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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	474001	A. BUILDING ______ B. WING ______	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

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A 000 INITIAL COMMENTS

An unannounced on-site visit was conducted on 2/11/13 - 2/14/13 and 2/19/13 - 2/21/13 by the Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services, to investigate mutliple complaints. The following regulatory violations were identified related to some of those complaints.

A 020 482.11 COMPLIANCE WITH LAWS

Compliance with Federal, State and Local Laws

This CONDITION is not met as evidenced by:
Based on record review and staff interview, the hospital failed to be in compliance with State of Vermont Statute Title 18, Chapter 42: Bill of Rights for Hospital Patients for 1 applicable patient. (Patient #10). Findings include:

1. Per State Statute 1852. Patients' Bill of Rights for Hospital Patients: "(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." However, per record review, from 11/21/12 through 12/21/12 Patient #10, admitted with a diagnosis Borderline Personality Disorder and Polysubstance Abuse, was frequently subjected to removing his/her clothes and mandated to wear paper scrubs often times without underwear. Per review on 2/21/13, a behavioral treatment plan, signed on 11/21/12 by the Osgood 3 interdisciplinary treatment team, states: "While in ALSA (low stimulation area) you [Patient #10] will be provided with paper scrubs to wear." If Patient #10 was wearing his/her own clothes at the time of an emergency procedure for restraint

A 000 AOOO Summary Statement
Subsequent to the seven day survey completed on February 21st, 2013 by the VT Division of Licensing and Protection Agency, the Brattleboro Retreat and Governing Body has undertaken a series of significant targeted actions that address all areas of noncompliance noted in the Condition and Standard level findings. We are fully committed as an organization to correct any deficiencies and achieve and sustain a high level of quality patient care. Of note is that the survey was conducted for 14 complaints that spanned back over a period of 10 months from the date of the survey. We are responding to the three condition level deficiencies and standard level deficiencies through the plans of action below. We believe that our targeted plans of action for each of the standards noted below achieve compliance with laws including VT Statutes; fully protect and promote the rights of our patients, and ensure a comprehensive QI/PI program.

A 020 A 020 482.11 COMPLIANCE WITH LAWS
Compliance with Federal, State and Local Laws — 4/02/13

PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES:

1. On March 13, 2013 members of the Executive Leadership Team consisting of the CMO, the CNO, and the VP of Clinical Operations met with the Unit Leadership Team of the inpatient psychiatric unit noted in this report. The Unit Leadership Team of the inpatient psychiatric unit noted in this report. The Unit Leadership Team consists of the Medical Director, Clinical Nurse Manager and the unit's Social Work Supervisor. This meeting was held to clarify expectations of the Leadership Team in providing behavioral interventions that ensure a patient's personal dignity at all times. The use of paper scrubs (plastic reinforced, paper clothes in the form of pants and tops) was a behavioral intervention chosen by the Unit Leadership and Treatment teams as a protective

POC accepted B Hauie/F Keller 4/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] DSW, MPH — TITLE: President & CEO — (X6) DATE: 4/10/13

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 020	Continued From page 1 and/or seclusion, the patient was required to remove his/her clothes in front of female staff, a contraband search was often conducted and Patient #10 was then required to dress in paper scrubs. The mandating of paper scrubs often triggered Patient #10 to have increased agitation. Per Nursing Progress Note, on 12/9/12, "3 security staff and 5 staff escorted without hands on to Q.R. (seclusion) but did put hands on at 8:10 AM when patient refused to change into paper scrubs". Per progress note for 11/23/12 at 5:18 PM states "...Pt. tearing off paper clothing and threatening harm to himself/herself." Nursing Shift Progress Note, for 11/25/12 at 7:25 PM, states "Reports mood angry. Expressing desire to wear regular clothing stated that [s/he] could harm [himself/herself] with paper clothing, if [s/he] desired". Per Shift Progress Note, at 12/9/12 1:40 PM, states " ....ended up being put in restraints and [her/his] personal clothing was removed. After being released, client removed elastic waistband from paper clothes and wrapped it around [his/her] neck". Nursing Shift Progress Note for 12/10/12 at 10:00 AM report Patient #10 states "I'll just be running around naked" after,again, being mandated to wear paper scrubs. Per interview on 2/21/13 at 10:15 AM an Osgood 3 charge nurse stated, when the paper scrubs rip, staff will put a towel over the exposed area. Although, the paper scrubs were part of a treatment plan in an effort to maintain behavioral control and to manage Patient #10's self-harming behaviors, it also created an infringement of the patient's personal dignity.	A 020	A 020 482.11 COMPLIANCE WITH LAWS continued measure, in response to the patient's use of regular clothes as a means of self-harm in an effort to asphyxiate. The use of paper scrubs is one of the standard potential measures in the treatment of self-harming and suicidal patients whose severe mental illness impedes their self-sustaining capacity and judgment. However, this must be balanced with the value of preserving a patient's personal dignity that includes ensuring that the person has the appropriate size. The Materials Management Department orders paper scrubs weekly in sizes, Small, Medium, Large, XL, 2XL and 3xL. Of note is that this behavioral treatment plan had been revised prior to this survey that ended on 2/21/13. This intervention was no longer being used at the time of the survey. This change in intervention was a result of a Case Conference with Dr. Simpson, and Dr. Engstrom, with the Unit Leadership and Treatment Team members. The Case Conference explored the nature of the specific psychodynamics presented by the patient relative to the interaction of suicidal behaviors, trauma history and potential effective treatment strategies that arose during the treatment of patient # 10 which also mirrored this patient's complex treatment dynamics with community providers. During the Case Conference the Leadership and Treatment Teams also explored alternative means of reducing the patient's suicide risk and developed a new treatment plan that did not employ the use of scrubs for suicidal actions or ideation. This treatment plan led to the successful discharge of the patient. Additionally, the policy titled "Observation Levels/Safety Levels" policy was revised on 3/18/13 to incorporate two new items as stated below in numbers 8 and 12. The revision to the policy was done in order to make it very clear that when a patient is to be put on suicide precautions and the intervention of using paper/plastic reinforced scrubs is chosen by the treatment team, the scrubs need to be of a size that fits the patient comfortably and will not easily tear. This policy revision also includes a mandatory review of this serious level of suicide precautions at each treatment team meeting in orde	

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A 020	Continued From page 2 2. Per State Statute 1852. Patients' Bill of Rights for Hospital Patients: "(5) The patient has the right to refuse treatment to the extent permitted by law. In the event the patient refuses treatment, the patient shall be informed of the medical consequences of that action and the hospital shall be relieved of any further responsibility for that refusal." Per review on 2/21/13, Patient #10 was admitted involuntarily, s/he had not been determined to be incompetent, a state appointed guardian was determined to be unnecessary and s/he had not designated a representative to participate in the patient's treatment plan. During the course of hospitalization, Patient #10 had periodically refused to have BS (blood sugar) testing or doses of insulin administered. Per review of Nursing Shift Progress Notes staff document Patient #10 was aware of the consequences of not maintaining a proper diet, failing to have BS testing and accepting insulin administration. However, both nursing and medical staff failed to acknowledge the patient's right to accept or refuse treatment. Per review of a Psychiatric Progress Note, dated 11/23/12, states ".....involuntary administration of insulin on the basis that [s/he] is at imminent risk of serious injury due to DKA (Diabetic Ketoacidosis). If [s/he] consistently refuses insulin finger sticks for 24 hours, a finger stick will be checked involuntarily on the basis that [s/he] is likely to be entering DKA which must be verified or refuted and treated accordingly." This treatment plan remained consistent throughout the patient's hospitalization as evidenced by the following documentation including physician orders and nursing notes: Per physician order for 11/27/12 at 10:55 AM: " May not refuse noon finger stick BS . May board (place patient in 6 point restraints on a board) for	A 020	A 020 482.11 COMPLIANCE WITH LAWS continued to determine the continued necessity for this level of intervention and that the interventions are not infringing on a patient's personal dignity. This review must also be documented in the patient's treatment plan update section of the medical record. Suicide Precautions: (additions to policy) 8. Patients may be given paper scrubs only if they fit and the patient can comfortably wear them without tearing and if it is determined that their own clothing may be used to hurt themselves. 12. This level of precaution shall be re-evaluated at each treatment team meeting in order to determine the continued necessity for this level of intervention and that the interventions are not infringing on a patient's personal dignity. Justification for continued use of this level will be documented on in the treatment plan update section of the medical record. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION The "Observation Levels/Safety Levels" policy was sent to all Clinical Nurse Managers on 3/19/13 by the Executive Coordinator with the expectation that they ensured that the revisions to this policy were reviewed with their respective unit Direct Care Staff and Leadership Team members. In addition on 3/22/13, at a CMS Survey Regulatory Readiness meeting, all Clinical Managers were asked to also ensure that their respective staff understood the policy changes and then signed off on the policy changes. 100% of inpatient unit staff will be educated on this policy change by 4/15/13. If staff who are per-diem and are not scheduled to work within this time period then their Unit Manager will mail them a copy of the policy and indicate what the revisions were made to the policy and that the staff member can contact their Manager for questions. The Clinical Education staff will round each unit three times a week until 5/15/13, to offer additional education and support to staff around policy and practice changes during the educational roll out and the reasoning behind policy and practice changes.	3/19/13 4/15/13

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A 020	Continued From page 3 finger sticks blood sugar. Call Dr. X (hospital clinic physician) with noon finger stick BS results." A second physician order for 11/30/12 at 5:00 PM: "May not refuse insulin, get order to restrain if needed for D.O.C (doctor on call). Per Nursing Shift Progress Note, dated 11/29/12 at 12:50 PM, states Patient #10 had refused an injection of insulin. "Dr. X. called again and did not order med to be given involuntarily. Order for 4:30 PM BS which can not be refused written up as a standing order for 4:30 PM BS only". After the patient refused to receive a prescribed dose of insulin the following Nursing Shift Progress Note, dated 12/10/12, states "At 5:45 PM [s/he].....refused [his/her] insulin. Orders were obtained for Thorazine 200 mg IM, restraints and to give [her/his] insulin at that time.....Meds were drawn up, hands on at 6:17 PM to restrain, on restraint board at 6:25 PM." Per review of Medication Administration Record notes both medications were administered as ordered while the patient was restrained. Per interview on the afternoon of 2/21/13, the Vice President of Patient Care & CNO (Chief Nursing Officer) acknowledged staff per hospital policy could restrain a patient for the administration of an emergency medication such as Thorazine, however a court order would be needed to enforce the administration of insulin. There was no evidence that the hospital obtained a court order forcing the patient to receive prescribed insulin.	A 020	A 020 482.11 COMPLIANCE WITH LAWS continued MONITORING/TRACKING: (method, frequency and responsible person) The Unit TRIAD Leadership which includes MD, SW, and Nurse Manager will review 100% of all cases, including medical record audits using the compliance audit tool for these cases of patients placed on suicide risk precautions for a period of 4 months to determine compliance with the revised policy titled Observation/Safety Levels. Compliance will be determined by auditing the EHR for documentation of treatment plan updates that contain justification as to the need for the Suicide Precautions level and the wearing of scrubs. If 100% compliance with revisions in the policy has been obtained then the audit cycle will be completed. The TRIAD teams will report on a weekly basis any patients who are on Suicide Risk Precautions to the CMO, CNO, Senior Medical Director, and VP of Clinical Operations who will then review with the appropriate Unit Leadership Teams to ensure all clinical parameters are being followed and that any use of scrubs are done so in a manner that maintains a patient's dignity. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The audit results of 100% of medical records a month of patients placed on suicide risk precautions will be reported monthly to the Regulatory Readiness meeting and quarterly to the Organization Wide PI committee. Title of Responsible Person(s): The CMO, CNO, and VP of Clinical Operations	
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights.	A 115	2. VT State Statute 1852. Patients' Bill of Rights for Hospital Patients: (5) PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES:	

