

Division of Licensing and Protection
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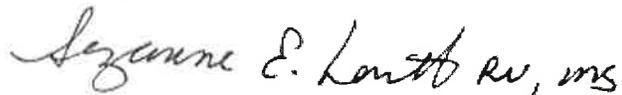
May 15, 2015

Mr. Jeff Rothenberg, Administrator
Vermont Psychiatric Care Hospital
350 Fisher Road
Berlin, VT 05602

Dear Mr. Rothenberg:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 4, 2015**. Please post this document in a prominent place in your facility.

Sincerely,



Suzanne Leavitt, RN, MS
Assistant Division Director
Director State Survey Agency

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

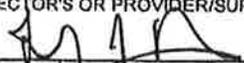
PRINTED: 02/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 474004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/04/2015
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NAME OF PROVIDER OR SUPPLIER VERMONT PSYCHIATRIC CARE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 350 FISHER ROAD BERLIN, VT 05802
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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A 000	INITIAL COMMENTS	A 000		
A 145	<p>482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT</p> <p>The patient has the right to be free from all forms of abuse or harassment.</p> <p>This STANDARD is not met as evidenced by: Based on staff and patient interviews and record review, the hospital failed to ensure all patients were free from verbal harassment for 1 of 10 applicable patients. (Patient # 2). Findings include:</p> <p>Per record review on 2/3/15 & 2/4/15, Patient #2 was admitted to the hospital on 11/19/14 with severe OCD (Obsessive Compulsive Disorder associated with anxiety characterized by recurrent, unwanted thoughts and repetitive behaviors). During Patient #2's hospitalization, certain "triggers" and "fears" have resulted in maladaptive behaviors which have impacted the patient's ability to sustain and maintain compliance with hospital rules, medication administration, activities of daily living and food consumption. Since admission various behavioral plans have been developed by the treatment team (Psychiatrist, psychologist, social worker, nursing and recreational therapy) to include very specific schedules to address personal hygiene, acceptance of meals and prescribed medication.</p>	A 145		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE LEO	(X6) DATE 5/8/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 145	<p>Continued From page 1</p> <p>Per physician progress note for 1/02/15, Patient #2's attending psychiatrist states: " We all have difficulties trying to find a consistent and recovery centered approach and everybody wants a magic formula". Record review noted evidence of various approaches to assist both Patient #2 and staff to manage his/her day to day stressors.</p> <p>However, on the evening of 1/3/15 and 1/4/15 the evening Charge Nurse decided s/he would manage Patient #2's behaviors by directing staff to play a role in "planned ignoring" (behavioral management strategy used to reduce attention seeking behaviors). During the course of both evening shifts, staff were directed to ignore Patient #2's requests, to include special accommodations previously provided to assist with the patient's significant OCD, forbidding any interaction with the patient unless specifically directed by the charge nurse. Per written statements obtained on 1/5/15 by Administration from staff assigned on 1/3/15 and 1/4/15 noted staff were told to not engage with or answer requests from Patient #2. Staff described Patient #2 as visibly upset, crying and pleading for assistance through out the evening. Witnesses described the charge nurse as "taunting" Patient #2 by repeatedly asking the patient to play a horseshoe game. The patient continuously refused, saying "No", expressing increased agitated and emotional frustrating with each repeated request made by the Charge Nurse over and over again.</p> <p>A second reported interaction transpired at the nurses station on 2/5/15. Patient #2 approached the nurses station requesting staff to call the nursing supervisor or on call physician regarding the escalating anxiety s/he was experiencing,</p>	A 145			

