Allen St
Rutland, VT 05701

Provider ID #:470005

Dear Mr. Huebner:

On **March 21, 2013**, a complaint investigation was completed at your facility which resulted in Standard Level Deficiencies. Subsequently, you submitted a plan of correction for that complaint investigation even though a plan of correction was not required.

Thank you for the Plan of Correction and it will be put in your facility file.

Sincerely,



Frances L. Keeler, RN, MSN, DBA
Assistant Division Director
Director State Survey Agency

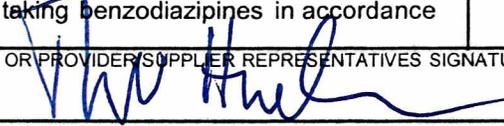
Enclosure



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

PRINTED: 04/10/2013
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470005	(X2) MULTIPLE CONSTRUCTION A. BUILDING ----- B. WING	(X3) DATE SURVEY COMPLETED C 03/21/2013
NAME OF PROVIDER OR SUPPLIER RUTLAND REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 160 ALLEN ST RUTLAND, VT 05701	
(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	A000	A131 Patient Rights: Informed	Complete by 8/31/13
A 131	<p>An onsite unannounced complaint investigation was completed by the Department of Licensing and Protection on 3/21/13 as authorized by the Centers for Medicare and Medicaid. The following regulatory violations were identified.</p> <p>482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT</p> <p>The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care.</p> <p>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. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to respect the right to refuse a specific medical intervention during the course of hospitalization for 1 patient. (Patient #4). Findings include:</p> <p>Per record review Patient #4 presented to the ED at 6:48PM on 11/27/12, with depression, suicidal ideation and mental status changes. A note by the ED provider stated the patient had gone to ED, reported an interest in talking to Crisis and was having thoughts of harming self and a history of attempts. The note further identified that the patient had a significant mental health history including PTSD and bipolar anxiety. The patient did report taking benzodiazepines in accordance</p>	A 131	<p>Rutland Regional Medical Center (the Hospital) acknowledges that, as identified on page 5 of 14 of this report, the physician failed to document, as required by the Hospital's Informed Consent policy, his / her decision that the patient's condition represented an emergency and the initiation of the procedure was immediately necessary to prevent serious patient harm. In addition, Rutland Regional Medical Center acknowledges that there was inadequate communication with the patient and among the treatment providers regarding the risks of not initiating the procedure and potential alternatives. In order to address this, the Hospital has taken the following actions:</p> <ul style="list-style-type: none"> • Provide education to the following groups of physicians on Informed Consent and Restraints, and documentation of consent issues in the context of an emergency: Emergency Department, Hospitalists, Intensivists, Psychiatrists, and other physicians who admit patients to the Hospital. The education includes the following elements: <ul style="list-style-type: none"> ○ Patient rights to informed consent ○ RRMC informed consent policy ○ Emergency exception to informed consent ○ Documentation of the physician's decision making in the context of an emergency ○ How informed consent applies to agents, guardians, and family members <p>Responsible person: RRMC Chief Compliance Officer</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE  TITLE **President** (X6) DATE **6/10/13**

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 131	Continued From page 1 with his/her prescription and reportedly denied overdose of medication on that date, but presented extremely drowsy with somewhat slurred speech. S/he stated a past medical history of a blood clotting disorder as well as DVT (Deep Vein Thrombosis), and reported that s/he had injected him/herself with 2 doses of Lovenox (medication used to prevent blood clotting), in the hopes it would cause bleeding from old self inflicted neck wounds, and cause death. The ED note also indicated that the patient denied any urinary symptoms, and a urine toxicology screen, collected while the patient was in the ED, showed evidence of benzodiazepines and marijuana. The ED provider note further stated that the patient appeared extremely sleepy and the provider questioned if the patient had ingested more benzodiazepines that s/he had admitted to. The note stated the patient did have Crisis screening done and it was recommended the patient be admitted for 1:1 observations, and then inpatient psychiatric consult, all of which was agreed upon by the patient. The patient was admitted to a medical unit at 1:13 AM on 11/28/12. The H&P (History and Physical), completed on 11/28/12 at 12:20 AM by Physician #1, under whose care Patient #4 was admitted, reiterated that the patient had visited the ED seeking someone to talk to as s/he was considering suicide and had a history of previous suicide attempts. The H&P further stated that a Crisis worker had evaluated the patient, deemed him/her a suicide risk and suggested 1:1 observation. Despite the reference made to Crisis screening by both the ED provider and Physician #1, there was no documentation regarding this consult in the medical record.	A 131	A131 continued <ul style="list-style-type: none"> Communication to the Medical Staff on Informed Consent and documentation of consent issues in the context of an emergency. The communication included the following elements: <ul style="list-style-type: none"> ○ Patient rights to informed consent ○ RRMC informed consent policy ○ Emergency exception to informed consent ○ Documentation of the physician's decision making in the context of an emergency ○ How informed consent applies to agents, guardians, and family members. <p>Responsible person: RRMC Chief Medical Officer</p> <ul style="list-style-type: none"> Measure of effectiveness: All physicians identified above must complete the education sessions either in person or through an online or hard copy learning module by the complete date of August 31, 2013. Quality Assurance / Performance Improvement (QAPI): A Restraint & Involuntary Procedure Review Team will be formed to ensure that the Hospital Informed Consent policy was followed for emergency procedures and documentation to support the physician's decision. This team will meet weekly to conduct review of any restraints initiated since their last meeting. 	Complete by 7/31/13
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J L Hand 6/10/13