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A 115	Continued From page 4 This CONDITION is not met as evidenced by: Based on survey findings the Condition of Participation for Patient Rights was not met related to a failure to respect the patient's right to refuse treatment, failure to promote and maintain a physically and emotionally safe environment, failure to implement appropriate use of restraints and/or seclusion in accordance with federal requirements and facility policy and failure to report allegations of mistreatment in accordance with state and federal requirements. Refer to A-0131, A-0144, A-0145, A-0154, A-0162 and A-0167.	A 115	A 020 482.11 COMPLIANCE WITH LAWS continued The State Statute 1852, Patients' Bill of Rights for Hospital Patients; "(5) was reviewed in depth in relation to patient # 10's treatment with the Leadership Team and all staff members on the Adult Inpatient Unit referenced in this CMS survey report. The CMS survey results received on 3/13/13 were also reviewed in depth and education provided to the attendees regarding what constitutes emergency medical treatment as well as the CMS standards for restraint and seclusion. This educational session took place on 3/15/13 and was completed by the Unit' Clinical Manager. On 3/21/13, the Medical Executive Committee including the Medical Director of the Medical Clinic also reviewed the CMS survey findings received on 3/13/13 and collaborated on a clear policy for use in instances where emergency medical treatment is required in order to save a patient from dying at the Brattleboro Retreat. The CMO, in collaboration with the Brattleboro Retreat Attorney, has revised the Emergency Involuntary Medication policy in order to make clear the legal statutes of administering both psychiatric and non-psychiatric medication.	
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 recognize and protect a patient's right to accept or refuse treatment for 1 applicable patient. (Patient #10) Findings include: 1. Per review on 2/21/13, Patient #10 was admitted to the hospital on 11/21/12 with a diagnosis of Borderline Personality Disorder, Polysubstance Abuse and Insulin Dependent	A 131	PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION 100% of Inpatient RN/LPN staff, A and E RN and LIP staff and Medical Staff will be provided with education on the revised policy for "Emergency Involuntary Medication Treatment by April 25th, 2013. All staff receiving this education is required to sign off on the policy change. In addition, each Inpatient unit will review the policy changes at their respective staff meetings in April 2013. The Clinical Education staff will be rounding on each inpatient unit three times weekly until 5/15/13 to offer additional education and support to staff around policy changes during the education roll out and the reasoning behind policy and practice changes.	4/25/13

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A 131	Continued From page 5 Diabetes. Although the patient was admitted involuntarily, s/he had not been determined to be incompetent, a state appointed guardian was determined to be unnecessary and s/he had not designated a representative to participate in the patient's treatment plan. During the course of hospitalization, Patient #10 had periodically refused to have BS (blood sugar) testing or doses of insulin administered. Per review of Nursing Shift Progress Note staff document Patient #10 was aware of the consequences of not maintaining a proper diet, failing to have BS testing and accepting insulin administration. However, both nursing and medical staff failed to acknowledge the patient's right to accept or refuse treatment as evidenced by the following documentation including physician orders and nursing notes: Per physician order for 11/27/12 at 10:55 AM: "May not refuse noon singlestick BS. May board (place patient in 6 point restraints on a board) for fingersticks blood sugar. Call Dr. X(hospital clinic physician) with noon fingerstick BS results." A second physician order for 11/30/12 at 5:00 PM: "May not refuse insulin, get order to restrain if needed for D.O.C (doctor on call). Per Nursing Shift Progress Note dated 11/29/12 at 12:50 PM states Patient #10 had refused an injection of insulin "Dr. X. called again and did not order med to be given involuntarily. Order for 4:30 PM BS which can not be refused written up as a standing order for 4:30 PM BS only". After the patient refused to receive a prescribed dose of insulin the following Nursing Shift Progress Note, dated 12/10/12, states "At 5:45 PM [s/he].....refused [his/her] insulin. Orders were obtained for Thorazine 200 mg IM, restraints and to give	A 131	A 020 482.11 COMPLIANCE WITH LAWS continued MONITORING/TRACKING: (method, frequency and responsible person) 100% of medical records a month of patients who receive emergency medical procedures will be audited by the Clinical Manager of the Medical Clinic and Access and Evaluation in collaboration with the Medical Director for the Medical Clinic. These medical records will be audited for compliance with the Brattleboro Retreat policy, procedure and state and federal laws. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The audit results of 100% of medical records will be reported bi-weekly in a medical review meeting that includes the CMO, CNO, Director of Medical Clinic, the Manger of the Medical Clinic and the PI/Risk Manager. TITLE OF RESPONSIBLE PERSON: CMO, Medical Director for the Medical Clinic and CNO A 115 482. 13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. A 131 482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: The State Statute 1852. Patients' Bill of Rights for Hospital Patients:"(5) was reviewed with all the Leadership Team and all staff members on the Inpatient Adult Psychiatric Unit where the incident occurred as referenced in this CMS survey report. The CMS survey results received on 3/13/13 and patient # 10's case were reviewed also in regards to this state statute and a patient's right to refuse medical treatment. This educational session took place on 3/15/13 and was completed by the Unit Clinical Manager.	

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A 131	Continued From page 6 [her/his] insulin at that time.....Meds were drawn up, hands on at 6:17 PM to restrain, on restraint board at 6:25 PM." Per review of Medication Administration Record notes both medications were administered as ordered while patient was restrained. Per review of Psychiatric Progress Note, dated 11/23/12, states ".....involuntary administration of insulin on the basis that [s/he] is at imminent risk of serious injury due to DKA (Diabetic Ketoacidosis). If [s/he] consistently refuses insulin finger sticks for 24 hours, a finger stick will be checked involuntarily on the basis that [s/he] is likely to be entering DKA which must be verified or refuted and treated accordingly." This plan remained consistent throughout the patient's hospitalization. Per interview on the afternoon of 2/21/13, the Vice President of Patient Care & CNO acknowledged staff, per hospital policy, could restrain a patient for the administration of an emergency medication such as Thorazine, however a court order would be needed to enforce the administration of insulin. There was no evidence that the hospital obtained a court order.	A 131	A 131 482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT continued On 3/21/13, the Medical Executive Committee including the Medical Director of the Medical Clinic also reviewed the CMS survey findings received on 3/13/13 and collaborated on a clear policy for use in instances where emergency medical treatment is required in order to save a patient from dying at tha Brattleboro Retreat. On March 20th, 2013, the CMO, in collaboration with the Brattleboro Retreat Attorney, has revised the Emergency Medical treatment policy in order to make it clear when staff can intervene with a medical intervention against a patient's will and when they cannot intervene. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION 100% of Inpatient RN/LPN staff, A and E RN and LIP staff and Medical Staff will be provided with education on the revised policy for "Emergency Involuntary Medication Policy by 4/25/13. All staff receiving this education are required to sign off on the policy change. In addition, each inpatient unit will review the policy changes at their respective staff meetings in April 2013. Clinical Education will be rounding on aach inpatient unit three times weekly until 5/15/13 to offer additional education and support to staff around policy changes during the education roll out and the reasoning for policy and practice changes.	4/25/13
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 observations, patient and staff interviews and record review the facility failed to assure care was provided in an environment that	A 144	MONITORING/TRACKING: (method, frequency and responsible person) 100% of medical records a month of patients who receive emergency medical procedures will be audited by the Clinical Manager of the Medical Clinic and Access and Evaluation in collaboration with the Medical Director for the Medical Clinic. These medical records will be audited for compliance with the Brattleboro Retreat policy, procedure and state and federal laws.	

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A 144	Continued From page 7 promoted and protected the physical and emotional well being and safety of 3 of 13 patients. (Patients #1, #3 and #10). Findings include: 1. Per patient and staff interview and video and medical record review, staff failed to protect the emotional well being of Patient #1, who was admitted, involuntarily, on 9/7/12 with a diagnosis of Schizoaffective Disorder, Bipolar type. Per interview, conducted on the afternoon of 2/14/13, Patient #1 verbalized that s/he felt s/he had been treated in a disrespectful and uncaring manner by staff after disclosing that s/he had been involved in a recent sexual encounter with another patient. The patient stated that, although on the morning of 2/6/13, s/he had requested a specific medical intervention related to a recent sexual encounter, s/he was not seen by the medical clinician until several hours later in the afternoon. The patient stated s/he experienced increasing fear, that because of the delay in time, the medical intervention s/he had requested would not be effective. A Psychiatry Progress Note, dated 2/6/13 at 10:00 AM, indicated that Patient #1 had disclosed to the psychiatrist, at that time, that s/he had recently been involved in a sexual encounter with another patient and had requested a specific medical intervention. The patient had refused to offer any further details about the encounter but "....Agrees to see a female from the med clinic to discuss this concern." A consult was faxed to the facility's medical clinic at 10:35 AM on 2/6/13 which stated: "Reports recent sexual activity. Unclear if [patient] claim is real or delusional.....will only discuss with a female." Despite the stated request the patient was not	A 144	A 131 482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT continued PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The audit results of 100% of medical records will be reported bi-weekly in a medical review meeting that includes the CMO, CNO, the Medical Director of the Medical Clinic, the Manager of the Medical Clinic, and the PI/Risk Manager. TITLE OF RESPONSIBLE PERSON: CMO, Medical Director for the Medical Clinic and CNO A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING PLAN OF CORRECTION/ EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: On March 13th, 2013 a new system for triaging medical consults was approved by the CMO. The system was revised in order to assist the Medical Clinic in determining the priority of the requested consult and to ensure that Medical Consults are completed in a timely manner based on the severity of the request. This system also helps to decrease a patient's psychological distress while waiting for a medical Consult as Nursing Staff can provide education directly to the patient about expected wait times. The Medical Consult form has been revised to have a 4 point rating that the MD, who orders the consult, will check off as to the level of urgency. The revised Medical Consult form also includes room for the reason for consultation and any relevant data such as lab-work and Vital Signs. Additionally on February 26th, 2013, the Clinical Manager of Medical Clinic and Access and Evaluation met with the Nurse Practitioner noted in this report. The Manager provided 1-1 for performance counseling and coaching regarding the incident and timeliness of providing medical consults in this specific circumstance.	2/26/13

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A 144	Continued From page 8 seen by a clinician until 3:00 PM, almost four and a half hours after the request for consult. During the assessment by NP (Nurse Practitioner) #1 the patient alleged that sexual assault by another patient had occurred on the evening of 2/5/13, and the patient was then transported to the ER (Emergency Room) for evaluation and treatment. Upon return from the ER, that evening, the patient's room was changed, and s/he was located closer to the nursing station, and the following day, on 2/7/13, the patient was offered and accepted, a transfer to a separate unit in an effort to assure ongoing physical and emotional well-being and safety. Review of a facility video tape, at 10:40 AM on 2/13/13, revealed the following: Patient #13 entered the room of Patient #1 at 7:16 PM, closed the door and exited the room 2 minutes later at 7:18 PM. Patient #13 returned to the room of Patient #1 at 7:21 PM, closed the door and exited the room, 7 minutes later, at 7:28 PM. Patient #13 again entered Patient #1's room at 7:29 PM and exited after only 20 seconds. During interview, at 2:20 PM on 2/14/13, RN (Registered Nurse) #1, who had worked as the med nurse on 2/6/13, stated that at approximately 9:30 AM on that date Patient #1 had made, what the patient identified as a "strange request", for a specific medical intervention and disclosed that s/he had been involved in sexual activity within the previous 24 hours. The patient refused to provide any other information regarding the sexual encounter to RN #1. The RN stated s/he spoke with Patient #1's Psychiatrist about the issue. Nurse #1 further stated that s/he did hear Patient #1 getting more agitated later on that morning, pacing in the hall and yelling about getting the medical intervention s/he had	A 144	A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING continued PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION The new consult form will be instituted on April 15, 2013. Education for all LIP's, Medical and RN staff will begin on April 8th 2013. 100 % of inpatient Unit RN/LPN staff and 100% of Medical Staff including LIP's will receive education on the new process by 4.15.13. In addition the incident of failure to assess the patient in a timely manner by the Nurse Practitioner was discussed in detail with this Practitioner during supervision with the Medical Director of the Medical Clinic. MONITORING/TRACKING: (method, frequency and responsible person) The Clinical Manager of Medical Clinic and Access and Evaluation will audit a random sample of 30 medical consults a month in order to determine compliance with consult times established in this new procedure. The audits of a random sample of 30 medical consults will be conducted for a minimum period of 4 months. If 100% compliance has been obtained the random sample will decrease to 15 per month. The Manager and the Medical Director of the Clinic will review the audits completed to date on a weekly basis and will review the entire random sample monthly. Any trends and performance issues will also be reported to the Medical Executive Committee for inclusion in the Ongoing Practitioner Performance Evaluation and Focused Practitioner Performance Evaluation (OPPE/FPPE) process if needed. In addition, the Medical Director for the Medical Clinic has completed a review of a random sample of 5 medical consults that were conducted by the Nurse Practitioner noted in this section of the CMS survey report. The audits were completed in order to determine if 1) the consultations was completed within standards of practice for clinical thoroughness	4/15/13

