STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	470012		C 11/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWESTERN VERMONT MEDICAL CENTER	100 HOSPITAL DRIVE BENNINGTON, VT 05201

(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	A 000		
	An unannounced on site complaint investigation was conducted on 11/5/12 - 11/6/12 and completed on 11/14/12 by the Division of Licensing and Protection as authorized by the Centers for Medicare and Medicaid. The following Conditions of Participation reviewed included: Patient Rights, Nursing Services and Quality Assessment/Performance Improvement. The following regulatory violations were identified:			
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure attempts were made to provide the opportunity for patients and/or family or other patient representatives, to make informed decisions regarding the proposed treatment and plan of care.for 2 patients. (Patient #1 and #9) Findings include: 1. Per record review on 11/5/12, Patient #1 was involuntarily admitted to the hospital on 7/14/12 on observation status pending psychiatric hospital placement after it was determined s/he	A 131		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 131	Continued From page 1 required involuntary inpatient psychiatric treatment for Bipolar Disorder with acute psychotic break. Upon presentation to the Emergency Department (ED) Patient #1 demonstrated a rapid heart rate and fever with possible symptoms of a systemic inflammatory response syndrome. As a result, the patient required monitoring of presenting symptoms and was admitted to a patient care unit.. Although the earlier symptoms of fever and elevated heart rate resolved, Patient #1 remained a significant challenge for hospital staff. Behaviors included restless agitation, withdrawn at times, combative, refusing medications and threatening the safety of others. During this period of time medications were ordered in an attempt to manage the patient's behaviors and to relieve symptoms of anxiety and agitation. Late in the evening of 7/14/12, Geodon 20 mg. (a antipsychotic for the treatment of Bipolar disorders) was administered by nursing staff via intramuscular injection (IM) because of accelerating disruptive behaviors including throwing and shattering a glass dish in the hospital room. The Patient Note states "PT. educated about plan for IM injection and made no responses either verbally or physically." On 7/15/12 Patient #1 was medicated with Ativan 1 mg. IM at approximately 12:45 AM for increased anxiety after patient exited their hospital room and began pushing and shoving staff. Per Patient Note "Pt agreeable to medication. Pt. tolerated 1 mg IM Ativan well". Later on 7/15/12, at 3:21 AM Patient #1 required additional Ativan injection due to staff difficulty to redirect and the patient's activity out on the patient unit. Per nurses note " Pt. agreeable to to Ativan to help s/he relax and sleep".	A 131		

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A 131	Continued From page 2 On 7/15/12 the day shift assignment for Nurse #1 was to be the primary nurse for Patient #1. Patient #1 was again displaying signs of agitation, bouts of crying and angry threats. The patient removed the mattress from their bed and stood on the bed frame until hospital security responded to the patient's room and was able to assist the patient off the bed frame. When approached by Nurse #1 with the patient's scheduled morning medications, Patient #1 refused to accept the medication prescribed. It was then the decision of Nurse #1 to conceal Patient #1's Clonidine 0.1 mg in pudding which the patient did consume without being informed s/he was being administered medication. Per interview on 11/6/12 at 10:00 AM, Nurse #1 confirmed s/he had not asked Patient #1 if they would accept an IM injection of prescribed medications. Nurse #1 also stated s/he thought administering an IM injection would be more traumatic for the patient, however over the previous 24 hours nursing notes clearly documented the patient had accepted injections when offered. Nurse #1 stated "I just had her/his best interest at heart" and wanted to do what s/he thought was "best" for the patient.". Later in the day, Nurse #1 informed a hospitalist physician about medicating Patient #1 without the patient's consent. Both the nurse and the hospitalist failed to identify the breach of patient's rights by not allowing Patient #1 to make their own informed decision regarding her/his care specifically the refusal of medication. It was not until Nurse #1 mentioned during shift report what s/he had done the morning of 7/15/12 it was identified as an adverse patient event for the improper administration of medication without	A 131		