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A 131	Continued From page 2 A Restraint and Seclusion Physician Progress Note, dated 11/28/12 at 4:20 AM, and completed by Physician #1, identified the Reason for Restraint as "Prevention self harm". The note stated that the patient, who was admitted to medical service for close observation until mental status cleared, prior to transfer to psychiatric services, became agitated once on the floor, yelling and screaming that s/he was going to leave the hospital AMA (against medical advice) and attempted to physically leave. "At this point [his/her] safety was paramount and [s/he] was placed into 4 point restraints. [S/he] seemed calmer after this was taken care of." Nursing notes indicate the patient was placed in 4 point restraints, at 3:45AM, as a result of attempts at self harm by head banging. Despite the evidence that restraints were initiated as a result of the patient's self harming behavior, the physician order directed staff to initiate Medical/Surgical Restraints; pt lacks capacity, interfer w/medial tx, keyed velcro, padded side rails. Per the physical exam conducted by Physician #1; "After restraints were place showed a young [male/female] who was still upset, still very negative and refusing many aspects of care." The note further stated there was some distention of the suprapubic area and a bladder scan revealed over 900 cc of urine in the bladder. The patient refused to use a bedpan and a straight cath was ordered. The patient stated s/he did not want a straight cath. A Nurse's Note stated that at 4:15AM the patient had reported a need to void. Although there was evidence that nursing staff offered use of a bedpan on multiple occasions, the patient refused it and there was no evidence that the patient was	A 131	<p>A131 continued</p> <ul style="list-style-type: none"> The results from this QAPI will be shared with the relevant leaders and staff from the areas involved. Results indicating non-compliance with the new process will require immediate corrective action to bring the department or physician back into full compliance with the requirements and policy. <p>Responsible person: Director of Quality Improvement, Chief Medical Officer</p> <p>A154 Use of Restraint or Seclusion</p> <p>In order to protect and promote each patient's right to be free from restraint or seclusion, and that 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, Rutland Regional Medical Center has taken the following actions:</p> <ul style="list-style-type: none"> Develop a revised restraint & seclusion process guided by an "Emergency Involuntary Procedure," Flow Sheet, and Patient Assessment documents. The revised process and documents are designed in a manner that effectively allow the physician, nurse 	Team to begin meeting 6/14/13 and ongoing	