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A 144	Continued From page 9 requested earlier. RN #2, the Nurse Manager of the Unit Patient #1 resided on at the time of the incident, stated, during interview at 2:28 PM on 2/14/13, that s/he had been made aware of the information disclosed by Patient #1 and, although s/he had not been alarmed by the information because Patient #1 "frequently made statements that were non reality based", s/he had followed up to assure an order had been written for a clinic consult. RN #2 further stated that later that morning Patient #1, who had become increasingly agitated, had demanded to see the medical clinician and receive the intervention s/he had requested. Physician #1 confirmed, during interview at 1:15 PM on 2/14/13, that s/he had approached Patient #1 about the patient's concerns and the patient refused to answer any questions about sexual activity. S/he stated the patient did agree to see a female in the clinic because s/he wanted to receive a specific medical intervention. NP (Nurse Practitioner) #1 confirmed, during interview at 10:48 AM on 2/19/13, that on the afternoon of 2/6/13 s/he had spoken with Patient #1, who alleged sexual assault by another patient had occurred the evening of 2/5/13 and Patient #1 had then been transferred to the ER for evaluation and treatment. NP #1 stated that s/he did not know why there had been a delay in Patient #1's assessment, for a period of greater than 4 hours from the time the consult was sent. S/he stated that there was nothing in the referral that led him/her to believe the consult was urgent or that there had been a sexual assault. The NP also indicated that Patient #1 had been delusional and made similar allegations on previous occasions. Despite the fact that intimate contact between	A 144	A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING continued 2) timeliness as determined by the BR Medical Staff. This LIP has subsequently resigned effective March 12, 2013. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The random sample audit results of 30 medical consults a month will be reported monthly to the Regulatory Readiness meeting and quarterly to the Organization Wide PI committee. The monitoring of OPPE/FPPE will be done by the Medical Executive Committee. TITLE OF RESPONSIBLE PERSON: Clinical Manager of Medical Clinic and Access and Evaluation and the Medical Director of the Medical Clinic. PLAN OF CORRECTION/ EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: 2. An educational memo dated 2/15/13 written by the Chief Medical Officer, occurred during the survey. The memo reviewed our internal policy and procedure and education as to noncompliant areas noted by surveyors. On 3/1/13 , the policy titled "Safety Emergencies" was revised as follows: - Any use of locked door seclusion or mechanical restraint must be initiated by a Registered Nurse followed up by an order from a physician. - MHW's may place patients in physical holds or escorts for instances in which there is a clear need to protect immediate physical safety of the patient, a staff member, or others. A Registered Nurse must obtain an order from a physician as soon as possible. On 3/1/13, the Chief Nursing Officer outlined the above noted changes to this policy and procedure in an educational memo that was distributed to all staff on inpatient units.	2/15/13 3/1/13 3/1/13

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A 144	Continued From page 10 patients is prohibited as evidenced by the General Information provided to patients on the AIU (Adult Intensive Unit) upon admission which states, "Relationships....No touching, hugging, or kissing is allowed. Patients are not allowed to enter each other's rooms for any reason", staff failed to take seriously the potential implications of Patient #1's disclosure of involvement in recent sexual activity, failed to assure a clinical assessment and treatment was conducted in a timely manner, failed to recognize the patient's increasing agitation as being related to the delay in the clinic consult, and in so doing, failed to promote and protect the emotional safety and well-being of Patient #1. 2. On 8/17/12 Patient #5, age 13, was involuntarily admitted to Tyler 3 with a diagnosis of Bipolar Disorder, PTSD (Post Traumatic Stress Disorder) with a past history of sexual abuse over a 4 year period. During this first psychiatric hospitalization, Patient #5 presented with manic symptoms, exhibiting hyper verbal and hypersexual talk, and threatening physical gestures toward staff. As a result of aggressive behavior, Patient #5 was placed on 1:1 observations and assigned and restricted to the LSA (Low Stimulation Area) which included his/her bedroom (room 306) and a seclusion room located opposite to room 306. Per observation on 2/13/13 at 10:55 AM facility video recorded on 8/18/12 and time stamped beginning at 17:13 showed Patient #5 being placed in locked seclusion room. Shortly after, MHW #1 is observed sitting in a chair facing the locked seclusion door positioned approximately 3 feet from the door. Per "Safety Emergencies:	A 144	A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING continued Additionally, the memo reinforced the need to comply with all requirements for observation while a patient is in seclusion including the need to stand and observe a patient through the window. On 2/26/2013 the Unit Manager met with MHW for supervision regarding her duties in caring for a patient in seclusion. The Manager instructed the staff person that sitting in chair outside of the seclusion room is not an appropriate practice as it does not offer full view of the secluded patient. Direct visualization requires that the employee stand and this MHW was counseled that going forward she would stand when observing secluded patients. On April 4, 2013 the Medical Executive Team implemented a plan, for all Inpatient Psychiatric Unit Leadership Teams to begin weekly da-briefing meetings for all instances of seclusion and restraint. It was decided that the Adult Intensive Unit in particular would meet twice weekly to de-brief their instances of seclusion and restraint. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION All Clinical Managers were asked to distribute these memos to all their respective staff on 2/15/13 and also on 3/11/13. The revised policy "Safety Emergencies" was sent to all Clinical Nurse Managers on 3/1/13 by the CNO with the expectation that they ensured that the revisions to this policy were reviewed with their respective unit Direct Care Staff and Leadership Team members. In addition on 3/22/13, at a CMS Survey Regulatory Readiness meeting, all Clinical Managers were asked to also ensure that their respective staff understood the policy changes and then signed off on the policy changes. 100% of inpatient unit staff will be educated on this policy change by 4/20/13. If staff who are per-diem and are not scheduled to work within this time period then their Unit Manager will mail them a copy of the policy and indicate what the revisions were made to the policy and that the staff member can	4/4/13

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A 144	Continued From page 11 Restraint, Seclusion and Therapeutic Holding of Patients", last approved 07/2012, states when a patient is placed in seclusion 1:1 constant monitoring must be provided. Per observation of the seclusion room within the LSA on 2/13/13 at 2:10 PM noted a small window within the seclusion room door measuring approximately 8 inch by 12 inches. Within the seclusion room was a mirror mounted in the left corner between the wall and ceiling. The clarity of the door window and mirror was fair, and the visibility of a patient through the window when standing at the window required the use of the mirror. A chair was placed at the location where MHW #1 had sat, as per the video. While sitting in the chair, visualization of the seclusion room using the door window was very limited due to the clarity of the window and the height of the window when viewing from a sitting position. Per interview on 2/13/13 at 2:50 PM, MHW #1 stated "I was watching [Patient #5] through the mirror on the wall ...I could see [Patient #5] reflection in the mirror ....I think you can just see the corner, you can't see when you look down ...it is difficult to see in there from anywhere". MHW #1 further stated "I could see movement ....I could hear [Patient #5] loud and clear". The MHW remained sitting for the majority of the 1 hour 1:1 constant observation assignment. Per interview at 3:00 PM on 2/13/13, the unit nurse manager stated " ....after seeing the video of the MHW sitting in the chair and our discussion, I want the chair out of the room ". (The "room" within this area of LSA is outside of the seclusion room, where staff are stationed during the provision of continuous 1:1 observation) 3. During observations on 2/13/13, of video	A 144	A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING continued contact their Manager for questions. MONITORING/TRACKING: (method, frequency and responsible person) The Clinical Manager or their designee on the unit noted in this survey are report will conduct observation of staff on all shifts who assigned to monitor patients while in seclusion to ascertain whether or not they are following the Brattleboro Retreat policy and procedure. A minimum of 4 observations of seclusion episodes will be conducted weekly for a period of 4 months. These compliance checks will be reported to the Clinical manager and CNO for determination of remedial education needs and/or performance counseling. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The compliance audits performed on all units will be reported by the Unit Clinical Managers monthly to the Regulatory Readiness meeting and quarterly to the Organization Wide PI committee. TITLE OF RESPONSIBLE PERSON: CNO, PI/RM and Inpatient Unit Clinical Managers PLAN OF CORRECTION/ EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: 3. The Adolescent Inpatient Leadership team is engaged in a rapid redesign PI team to explore options for managing the Tyler 3 ALSA area. The team will make recommendations to the executive team by April 30, 2013. The team will include options that include: a) Potential changes to the environment of care-Relocation of the social work office, patient bedrooms program space and/or the quiet room used for locked door seclusion;	4/30/13

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A 144	Continued From page 12 recorded on 8/18/12, when not in seclusion, Patient #5 was frequently observed standing in the area (measured approximately 8 ft. by 12.5 ft) between room 306 and the seclusion room talking with MHWs and nursing staff. As noted in the Discharge Summary, Patient #5 upon admission " ....initially presented with manic behaviors .....[s/he] was hyperactive .....noted to be extremely disinhibited ". A Social Work progress note for 8/20/12 states; " ....struggled to be contained" and further describes Patient #5 as " ...agitated ...easily aggravated." The intent of the LSA is to provide a low stimulation environment to help patients separate from the milieu during a time when assaultive behavior and/or verbal aggression had played a role in their admission to LSA. However, per review of the video, during Patient #5's time in LSA on 8/18/12 over a 3 hour period, anywhere from 1 to 3 staff members at a time, were observed, on multiple occasions, entering and/or leaving the LSA, and walking through the LSA area to access a separate locked area behind the LSA. Doors were repeatedly opened into the section of LSA where Patient #5 was either standing, in seclusion or in room 306. The traffic of staff members was disruptive and also created an opportunity for Patient #5 to consider potential elopement from the restricted LSA. Patient #5 is observed at one point attempting to open the locked LSA door which lead to the restricted area behind the LSA. During the viewing of the video on 2/13/12, with the V.P. of Patient Care Services & CNO and the Senior Director of Regulatory Compliance, both agreed the traffic to and from the above mentioned restricted area was disruptive for the patient and not beneficial during treatment of Patient #5 who was in a hyperactive and agitated	A 144	A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING continued b) Exploration for use of alternate spaces and methodologies for managing patient acuity that include sensory interventions and modalities. c) Consideration of no longer providing an ALSA-type environment on this particular unit. While the PI team is evaluating options for the ALSA space the following interim measures will be taken to ensure that the ALSA area remains a low stimulation area without unnecessary interruption due to foot traffic. a) When a patient is in the ALSA area or in Locked Door Seclusion: the door will be closed. At those times social work and other staff will use an alternate route for access to the social work office. b) When there is not a physician order for a patient to be placed in the ALSA or in locked door seclusion the ALSA door will remain open and that area will be used for unit programming. At these times access to the social work space will be granted through this corridor. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION Education to the Adolescent Inpatient Staff. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The monitoring of excessive foot traffic will be reported along with all restraint and seclusion direct observation of care audits monthly to the Regulatory readiness Committee and quarterly to the Organization Wide PI Committee. MONITORING/TRACKING: (method, frequency and responsible person) While performing the Hospital wide observation and audit of staff during direct observation of care for patients in restraint and/or seclusion, the clinical manager and/or supervisor(s) will audit for foot traffic in the Tyler Three ALSA area.	

