STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	380007	A. BUILDING _____ B. WING _____	R-C 07/30/2018

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LEGACY EMANUEL MEDICAL CENTER	**2801 N GANTENBEIN AVENUE PORTLAND, OR 97227**

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{A 000}	INITIAL COMMENTS This report reflects the findings of the unannounced, onsite Federal revisit survey at the Legacy Emanuel Medical Center's (LEMC) off-campus satellite behavioral health inpatient and outpatient facility, the Unity Center for Behavioral Health (UCBH). The revisit survey was concluded on 07/30/2018. The revisit survey resulted from Federal complaint investigation survey #OR14492 that concluded on 05/22/2018, during which non-compliance at the Condition-level was identified. During that survey on 05/18/2018 an immediate jeopardy (IJ) situation was identified to exist to which the hospital responded with an acceptable mitigation plan. The survey concluded on 05/22/2018 with findings of non-compliance for the following Conditions of Participation (CoP) and the hospital was placed on a 90-day termination track: * CFR 482.12 - CoP Governing Body * CFR 482.13 - CoP Patient's Rights * CFR 482.21 - CoP Quality Assessment and Performance Improvement * CFR 482.23 - CoP Nursing Services * CFR 482.41 - CoP Physical Environment During the revisit survey, on 07/27/2018 at 1715, surveyors informed the hospital it was determined that a second IJ situation existed. During the revisit survey observations, interviews, review of medical records and incident/event investigation documentation, and review of policies and procedures revealed continued hazards in the physical environment, continued lack of assessment and observation of patients at risk for suicide or other self-harm, continued presence of	{A 000}		

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

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{A 000}	Continued From page 1	{A 000}		

unsafe contraband items, and continued medication errors. Those failures resulted in a successful patient suicide by hanging using a ligature fashioned from clothing, other suicide attempts and self-harm attempts with items that included linens and clothing, patient possession of contraband, and medication errors one of which resulted in a change of patient condition that was not monitored and the patient was subsequently transferred for medical hospitalization.

Surveyors remained at the hospital until an acceptable, written IJ mitigation plan was developed and submitted on 07/28/2018 at 0030. The hospital's plan reflected:
"7/28/18
This letter is in reference to the ongoing OHA investigation at Unity Center for Behavioral Health, which began on 7/23/18. The following steps have been taken to alleviate the immediacy of the deficiencies identified on 7/27/18.
*Suicide Precautions -
All patient admissions will be discontinued effective 7/27/18.
All patients will be screened for suicide risk a minimum of each shift and with change in patient condition. All patients with a positive screen will be assessed by a provider. All patients identified as a suicide risk will be placed on constant observation. This process will be implemented on 7/28/18.
Constant observation will also mitigate the risks associated with visitor belongings, contraband, ligature points, and other environmental concerns.
*Contraband/Unsafe Items -
All patients on suicide precautions will have their personal belongings and room searched by

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{A 000}	Continued From page 2 7/28/18. Unsafe items, as identified in personal belongings policy #902.3107, will be secured. No new personal belongings will be given to patients until a new process is implemented for searching and inventorying patient belongings. Room searches will be documented in a progress note. * Medication Errors - Every medication administration will be observed by a second RN from the point of pulling the medication to patient taking the medication beginning on 7/28/18. A medication administration checklist will be used to document the second RN's observation of the process. * Environmental Safety Risks - Linen carts in all patient care areas will be secured behind locked doors, out of the general milieu effective 7/28/18. On 07/31/2018 a written "amended" IJ mitigation plan was received from the hospital. The plan was dated 07/31/2018 and the only change was that "All patient admissions will be discontinued effective 7/27/18" was removed. All other language remained the same as the plan received 07/28/2018 at 0030. Although the hospital mitigated the second IJ, the findings from the revisit survey reflect its continued limited capacity to provide safe and adequate care as continued non-compliance was identified for the following CoPs: * CFR 482.12 - CoP Governing Body * CFR 482.13 - CoP Patient's Rights * CFR 482.21 - CoP Quality Assessment and Performance Improvement * CFR 482.23 - CoP Nursing Services * CFR 482.41 - CoP Physical Environment Abbreviations and Acronyms used throughout this	{A 000}		

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{A 000}	Continued From page 3	{A 000}		

report:

ACC - Accreditation & Clinical Compliance
AD - Advance Directives
ADLs - Activities of Daily Living
admin - administration
AED - Automated External Defibrillator
AH - Auditory hallucinations
AMR - American Medical Response ambulance
Ambu bag - A manual resuscitator
ANM - Assistant Nurse Manager
AOC - Administrator on Call
approx - approximately
BID - Twice a day
BHT - Behavioral Health Therapist
BHU - Behavioral Health Unit
BLS - Basic Life Support
BR - Bathroom
CHT - Unknown
CFR - Code of Federal Regulations
cm - centimeter
CMS - Federal Centers for Medicare and Medicaid Services
CN - Charge Nurse
CNA - Certified Nursing Assistant
CoP - Condition of Participation
Code Gray - Response to threatening or assaultive behaviors
Code M - Response to urgent and emergency medical conditions
Code Silver - Response to weapons, active shooter, etc.
CoP - Condition of Participation
COTA - Certified Occupational Therapy Assistant
CPR - Cardiopulmonary Resuscitation
CSSRS - Columbia Suicide Severity Rating Scale
DCS - Dietary Care Services
DPC - Director Patient Care
DS - Director of Services

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{A 000}	Continued From page 4	{A 000}		

DSS - Director of Safety/Security
d/c'd - discontinued
d/t - due to
DPCS = Director of Patient Care Services
ED - Emergency Department
EHR - Electronic Health Record
EKG - Electrocardiogram
EMS - Emergency Medical Services
EOC - Environment of Care
EOCC - Environment of Care Committee
FDA - U.S. Food and Drug Administration
FM - Facilities Manager
Good Sam - Legacy Good Samaritan Medical Center
HA - headache
HCRQI - Health Care Regulation and Quality Improvement
HH - Hold
HI - homicidal ideation
HS - House Supervisor
HS - hour of sleep
h/o - history of
IJ - Immediate Jeopardy
IM - Important Message From Medicare
IM - Intramuscular
JC - The Joint Commission
L - Left
Lac - Laceration
LEMC - Legacy Emanuel Medical Center
LH - Legacy Health
LIMS - Legacy Internal Medicine Services
LIP - Licensed Independent Practitioner
LSO - Legacy Security Staff
MAR - Medication Administration Record
MD - Doctor of Medicine
meds - Medications
mg - milligram
MHT - Mental Health Therapist
mtg - Meeting

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{A 000}	Continued From page 5 NA - Nursing Administration NEBHS - Nurse Education & Behavioral Health Specialty NM - Nurse Manager OD - Overdose OHA - Oregon Health Authority OHSU - Oregon Health & Science University Hospital OT - Occupational Therapist O2 - Oxygen NP - Nurse Practitioner NTICU - Neurotrauma Intensive Care Unit PES - Psychiatric Emergency Service POC - Plan of correction PRN - As needed PSA - Patient Safety Alert Pt - Patient Q, q - Every QAPI - Quality Assessment Performance Improvement QIO - Quality Improvement Organization QR - Quiet Room R - Right RLQ - Right Lower Quadrant RN - Registered Nurse SA - State Agency that conducts CMS survey and certification activities. In Oregon that is the Oregon Health Authority, Public Health, Health Care Regulation and Quality Improvement. Sec - Second SI - Suicidal Ideation SLM - Self Learning Module SM - Security Manager SS - Security Supervisor SSO - Safety Security Officer TID - Three times a day UCBH - Unity Center for Behavioral Health UM - Utilization Management VH - Visual hallucinations	{A 000}		

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{A 000}	Continued From page 6 VPU - Vice President Unity VPFO - Vice President Facilities Operations VS - Vital signs VSD - Violent Self Destructive w - With X - times	{A 000}		
{A 043}	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observations, interviews, review of incident/event and medical record documentation for 7 of 10 patients who experienced actual or potential self-harm between 06/25/2018 and 07/29/2018 (Patients 48, 50, 52, 57, 61, 65 and 71), incident/event and medical record documentation for 8 of 8 patients who were reviewed for medication errors that occurred between 07/04/2018 and 07/27/2018 (Patients 47, 51, 58, 59, 60, 66, 73 and 74), review of medical record documentation for 2 of 2 patients who were placed in seclusion (Patients 53 and 55), review of restraint and seclusion training documentation for 16 of 16 staff (Employees 6, 10, 20, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34 and 35), review of policies and procedures, and review of other documentation related to safety and physical environment risk, it was determined that the governing body failed to ensure the provision of safe and appropriate care	{A 043}		