R L Hurd 6/10/13

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A 131	<p>Continued From page 3</p> <p>provided the option of using the bathroom or bedside commode. Although the patient also refused straight catheter, s/he was subsequently restrained by several nurses while a straight cath procedure was completed, and 1000 cc of urine was obtained. The nurse's note indicated that upon completion of the catheterization, the patient was calm in bed. A subsequent note, documented in the Clinician Notification section of the record, at 10:25 AM on 11/28/12, stated that the physician was notified of the patient's report of inability to void. A bladder scan revealed 600 cc of urine and a subsequent note, at 11:15 stated the patient had reported an inability to void, a bladder scan revealed over 800 cc of urine in the bladder, the patient was accepting of a catheter and a straight cath procedure was performed in which over 800 cc of urine was obtained. Although the patient remained hospitalized until the morning of 11/29/12, there was no evidence of any further reports of inability to void with or catheterization.</p> <p>During interview, at 11:00 AM on 3/21/13, the VP of Professional Support Services confirmed that a straight cath procedure had been completed on Patient #4 despite the patient's refusal to consent. S/he stated that Physician #1 had made the decision to use a straight cath based on the patient's exam, bladder scan showing a large amount of urine, and the concern of bladder rupture in the setting of the patient's self report of having injected 2 doses of Lovenox. S/he indicated use of the bathroom or bedside commode had reportedly not been offered to the patient, because Physician #1 had been concerned the patient might attempt self harm if restraints were removed. The VP of Medical</p>	A 131	<p>A154 continued</p> <p>and other staff involved to document the indication for initiation of behavioral restraints, the need to consider & document less restrictive alternatives before initiating a restraint on a patient, the need for ongoing assessment & monitoring of the patient's condition while in restraints, and the need to discontinue restraints at the earliest possible time, once the unsafe condition has ended. This new process and supporting documentation is one that is currently used by the Inpatient Psychiatric Services Department at RRMCM and will now be standardized across the organization to other relevant medical, surgical and emergency departments.</p> <ul style="list-style-type: none"> As part of the revised Emergency Involuntary Procedure process and documents, a second person verification step will be added for review of the initiation of behavioral restraints on a patient in our medical, surgical, psychiatric or emergency departments. The purpose of having second person verification is to review & assess the restraint documentation and discuss with relevant staff the sufficiency of indications for the restraint, the consideration of less restrictive alternatives, the continuing necessity of the restraint currently being used, 	Complete by 7/31/13	



6/10/13

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A 131	Continued From page 4 Affairs agreed there was a lack of documentation in the medical record to support the decision by Physician #1 to use a straight catheter to empty the bladder of Patient #4 against his/her wishes. The RN Unit Manager confirmed, during interview at 3:33 PM on 3/20/13, that Patient #4 had been restrained by staff for the purpose of performing a straight cath, despite the patient's refusal to consent to the procedure. The Unit Manager also confirmed the lack of evidence that use of the bathroom or bedside commode had been offered to Patient #4 prior to the straight cath procedure. S/he stated that staff providing care for the patient had reported concern the patient would attempt self harm if restraints were removed.	A 131	<p>A 154 continued</p> <p>assessment & monitoring requirements for the patient, the possibility for earliest discontinuation, and the completeness of the related nursing and physician documentation, all with the intent to maintain patient rights as noted above.</p> <ul style="list-style-type: none"> The employees that will be educated & authorized to conduct the second person verification will include all Nursing Directors, Clinical Managers, and Nurses from the medical, surgical, psychiatric, and emergency departments, and RRMC Patient Flow Managers. Additionally, the revised process will include "one-to-one" continuous monitoring of patients in behavioral restraints by trained patient sitters to adequately assess and monitor the patient's response to the restraints and any sudden changes in patient condition. The results of the assessment and monitoring will be documented by the patient sitter every 15 minutes on designated Flow Sheets. The RRMC policy and procedures on Restraints & Seclusion will be revised to reflect the revised process as described in the above paragraphs. 	Complete 7/31/13	
A 154	482.13(e) USE OF RESTRAINT OR SECLUSION Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to assure that there was indication for initiation of physical restraints and/or that restraints were discontinued at the earliest possible time for 2 applicable patients. (Patients #4 and #7). Findings include: 1. Patient #7 presented to the Emergency	A 154		Complete 7/31/13	Complete by 7/31/13