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A 144	Continued From page 13 state. 4. Patient #10 was involuntarily readmitted on 11/21/12 with a diagnosis of Borderline Personality Disorder, Polysubstance Abuse and Insulin Dependent Diabetes. A treatment plan was implemented by the interdisciplinary treatment team on 11/21/12 in response to Patient #10's challenging behaviors. The consequences and response facilitated by the treatment plan and acted upon by staff included: "While in the ALSA you (Patient #10) will be provided scrubs to wear. If you disrobe, locked seclusion will be ordered; if you make an effort to injure yourself, mechanical restraints will be ordered; if you toilet in any location other then the toilet, your body waste is considered to be infectious and this will be considered an assault and locked door seclusion or mechanical restraints will be ordered; mechanical restraint will occur using the restraint board in the seclusion room. The board provides thigh and chest restraint capabilities". From 11/21/12 through 12/21/12 Patient #10 was placed in seclusion and/or tied to a restraint board over 25 times. On several occasions, as per the behavioral treatment plan, staff required Patient #10 to remove his/her clothes, often including underwear, and required to wear a paper scrub suit which could be easily ripped by the patient. The mandating of paper scrubs often triggered Patient #10 to have increased agitation and emotional distress.. Per "Nursing Progress Note" 12/9/12 " 3 security staff and 5 staff escorted without hands on to Q.R. (seclusion) but did put hands on at 8:10 AM when patient refused to change into paper scrubs", Per "Shift Progress	A 144	A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING continued TITLE OF RESPONSIBLE PERSON CNO, Clinical Manager of the Adolescent Program/Supervisors. PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: 4. On March 13, 2013 a meeting with all Medical Staff facilitated by the CMO occurred to review the events that arose during the treatment of patient # 10. This meeting was also convened to address the topic of Seclusion, Restraint and recent incidents that arose during the recent Licensing and Protection/CMS complaint survey. As a basis for the meeting, the treatment plan referenced in this CMS survey report was reviewed in detail and the following items were reviewed: · CMS conditions of participation and standards and our own policy were reviewed. · Staff used the time to discuss how to treat a highly suicidal and challenging patient. Discussed interventions that would be useful in protracting suicidal behavior and to provide support in a dignified manner. · Need to frame interventions that address risk of serious harm to self or others (or occurrence of same). - Rationale for interventions - Precipitants, attempted de-escalation - Guidance to staff members - When rights to privacy and dignity are contravened there must be a clear rationale why this is necessary to protect safety of patient or others. In this case, the bathroom restrictions relate to the patient's previous serious self-harm in bathrooms, and the disrobing has been the first step in a cascade of events leading to assault (physical). - An "emergency response plan" and behavioral plan as part of treatment plan in the chart to guide on-call decisions and admission decisions. - Inform patient of treatment plan.	3/13/13

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A 144	Continued From page 14 Note" at 12/9/12 1:40 PM states " ....ended up being put in restraints and her/his personal clothing was removed. After being released, client removed elastic waistband from paper clothes and wrapped it around his/her neck". Nursing Shift Progress Note for 12/10/12 at 10:00 AM report Patient #10 states "I'll just be running around naked" after being again mandated to wear paper scrub. Per interview on 2/21/13 at 10:15 AM an Osgood 3 charge nurse stated, when the paper scrubs rip, staff will put a towel over the exposed area". Although, the purpose of the paper scrubs was to assist in the management of Patient #10's self harming behavior, staff failed to identify the impact this plan played in the recognition of the patient's dignity.	A 144	A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING continued - All Unit Leadership Teams are required to do a weekly review of all incidents of restraint and seclusion and to look for system issues and performance issues. - If a patient experiences 5 or more restraints and/or seclusions in one week, then the Risk manager will inform both the CMO, CNO and VP of Clinical Operations so that the TRIAD Executive Team can meet with the Unit Leadership team for clinical case consultation. In addition, the Senior Medical Director has designed a method for on-going case conferences in order to proactively have structure and forum in place to present and review challenging clinical cases. The conference will also provide a quality improvement function for the medical staff. The discussion and review includes the following:	
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record review and staff interviews the facility failed to report to the appropriate SA (State Agency) allegations of abuse of 2 patients by care providers. (Patients #2 and #7). Findings include: 1. Per record review Patient #2, who was admitted, involuntarily, on 12/11/12, alleged an incident of staff mistreatment against him/her that was not reported to the appropriate SA. Per review a Psychiatry Progress Note, dated 1/10/13, stated; "... [Patient #2] reports that [Patient #2] was physically assaulted by a staff member during an altercation with a peer..... [Patient #2] has contacted patient	A 145	· diagnostic dilemmas, · psychotherapeutic approaches, · pharmacologic challenges, · ethical situations, · comprehensive treatment plan design, · any other issues encountered in treating complex and severely ill patients Staff Psychiatry Case Conferences 2013 First meeting: April 4th, 3:30 - 4:30pm, Large Board Room. A clinical case from the Adult Intensive Unit will be presented. Purpose: To present and discuss clinical cases. The conference will also provide a quality improvement function for clinical staff. The discussion will include diagnostic dilemmas, psychotherapeutic approaches, transference and countertransference issues, pharmacologic challenges, ethical situations, comprehensive treatment plan design, and other issues encountered in treating complex and severely ill patients.	4/4/13

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	474001	A. BUILDING _____ B. WING _____	C 02/21/2013

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A 145	Continued From page 15 advocate.....and [Patient Representative] has also made a complaint on [Patient #2] behalf. [Patient #2] reported staff member in question grabbed [Patient #2] by the neck in a choking fashion. Today reports no injuries associated with the event. Examination of [Patient #2] neck shows no areas of erythema. Direct examination of [Patient #2] left thoracic rib cage reveals no ecchymosis and palpitation is without noted tenderness. The incident has been internally investigated with statements taken by individuals involved. This matter is being managed by unit clinical manager..." Per interview, at 9:11 AM on 2/12/13, the Manager of Performance Improvement and Risk Management confirmed knowledge, as of 1/2/13, of the allegation by Patient #2 of abuse by a staff member on 1/1/13. S/he stated an investigation had been conducted in response to the allegation and "we didn't feel, after reviewing/investigating that it was abuse.....so didn't report it....but we did tell [Patient #2] could report it to APS him/herself if [Patient #2] wanted." 2. Per record review Patient #7, who was admitted, involuntarily on 12/11/12 with a diagnosis of Bipolar Disorder, had a Medical Clinic Consult, dated 12/18/12 that stated; Reason for consultation: "Pt reports falling, injuring R knee. Increased pain, limited ROM (Range of Motion). Pt also requests pictures be taken of bruising on [his/her] forearms." A Psychiatry Progress Note, dated 12/19/12 stated "Follow up with [Patient #7] on various grievances.....including a claim that [Patient #7] was assaulted over the weekend...by staff member." Although there is documentation by the RN Unit Manager, dated 12/20/12, that Patient #7	A 145	A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING continued Format: Each session an attending psychiatrist signs up to present a case with the treatment team. They provide a 20 minute oral case description. Case discussion follows. Participants: CMO, Senior Medical Director, Unit chiefs, Staff psychiatrists, Chief psychologist, Admissions and evaluation department medical staff members, social workers and therapists, clinical managers, any interested nurses and mental health workers, medical students, psychology and social work interns. Other participants are welcome. Schedule: 1st and 3rd Thursday of every month, 3:30 - 4:30pm, Large Board Room. MONITORING/TRACKING: (method, frequency and responsible person) The PI/Risk Manager will attend the case conferences and assist the CMO and Senior Medical Director to identify any performance improvement initiatives that arise due to the case conferences. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM Any new performance improvement initiatives will be reported on in the Organizational Wide PI committee. TITLE OF RESPONSIBLE PERSON: CMO and Senior Medical Director A 145 482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment.	

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A 145	Continued From page 16 had alleged that, during the prior weekend, MHW #2 had struck him/her on the left arm twice, there is no evidence of when that allegation was first reported to staff. The documentation included notation that the physician had reported that Patient #7 told him/her that s/he may have fabricated the allegations as s/he was angry with staff members. The conclusion of the investigation indicated that, although there was no evidence of physical contact between Patient #7 and MHW #2, the patient had requested and been referred to, the Patient Advocate for further follow up. Despite the fact that an internal investigation was conducted, the facility did not report the allegation to the appropriate SA as required.	A 145	A 145 482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT continued PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: On 2/28/13 the Risk Manager sent an educational packet to all Inpatient Clinical Managers to share with their respective leadership team and unit staff. The educational packet includes the following: · Abuse, Neglect and Exploitation -Mandatory Reporting Guidelines · Mandated Reporters and Significant Event Forms · Brattleboro Retreat Policy titled "Abuse, Neglect and Exploitation-Adult Patient"	2/28/13 3/15/13
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 observation, interview and record review, there was no indication of threat to the immediate physical safety of patient, staff or others, to warrant the use of restraint or seclusion imposed on 3 of 6 patients.(Patients #3, #5 and #10). A behavioral treatment plan imposed the use of restraint and/or seclusion as a consequence for behaviors exhibited by Patient	A 154	· Clinical Managers reviewed this educational packet with their respective leadership team and unit staff and completed on 3/15/13. In addition, the PI/Risk Manager ensures investigations are initiated by the unit Clinical Manager; collects and reviews all investigation documents; creates a timeline and determines if appropriate external agencies have been notified. - If the Risk Manager and CNO determine within the 48 hr investigation time period that a report to APS should have occurred and did not occur then the following steps will be taken: - The Risk Manager will let the Unit Manager know to have staff report the incident of alleged abuse by a staff member or another patient to APS immediately. - A copy of the APS written notification will be placed in the PI/Risk Manager's case file and if the report was verbal than a note from the reporting staff person as to the date and time of the APS notification will be placed in the Risk Manager's files. On March 28th, an external expert provided the Inpatient Unit Leadership teams consisting of the unit Medical Director, Clinical Manager and Social Work Supervisor, an educational session in regards to the VT Statute for mandated reporting of Abuse, Neglect and Exploitation. This education emphasized that the allegations do not have to be substantiated via an internal investigation in order to be reported to APS.	3/28/13

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A 154	Continued From page 17 #10. Findings include: Per review, the facility policy, Safety Emergencies: Restraint, Seclusion and Therapeutic Holding of Patients, last approved 07/2012, states in the Philosophy; "....Beginning with the admission assessment.....specific individualized information is gathered to identify techniques, methods or tools that may help the patient manage his/her behavior by managing underlying distressing emotions, pre-existing conditions or physical disabilities and limitations that would place the patient at greater risk during restraint or seclusion, any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint or seclusion." The policy further states "Non-restrictive, non-coercive, non-physical techniques are preferred in the management of behavior. If these techniques are ineffective or non-viable and an emergency as defined below exists, then seclusion or restraint may be initiated for safety purposes only...." The definition of Safety Emergency includes: "substantial risk of serious physical assault; Occurrence of serious physical assault; Substantial risk of self-destructive behavior; Occurrence of self-destructive behavior. The definition of restraint includes: "....holding a patient in a standing, seated or horizontal position i.e. 2 person walking escort or physical assist to the floor, in which the patient cannot remove himself/herself from the staff member's grip." 1. On 8/17/12 Patient #5, age 13, was involuntarily admitted to Tyler 3 with a diagnosis of Bipolar Disorder, PTSD (Post Traumatic Stress Disorder) with a past history of sexual abuse over	A 154	A 145 482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT continued MONITORING/TRACKING: (METHOD, FREQUENCY AND RESPONSIBLE PERSON) The PI/Risk Manager will review all incident reports reported data and monitor time frames. Reported events will be reviewed in morning meeting and aggregate data from our online incidents will be reviewed in the Monthly Patient Safety Committee. PI/RM will assist the CMO/CNO to identify any performance improvement initiatives that arise. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The PI/Risk Manager will report on the outcome of review of all incident reports and subsequent identification of performance improvement initiatives needed at the monthly Patient Safety Committee meeting and the quarterly Organization Wide PI Committee. TITLE OF RESPONSIBLE PERSON: CNO and PI/Risk Manager A 154 482.13(e) USE OF RESTRAINT OR SECLUSION PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: 1. On February 26th 2013 The VPCCC and the Clinical Manager for Tyler 3 provided performance counseling and education for the RN noted in this report who did not use the CPI 1 person escort technique. - Discussed following policies and correct procedures for seclusion and restraint. Also discussed de-escalation techniques and alternatives to putting hands on or putting patients in seclusion without sacrificing safety. - Reviewed CPI 1 person escort technique. - Discussed that as Charge Nurse he/she is responsible for both interventions with a secluded patient but those interventions of Mental Health Workers working with the Charge Nurse.	2/26/13