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{A 043}	Continued From page 7 to patients in the hospital that complied with the Conditions of Participation in the following areas: * Patients identified at risk for suicide were not protected from self-harm and suicide attempts. Patient 50 committed suicide by hanging and died. * The physical environment contained ligature risks that resulted in actual patient harm. * The physical environment contained unsafe items that resulted in actual patient harm. * The physical environment contained blind spots that created the opportunity for patient self-harm or suicide without immediate detection. * Communication safety devices required for staff use were not available. * Elopement prevention, and staff awareness and alertness to potential hazards and risks were lacking. * Systems to ensure that equipment and supplies necessary for response to urgent and emergent medical conditions were available and in safe working condition were not fully implemented. * Medication errors occurred when RNs failed to administer the right medication to the right patient, in the right dose, by the right route and at the right time. Patient 58 experienced a change of condition and required EMS transfer and medical hospitalization as a result of receiving another patient's medications. * Seclusion requirements were not met for those patients placed in seclusion. * Restraint and seclusion were not implemented by staff who met the restraint and seclusion training requirements. * Investigations of and response to patient incidents/events were not timely or complete to prevent recurrence. This Condition-level deficiency was uncorrected	{A 043}		

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{A 043}	Continued From page 8 and represents a limited capacity on the part of the hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited under Tag A115, CFR 482.13 - CoP Patient's Rights. 2. Refer to the findings cited under Tag A263, CFR 482.21 - CoP Quality Assessment and Performance Improvement. 3. Refer to the findings cited under Tag A385, CFR 482.23 - CoP Nursing Services. 4. Refer to the findings cited under Tag A700, CFR 482.41 - CoP Physical Environment.	{A 043}		
{A 115}	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observations, interviews, review of incident/event and medical record documentation for 7 of 10 patients who experienced actual or potential self-harm between 06/25/2018 and 07/29/2018 (Patients 48, 50, 52, 57, 61, 65 and 71), incident/event and medical record documentation for 8 of 8 patients who were reviewed for medication errors that occurred between 07/04/2018 and 07/27/2018 (Patients 47, 51, 58, 59, 60, 66, 73 and 74), review of medical record documentation for 2 of 2 patients who were placed in seclusion (Patients 53 and 55), review of restraint and seclusion training documentation for 16 of 16 staff (Employees 6,	{A 115}		

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{A 115}	Continued From page 9 10, 20, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34 and 35), review of policies and procedures, and review of other documentation related to safety and physical environment risk, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured patient's rights to care in a safe setting in the following areas: * Patients identified at risk for suicide were not protected from self-harm and suicide attempts. Patient 50 committed suicide by hanging and died. * The physical environment contained ligature risks that resulted in actual patient harm. * The physical environment contained unsafe items that resulted in actual patient harm. * The physical environment contained blind spots that created the opportunity for patient self-harm or suicide without immediate detection. * Communication safety devices required for staff use were not available. * Elopement prevention, and staff awareness and alertness to potential hazards and risks were lacking. * Systems to ensure that equipment and supplies necessary for response to urgent and emergent medical conditions were available and in safe working condition were not fully implemented. * Medication errors occurred when RNs failed to administer the right medication to the right patient, in the right dose, by the right route and at the right time. Patient 58 experienced a change of condition and required EMS transfer and medical hospitalization as a result of receiving another patient's medications. * Seclusion requirements were not met for those patients placed in seclusion. * Restraint and seclusion were not implemented by staff who met the restraint and seclusion	{A 115}		