Handwritten signature and date: [Signature] 6/10/13

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A 154	<p>Continued From page 5</p> <p>Department (ED) on 1/11/13 at 01:52 with a chief complaint of being unable to sleep and stating s/he stopped taking prescribed medication. Prior to arrival, Patient #7 was encouraged by his/her counselor to seek treatment in the ED, requesting an evaluation for suicidal and homicidal ideation. Patient #7 has a past history of depression, anxiety, substance abuse and PTSD. The ED Physician who examined Patient #7 described the patient as "...very tangential and disorganized....." and further states "the patient was demonstrating behaviors that were progressively more agitated and paranoid." Due to these symptoms, Patient #7 accepted Ativan 2 mg orally. Per the ED Note-Nursing states "Pt (patient) is fluctuating from calm and cooperative to violent and enraged. Patient refusing to get undressed into hospital clothing..." The ED physician further states " For staff and patient safety the patient was placed in four-point restraints and treated with Haldol and diphenhydramine". At approximately 02:50 Patient #7 was placed in restraints and was administered chemically restraining medication to include: Haldol 5mg Intramuscular (IM) and diphenhydramine 50 mg IM at 02:47.</p> <p>Per review of the ED record , staff failed to assess and monitor Patient #7's condition on an ongoing basis to ensure that the patient was released from the four-point restraints at the earliest possible time. While the chemical and physical restraints were employed when the ED physician determined the provision of care for Patient #7 was an "unsafe situation", once the unsafe situation ends, the use of restraints should be discontinued. However, Patient #7 remained in restraints for over 3 hours despite the fact the</p>	A 154	<p>A154 continued</p> <ul style="list-style-type: none"> • Education will be provided to nurse leaders, nurses, licensed nursing aides, patient sitters and the Emergency Department, Hospitalists, Intensivists, Psychiatrists, and other physicians who admit patients to the Hospital on the revised Emergency Involuntary Procedure process and documents as described in the paragraph above. • Measure of effectiveness: All employees & physicians identified above must complete the education sessions either in person or through an online or hardcopy learning module by the complete by date of 8/31/13. • Quality Assurance / Performance Improvement: A Restraint & Involuntary Procedure Review Team will be formed to ensure that the following requirements are met: <ul style="list-style-type: none"> ○ The "Emergency Involuntary Procedure" for restraint is completed. ○ Verification of a physician order for restraint initiation or re-order done per requirements. ○ Indication for restraint initiation meets requirements; less restrictive alternatives considered / attempted. ○ Behavioral restraints >4 hours were re-ordered per policy ○ One-ton-one sitter documentation of 15 minutes checks 	Complete by 8/31/13
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Handwritten signature and date: [Signature] 6/10/13

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A 154

Continued From page 6
ED physician had noted ".....due to being too sedated to be fully evaluated." Patient #7 could not be evaluated by crisis services for determination of possible hospitalization.

Per interview on 3/21/13 at 3:55PM the ED Medical Director confirmed the ED physician's written explanation for continued restraint use for Patient #7 "...was limited". The Medical Director also acknowledged the nursing notes did not provide a "...clear explanation" for the ongoing justification for continued use of the restraints.

2. Per record review Patient #4 presented to the ED at 6:48PM on 11/27/12, with depression, suicidal ideation and mental status changes. A note by the ED provider stated the patient had presented to the ED, reported an interest in talking to Crisis and was having thoughts of harming self and had a history of attempts. The note further identified that the patient had a significant mental health history including PTSD and bipolar anxiety. The patient did report taking benzodiazepines in accordance with his/her prescription and reportedly denied overdose of medication on that date, but presented extremely drowsy with somewhat slurred speech. S/he stated a past medical history of a blood clotting disorder as well as DVT (Deep Vein Thrombosis), and reported that s/he had injected him/herself with 2 doses of Lovenox (medication used to prevent blood clotting), in the hopes it would cause bleeding from old self inflicted neck wounds, and cause death. The ED note further stated that the patient appeared extremely sleepy and the provider questioned if the patient had ingested more benzodiazepines that s/he had admitted to. The note stated the patient did have

A 154

A154 continued

- o Restraint discontinuance documented at earliest possible time
- o Nursing assessment & documentation
- o Physician assessment & documentation
- o Second Person verification completed per requirements
- o Crisis screening notes scanned for behavioral restraints if indicated

- The results from this QAPI review will be shared with the relevant leaders and staff from the areas involved. Results indicating non-compliance with the new process will require immediate corrective action to bring the department or physician back into full compliance with the requirements and policy.

Responsible persons: Director of Quality Improvement, Chief Nursing Officer

A188 Patient Rights: Restraint or Seclusion

In order to protect and promote each patient's right to be free from restraint or seclusion, and that 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, Rutland Regional Medical Center has taken the following actions:

Team to begin meeting weekly 6/14/13

Handwritten signature and date: [Signature] 6/10/13

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A 154	<p>Continued From page 7</p> <p>Crisis screening done and it was recommended the patient be admitted for 1:1 observations, and then inpatient psychiatric consult, all of which was agreed upon by the patient. The patient was admitted to a medical unit at 1:13 AM on 11/28/12.</p> <p>The History and Physical, completed on 11/28/12 at 12:20 AM by Physician #1, under whose care Patient #4 was admitted, reiterated that the patient had visited the ED seeking someone to talk to as s/he was considering suicide and had a history of previous suicide attempts A Restraint and Seclusion Physician Progress Note, dated 11/28/12 at 4:20AM, and completed by Physician #1, identified the Reason for Restraint as "Prevention self harm". The note stated that the patient, who was admitted to medical service to clear toxidrome prior to transfer to psychiatric services, became agitated once on the floor, yelling and screaming that s/he was going to leave the hospital AMA (against medical advice) and attempted to physically leave. "At this point [his/her] safety was paramount and [s/he] was placed into 4 point restraints. [S/he] seemed calmer after this was taken care of." The note went on to say that the patient continued to have slurred speech and was at high risk for self harm, and the plan of management stated; "Use of 4 point restraint will be continued for the next 4 hours until such time that [s/he] can be re-evaluated, hopefully by the Department of Psychiatry, for suicidality." Nursing notes indicate the patient was placed in 4 point restraints, at 3:45AM, as a result of attempts at self harm by head banging. Despite the evidence that restraints were initiated as a result of the patient's self harming behavior, the physician order</p>	A 154	<p>A188 continued</p> <ul style="list-style-type: none"> Develop a revised restraint & seclusion process guided by an "Emergency Involuntary Procedure," Flow Sheet, and Patient Assessment documents. The revised process and documents are designed in a manner that effectively allow the physician, nurse, and other staff involved to document the indication for initiation of behavioral restraints, the need to consider & document less restrictive alternatives before initiating a restraint on a patient, the need for ongoing assessment & monitoring of the patient's condition while in restraints, and the need to discontinue restraints at the earliest possible time, once the unsafe condition has ended. This new process and supporting documentation is one that is currently used by the Inpatient Psychiatric Services Department at RRMCC and will now be standardized across the organization to other relevant medical, surgical and emergency departments As part of the revised Emergency Involuntary Procedure process and documents, a second person verification step will be added for review of the initiation of behavioral restraints on a patient in our medical, surgical, psychiatric or emergency departments. The purpose of having second person verification is to review & assess the restraint 	<p>Complete by: 7/31/13</p> <p>Complete by 7/31/13</p>
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[Handwritten signature] *[Handwritten signature]* 6/10/13

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A 154	<p>Continued From page 8</p> <p>directed staff to Initiate Medical/Surgical Restraints; pt lacks capacity, interfering w/medial tx, keyed velcro, padded side rails. Although staff conducted regular assessments of the use of restraints the Reason Necessitating Restraint was consistently documented as "pt lacks capacity interfering with medically necessary tx", and the Behavior Description identified "pt resistive to care" and "pt wants to go AMA." Per the physical exam conducted by Physician #1; "After restraints were place showed a young [male/female] who was still upset, still very negative and refusing many aspects of care."</p> <p>Although there was documentation at 6:00 AM and 6:30AM, that indicated the patient was, at those times agitated, yelling and uncooperative, there was no evidence that s/he posed a threat to the safety of self or others. A physician progress note, at 7:20AM, identified the patient's behavior as tearful, acknowledged the patient's ability to contract for safety and indicated that s/he could have ankle restraints removed at that time. Despite the lack of evidence, between 6:00 AM and 9:00AM, that the patient posed a threat to the immediate physical safety of self or others, and despite the fact that continuous 1:1 observation was conducted by staff from the time of the patient's admission, restraints were not removed from the patient until 9:00 AM.</p> <p>During interview, at 3:33 PM on 3/20/12, the RN Unit Manager confirmed the restraints were initiated as the result of self harming behavior. S/he further agreed that there was a lack of evidence to indicate the patient's behavior was violent or self-destructive and jeopardized the immediate physical safety of himself/herself or</p>	A 154	<p>A188 continued</p> <p>documentation and discuss with relevant staff the sufficiency of indications for the restraint, the consideration of less restrictive alternatives, the continuing necessity of the restraint currently being used, assessment & monitoring requirements for the patient, the possibility for earliest discontinuation, and the completeness of the related nursing and physician documentation, all with the intent to maintain patient rights as noted above.</p> <ul style="list-style-type: none"> The employees that will be educated & authorized to conduct the second person verification will include all Nursing Directors, Clinical Managers, and Nurses from the medical, surgical, psychiatric, and emergency departments, and RRMC Patient Flow Managers. Additionally, the revised process will include "one-to-one" continuous monitoring of patients in behavioral restraints by trained Patient sitters to adequately assess and monitor the patient's response to the restraints and any sudden changes in patient condition. The results of the assessment and monitoring will be documented by the patient sitter every 15 minutes on designated Flow Sheets. The RRMC policy and procedures on Restraints & Seclusion will be revised to reflect the revised process as described in the above paragraphs. 	<p>Complete by 7/31/13</p> <p>Complete by 7/31/13</p> <p>Complete by 7/31/13</p>
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TL L. Hand 6/10/13