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A 131	Continued From page 3 patient awareness. 2. Per record review there was no evidence that an attempt had been made to obtain informed consent for treatment for Patient #9, who presented to the ED in a state of altered mental status following a roll over motor vehicle accident. The record revealed that although the patient had been agitated, uncooperative, combative ,and refused to answer questions s/he had, at one point, admitted to alcohol consumption. Nurses notes identified that the patient arrived via ambulance at 2:40 AM on 9/16/12 and a note, at 2:46 AM stated, the patient was fully immobilized and was "yelling and swearing, speaks incomplete sentences, though not all making sense.....Pt. alternating between yelling and speaking quietly to officers. ...c-collar in place, but pt throwing head against backboard, yelling to have collar taken off." Documentation by the attending physician indicated that upon arrival to the ED Patient #9 was aggressive, combative, with periods of nonsensical speech, raising concern for intracranial injury or other significant process. Despite attempts to console the patient, the aggression, defiance, nonsensical speech.....continued. The patient was "therefore sedated, paralyzed, and placed on mechanical ventilation to facilitate diagnostics with concern for severe injury." Subsequent nurses notes indicated that the patient was medicated and intubated at 3:06 AM. A nurse's note, at 3:36 AM, stated that the patient's SO (significant other), who was identified by name and phone number, "called prior to pts arrival." However, despite the fact that staff had the SO name and contact information there was no evidence of any attempt to contact the SO and discuss options for	A 131		

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A 131	Continued From page 4 treatment after the patient's arrival. The Uniform Consent and Authorization to Release Information, which included 'Consent for Medical and/or Diagnostic Treatment' had no signature by patient, patient family or other patient representative. There was documentation on the Patient or Legal Representative signature line that stated 'unable to sign - Intoxicated', and although it was dated 9/16/12 at 3:20 AM, there was no signature identifying the author of the statement. Patient #9 continued on mechanical ventilation until extubated at 2:55 PM on 9/16/12. Although a nurse's note, at 9:51 AM on 9/16/12, identified that the patient's parents and SO were at the bedside there was no evidence that attempt to obtain consent for treatment was initiated until 10:00 AM on the morning of 9/17/12, when the patient signed a consent form, just prior to his/her discharge from the hospital at 10:56 AM on that date. A physician Progress Note, dated 9/16/12, stated that the patient's father noted that Patient #9 had always been extremely sensitive to being handled by anyone else and felt that must have contributed to the patient's presentation in the ED the prior evening. During interview, at 1:33 PM on the afternoon of 11/6/12, the ED physician who had provided care for Patient #9 stated that because of the patient's presentation, which included combative, agitated behavior with intermittent nonsensical verbalization, in the setting of an unwitnessed motor vehicle accident in which the car had rolled over, there was concern for possible traumatic head injury. The physician stated the patient did complain of low back pain but, s/he was unable, because of the patient's behavior, to conduct an appropriate physical exam to assess that injury or	A 131		

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A 131	Continued From page 5	A 131		
	determine existence of any other injury, and therefore the decision was made to paralyze and intubate Patient #9 so that diagnostic testing could be conducted to determine scope and severity of injury. The physician stated s/he had not attempted to contact family or other patient representative for consent as s/he felt there were time constraints to identifying potential serious injury and initiating treatment. During interview, on the morning of 11/14/12, the Director of Quality stated that s/he had spoken with the nurse in the ED who had documented in Patient #9's record that the patient's SO had called prior to patient ' s arrival in ED. The Director of Quality stated the SO had evidently called looking for Patient #9 and ED staff were not aware, at the time of the call, that Patient #9 would be coming into the ED. S/he confirmed that staff did not contact the SO, family or any other patient representative when the patient did arrive in ED. S/he further stated Patient #9's parents came to the hospital later on the morning of 9/16/12, but there is no documentation of when or how they were notified the patient was in the hospital and no consent for treatment for Patient #9 was obtained.			
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the hospital failed to assure all patients received care in a safe setting. (Patients # 1, 3) Findings include:	A 144		