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A 145	<p>Continued From page 2</p> <p>attempting to seek help from staff outside the unit. At that point the Charge Nurse opened the door to the nurses station and Patient #2 grabbed the door and slammed it shut. Per witness accounts, the Charge Nurse continued to reopen the door to the nurses station approximately 5-7 times , each time smiling and laughing at the patient, inciting and provoking the patient, who then slammed the door. Per interview on the afternoon 2/4/15, a staff member described Patient #2 during the door slamming incident as "...angry, yelling and hysterical..." Per interview on the afternoon of 2/4/15 the evening Charge Nurse confirmed the door slamming incident, identifying it as a physical "distraction", assisting the patient to "deescalate".</p> <p>Per review of Precaution Monitoring Special Consideration/15 minute observation record for both 1/3/15 and 1/4/15, staff had recorded during the evening shift on 1/3/15 from 3:00 PM to 7:00 PM Patient #2 was observed to be "restless/troubled; afraid & anxious; angry talking or behavior; possible internal stimulation and expresses or appears sad". On 1/4/15 staff again recorded similar observations from 4:00 PM through 11:00 PM. These behaviors were not observed on 1/3/15 or 1/4/15 on the other shifts (7:00 am - 3:00 PM or 11:00 PM - 7:00AM).</p> <p>Per Psychology Service Progress note for 1/5/15 at 1430 notes: Patient #2 "...reported that her/his anxiety level has been "through the roof" the past several days because s/he feels that most staff don't understand her/him..." to include the diagnosis of OCD. S/he reported that the anxiety level has been so bad that s/he thought about killing herself." S/he further requested a transfer off the unit to get away from staff who were</p>	A 145			

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A 145	<p>Continued From page 3</p> <p>triggering behaviors. Per interview on 2/4/15 at 10:30 AM the Licensed Psychologist confirmed "planned ignoring" was not part of Patient #2's treatment plan nor was it recommend to be used with OCD, especially not with Patient #2. It was further confirmed nursing should not be determining such a technique be used to manage Patient #2's behaviors.</p> <p>Per a Physician Progress Note dated 1/5/05 at 15:30, Patient #2's Psychiatrist states: "S/he also had complaints about the staff not been available to work with (Patient #2) or talk to her/him over the weekend mainly during second shift. I got the report that many people thought that this approach was not productive." Per interview on 2/4/15 at 11:35 AM, the attending psychiatrist reconfirmed "planned ignoring" was "...never part of the plan..." and the evening Charge Nurse should not have instituted this behavioral technique. The Psychiatrist stated decisions such as this are only determined through discussions with the treatment team. Further noting "planned ignoring" was inappropriate and not used in psychiatry for patients with OCD.</p> <p>Per interview on 2/4/15 at 1:40 PM, Patient #2 confirmed the events which occurred during the 2 evening shifts on 1/3/15 and 1/4/15. S/he expressed how emotionally difficult it was to have staff ignore her/him. Patient #2's account of the events concurred with staff statements and specifically acknowledged the evening Nurse Manager had "harassed" her/him during both evening shifts. The patient also noted s/he should not have been subjected to "planned ignoring" and all staff involved should have refused to be compliant with direction of the evening Charge Nurse.</p>	A 145			

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A 154	<p>482.13(e) USE OF RESTRAINT OR SECLUSION</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that 1 of 6 applicable patients in the targeted sample was released from seclusion at the earliest possible time. (Patient #1). Findings include:</p> <p>Per review of the medical record for Patient #1 on 2/3/15, the patient was secluded and administered emergency involuntary medication on 11/5/14 after attempting to physically assault and then threatening to kill the psychiatrist. Although the seclusion and subsequent administration of involuntary medication was determined to be necessary, there was a lack of documentation to show evidence of the continued need for seclusion after 2250 hours. Per the psychiatrist notes of 11/5/14 at 2245 hours, "he/she became enraged ,....threatened to kill me and rapidly approached down the hallway. When a staff member tried to intervene, patient came within a few inches of staff", (hands raised per the Registered Nurse) "and threatened to kill him/her." (The patient was offered PRN medication and had refused this.) The patient was restrained at 2155 hours and brought to the seclusion room. In the seclusion room, "the</p>	A 154			