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

PRINTED: 04/10/2013
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/21/2013
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A 154	Continued From page 9 others, necessitating a need for ongoing use of restraints, between the hours of 6:00AM and 9:00AM.	A 154	A188 Continued	Complete by 8/31/13
A 188	482.13(e)(16)(v) PATIENT RIGHTS: RESTRAINT OR SECLUSION (there must be documentation in the patient's medical record of the following:) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention. This STANDARD is not met as evidenced by: Based on interview and record review, staff failed to conduct an ongoing assessment of a patient's behavioral response after the application of restraints to include the rationale for continued use for 1 applicable patient. (Patient #7). Findings include: 1. Per review on 3/20/13, Patient #7 arrived to the Emergency Department (ED) on 1/11/13 at 01:50 AM requesting to be evaluated by a mental health screener after being unable to sleep and reporting s/he had stopped taking prescribed medications. Patient #7 has a previous history of anxiety, depression and drug abuse and was referred by his/her counselor after the patient expressed suicidal and homicidal ideation. Upon admission to the ED, Patient #7 was described in ED Note-Nursing to be "....mildly agitated". Per ED physician's "Final Report" for 1/11/13 at 02:24:00 states "While in the emergency department the patient was demonstrating behaviors that were progressively more agitated and paranoid.....the patient was refusing to undress and when asked to by staff was	A 188	<ul style="list-style-type: none"> • Education will be provided to nurse leaders, nurses, licensed nursing aides, patient sitters, and the Emergency Department, Hospitalists, Intensivists, Psychiatrists, and other physicians who admit patients to the Hospital on the revised Emergency Involuntary Procedure process and documents as described in the paragraph above. • Measure of effectiveness: All employees & physicians identified above must complete the education sessions either in person or through an online or hardcopy learning module by the complete by date of August 31, 2013. • Quality Assurance / Performance Improvement: A Restraint & Involuntary Procedure Review Team will be formed to ensure that the following requirements are met: <ul style="list-style-type: none"> ○ The "Emergency Involuntary Procedure" for restraint is completed ○ Verification of a physician order for restraint initiation or re-order done per requirements ○ Indication for restraint initiation meets requirements; less restrictive alternatives considered / attempted ○ Behavioral restraints >4 hours were re-ordered per policy 	Team to begin meeting weekly 6/14/13

[Handwritten Signature] 6/10/13

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A 188

Continued From page 10
becoming more and more confrontational and agitated. For staff and patient safety the patient was placed in four-point restraints and treated with Haldol and diphenhydramine".

Per hospital policy "Restraint and Seclusion" approved 2/22/13 states "Comprehensive Restraint Assessment (every 2 hours)- An RN shall document a Comprehensive Restraint Assessment following the initiation of BR/S (Behavioral Restraints/Seclusion), and every two (2) hours (plus or minus 15 minutes to allow for nursing to safely prioritize clinical situations)". However, per review of the ED "Violent and Self-Destructive Restraint and/or Seclusion Doctor's Order and Daily Record" the RN is required to perform hourly assessments for restraint use to determine patient needs, provide restraint release for range of motion and readiness for discontinuation. Patient #7 was placed in bilateral hard wrist and ankle restraints at 02:50. Only one hourly assessment was documented on this ED form, the time it was conducted was not documented. Patient #7 remained in restraints for approximately 3 hours and 10 minutes, there was no evidence during this time that the RN assessed the patient for restraint reduction or the patient's behavioral or physical response to being in four- point restraints or the rationale for continued use.

Per interview on 3/21/13 at 11:35 AM ED staff Nurse #1 confirmed the hourly RN assessment of Patient #7 and the ongoing need and rationale for the continued use of four-point restraints was not documented as required per hospital policy.

A 188

A188 Continued

- One-to-one sitter documentation of 15 minute checks
- Restraint discontinuance documented at earliest possible time
- Nursing assessment & documentation
- Physician assessment & documentation
- Second person verification completed per requirements
- Crisis screening notes scanned for behavioral restraints if indicated
- The results from this QAPI review will be shared with the relevant leaders and staff from the areas involved. Results indicating non-compliance with the new process will require immediate corrective action to bring the department or physician back into full compliance with the requirements and policy.