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{A 115}	Continued From page 10 training requirements. * Investigations of and response to patient incidents/events were not timely or complete to prevent recurrence. This Condition-level deficiency was uncorrected and represents a limited capacity on the part of the hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited under Tag A144, CFR 482.13(c) - Standard: Privacy and Safety. Those findings reflect the hospital's failure to ensure the provision of care in a safe setting. 2. Refer to the findings cited under Tag A145, CFR 482.13(c) - Standard: Privacy and Safety. Those findings reflect the hospital's failure to ensure that patient incidents/events were fully investigated in a timely manner to identify causes and implement corrective actions to prevent recurrence. 3. Refer to the findings cited under Tag A175, CFR 482.13(e) - Standard: Restraint or seclusion. Those findings reflect the hospital's failure to ensure seclusion was assessed, and monitored as required. 4. Refer to the findings cited under Tag A202, CFR 482.13(f) - Standard: Restraint or seclusion: Staff training requirements. Those findings reflect the hospital's failure to ensure that staff participating in restraint or seclusion received appropriate training and demonstrated competency as required.	{A 115}		
{A 144}	PATIENT RIGHTS: CARE IN SAFE SETTING	{A 144}		

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{A 144}	Continued From page 11 CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observations, interviews, review of incident/event and medical record documentation for 7 of 10 patients who experienced actual or potential self-harm between 06/25/2018 and 07/29/2018 (Patients 48, 50, 52, 57, 61, 65 and 71), incident/event and medical record documentation for 8 of 8 patients who were reviewed for medication errors that occurred between 07/04/2018 and 07/27/2018 (Patients 47, 51, 58, 59, 60, 66, 73 and 74), review of Code M cart documentation, review of policies and procedures, and review of other documentation related to safety and physical environment risk, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured the patients' rights to receive care in a safe setting in the following areas: * Patients identified at risk for suicide were not protected from self-harm and suicide attempts. Policies and procedures related to suicide risk assessment and suicide precautions were unclear. Policies and procedure related to patient observation were unclear and the frequency of observations was not adequate. Patient access to unsafe items was not prevented. Patient 50 committed suicide by hanging and died. * The physical environment contained ligature risks that resulted in actual patient harm. * The physical environment contained unsafe items that resulted in actual patient harm. * The physical environment contained blind spots that created the opportunity for patient self-harm or suicide without immediate detection.	{A 144}		

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{A 144}	Continued From page 12 * Communication safety devices required for staff use were not available. * Elopement prevention, and staff awareness and alertness to potential hazards and risks were lacking. * Systems to ensure that equipment and supplies necessary for response to urgent and emergent medical conditions were available and in safe working condition were not fully implemented. * Medication administration policies and procedures, and standards of practice were not followed and enforced. Numerous medication errors occurred when RNs failed to administer the right medication to the right patient, in the right dose, by the right route and at the right time. Patient 58 experienced a change of condition and required EMS transfer and medical hospitalization as a result of receiving another patient's medications. Findings include: 1. Patient's 48, 50, 57, 61, and 65, identified at risk for suicide were not assessed, restricted access to items that could be used for self-harm, and continuously observed to ensure prevention of self-harm and suicide attempts. Patient 50 who was identified at high risk for suicide successfully committed suicide by hanging him/herself from the BR door in his/her room. a. Policies and Procedures related to patient suicide risk assessment, suicide precautions, and patient monitoring and observation for all patients including those at risk for suicide, contained unclear and contradictory direction, or were not followed. * The policy and procedure titled "Unity	{A 144}		

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{A 144}	Continued From page 13 Adolescent Psychiatry...Scope of Service" dated as last reviewed "May 2018" reflected "Monitor location and status of patient approximately every hour. Monitor location and status of patient approximately every 30 minutes from 2300 to 0700. Hourly patient monitoring will be done in-person between 0700-2300. Between 2300-0700, patient monitoring will be done approximately every 30 minutes alternating between in-person and camera monitoring. If a patient cannot be visualized via the camera, the patient will be checked in-person. Hourly in person checks will include visualization of patient breathing (rise of the chest). Patients answering yes on questions 2-6 in the [CSSRS] or deemed at high risk for other unsafe behaviors will be placed on 15-minute checks that can only be discontinued by provider order." However, the policy and procedure more recently reviewed titled "Standard of Care...Adolescent Psychiatry Inpatient," dated as reviewed "Jul 2018," reflected "Monitor and document patient location in-person approximately every hour during the 0700-2300 hours and approximately every 30 minutes during the hours of 2300-0700." There were no provisions for camera monitoring. * The policy and procedure titled "Unity Adult Inpatient Psychiatric Services Standard of Care" dated as reviewed "Jul 2018" reflected "Monitor and document patient location in-person approximately every hour during the 0700-2300 hours and approximately every 30 minutes during the hours of 2300-0700." There were no provisions for camera monitoring. * The policy and procedure titled "Suicide Behavior - Patient Management" dated as revised	{A 144}		