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A 154	Continued From page 5 patient remained severely agitated... When I attempted to speak with him,he began to slam...head repeatedly on the seclusion room door". The psychiatrist ordered emergency medication to be given, including Haldol, 5 mg. (milligrams), Ativan 2 mg., and Benadryl, 50 mg. I.M. (intramuscularly) and this was administered by the nurse at 2205 hours, per the CON (Certificate of Need) documentation flow sheet. Per review of the "Emergency Seclusion/Restraint Record" log of recorded patient behaviors at designated times, at 2250 hours, the patient was coded to be 'restless and confused'; at 2305 hours the patient was coded as 'confused'; at 2320, the patient was coded as 'resting/RN notified'. At 2330 hours, the seclusion ended. Per review of the RN assessment of need to continue seclusion beyond 1 hour, Section 2 of the CON, Pg. 2 of 4, the RN wrote "calming but still incessantly talking at 2250 hours". 'The patient drank offered water.' During interview on 2/4/15 at 2:25 PM, the ADON (Assistant Director of Nursing Services) confirmed that the RN documentation regarding the need for continued seclusion lacked evidence that the need continued until 2330 hours. The descriptors used to describe the behaviors did not indicate a risk of serious harm continued after 2250 hours.	A 154			
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 and patient interview and record review, the RN (Registered Nurse) failed to follow	A 395			

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NAME OF PROVIDER OR SUPPLIER VERMONT PSYCHIATRIC CARE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 350 FISHER ROAD BERLIN, VT 05602
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A 395	<p>Continued From page 6</p> <p>the current care and treatment plan established by the treatment team to manage the behaviors of 1 of 10 patients in the total sample. (Patient #2)</p> <p>Regarding a targeted sample of 6 patients who were restrained, RNs failed to consistently perform an assessment of one patient who had undergone a restraint procedure, to assure that there were no possible injuries sustained, in accordance with accepted standards of nursing practice and hospital nursing documentation policy. The Patient was affected on 2 occasions. (Patient #1).</p> <p>Findings for Patient #2 include:</p> <p>1. Per record review on 2/3/15 & 2/4/15, Patient #2 was admitted to the hospital on 11/19/14 with severe OCD (Obsessive Compulsive Disorder associated with anxiety characterized by recurrent, unwanted thoughts and repetitive behaviors). During Patient #2's hospitalization, certain "triggers" and "fears" have resulted in maladaptive behaviors which have impacted the patient's ability to sustain and maintain compliance with hospital rules, medication administration, activities of daily living and food consumption. Since admission various behavioral plans have been developed by the treatment team (Psychiatrist, psychologist, social worker, nursing and recreational therapy) to include very specific schedules to address personal hygiene, acceptance of meals and prescribed medication. Per physician progress note for 1/02/15, Patient #2's attending psychiatrist states: " We all have difficulties trying to find a consistent and recovery centered approach and everybody wants a magic formula". Record review noted evidence of various approaches to assist both Patient #2 and</p>	A 395		
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A 395	<p>Continued From page 7 staff to manage his/her day to day stressors.</p> <p>However, on the evening of 1/3/15 and 1/4/15 the evening Charge Nurse decided s/he would introduce a new plan of treatment to manage Patient #2's behaviors by directing staff to play a role in "planned ignoring" (behavioral management strategy used to reduce attention seeking behaviors). During the course of both evening shifts, staff were directed to ignore Patient #2's requests, to include special accommodations previously provided to assist with the patient's significant OCD. Within the new "plan" staff were forbidden any interaction with the patient unless specifically directed by the charge nurse. Per written statements from staff dated 1/5/15, who witness events on 1/3/15 and 1/4/15 noted staff were told to not engage with or answer requests from Patient #2. Staff described Patient #2 as visibly upset, crying and pleading for assistance through out the evening. Witnesses described the charge nurse as "taunting" Patient #2 by repeatedly asking the patient to play a horseshoe game. The patient continuously refused, saying "No", expressing increased agitated and emotional frustrating with each repeated request made by the Charge Nurse.</p> <p>A second reported interaction transpired at the nurses station on 2/5/15. Patient #2 approached the nurses station requesting staff to call the nursing supervisor or on call physician regarding the escalating anxiety s/he was experiencing, attempting to seek help from staff outside the unit. At that point the Charge Nurse opened the door to the nurses station and Patient #2 grabbed the door and slammed it shut. Per witness accounts, the Charge Nurse continued to reopen</p>	A 395			