Responsible persons: Director of Quality Improvement, Chief Nursing Officer

A464 Content of Record-Consults

In order to ensure that the results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient are documented in the medical record, Rutland Regional Medical Center has taken the following actions:

A 464

482.24(c)(2)(iii) CONTENT OF RECORD-CONSULTS

A464

 6/10/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 470005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/21/2013
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A 464	<p>Continued From page 11</p> <p>[All records must document the following, as appropriate:]</p> <p>Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review the medical record was lacking documentation of the results of consultative evaluations for 1 applicable patient. (Patient #4). Findings include:</p> <p>Per record review Patient #4 presented to the ED at 6:48 PM on 11/27/12, with depression, suicidal ideation and mental status changes. A note by the ED provider stated the patient had gone to ED, reported an interest in talking to Crisis and was having thoughts of harming self and a history of attempts. The note further identified that the patient had a significant mental health history including PTSD and bipolar anxiety. The patient did report taking benzodiazepines in accordance with his/her prescription and reportedly denied overdose of medication on that date, but presented extremely drowsy with somewhat slurred speech. S/he stated a past medical history of a blood clotting disorder as well as DVT (Deep Vein Thrombosis), and reported that s/he had injected him/herself with 2 doses of Lovenox (medication used to prevent blood clotting), in the hopes it would cause bleeding from old self inflicted neck wounds, and cause death. The note also stated that the patient appeared extremely sleepy and the provider questioned if the patient had ingested more benzodiazepines that s/he had admitted to. The note further stated that the</p>	A464	<p>A464 Continued</p> <ul style="list-style-type: none"> Communicate with the partner organization providing emergency crisis screenings for RRMC and the RRMC Emergency Department leadership and Emergency Department Physicians about the requirements of the CMS Conditions of Participation for content of the medical record to ensure the requirements are met, in particular as relates to crisis screenings. <p>Responsible persons: Director of Quality Improvement, Chief Nursing Officer</p> <ul style="list-style-type: none"> Communicate with RRMC personnel that scan the completed crisis screening results into the RRMC medical record that the requirements are met <p>Responsible person: Nurse Director of Emergency Department</p> <ul style="list-style-type: none"> Measure of effectiveness: Communication with internal personnel and external organizations completed by July 31, 2013 The Quality Assurance / Performance Improvement: A Restraint & Involuntary Procedure Review Team will be formed to ensure that the following requirements are met: <ul style="list-style-type: none"> The "Emergency Involuntary Procedure" for restraint is completed 	Complete by 7/31/13
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6/10/13

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A 464	Continued From page 12 patient did have Crisis screening done and it was recommended the patient be admitted for 1:1 observations, and then inpatient psychiatric consult, all of which was agreed upon by the patient. The patient was admitted to a medical unit at 1:13 AM on 11/28/12. The H&P (History and Physical), completed on 11/28/12 at 12:20 AM by Physician #1, under whose care Patient #4 was admitted, reiterated that the patient had visited the ED seeking someone to talk to as s/he was considering suicide and had a history of previous suicide attempts. The H&P further stated that a Crisis worker had evaluated the patient, deemed him/her a suicide risk and suggested 1:1 observation. Despite the reference made to Crisis screening by both the ED provider and Physician #1, there was no documentation regarding this consult in the medical record. This was confirmed by the VP of Quality Improvement during interview on the afternoon of 3/21/13.	A464	A464 <ul style="list-style-type: none"> ○ Verification of a physician order for restraint initiation or re-order done per requirements ○ Indication for restraint initiation meets requirements; less restrictive alternatives considered / attempted ○ Behavioral restraints >4 hours were re-ordered per policy ○ One-to-one sitter documentation of 15 minutes checks ○ Restraint discontinuance documented at earliest possible time ○ Nursing assessment & documentation ○ Physician assessment & documentation ○ Second person verification completed per requirements ○ Crisis screening notes scanned for behavioral restraints if indicated 	
A 467	482.24(c)(2)(vi) CONTENT OF RECORD - OTHER INFORMATION [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition. This STANDARD is not met as evidenced by: Based upon staff interview and record review there was no evidence of a physician order for	A467	<ul style="list-style-type: none"> • The results from this QAPI review will be shared with the relevant leaders and staff from the areas involved. Results indicating non-compliance with the new process will require immediate corrective action to bring the department or physician back into full compliance with the requirements and policy. <p>Responsible persons: Director of Quality Improvement, Chief Nursing Officer</p>	Team to begin meeting weekly 6/14/13