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A 154	Continued From page 18 a 4 year period. During this first psychiatric hospitalization, Patient #5 presented with manic symptoms, exhibiting hyper verbal and hyper sexual talk, and threatening physical gestures toward staff. As a result of aggressive behavior, Patient #5 was placed on 1:1 observations and assigned and restricted to the LSA (Low Stimulation Area) which included his/her bedroom (room 306) and a seclusion room located opposite to room 306. Per observation, on 2/13/13 at 10:55 AM, facility video recorded on 8/18/12 and time stamped beginning at approximately 17:13 showed Patient #5 sitting in a chair outside room 306. With his/her right hand, Patient #5 tosses something toward the MHW (Mental Health Worker), which was later identified by staff as a granola bar. The MHW was observed quickly getting up from his/her chair, secures a hand around Patient #5's right arm and leads the patient rapidly into the seclusion room and locks the door. Patient #5 immediately became agitated and began banging on the seclusion room door, yelling to get out. The physician telephone order, dated 8/18/12 at 5:23 PM, states the reason for seclusion was for "Assaultive behavior". However, per interview on 2/13/13 at 3:55 PM, the Tyler 3 Nurse Manager stated staff "...should not be putting him/her in locked seclusion for throwing a granola bar". In addition, per interview at 10:55 AM on 2/13/13, the VP for Patient Care Services and Chief Nursing Officer confirmed only a LIP (Licensed Independent Practitioner), MD or RN can authorize the use of seclusion, and a MHW is not permitted or authorized to place any patient in seclusion. The evening charge nurse placed Patient #5 in and out of seclusion on 8/18/12 for	A 154	A 154 482.13(e) USE OF RESTRAINT OR SECLUSION continued - Discussed that the Charge Nurse must intervene if he/she observes Mental Health Workers placing their bodies in front of a door creating seclusion. Charge Nurse must intervene if he/she observes a Mental Health Worker not continuously observing a secluded patient. - Charge Nurse must intervene and not allow a Mental Health worker to place a patient in locked seclusion unless he/she has assessed this patient and made a clinical determination that there is no other safe intervention other than locked door seclusion. On 2/26/13, The Clinical Manager for the MHW noted in this report, met with the employee for 1-1 performance counseling and supervision and reviewed the following: - Discussed following policies and correct procedures for seclusion and restraint. Also discussed de-escalation techniques and alternatives to putting hands on or putting patients in seclusion without sacrificing safety. - Discussed tone when talking with the patients. An educational memo dated 2/15/13 written by the Chief Medical Officer, occurred during the survey. The memo reviewed our internal policy and procedure and education as to noncompliant areas noted by surveyors. On 3/1/13 , the policy titled "Safety Emergencies" was revised as follows: - Any use of locked door seclusion or mechanical restraint must be initiated by a Registered Nurse followed up by an order from a physician. - MHW's may place patients in physical holds or escorts for instances in which there is a clear need to protect immediate physical safety of the patient, a staff member, or others. A Registered Nurse must obtain an order from a physician as soon as possible. On 3/1/13, the Chief Nursing Officer outlined the above noted changes to this policy and procedure in an educational memo that was distributed to all staff on	

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A 154	Continued From page 19 "...posturing and raised fists.." Each time Patient #5 was placed in seclusion, s/he became increasingly agitated and repeatedly hit the door and window of the seclusion room. Per review of Nursing Progress notes for 8/18/12, the evening charge nurse states "Pt. was frustrated at the beginning of this shift with remaining in the ALSA for the Assault Protocol". Per review the Tyler 3 "Protocol for Assaultive Behavior", which is provided to patients on Tyler 3, states, "Any of the following behaviors will require time away from the community engaging in individual work to help make sense of what happened and understand the impact of your choices. These behaviors include: hitting, kicking, biting, punching, spitting or pushing of staff or patients ". Continued review of the video of Patient #5, there was no evidence from what was visualized, the patient demonstrated behaviors identified in the "Protocol for Assaultive Behavior". Nursing progress note for the evening of 8/18/12 states Patient #5 continually used "...foul language, sexually inappropriate comments and racial slurs". Audio was not part of the video observed, however per the Discharge Summary dated 11/7/12, the attending psychiatrist states, "[S/he] was hyperactive with pressured speech. [S/he] was noted to be extremely disinhibited, engaging in sexual talk, making sexual gestures, using foul language ....[his/her] mood was elevated and quite irritable." However, the psychiatrist also noted during any discussion with the patient regarding his/her past history as a victim of sexual assault resulted in "[S/he] making explicit sexual comments and could not be	A 154	A 154 482.13(e) USE OF RESTRAINT OR SECLUSION continued inpatient units. Additionally, the memo reinforced the need to comply with all requirements for observation while a patient is in seclusion including the need to stand and observe a patient through the window. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION All Clinical Managers were asked to distribute these memos to all their respective staff on 2/15/13 and also on 3/11/13. The revised policy "Safety Emergencies" was sent to all Clinical Nurse Managers on 3/1/13 by the CNO with the expectation that they ensured that the revisions to this policy were reviewed with their respective unit Direct Care Staff and Leadership Team members. In addition on 3/22/13, at a CMS Survey Regulatory Readiness meeting, all Clinical Managers were asked to also ensure that their respective staff understood the policy changes and then signed off on the policy changes. 100% of inpatient unit staff will be educated on this policy change by 5/15/13. If staff who are per-diem and are not scheduled to work within this time period then their Unit Manager will mail them a copy of the policy and indicate what the revisions were made to the policy and that the staff member can contact their Manager for questions. The staff of Clinical Education will round on the units three times a week until 5/15/13 to educate and engage in dialog with staff members regarding the changes in policy and the reasons behind the need for changes in policy and practice. MONITORING/TRACKING: (method, frequency and responsible person) The Clinical Manager or their designee on the unit noted in this survey report will conduct observation of staff on all shifts who assigned to monitor patients while in seclusion to ascertain whether or not they are following the Brattleboro Retreat policy and procedure. The Clinical Manager or their designee on the unit noted in this survey report will conduct observation of	2/15/13 3/1/13

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A 154	Continued From page 20 redirected or refocused". The use of repeated seclusion lacked the consideration of Patient #5's past history of abuse and did not coincide with the hospital's Philosophy stated in the policy for "Safety Emergencies: Restraint, Seclusion and Therapeutic Holding of Patients" referenced above. In addition, the behaviors demonstrated by Patient #5 did not meet the facility's definition for the use of seclusion. There is no evidence a safety emergency existed as defined per hospital policy. 2. Per record review Patient #3 was restrained, through use of 2 person physical Escort, without indication that s/he presented immediate threat to the physical safety of self or others. A Progress Note, dated 1/6/13 at 10:30 PM stated that at approximately 6:00 PM Patient #3 had required redirection for the use of foul language, was unable to accept the redirection and increased his/her use of foul language. The note indicated that although staff informed the patient s/he would need to take space and process his/her behaviors with staff, Patient #3 refused to cooperate and went to the CA (Community Area) to sit. Ongoing encouragement by staff for Patient #3 to voluntarily retire to his/her room or the open door QR (Quiet Room) was ignored by the patient who continued to refuse to cooperate. Despite the lack of evidence that a safety emergency, as defined in the policy, existed, the note stated that "At 6:34 PM hands on began as a two person CPI escort. Pt refused to walk in the escort and let [his/her] legs relax. Pt was lowered to the floor and the escort was broken at 6:35 PM. After several prompts Pt agreed to walk under escort to the open QR. Pt was escorted to the QR and released at 6:38 PM. Pt continued to verbally	A 154	A 154 482.13(e) USE OF RESTRAINT OR SECLUSION continued staff on all shifts who assigned to monitor patients while in seclusion to aacertain whether or not they are following the Brattleboro Retreat policy and procedure. A minimum of 4 observations of seclusion episodes will be conducted weekly for a period of 4 months. These compliance checks will be reported to the Clinical manager and CNO for determination of remediat education needs and/or performance counseling. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The compliance audits performed on this unit will be reported by the Unit Clinical Manager monthly to the Regulatory Readiness meeting and quarterly to the Organization Wide PI committee. PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: The Performance Improvement/ Risk Manager will lead all inpatient unit programs in a structured consistent review of all episodes of restraint and/or seclusion on a daily and weekly basis , in addition to the aggregate analysis of data already in place. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION On April 4, 2013 a referral process and form was developed for identified clinical education needs of an individual, shift, or unit. Managers can formally submit a request for assistance in dealing with specific clinical presentations and approaches when working with patients. PI/RM will meet clinical education bi monthly to review incidents and monitor for educational needs. All Unit Leadership Teams are required to do a weekly review of all incidents of restraint and seclusion and to look for system issues and performance issues and any episodes of 4 or more restraint and/or seclusion incidents will be reported to the CMO and CNO who	

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A 154	Continued From page 21 abuse staff, but remained in the QR....for 45 min." A physician order for the use of restraints, dated 1/6/13 at 6:50 PM, noted the type of restraint as 'Escort' and identified the reason for seclusion/restraint as; "Agitation, Belligerence, Defiance...Hx of assaultive bhx" (behavior). During interview, at 2:50 PM on 2/13/12, RN #3, the Unit Manager for the unit Patient #3 resided on at the time of the incident, agreed there was no evidence that Patient #3 was a threat to self and others at the time of restraint. RN #3 further agreed that the physician order for the use of the Escort for agitation, belligerence defiance and a history of assaultive behavior is not an appropriate reason for use of restraints. 3. Patient #10 was involuntarily readmitted on 11/21/12 with a diagnosis of Borderline Personality Disorder, Polysubstance Abuse and Insulin Dependent Diabetes. A treatment plan was implemented by the interdisciplinary treatment team on 11/21/12 in response to Patient #10's challenging behaviors. The consequences and response facilitated by the treatment plan and acted upon by staff included: "While in the ALSA you (patient #10) will be provided scrubs to wear. If you disrobe, locked seclusion will be ordered; if you make an effort to injure yourself, mechanical restraints will be ordered; if you toilet in any location other then the toilet, your body waste is considered to be infectious and this will be considered an assault and locked door seclusion or mechanical restraints will be ordered; mechanical restraint will occur using the restraint board in the seclusion room. The board provides thigh and chest restraint capabilities".	A 154	A 154 482.13(e) USE OF RESTRAINT OR SECLUSION continued will then provide clinical consultation to the unit leadership team regarding the particular patient's case. The Manager of Risk Management/Performance Improvement will be working with I.T. to create the Certificates of Need (CON) document and report from EHR and making these reports available to Clinical Managers. The goal is to allow a wider group access to the CON. The CON is a document which captures type of emergency procedure, duration, clinical justification, recoding of less restrictive alternatives, past response to the event, debriefing and 1 hour assessment. Certificates of Need will be documented in the Electronic Health Record. We are currently trialing the process on 2 units. Beginning 4/15 this will be available to all units. Managers will have access to CON reports for their units and will be expected to run them and review daily during the week. Unit leadership will review all emergency procedures on a weekly basis utilizing the "Weekly Unit Triad Review" of emergency procedures. For any patient requiring 5 or more emergency procedures in a 1 week time frame the unit leadership triad will indicate on the "Weekly Unit Triad Review", that treatment planning updates have occurred upon completion these reviews will be copied to PI/RM. MONITORING/TRACKING For a period of 4 months PI/RM manager will audit all CON's and review criteria related to Assessment of need, alternatives tried, Physician Orders, criteria for release, and documentation of treatment team planning following 5 or more procedures in 1 week and work with managers and clinical education and CNO to monitor for additional educational needs. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM	3/1/13 5/15/13

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A 154	Continued From page 22 Psychiatric Progress Note dated 11/26/12 states Patient #10 " ....had a tendency to act out in an effort to get herself/himself restrained " . It was also noted Patient #10 " ...finds involuntary procedures including physical holds, physical restraints and intramuscular administration of medications reinforcing and therefore will act out to force staff to implement these procedures. " It was further recommended " ...using strategies only when absolutely necessary to preserve his/her safety and to not think of them as consequences that will alter or mold his/her behavior ". A "Certificate of Need for Emergency Involuntary Procedures" for 11/23/12 at 5:30 PM demonstrated Patient #10's reinforced behavior when a "Therapeutic hold was used to place pt. on restraint board, pt. cooperative, wanted to use restraint board ." Staff documented justification for the use of emergency restraint and/or seclusion as a response to Patient #10 ' s threats to hurt herself/himself. However, also noted in the Psychiatric Progress Note " ....s/he has had numerous self injurious acts, her/his threats of suicide are frequently not genuine but rather tend to be attempts to get attention and cause herself/himself to be hospitalized, remain hospitalized or to receive in involuntary procedures.." Locked door seclusion and/or 6 point restraint board was initiated over 25 times from 11/21/12 through 12/21/12 with staff referencing the above mentioned behavioral treatment plan and initiating the consequences when Patient #10 was not compliant with the treatment plan. improper use of restraints were also ordered and used by staff for the purpose of administering non	A 154	A 154 482.13(e) USE OF RESTRAINT OR SECLUSION continued The Performance Improvement/Risk Manager will utilize this specific data along with the aggregate analysis and report information monthly by unit in Patient Safety with quarterly aggregate data compiled and reported in Pt. Safety. TITLE OF RESPONSIBLE PERSON (S) PI/RM manager and CNO A 162 482.13(e)(1)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: On 2/26/13, The Clinical Manager for the MHW noted in this report, met with the employee for 1-1 performance counseling and supervision and reviewed the following: - Discussed following policies and correct procedures for seclusion and restraint. Also discussed de-escalation techniques and alternatives to putting hands on or putting patients in seclusion without sacrificing safety. - Discussed tone when talking with the patients. - Discussed tone and response when asked to do something by his supervisors. - Discussed recognizing when he was not being therapeutic with a patient and switching out with other staff. An educational memo dated 2/15/13 written by Dr. Engstrom, CMO, occurred during the survey. The memo reviewed our internal policy and procedure and education as to noncompliant areas noted by surveyors: see 1-3 and 7. Memo from Deb Lucey, CNO on 3/1/13 clarified changes to the policy and procedure and was distributed to all staff on inpatient units. The changes are as noted:	2/26/13 3/1/13