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A 395	<p>Continued From page 8</p> <p>the door to the nurses station approximately 5-7 times , each time smiling and laughing at the patient, inciting and provoking the patient, who then slammed the door. Per interview on the afternoon 2/4/15, a staff member described Patient #2 during the door slamming incident as "...angry, yelling and hysterical...." Per interview on the afternoon of 2/4/15 the evening Charge Nurse confirmed the door slamming incident, identifying it as a physical "distraction", assisting the patient to "deescalate". This mode of "deescalating" for Patient #2's behaviors was not part of of the treatment/nursing plan.</p> <p>Per Psychology Service Progress note for 1/5/15 at 1430 notes: Patient #2 "...reported that her/his anxiety level has been "through the roof" the past several days because s/he feels that most staff don't understand her/him..." to include the diagnosis of OCD. S/he reported that the anxiety level has been so bad that s/he thought about killing herself." S/he further requested a transfer off the unit to get away from staff who were triggering behaviors. Per interview on 2/4/15 at 10:30 AM the Licensed Psychologist confirmed "planned ignoring" was not part of Patient #2's treatment plan nor was it recommend to be used with OCD, especially not with Patient #2. It was further confirmed nursing should not be determining such a technique be used to manage Patient #2's behaviors. The Licensed Psychologist stated "...not a nursing function".</p> <p>Per a Physician Progress Note dated 1/5/05 at 15:30, Patient #2's Psychiatrist states: "S/he also had complaints about the staff not been available to work with (Patient #2) or talk to her/him over the weekend mainly during second shift. I got the report that many people thought that this</p>	A 395			

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A 395	<p>Continued From page 9</p> <p>approach was not productive." Per interview on 2/4/15 at 11:35 AM, the attending psychiatrist reconfirmed "planned ignoring" was "...never part of the plan..." and the evening Charge Nurse should not have instituted this behavioral technique. The Psychiatrist stated decisions such as this are only determined through discussions with the treatment team. Further noting "planned ignoring" was inappropriate and not used in psychiatry for patients with OCD.</p> <p>Per interview on 2/4/15 at 1:40 PM, Patient #2 confirmed the events which occurred during the 2 evening shifts on 1/3/15 and 1/4/15. S/he expressed how emotionally difficult it was to have staff ignore her/him and being subjected to "planned ignoring" plan of treatment instituted by the evening Charge Nurse without the approval of the Treatment Team.</p> <p>Findings for Patient #1 include:</p> <p>2. Per review of the CON (Certificate of Need) and Treatment Plan Addendum for Seclusion dated 11/5/14 and 11/15/14 for Patient #1, RNs failed to document assessment of possible injury after the patient required hands on manual restraint for transport to the seclusion room. Section 1 includes a check box which should be completed if the patient required manual restraint during the seclusion process. For each of the CONs completed for 11/5/14 and 11/15/14, the check box stating "Was patient checked for injuries?" was blank.</p> <p>Per review of the hospital's Nursing Procedure - Restraint/Seclusion Care Tasks, .2, #8, Addressing Injuries: any indication of possible injury should be reported. No evidence of assessment for injury was documented on the</p>	A 395		
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A 395	Continued From page 10 CON. The failure of nurses to document assessment for possible injury after manual restraint was confirmed during interview with the Director of Nurses (DON) and Assistant Director of Nurses (ADON) on 2/4/15 at 2:20 PM.	A 395			