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A 144	Continued From page 6 1. Per record review on 11/5/12, Patient #1 was involuntarily admitted to the hospital on 7/14/12 on observation status pending psychiatric hospital placement after it was determined s/he required involuntary inpatient psychiatric treatment for Bipolar Disorder with acute psychotic break. Upon presentation to the Emergency Department (ED) Patient #1 demonstrated a rapid heart rate and fever with possible symptoms of a systemic inflammatory response syndrome. As a result, the patient required monitoring of presenting symptoms and was admitted to a patient care unit. Although the earlier symptoms of fever and elevated heart rate resolved, Patient #1 remained a significant challenge for hospital staff. Behaviors included restless agitation, withdrawn at times, combative, refusing medications and threatening the safety of others while attempting to exit the nursing unit. Per review of "Suicide Precautions/Behavioral Observation Flow Sheet" staff documented on 7/14/12 the patient's room was secured before the patient's arrival to "...include the removal of glass, breakable objects, sharp and/or potential sharp objects, and other cord like objects not medically necessary" and that "...patient's belongings secured". Per Patient Notes at 7/14/12 at 2234 "Pt. noted to have a glass plate on her/his bed, PT. Threw plate and it shattered on the floor.....". In addition, Patient Notes indicated on 7/15/12 at 0045 patient had access to their belongings and at one point had put on their sneakers and attempted to exit the nursing unit, ".....PT. pushing staff & forceful. "creating a threat to staff and potentially other patients on the unit. On the afternoon of 11/6/12 accompanied	A 144		

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A 144	Continued From page 7 by the nurse manager, observations were made of a patient room on 2 West Med/Surgical Unit identified similar to the room occupied by Patient #1 when hospitalized. It was evident, if a acute psychiatric patient was admitted to the room and although staff could attempt to remove items, furniture and equipment from the room, safety concerns would remain. From glass walls/doors, non-breakaway curtains; a moveable bed which could be used to blockade the entrance; loopable bathroom equipment, multiple hooks and access to other patients in close proximity created a significant safety concern during the provision of care for Patient #1. The availability of a patient room which could assist in ensuring the provision of a safe environment for psychiatric/suicidal patients remains unavailable on the inpatient units. 2. Per record review staff failed to assure Patient #3 was admitted to a safe environment, in accordance with the facility's policies, during an admission for suicide attempt. Patient #3 was brought to the ED at 1:06 PM on the afternoon of 10/7/12 and the ED physician documentation revealed that the patient had attempted suicide by overdose and also had a history of prior suicide attempt. A nurse's note at that time indicated that security had been called to the patient room to assist maintaining/to monitor patient safety. The facility policy entitled: Psychiatric Emergencies: Suicidal/Homicidal/Psychosis Related Behaviors Patient Precautions, last revised on 3/2012, stated; III. Policy Statement: 'A. Any patient presenting to the Emergency Department who exhibits suicidal/homicidal/psychosis related behaviors will be triaged promptly and placed under constant observation in a secure	A 144		

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A 144	Continued From page 8 environment until it is determined by the physician that the patient is no longer considered a danger to him/herself or to others; and, G. Only the attending physician may discontinue orders for constant observation in a secure environment. A written order is required.' Subsequent nurses notes identified that security continued to provide constant observations of the patient, including accompanying the patient to radiology, while the patient remained in the ED. However, the patient was subsequently admitted to the ICU at 5:05 PM, and although there were no physician orders to indicate that the level of observation status could be decreased, nursing staff documented that the observation status required just 15 minute interactions with, or close observation of the patient. In addition, although the facility policy for Suicide Precautions, last revised in October 2009, and identified as the current policy utilized by staff, stated: 'IV. Procedure: B. Interventions: 5. Remove all potentially harmful items from the patient's room or send home with family member. Document disposition of items..', the Suicide Precaution/Behavioral Observation Flow Sheet identified that the patient's room had not been secured, to include; removal of glass, breakable objects, sharp and/or potentially sharp objects, and other cord like objects not medially necessary, prior to the patient's arrival. During interview, at 4:19 PM on 11/6/12, the Administrative Director of Inpatient Services confirmed that staff should have assured the room was secured by removal of potentially hazardous items, prior to Patient #3's admission to ICU. In addition, it was also confirmed during interview on 11/6/12 at 11:00 AM with the Administrative Director of Inpatient Services,	A 144		

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A 144	Continued From page 9 nursing staff can not decrease the level of observation ordered by a physician without obtaining an order from the physician.	A 144		
A 286	482.21(a), (c)(2), (e) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to ensure through their Quality Assurance/Performance Improvement (QA/PI) preventative actions and mechanisms were implemented in a timely manner that	A 286		