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A 154	Continued From page 23 emergency medication and performing blood testing which had been refused by Patient #10. Per physician order for 11/27/12 at 10:55 AM: " May not refuse noon fingerstick BS. May board (place patient in 6 point restraints on a board) for finger sticks blood sugar ..... " Per Nursing Shift Progress Note for 12/10/12 at 5:45 PM, because the patient had urinated on the floor in ALSA and refused his/her insulin injection Patient #10 was placed in 6 point restraints and once restrained, was administered both Thorazine and Insulin. Per interview on the afternoon of 2/21/13, the Vice President of Patient Care & CNO acknowledged staff, per hospital policy, could restrain a patient for the administration of an emergency medication such as Thorazine, however a court order would be needed to enforce the administration of insulin. There was no evidence the hospital obtained a court order.	A 154	A 162 482.13(e)(1)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION continued - Any use of locked door seclusion or mechanical restraint must be initiated by a Registered Nurse followed up by an order from a physician. - MHW's may place patients in physical holds or escorts for instances in which there is a clear need to protect immediate physical safety of the patient, a staff member, or others. A Registered Nurse must obtain an order from a physician as soon as possible. A 167 482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES On 3/4/13, the Clinical Manger for the MHW noted in this report, met with the employee for 1:1 performance counseling and supervision and reviewed the following: - Discussed that locked door seclusion can only be initiated by a Registered Nurse or Physician. - Discussed that the application of mechanical restraints can only be initiated by a Registered Nurse or Physician. - Discussed that it is against policy and regulation for a MHW to independently place a patient in locked seclusion or apply mechanical restraints. - Discussed de-escaletion techniques and alternatives to putting hands on without compromising safety. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION 1:1 Performance Counseling and Written Supervision for all employee involved in citation. All Clinical Managers were asked to distribute these memos to all their respective staff on 2/15/13 and also on 3/11/13. The revised policy "Safety Emergencies" was sent to all Clinical Nurse Managers on 3/1/13 by the CNO with the expectation that they ensure that the revisions to this policy were reviewed with their respective unit Direct Care Staff and Leadership Team members.	3/4/13
A 162	482.13(e)(1)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the hospital failed to ensure the use of seclusion for Patient #5 would only be used for the management of violent or self-destructive behavior. (Findings include: On 8/17/12 Patient #5, age 13, was involuntarily admitted to Tyler 3 with a diagnosis of Bipolar	A 162		

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A 162	Continued From page 24 Disorder, PTSD (Post Traumatic Stress Disorder) with a past history of sexual abuse over a 4 year period. During this first psychiatric hospitalization, Patient #5 presented with manic symptoms, exhibiting hyper verbal and hypersexual talk, and threatening physical gestures toward staff. As a result of aggressive behavior, Patient #5 was placed on 1:1 observations and assigned and restricted to the LSA (Low Stimulation Area) which included his/her bedroom (room 306) and a seclusion room located opposite room 306. Per record review and observation of video recorded during the evening of 8/18/12, staff repeatedly placed Patient #5 in locked door seclusion or confined the patient in the seclusion room while the door was left opened. The behaviors demonstrated by Patient #5 did not meet the definition for the use of seclusion. There is no evidence a safety emergency existed as defined per hospital policy as: " Substantial risk of serious physical assault; occurrence of serious physical assault; substantial risk of self-destructive behavior or occurrence of self-destructive behavior ". The patient expressed anger, yelled obscenities, made sexual gestures toward staff and at times had raised his/her fists, however these behaviors did not jeopardize the immediate physical safety of the patient, a staff member or others. One episode, observed on video on 2/13/13, resulted in locked door seclusion, on 8/18/12, for 30 minutes after Patient #5, while sitting in a chair, tossed a granola bar at a MHW. Locked door seclusion was again initiated at 8:23 PM after Patient #5 became agitated and per Nursing progress note "began threatening and using	A 162	A 167 482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION continued In addition on 3/22/13, at a CMS Survey Regulatory Readiness meeting, all Clinical Managers were asked to also ensure that their respective staff understood the policy changes and then signed off on the policy changes. 100% of inpatient unit staff will be educated to this policy by 4/20/13. If staff who are per-diem and are not scheduled to work within this time period then their Unit Manager will mail them a copy of the policy and indicate what the revisions were made to the policy and that staff can contact their Manager for questions. Clinical Education Staff will be rounding the units three times a week until May 15, 2013 to further educate to the policy changes and speak to the reasoning behind the need for policy and practice changes. MONITORING/TRACKING: (method, frequency and responsible person) The Clinical Manger or their designee on the unit noted in this survey will report conduct observation of staff on all shifts who are assigned to monitor patients while in seclusion to ascertain whether or not they are following the Brattleboro Retreat policy and procedure. A minimum of 4 observations of seclusion episodes will be conducted weekly for a period of 4 months. These compliance checks will be reported to the clinical Manager and CNO for determination of remedial education needs and or performance counseling. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The compliance audits performed on this unit will be reported by the Unit Clinical Manager monthly to the Regulatory Readiness meeting and quarterly to the Organization Wide PI committee. TITLE OF RESPONSIBLE PERSON: Clinical Manager of Adolescent Program, House Supervisors, CNO	4/20/13

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A 162	Continued From page 25 sexually explicit language", followed by "...threatening posture and raised fists.....and moved quickly and aggressively toward female 1:1 staff ". No other interventions were attempted, and the nurse is seen on video placing hands on the patient and directing him/her into seclusion. In addition, the physician's order for seclusion dated 8/18/12 at 8:34 PM did not provide a reason for the use of seclusion nor where behavioral objectives for release from seclusion documented.	A 162	A 263 482.21 QAPI A 263 482.21(b)(1), (c) PROGRAM DATA, PROGRAM ACTIVITIES PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: The Performance Improvement /Risk Manager will lead all inpatient unit programs in a structured consistent review of all episodes of restraint and/or seclusion on a daily and weekly basis , in addition to the aggregate analysis of data already in place..	
A 167	482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The use of restraint or seclusion must be--] (ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the implementation of seclusion by a MHW was not in accordance with hospital policy for 1 applicable patient. (Patient #5) Findings include: On 8/17/12 Patient #5, age 13, was involuntarily admitted to Tyler 3 with a diagnosis of Bipolar Disorder, PTSD (Post Traumatic Stress Disorder) with a past history as a victim of sexual abuse over a 4-year period. During this first psychiatric hospitalization, Patient #5 presented with manic symptoms, exhibiting hyper verbal and hypersexual talk, and threatening physical gestures toward staff. As a result of aggressive behavior, Patient #5 was placed on 1:1 observations and assigned and restricted to the	A 167	PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION On April 4, 2013 a referral process and form was developed for identified clinical education needs of an individual, shift, or unit. Managers can formally submit a request for assistance in dealing with specific clinical presentations and approaches when working with patients. Performance Improvement/ Risk Manager will meet clinical education bi monthly to review incidents and monitor for educational needs. All Unit Leadership Teams are required to do a weekly review of all incidents of restraint and seclusion and to look for system issues and performance issues and any episodes of 4 or more restraint and/or seclusion incidents will be reported to the CMO and CNO who will then provide clinical consultation to the unit leadership team regarding the particular patient's case. The Manager of Risk Management/Performance Improvement will be working with I.T.to create the Certificates of Need (CON) document and report from EHR and making these reports available to Clinical Managers.. The goal is to allow a wider group access to the CON. The CON is a document which captures type of emergency procedure, duration, clinical justification, recoding of less restrictive alternatives, pats response to the event, debriefing and 1 hour assessment.	

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A 167	Continued From page 26 LSA (Low Stimulation Area) which included his/her bedroom (room 306) and a seclusion room located opposite to room 306. Per observation, on 2/13/13 at 10:55 AM, facility video recorded on 8/18/12 and time stamped baginning at approximately 17:13 showed Patient #5 sitting in a chair outside room 306. With his/her right hand, Patient #5 tosses something toward a MHW (Mental Health Worker), which was later identified by staff as a granola bar. The MHW was observed quickly getting up from his/har chair, secures a hand around Patient #5's right arm and leads the patient rapidly into the seclusion room and locks the door. Per review of "Safety Emergencies: Restraint, Seclusion and Therapeutic Holding of Patients", last approved 07/2012 states only a LIP (Licensed Independent practitioner), MD or specially trained RN with current competency can authorize restraint or seclusion if a patient exhibits an imminent risk to self or others." Per interview at 10:55 AM on 2/13/13, the VP for Patient Care & CNO confirmed a MHW does not have the authority to place a patient in seclusion.	A 167	A 283 482.21(b)(1), (c) PROGRAM DATA, PROGRAM ACTIVITIES continued Certificates of Need will be documented in the Electronic Health Record. We are currently trialing the process on 2 units. Beginning 4/15 this will be available to all units. Managers will have access to CON reports for their units and will be expected to run them and review daily during the week. Unit leadership will review all emergency procedures on a weekly basis utilizing the "Weekly Unit Triad Review" of emergency procedures. For any patient requiring 5 or more emergency procedures in a 1 week time frame the unit leadership triad will indicate on the "Weekly Unit Triad Review", that treatment planning updates have occurred upon completion these reviews will be copied to Performance Improvement /Risk Manager. MONITORING/TRACKING For a period of 4 months Performance Improvement /Risk Menager will audit all CON's and review criteria related to Assessment of need, alternatives tried, Physician Orders, criteria for release, and documentation of treatment team planning following 5 or more procedures in 1 week and work with managers and clinical education and CNO to monitor for additional educational needs.	
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or	A 263	PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The Performance Improvement/ Risk Manager will utilize this specific data along with the aggregate analysis and report information monthly by unit in Patient Safety with querterly aggregate data compiled and reported in Pt. Safety. TITLE OF RESPONSIBLE PERSON (S) Performance Improvement/ Risk Manager and CNO	

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A 263	Continued From page 27 arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on survey findings the Condition of Participation for Quality Assessment and Performance Improvement was not met related to the failure to identify deficient practice and opportunity for improvement regarding a patient's right to refuse treatment and ongoing inappropriate use of restraints and or seclusion. Refer to A-0283	A 263	A 283 482.21(b)(1), (c) PROGRAM DATA, PROGRAM ACTIVITIES continued PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESS THAT LED TO THE DEFICIENCIES: 3. The State Statute 1852, Patient's Bill of Rights for Hospital Patients. "(5) was reviewed in depth in relation to patient #10's treatment with the Leadership Team and all staff members of the Adult Inpatient Unit referenced in this CMS survey report. The CMS survey results received on 3/13/13 were also reviewed in depth and education provide to the attendees regarding what constitutes emergency medical treatment as well as the CMS standards for restraint and seclusion. This educational session took place on 3/15/13 and wes completed by the Unit Clinical Manager. On 3/13/13 the CMO met with the individual physician that gave the order for Insulin to individually review the criteria and legal statutes for administering both involuntary psychiatric and non-psychiatric medications. On 3/21/2013, the Medical Executive Committee including the Medical Director of the Medical Clinic also reviewed the CMS survey findings received on 3/13/13 and collaborated on a clear policy for use in instances where emergency medical treatment is required in order to save a patient from dying at the Brattleboro Retreat. The CMO, in collaboration with the Brattleboro Retreat Attorney, has revised the Emergency Involuntary Medication policy in order to make clear the legal statutes of administering both psychiatric and non-psychiatric medication. On 3/21/13 the Clinical Manager of the referenced unit met with the individual nurse that administered the insulin to review the criteria and legal statutes for administering both involuntary psychiatric and non-psychiatric medications.	
A 283	482.21(b)(1), (c) PROGRAM DATA, PROGRAM ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at	A 283		

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A 283	Continued From page 28 performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on staff interviews and video and medical record review the facility failed to identify deficient practice and opportunity for improvement related to patient rights, including the patient's right to refuse treatment and inappropriate use of restraints/seclusion. Findings include: Per review, the facility policy, titled Safety Emergencies: Restraint, Seclusion and Therapeutic Holding of Patients, states; "Non-restrictive, non-coercive, non-physical techniques are preferred in the management of behavior. If these techniques are ineffective or non-viable and an emergency as defined below exists, then seclusion or restraint may be initiated for safety purposes only...." The definition of Safety Emergency includes: "substantial risk of serious physical assault; Occurrence of serious physical assault; Substantial risk of self-destructive behavior; Occurrence of self-destructive behavior. In addition the definition of restraint includes: "....Restraints includes holding a patient in a standing, seated or horizontal position i.e. 2 person walking escort or physical assist to the floor, in which the patient cannot remove himself/herself from the staff member's grip." 1. On 8/17/12 Patient #5, age 13, was involuntarily admitted to Tyler 3 with a diagnosis of Bipolar Disorder, PTSD (Post Traumatic Stress	A 283	A 283 482.21(b)(1), (c) PROGRAM DATA, PROGRAM ACTIVITIES continued PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION 100% of Inpatient RN/LPN staff A and E RN and LIP staff and Medical Staff will be provided with education on the revised policy for "Emergency Involuntary Medication Treatment" by April 11, 2013. All staff receiving this education are required to sign off on the policy change. In addition, each inpatient unit reviews the policy changes at their respective staff meetings in April 2013. Additionally the Clinical Education staff will continue to round to all units including A&E three times weekly to further teach and explain this new policy and the reasoning behind policy and practice changes. MONITORING/TRACKING: (METHOD, FREQUENCY AND RESPONSIBLE PERSON) 100% of medical records a month of patients who receive emergency medical procedures will be audited by the Clinical Manager of the Medical Clinic in collaboration with the Medical Director for the Medical Clinic. These medical records will be audited for compliance with the Brattleboro Retreat policy, procedure and state and federal laws. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTD (QAPI) PROGRAM The Clinical Manager of the Medical Clinic will report the results of audits of emergency medical procedures monthly to the Regulatory Readiness meeting and quarterly to the Organization Wide PI committee. TITLE OF RESPONSIBLE PERSON: TCMO, CNO and Medical Director of the Medical Clinic.	