Vermont Psychiatric Care Hospital – Plan of Correction

Unannounced on-site survey on 02/04/2015 – survey report dated 02/12/2015

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	PROVIDER'S PLAN OF CORRECTION	Completion Date
	<p>An unannounced on-site survey was conducted by staff from the Vermont Division of Licensing and Protection, as authorized by the Centers for Medicare and Medicaid Services, to investigate a complaint (#12932) and a mandated self-report of alleged patient abuse (#12864). The following regulatory violations were found.</p>		
A 145	<p>482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARRASSMENT</p> <p>The patient has the right to be free from all forms of abuse or harassment.</p> <p>This STANDARD is not met as evidenced by: Based on staff and patient interviews and record review, the hospital failed to ensure all patients were free from verbal harassment of 1 of 10 applicable patients (Patient #2).</p> <p><i>A145 POC accepted 5/13/15 my Bulter, RN</i></p>	<p>The questionable behaviors by the registered nurse (will be referred to as RN Y) toward the patient (will be referred to as Pt Z) occurred on C Unit during 2nd shift on Saturday and Sunday, January 3 and 4, 2015.</p> <p>The behaviors were reported verbally by a mental health specialist (MHS) to the Nurse Manager late afternoon of Monday, January 5. RN Y was not at work Monday, Tuesday or Wednesday of that week.</p> <p>The Nurse Manager (NM) instructed the MHS to document the events on a Patient Event Form. The NM also asked this MHS and two other MHS who witnessed these behaviors to each write thorough descriptions of what they witnessed. Two MHS's completed Patient Event Forms describing these behaviors. Three MHS's wrote descriptive statements of RN M's behaviors toward this patient. This all occurred late afternoon of 1/5/15.</p> <p>The NM discussed these reports with the Associate Director of Nursing (ADN) during the afternoon of 1/5/15. The ADN informed the Director of Nursing (DON) by phone.</p> <p>On the morning of 1/6/15, the NM met with the DON. The DON reassigned RN Y to A-B Unit where she would have no contact with Pt Z. RN Y was not scheduled to work on 1/6 or 1/7.</p> <p>The DON submitted a report to Adult Protective Services (APS) of the alleged abuse. The DON consulted with State of Vermont Department of Human Resources (DHR) to determine whether</p>	

		<p>or not an investigation for misconduct was indicated. DHR indicated that an investigation for misconduct was indicated. When an investigation for misconduct of a classified employee is to be initiated by DHR, the supervisor is prohibited from addressing the topic of the misconduct investigation behavior with the employee and prohibited from directly investigating the issue being investigated by interviewing other staff members.</p> <p>Because RN Y has been employed at VPCH and its predecessor institutions, VSH and GMPCC, for 9 years, had a positive work history with no record of having mistreated a patient, RN Y was permitted to continue working at VPCH, on units separate from Pt Z, during the APS and HR investigations.</p> <p>VPCH Director of Nursing asked the APS investigator to prioritize this investigation. The APS investigator agreed to do so.</p> <p>The Director of Nursing received a letter from APS on March 11, 2015 stating that the allegation that RN Y had abused and neglected Pt Z had been substantiated. RN Y was immediately placed on administrative leave.</p> <p>On April 6, 2015, the Director of Nursing reported the finding of substantiation to the Vermont State Board of Nursing.</p> <p>VPCH Quality convened a Peer Review meeting on April 9, 2015, comprised of the Director of Quality, Associate Director of Nursing, and the Mental Health Specialists (MHS) who wrote Patient Event Forms describing the incidents under review. The third MHS who wrote a narrative report of the incidents was on medical leave secondary to an injury that occurred away from the workplace.</p> <p>The MHS's who participated in this peer review stated that when they first reported their concerns to the Nurse Manager (NM) on March 6, the NM encouraged them to complete Event Reports and to write narrative descriptions of these events. The MHS stated that they have experienced no negative consequences from having reported their concerns about RN Y's behavior toward Pt Z on the weekend of March 4 and 5, 2015.</p>	<p>January 8, 2015</p> <p>March 11, 2015</p> <p>April 9, 2015</p>
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A 154	<p>482.13(e) USE OF RESTRAINT OR SECLUSION</p> <p>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</p>		