Handwritten signature and date: 6/14/13

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A 467	<p>Continued From page 13</p> <p>the use of restraints for 1 applicable patient. (Patient #1). Findings include:</p> <p>Per record review Patient #1, admitted on 1/30/12, under involuntary status with a diagnosis of Schizophrenia and Paranoid Ideation, had a CON (Certificate of Need), for Seclusion, Restraint and Emergency Medication, dated 3/14/12 at 1:25 PM, for use of restraint in the form of CPI Technique (hands on escort). The CON stated the patient was in the dining room and refused to leave, was loud, angry, agitated, intimidating and frightening other patients. Although the CON did note that the physician was notified in person, at 1:40 PM and approved the emergency procedure, and although there was a Patient Assessment conducted by the physician at 1:40 PM on 3/14/13, there was no written physician order for the restraint.</p> <p>The lack of written physician order for the restraint was confirmed by the RN Unit Manager during interview at 2:35 PM on the afternoon of 3/21/13.</p>	A467	<p>A467 Content of Record – Other Information</p> <p>In order to ensure that all practitioners' orders are documented in the medical record, Rutland Regional Medical Center has taken the following actions:</p> <ul style="list-style-type: none"> • The lack of a physician order is being addressed through the education described in our response to A154 and A188. <ul style="list-style-type: none"> ○ Education will be provided to nurse leaders, nurses, licensed nursing aides, patient sitters, and the Emergency Department, Hospitalists, Intensivists, Psychiatrists, and other physicians who admit patients to the Hospital on the revised Emergency Involuntary Procedure process and documents as described in the paragraph above. This will include necessity of a physician order as part of the process. • Measure of effectiveness: All employees & physicians identified above must complete the education sessions either in person or through an on line or hardcopy learning module by the complete by date of August 31. <p>Continued on next page</p>	Complete by 8/31/13
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[Handwritten Signature] 4/10/13

	A467 Content of Record – Other Information	
	<ul style="list-style-type: none"> • Compliance with the physician order requirement will be monitored through the QAPI process described in our response to A154 and A188 above: <ul style="list-style-type: none"> ○ Quality Assurance/Performance Improvement: A Restraint & Involuntary Procedure Review Team will be formed to ensure that the following requirements are met: ○ The "Emergency Involuntary Procedure" for restraint is completed. ○ Verification of a physician order for restraint initiation or re-order done per requirements. ○ Indication for restraint initiation meets requirements; less restrictive alternatives considered/attempted. ○ Behavioral restraints >4 hours were re-ordered per policy ○ 1:1 sitter documentation of 15 minutes checks ○ Restraint discontinuance documented at earliest possible time ○ Nursing assessment & documentation ○ Physician assessment & documentation ○ Second person verification completed per requirements. ○ Crisis screening notes scanned for behavioral restraints if indicated • The results from this QAPI review will be shared with the relevant leaders and staff from the areas involved. Results indicating non-compliance with the new process will require immediate corrective action to bring the department or physician back into full compliance with the requirements and policy. <p>Responsible persons: Director of Quality Improvement, Chief Nursing Officer</p>	<p>Team to begin meeting weekly 6/14/13</p>

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6/10/13

JUN 11 2013



Rutland Regional Medical Center

AN AFFILIATE OF RUTLAND REGIONAL HEALTH SERVICES

160 Allen Street
Rutland, VT 05701

802.775.7111

June 6, 2013

Kathy Mackin, Health Insurance Specialist
Certification & Enforcement Branch
Centers for Medicare & Medicaid Services
Boston Regional Office
JFK Federal Building
Room 2350
Boston, MA 02203

Dear Ms. Mackin,

I am in receipt of your April 10th letter regarding the survey conducted on March 21, 2013 at the Rutland Regional Medical Center. We are pleased to have been found in compliance with the Medicare Conditions of Participation for Hospitals at 42 CFR Part 482 and that we will continue to be "deemed" to meet applicable requirements based upon accreditation by the Joint Commission.

Although you indicated in your April 10th letter that it is not necessary for our organization to submit a plan of correction for the five standard level deficiencies identified during the survey, Rutland Regional Medical Center values the feedback we receive from the survey process and we take pride in our ability to deliver high quality and safe patient care. To that end, we have developed a corrective action plan to address the five deficiencies, a copy of which I have attached to this letter on survey Form CMS 2567. The work to implement the corrective action plan is well underway.

If you have further questions, please feel free to contact me.

Sincerely,

Thomas W. Huebner,
President, CEO
Rutland Regional Medical Center