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A 283	Continued From page 29 Disorder) with a past history of sexual abuse over a 4 year period. During this first psychiatric hospitalization, Patient #5 presented with manic symptoms, exhibiting hyper verbal and hypersexual talk, and threatening physical gestures toward staff. As a result of aggressive behavior, Patient #5 was placed on 1:1 observations and assigned and restricted to the LSA (Low Stimulation Area) which included his/her bedroom (room 306) and a seclusion room located opposite to room 306. Per observation, on 2/13/13 at 10:55 AM, facility video recorded on 8/18/12 and time stamped beginning at approximately 17:13 showed Patient #5 sitting in a chair outside room 306. With his/her right hand, Patient #5 tosses something toward the MHW (Mental Health Worker), which was later identified by staff as a granola bar. The MHW was observed quickly getting up from his/her chair, secures a hand around Patient #5's right arm and leads the patient rapidly into the seclusion room and locks the door. Patient #5 immediately became agitated and began banging on the seclusion room door, yelling to get out. The physician telephone order, dated 8/18/12 at 5:23 PM, states the reason for seclusion was for "Assaultive behavior". However, per interview on 2/13/13 at 3:55 PM, the Tyler 3 Nurse Manager stated staff "...should not be putting him/her in locked seclusion for throwing a granola bar". In addition, per interview at 10:55 AM on 2/13/13, the VP for Patient Care Services and Chief Nursing Officer confirmed only a LIP (Licensed Independent Practitioner), MD or RN can authorize the use of seclusion, and a MHW is not permitted or authorized to place any patient in seclusion. The evening charge nurse placed	A 283	A395 482.23(b)(3) RN SUPERVISION OF NURSING CARE PLAN OF CORRECTION/EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: 1. During the RCA (Root Cause Analysis) of this case that occurred in June 14, 2012, and that is also noted in this CMS survey report; we had internally identified the same issues the surveyors cited that included lack of evidence or documentation that this patient had been assessed by Nursing as per the Brattleboro Retreat policy and procedure. Of note is that the patient's surgeon indicated to the Attending Psychiatrist that no harm came to this patient as a result of his care at the hospital. In addition, in late March 2013, the Brattleboro Retreat had implemented new documentation flow sheets that required Nurses to document whether or not a patient had any problems in the following set of physiological systems: - Neurological - Respiratory - Cardiovascular - Musculoskeletal - Integumentary The new documentation system requires the Nurse to identify whether or not each system is WNL (within normal limits) or Abnormal. For any sections checked off as abnormal, the RN must complete an assessment and document this assessment in the progress notes. After the RCA that was conducted in April 2012 for this case, a series of intensive education was provided for all Nurses on the Inpatient Units that consisted of the following: - Assessing and documenting what physical presentation constituted WNL and what symptoms constituted Abnormal Findings indicating the need for further assessment or referral to the Medical Clinic.	5/13/13

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A 283	Continued From page 30 Patient #5 in and out of seclusion on 8/18/12 for "...posturing and raised fists.." 2. Per record review Patient #3 was restrained, through use of 2 person physical Escort, without indication that s/he presented immediate threat to the physical safety of self or others. A Progress Note, dated 1/6/13 at 10:30 PM stated that at approximately 6:00 PM Patient #3 had required redirection for the use of foul language, was unable to accept the redirection and increased his/her use of foul language. The note indicated that although staff informed the patient s/he would need to take space and process his/her behaviors with staff, Patient #3 refused to cooperate, went to the CA (Community Area) and continued to swear and use foul language. Despite the lack of evidence that a safety emergency, as defined in the policy, existed, the note stated that "At 6:34 PM hands on began as a two person CPI escort. Pt refused to walk in the escort and let [his/her] legs relax. Pt was lowered to the floor and the escort was broken at 6:35 PM. After several prompts Pt agreed to walk under escort to the open QR. Pt was escorted to the QR and released at 6:38 PM. Pt continued to verbally abuse staff, but remained in the QR....for 45 min." A physician order for the use of restraints, dated 1/6/13 at 6:50 PM, noted the type of restraint as 'Escort' and identified the reason for seclusion/restraint as; "Agitation, Belligerence, Defiance...Hx of assaultive bhx" (behavior). During interview, at 2:50 PM on 2/13/12, RN #3, the Unit Manager for the unit Patient #3 resided on at the time of the incident, agreed there was	A 283	A395-482.23(b)(3) RN SUPERVISION OF NURSING CARE continued - Assessing for CMS (Color/Motion/Sensitivity) for casted patients and documenting cast and wound care and post –operative instructions. This education will occur an annual basis and individual staff will be sent for remedial education and/ or performance counseling as indicated via chart audits and next educational series is due by 5/13/13. Beginning in the 5/13 Monthly Nursing Skills Day RNs/LPNs will be educated with a competency on nursing care plans and documentation. Each nursing staff member will attend a skills training within the calendar year that will include this enhanced training on documentation. Nurses that are tracked by the audit tools to need enhanced training with nursing care plans or documentation will be referred to Clinical Education prior to their designated skills day for individual training. 100% of Nurses will be trained during the 2013 educational calendar.	5/13/13
			MONITORING/TRACKING: (method, frequency and responsible person) All Inpatient Unit Managers will conduct a random sample of 5 chart audits a week on their respective units. The charts audits will be audited for compliance with the following: - Completion of all sections of required documentation in the new EHR. - Assessment as per the patient's presentation and treatment plan problems and documentation in the EHR of the assessment. - Documentation in narrative format of any abnormal physical findings. - Documentation of notification of the attending psychiatrist or DOC and medical clinic LIP of abnormal findings needing further assessment and intervention.	5/13/13
			PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM	

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	474001	A. BUILDING _____ B. WING _____	C 02/21/2013

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A 283	Continued From page 31 no evidence that Patient #3 was a threat to self and others at the time of restraint. RN #3 further agreed that the physician order for the use of the Escort for agitation, belligerence defiance and a history of assaultive behavior is not an appropriate reason for use of restraints. 3. Patient #10 was involuntarily readmitted on 11/21/12 with a diagnosis of Borderline Personality Disorder, Polysubstance Abuse and Insulin Dependent Diabetes. A treatment plan was implemented by the interdisciplinary treatment team on 11/21/12 in response to Patient #10's challenging behaviors. The consequences and response facilitated by the treatment plan and acted upon by staff included: "While in the ALSA you (Patient #10) will be provided scrubs to wear. If you disrobe, locked seclusion will be ordered; if you make an effort to injure yourself, mechanical restraints will be ordered; if you toilet in any location other than the toilet, your body waste is considered to be infectious and this will be considered an assault and locked door seclusion or mechanical restraints will be ordered; mechanical restraint will occur using the restraint board in the seclusion room. The board provides thigh and chest restraint capabilities". Psychiatric Progress Notes indicated that Patient #10 had a tendency to act out in an effort to force staff to implement involuntary procedures including physical holds, restraints and injections of medications as a means of reinforcement of his/her behaviors. The acting out behaviors identified included numerous self injurious acts and threats of suicide "...that are frequently not genuine but rather tend to be attempts to get	A 283	A395 482.23(b)(3) RN SUPERVISION OF NURSING CARE continued The Inpatient Managers will report audit results at the monthly Regulatory Readiness meeting and Quarterly Organization Wide PI meeting. TITLE OF RESPONSIBLE PERSON Inpatient Clinical Managers CNO PLAN OF CORRECTION/ EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES 1.The RN noted in this CMS survey report received 1-1 education by the VP of Patient Care, CNO and SR Director Regulatory Compliance/Infection Control. All hospital wide RNs will have enhanced documentation/nursing care planning taught in monthly skills day beginning 5/13. 2. The Nurse Practitioner noted in this CMS survey report has received performance counseling and coaching on 3/6/13, regarding this incident. In addition this incident has been noted in the Medical Staff OPPE (Ongoing Practitioner Performance Evaluation) process that is part of the credentialing and re-credentialing process conducted by the Medical Executive Committee. The Medical Director for Medical Clinic will review a random sample of 5 medical consults weekly beginning on 2/28/13, that are completed by this LIP, in order to determine the following: 1) That consultation was completed within standards of practice for clinical thoroughness 2) Was the consult completed within the time frames established by the new triage process as noted above.	2/28/13

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A 283	Continued From page 32 attention and cause [herself/himself] to be hospitalized, remain hospitalized or to receive involuntary procedures.." The recommendation by the Psychiatrist was to use involuntary procedure strategies only when absolutely necessary to preserve the patient's safety and to not think of them as consequences that would alter or mold the patient's behavior. A "Certificate of Need for Emergency Involuntary Procedures" for 11/23/12 at 5:30 PM demonstrated Patient #10's "reinforced behavior" when a "Therapeutic hold was used to place pt. on restraint board, pt. cooperative, wanted to use restraint board." Staff documented, on this occasion, justification for the use of emergency restraint and/or seclusion as a response to Patient #10's threats to hurt herself/himself. Locked door seclusion and/or 6 point restraint board was initiated over 25 times from 11/21/12 through 12/21/12 with staff referencing the above mentioned behavioral treatment plan and initiating the consequences when Patient #10 was not compliant with the treatment plan. When informed Patient #10 had been restrained and/or placed in seclusion 13 times (from 11/21/12 - 11/26/12) the Vice President for Patient Care Services and Chief Nursing Officer stated on 2/21/13 at 2:10 PM " All these CONs (evidence of restraint/seclusion use) in one week, something isn't working". Improper use of restraints were also ordered and used by staff for the purpose of administering non emergency medication and performing blood testing which had been refused by Patient #10. Per physician order for 11/27/12 at 10:55 AM: " May not refuse noon fingerstick BS. May board	A 283	A395 482.23(b)(3) RN SUPERVISION OF NURSING CARE continued This chart audit will occur for a period of 2 months and will be reported to the Medical Executive Committee team for further consideration. PLAN OF CORRECTION/ EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: 3. On 2/25/13 CNO met with O3 Unit manager to establish the process for taking off MD orders. CMO met with MS and establish practice of having Psychiatrist alert the person doing safety checks and Charge RN. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION On 4/3/2013 the Observation Levels/Safety Policy was revised to ensure that when a physician orders higher level of observation on any patient that this higher leve of observation is immediately instituted. 100% staff will read and sign off on the amended Observation Level Policy by April 20, 2013. MONITORING/TRACKING: (method, frequency and responsible person) The Inpatient Unit Managers for the unit noted in this CMS survey report will conduct a random sample of 10 chart audits a week and audit for compliance with MD orders and safety checks completion for a period of 4 months or until 100% compliance is achieved and sustained for a minimum of 30 days. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The chart audit results will be reported on at the monthly Regulatory Readiness meeting and Quarterly Organization Wide PI meeting. TITLE OF RESPONSIBLE PERSON CNO and Unit Clinical Manager	2/25/13 4/3/13 4/20/13