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A 286	Continued From page 10 demonstrated measurable improvements related to the management of patients with acute psychiatric disorders; assuring a safe environment and the prevention of staff administrating medications without patient awareness. Findings include: 1. Per record review on 11/5/12, Patient #1 was involuntarily admitted to the hospital on 7/14/12 on observation status pending psychiatric hospital placement after it was determined s/he required involuntary inpatient psychiatric treatment for Bipolar Disorder with acute psychotic break. Upon presentation to the Emergency Department (ED) Patient #1 demonstrated a rapid heart rate and fever with possible symptoms of a systemic inflammatory response syndrome. As a result, the patient required monitoring of presenting symptoms and was admitted to a patient care unit. During Patient #1's hospitalization, Nurse #1 had administered on July 15, 2012 medication to the patient without their awareness. Although the patient had received IM medication for agitation and anxiety over the previous 24 hours, Nurse #1 did not offer this route or specific medication to Patient #1. Instead, Nurse #1 concealed Clonopin 0.1mg in pudding which the patient consumed without being made aware s/he was ingesting a drug. As a result of this incident, the leadership team identified the serious significance of the event and presently is developing policies and procedures and training for staff to address the issues related to improper administration of medications, managing behavioral health emergencies and securing and maintaining a	A 286		

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A 286	Continued From page 11 safe environment. However since the events, only an E-mail was sent out to nursing staff by the Administrative Director of Inpatient Services on 7/27/12 (twelve days after the event) addressing recommendations to nursing staff regarding patient rights to refuse medication; administration of emergency medications and psychiatric involuntary admissions who attempt to leave nursing units. Per interview on 11/6/12 at 11:00 AM, the Administrative Director of Inpatient Services confirmed although nursing managers met with staff to discuss the incident there was no written evidence regarding date, time and content of meetings and who attended the meetings, training's related to the events was not mandatory. 2. Per record review staff failed to assure Patient #3 was admitted to a safe environment, in accordance with the facility's policies, during an admission for suicide attempt. Patient #3 was brought to the ED at 1:06 PM on the afternoon of 10/7/12 and the ED physician documentation revealed that the patient had attempted suicide by overdose and also had a history of prior suicide attempt. A nurse's note at that time indicated that security had been called to the patient room to assist maintaining/to monitor patient safety. The facility policy entitled: Psychiatric Emergencies: Suicidal/Homicidal/Psychosis Related Behaviors Patient Precautions, last revised on 3/2012, stated; III. Policy Statement: 'A. Any patient presenting to the Emergency Department who exhibits suicidal/homicidal/psychosis related behaviors will be triaged promptly and placed under constant observation in a secure environment until it is determined by the physician that the patient is no longer considered a danger	A 286		

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A 286	Continued From page 12 to him/herself or to others; and, G. Only the attending physician may discontinue orders for constant observation in a secure environment. A written order is required.' Subsequent nurses notes identified that security continued to provide constant observations of the patient, including accompanying the patient to radiology, while the patient remained in the ED. However, the patient was subsequently admitted to the ICU at 5:05 PM, and although there were no physician orders to indicate that the level of observation status could be decreased, nursing staff documented that the observation status required just 15 minute interactions with, or close observation of the patient. In addition, although the facility policy for Suicide Precautions, last revised in October 2009, and identified as the current policy utilized by staff, stated: 'IV. Procedure: B. Interventions: 5. Remove all potentially harmful items from the patient's room or send home with family member. Document disposition of items..', the Suicide Precaution/Behavioral Observation Flow Sheet identified that the patient's room had not been secured, to include; removal of glass, breakable objects, sharp and/or potentially sharp objects, and other cord like objects not medially necessary, prior to the patient's arrival. During interview, at 4:19 PM on 11/6/12, the Administrative Director of Inpatient Services confirmed the lack of physician orders to change observation status from constant to every 15 minutes and also confirmed that staff should have assured the room was secured by removal of potentially hazardous items, prior to Patient #3's admission to ICU. Presently, 3 months since the incident of 7/15/12,	A 286		

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SOUTHWESTERN VERMONT MEDICAL CENTER	100 HOSPITAL DRIVE BENNINGTON, VT 05201

(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 286	Continued From page 13 there is a lack of evidence to support all nursing staff have been made aware of the implications of the event, training provided at the time of investigation has not been mandatory; and there is no evidence of hospital monitoring to ensure patient rights and care in a safe environment have been maintained since the series of concerns were identified during the admission of Patient #1 to the hospital on 7/14/12 through 7/17/12.	A 286		