<p>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.</p> <p>The STANDARD is not met as evidenced by: Based on staff interview and record review, the hospital failed to assure that 1 of 6 applicable patients in the targeted sample was released from seclusion at the earliest possible time. (Patient #1).</p> <p><i>A 154 POC accepted 5/13/15 Myrtle, RN</i></p>	<p>In the deficiency cited, VPCH agrees that the documentation by the mental health specialist (MHS) of patient behavior while in seclusion did not indicate a risk of serious harm after 2250, yet the patient remained in seclusion until 2330.</p> <p>Corrective Actions: The Emergency Seclusion/Restraint Record where direct care staff document patient behavior while in seclusion or mechanical restraint has been revised. This form provides prompts that instruct the MHS when to call for an RN to assess the need to continue seclusion or mechanical restraint.</p> <p>The behaviors listed from which MHS staff select to describe patient behavior has been revised to increase specificity. Several additional patient behaviors have been added to the monitoring form that prompt the staff observing to notify an RN to assess the need for continuing seclusion or restraint.</p> <p>Nursing and mental health specialist staff participated in revising the form. RN's were educated to respond promptly to each request to assess the patient, in addition to the required one-hour reassessments. The new form was implemented on April 15, 2015.</p> <p>Quality staff audit these forms as part of the ongoing review of emergency involuntary procedures documentation on the first working day following the emergency procedure. Quality has intensified attention to this aspect of documentation and provide corrective feedback if 1) the MHS staff do not notify an RN and request an assessment of the need to continue the EIP when the documentation indicates a need, and 2) if RN staff who provide the assessment of the patient, who do not find that the patient can be released safely, fail to document an assessment explaining why a risk</p>	<p>April 15, 2015</p> <p>February 5, 2015 and ongoing</p>
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		<p>of serious physical harm would remain if the patient were released at that time from restraint or seclusion.</p> <p>Nursing Supervisors, who are present in the hospital 24/7/365, and who are already responsible for leading a debriefing with staff following each emergency involuntary procedure (EIP), were assigned responsibility for reviewing nursing and physician documentation as soon as possible following each EIP. Whenever possible, this review of documentation should be done in collaboration with the Charge Nurse. The expectation is real-time review of documentation and immediate corrective feedback and education to the clinical staff member who documented, which will allow the author of the documentation to make necessary additions and corrections.</p> <p>Result since 2/5/15: There have been no occasions when 1) an MHS did not notify an RN when the documentation indicated a need for an assessment of the need to continue the EIP, and no occasions when 2) an RN failed to document an assessment explaining why a risk of serious physical harm would continue if the patient were released as that time from restraint or seclusion.</p>	<p>April 1, 2015 and ongoing</p> <p>May 4, 2015</p>
A 395	<p>482.23(b)(3) RN SUPERVISION OF NURSING CARE</p> <p>A registered nurse must supervise and evaluate the nursing care for each patient.</p> <p>The STANDARD is not met as evidenced by: Based on staff and patient interview and record review, the RN (Registered Nurse) failed to follow the current care and treatment plan established the treatment team to manage the behaviors of 1 of 10 patients in the total sample. (Patient #2)</p> <p>Regarding a targeted sample of 6 patients who were restrained, RNs failed to consistently perform an assessment of one patient who had undergone a restraint procedure, to assure that there were no possible injuries sustained, in</p>	<p><i>A 395 POE accepted 5/13/15 My [signature]</i></p> <p>In the deficiency cited, VPCH agrees that following one manual restraint procedure, the RN did not document that following the manual restraint, the patient had been checked for injuries in the example cited.</p>	

	<p>accordance with accepted standards of nursing practice and hospital nursing documentation policy. The Patient was affected on 2 occasions. (Patient #1)</p>	<p>Quality staff audit these forms as part of the ongoing review of emergency involuntary procedures documentation on the first working day following the emergency procedure. Quality has intensified attention to this aspect of documentation and provides corrective feedback whenever this section of the form has not been documented correctly.</p> <p>Nursing Supervisors, who are present in the hospital 24/7/365, and who are already responsible for leading a debriefing with staff following each emergency involuntary procedure (EIP), were assigned responsibility for reviewing nursing and physician documentation as soon as possible following each EIP. Whenever possible, this review of documentation should be done in collaboration with the Charge Nurse. The expectation is real-time review of documentation and immediate corrective feedback and education to the clinical staff member who documented, which will allow the author of the documentation to make necessary additions and corrections.</p> <p>Result since 2/5/15: On five separate occasions (2/10/15 X 2 - 2/11/15 - 2/17/15 - 3/25/15) five different RNs failed to document having checked the patient for injury following a manual or mechanical restraint. Corrective feedback was provided to each RN by Quality. In every case, the RN involved reported having checked the patient for injuries following the restraint, and each acknowledged having neglected to check the box to affirm that. Each RN corrected his/her documentation. Since 3/25/15, this section of all CONs for restraint has been completed correctly.</p>	<p>February 5, 2015 and ongoing</p> <p>April 1, 2015 and ongoing</p> <p>May 4, 2015</p>
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