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A 283	Continued From page 33 (place patient in 6 point restraints on a board) for finger sticks blood sugar ....." Per Nursing Shift Progress Note, for 12/10/12 at 5:45 PM, because the patient had urinated on the floor in ALSA and refused his/her insulin injection Patient #10 was placed in 6 point restraints and once restrained, was administered both Thorazine and insulin. Per interview on the afternoon of 2/21/13, the Vice President of Patient Care & Chief Nursing Officer acknowledged staff , per hospital policy, could restrain a patient for the administration of an emergency medication such as Thorazine, however a court order would be needed to enforce the administration of insulin. There was no evidence that the hospital obtained a court order. During interview, on 2/12/13 at 10:18 AM, the Manager of Performance Improvement and Risk Management stated that review of the video tapes by facility staff, referencing Patient #5, had occurred in August of 2012 following a request for the video by an outside agency at that time. S/he stated that a complaint was made to the facility in December of 2012 or January of 2013 regarding Patient #5. S/he further stated s/he again reviewed the video as did the Unit Manager, who stated s/he had no concerns regarding the care and treatment of Patient #5. Despite the fact that the aforementioned video had been reviewed by the Manager of Performance Improvement and Risk Management, and although all episodes of restraints and seclusion are reviewed for quality purposes, as confirmed by the Manager of Performance Improvement and Risk	A 283	A 396 482.23(b)(4) NURSING CARE PLAN PLAN OF CORRECTION/ EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: This case was internally reviewed in June 2012. The result of our own internal review prompted the implementation of a new treatment planning process and forms. All RNs were educated to the new forms and medical treatment plans. RNs named in the case received individual counseling and performance supervision following the root cause analysis. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION All Monthly Nursing Skills Day for RNs and LPNs, beginning 5/15, will include an advanced teaching and competency on nursing documentation and care planning. MONITORING/TRACKING: (method, frequency and responsible person) 100% of RNs and LPNS will attend Nursing Skills Day for the Educational Calendar of 2013. If an individual RN or LPN is found, by chart audit to need training prior to their assigned skills day, they will be referred to clinical education for individual training. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The number of individual staff determined by chart audit, to need remedial education will be reported to the monthly Regulatory Readiness Committee and the quarterly organization Wide PI Committee. TITLE OF RESPONSIBLE PERSON CNO	5/15/13

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A 263	Continued From page 34 Management, during interview on the afternoon of 2/21/13, the facility failed to identify the above cited examples of inappropriate use of restraint and/or seclusion, and failed to identify a violation of a patient's right to refuse medication, which led to a failure to identify opportunities for improvement.	A 263	A 438 482.24(b) FORM AND RETENTION OF RECORDS – PLAN OF CORRECTION/ EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: CNO met with AIU Unit manager to review the BR policy and procedure for maintaining medical records and the appropriate measures for thinning charts.	4/5/13
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on staff interviews and record review nursing staff failed to assess the health conditions and care needs of two patients each of whom exhibited a change in condition. (Patients #6 and #7): Findings include: 1. Per record review Patient #6, who was admitted on 5/20/12, underwent an outpatient surgical procedure to the right wrist to repair a damaged nerve on 6/1/12. Although the patient returned to the facility at approximately 2:30 PM on 6/1/12, there is no evidence assessment of the hand or surgical site had been conducted, until almost 24 hours later, at 1:00 PM on 6/2/12 when the note indicated the patient had returned movement in fingers and sensation in thumb of right post surgical hand. In addition, although the patient complained of and was treated for ongoing pain in the hand, the only nursing assessment of the condition of the hand was a note on 6/3/12 at 7:00 PM that stated the dressing had been changed, the wound site was clean and dry and without evidence of infection. A Medical Clinic Consultation request, dated 6/5/12,	A 395	PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION On 2/25/13 Director of Health Information met with the unit clerk of AIU and provided training regarding the order of the chart and system of thinning charts. Binders were purchased with tabs to organize all thinned charts. Medical records staff organized all thinned charts in correct order and these binders are available on the Adult Intensive Unit. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The Director of HIM will report to the monthly Regulatory Readiness Committee and quarterly Organization Wide PI Committee, any instances of noncompliance noted during the weekly audit MONITORING/TRACKING: (method, frequency and responsible person) Director of Health Information Management will review all charts of AIU weekly for a period of four months to ensure that all charts are in appropriate order. TITLE OF RESPONSIBLE PERSON RHIT Director of Health Information Management and Clinical Manager of AIU	2/25/13

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A 395	Continued From page 35 stated that the patient's plaster splint had gotten wet, that nursing staff "modified" with plaster and gauze and the patient was in need of wrist stabilization. An assessment was conducted by the PA (Physician Assistant), on 6/5/12, and the plan was to place in large cock up splint, allowed to remove when showering. Although subsequent nurses notes, on 6/7/12, at 7:35 PM and 6/8/12 at 2:45 PM, respectively, indicated that the patient had complained that his/her right wrist splint was too small and s/he had pain in the wrist, also complaining on 6/9/12, "feels like electric shocks going through my arm " and again, at 8:00 PM on 6/9/12, "about having more nerve pain in hand", there was no evidence of any assessment of the condition of the wrist/hand until 3 days later on 6/10/12. A medical clinic Consultation report, dated 6/10/12, stated the reason for the consultation was: "R wrist pain - evaluate for splint size". The consultation stated that the patient complained of continued Rt wrist pain with numbness of thumb; "States cast got wet and it wasn ' t recasted. Had splint but it was too small. Having increased pain with movement, numbness of thumb." The plan indicated a larger splint was applied, to be worn except when bathing. The patient had a follow up appointment, on 6/12/12, with the surgeon who had performed the surgery on 6/1/12 and, because of ongoing problems, the patient, subsequently underwent a second surgery of the right wrist, on 6/15/12. The VP of Patient Care & CNO confirmed the lack of assessment by nursing during interview on the afternoon of 2/21/13. 2. Per record review, Patient #7, who was admitted, involuntarily on 12/11/12, had a medical	A 395	A450 482.24(c)(1) MEDICAL RECORD SERVICES PLAN OF CORRECTION/ EFFORTS TO ADDRESS IMPROVING THE PROCESSES THAT LED TO THE DEFICIENCIES: The Electronic Medical Record will ensure that entries are correctly dated, timed and signed by the appropriate author. As it is an electronic entry this will assure that entries are not inadvertently misfiled into the record of another patient. The Brattleboro Retreat began using an EMR in 2/13. PROCEDURES FOR IMPLEMENTING THE PLAN OF CORRECTION On 3/5/13 the Clinical Manager of the Unit named in the citation was apprised of the citation concerning the medical records entries and the need to improve legibility and accuracy of entries. MONITORING/TRACKING: (method, frequency and responsible person) The Inpatient Unit Managers for the units will conduct 5 random chart audits per week to assess the completeness of nursing assessments and accuracy of documentation. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The Inpatient Unit Managers will report to the monthly Regulatory Readiness Committee and quarterly Organization Wide PI Committee, the results of all chart audits. TITLE OF RESPONSIBLE PERSON Clinical Managers, CNO	3/5/13

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A 395	Continued From page 36 clinic Consult, dated 12/18/12 that stated; Reason for consultation: "Pt reports falling, injuring R knee. Increased pain, limited ROM (Range of Motion). Pt also requests pictures be taken of bruising on.....forearms". Despite the request and documentation by RN#2, dated 12/20/12, that Patient #7 had alleged that, during the prior weekend, MHW #2 had struck him/her on the left arm twice, there is no evidence that any assessment of the condition of the forearms had ever been conducted. During interview on the morning of 2/21/13 at 10:05 AM, RN #3, who had completed the clinic consult form stated that Patient #7 had approached the RN and requested to see a doctor, stating s/he had fallen and felt his/her knee was broken. RN #3 further stated that the patient had also asked to heve some pictures taken of bruises on his/her forearms. The RN stated s/he remembered looking at the patient's forearms and did not remember seeing bruising, but did not recall doing any other assessment. The VP of Patient Care & CNO, who was present during the interview, confirmed the lack of nursing assessment. In addition, NP #2 stated, during interview on 2/20/13 at 2:00 PM, that s/he had spoken with RN #3, [prior to conducting the patient's assessment], about the request to have pictures taken, and had informed the RN that they did not need someone medical to take pictures. The NP further confirmed that s/he had evaluated the patient's knee but did not assess the patient's arms. 3. Per record review, staff failed to conduct observational checks of Patient #1 in accordance	A 395		

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A 395	Continued From page 37 with physician orders. A physician order, dated 2/5/13 at 8:40 AM, stated to "Change from 30 minute checks to 15 minute checks" and identified "paranoia" as the rationale for the order. Per review of the Level of Observation flow sheets, although staff continued the 30 minute observations of the patient they did not begin to conduct 15 minute checks until 1:00 PM, a period of greater than 4 hours after the order was written. The Senior Director of Regulatory Compliance confirmed, during interview at 1:05 PM on 2/19/13, that staff failed to conduct observation checks in accordance with physician orders.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on staff interviews and record review nursing staff failed to revise the care plan to reflect the current care needs for 1 patient. (Patient #6). Findings include: Per record review, the care plan for Patient #6, who was admitted on 5/20/2012, had not been revised to address the patient ' s care needs following a surgical procedure, on 6/1/2012, to repair a damaged nerve. Although the patient returned to the facility following the same day surgical procedure, with a dressing and plaster splint on the right hand there was no plan of care identified to meet those needs. The VP of Patient Care & CNO confirmed, during	A 396		

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A 396	Continued From page 38 interview on the afternoon of 2/21/2013, the care plan did not address the patient's post surgical status and care needs related to the surgical wound.	A 396		
A 438	482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on observation and staff interview, the hospital failed to ensure medical records were accurately written, and properly filed and accessible. Findings include: 1. During the days of survey, records were difficult to review due to the "thinning" of documentation by staff on Patient Units. Upon review of specific records of patients hospitalized on Osgood 3, it was difficult to review components of the record due to the removal of physician orders and progress reports. Documentation was scattered among folders and files. When requesting on 2/20/2013, the previous admission record for Patient #10 the record provided was disorganized in multiple folders and chart. The "Certificate of Need for Emergency Involuntary Procedures", physician orders, progress notes and other pertinent information, improperly filed and out of sequence. On the morning of 2/21/13, the Director of Medical	A 438		

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A 438	Continued From page 39 Records, confirmed staff on the patient units were disassembling records incorrectly. 2. Per review, Patient #13's medical record contained a written statement on a Progress Note, that was not dated, timed or signed by the author. The context of the note, which stated; "Pt said that peer [Patient #13] told [him/her] I haven't had sex in a while, but I was tested before then", did not appear to accurately reflect any information that would belong in Patient #13's record. The RN Unit Manager confirmed, during interview at 2:28 PM on 2/14/13, the lack of dates, time and authentication of documentation, and agreed that the context of the Progress Note did not appear to be an accurate reflection of information that would belong in Patient #13's record.	A 438		
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on staff interviews and record review the facility failed to assure that all entries in the medical records were dated, timed and authenticated. Findings include: Per review, Patient #13's medical record contained a written statement on a Progress Note, that was not dated, timed or signed by the author. The note, which stated "Pt said that peer	A 450		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRATTLEBORO RETREAT	ANNA MARSH LANE PO BOX 803 BRATTLEBORO, VT 05301

(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 450	Continued From page 40 [Patient #13] told [him/her] I haven't had sex in a while, but I was tested before then", did not appear to even belong in Patient #13's record. In addition, there was a Level of Observation flow sheet beginning at 7:00 PM and ending at 6:45 AM that lacked the date. The RN Unit Manager confirmed, during interview at 2:28 PM on 2/14/13, the lack of dates, time and authentication of documentation, and agreed that the Progress Note did not appear to belong in Patient #13's record.	A 450	A450 482.24(c)(1) MEDICAL RECORD SERVICES continued MONITORING/TRACKING: (method, frequency and responsible person) The Inpatient Unit Managers for the units will conduct 5 random chart audits per week to assess the completeness of nursing assessments and accuracy of documentation. PROCEDURES FOR INCORPORATING SYSTEMIC IMPROVEMENT ACTIONS INTO (QAPI) PROGRAM The Inpatient Unit Managers will report to the monthly Regulatory Resdiness Committee and quarterly Organization Wide PI Committee, the results of all chart audits. TITLE OF RESPONSIBLE PERSON Clinical Managers, CNO	