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{A 144}	Continued From page 14 "Aug 2017" reflected "All patients will be assessed for suicidality at the time of admission and patients deemed at high risk for suicidal behavior will be assessed every shift regarding their ability to maintain personal safety until the treatment team assesses that their symptoms have diminished to a safer level, and/or increased to warrant more frequent assessments Staff (sic) will remain alert to indications of increased suicidal risk on all patients throughout hospitalization. Measures will be initiated to maintain the safety and promote the recovery of patients deemed imminently suicidal...All patients presenting to the [PES] will be assessed for level of risk for suicide using the [CSSRS] in the [EHR] during the intake assessment. Patients on inpatient units...will be assessed on admission to the unit, upon the judgement of clinicians that there is a change in the patient status, (i.e. expressing suicidal ideation or intent) and on discharge. If the patient answers "Yes" to questions #4, #5, or #6 in the C-SSRS, they are considered HIGH RISK...The team member assessing a patient as HIGH RISK or MODERATE RISK for suicide will immediately communicate this information to the [CN] who will initiate the implementation of suicide precautions...Suicide precautions will continue even if a physician's order is not obtained...The need for suicide precautions will be reviewed daily...Visual observations of the patient will be made in person and recorded every fifteen (15) minutes utilizing [EHR] flowsheet. Patients on suicide precautions will be visually inspected in person by staff no less than every fifteen minutes...The patient's bathroom door will be locked (HIGH RISK) with standby of same gender staff for toileting/showering...Checks will be made each shift or more often if indicated to remove	{A 144}		

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{A 144}	Continued From page 15 potentially harmful objects from the patient's environment...In addition, various modifiers may be added to the order for suicide precautions...may include, but are not limited to, the following...Must remain within sight of staff member at all times...Door to room open at all times...Constant attendance by staff for HIGH risk with staff within no less than arm's length distance at all times...Use of suicide garment and suicide blanket...The LIP in concurrence with treatment team members shall evaluate the patient's ability to maintain safety daily and discontinue suicide precautions via an order when the patient is assessed as able to remain safe from self-harm. The LIP will document this decision in the Progress Record." * The policy and procedure titled "Guideline for Close Supervision" dated as last reviewed "Jul 2018" defined: - "Constant Observation: Patient to staff ratio is one patient to one staff. The staff member constantly observes the patient by direct line of sight via camera or in-person;" and - "Intermittent Observation: Patient to staff ratio is two to four patients to one staff. The staff member observes the patient more frequently than the unit's standard of care. Intermittent observation may include every 15-30-minute monitoring." The policy was not clear and did not definitively indicate when constant or intermittent observation must be used. For example: The "Criteria for considering constant observation" included "Patient identified at high risk for suicide and requires staff always to be within arms-length of the patient or in direct line of sight." There was no information to reflect when staff should "consider"	{A 144}		

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{A 144}	Continued From page 16 patients identified at high risk for suicide as not requiring "constant observation." The "Criteria for considering intermittent observation" was unclear and included "Patient identified at risk for suicide with ordered suicide precautions (every 15-minute checks)." This permitted staff to "consider" a lesser frequency of observation of up to 30 minutes, as denoted in the definition above, for patients identified at risk of suicide. * The policy and procedure titled "Restraint and Seclusion for Patient Safety" dated as revised "Jul 2018" reflected for "Restraint and Seclusion Assessment and Monitoring" for patients in restraints or seclusion for "Non-Behavioral or Non-Violent Behaviors: The RN will assess the patient in person every 2 hours..." For patients in restraints or seclusion for "Violent or Self-Destructive Behavior...patients shall be assessed in person every 2 hours...Additionally, all [Violent or Self-Destructive] patients shall be monitored every 15 minutes..." For patients in restraint AND seclusion they "shall be continuously monitored..." The policy required less frequent observation than the "Unit Standard of Care" for patients in restraints or seclusion. In addition, the frequency of observation for patients with violent or self-destructive behaviors was unclear and contradictory. * Standardized physician's orders for suicide precautions found in the patients' records were written as: "Initiate suicide precautions per CSSRS protocol only (discontinue if pt does not meet criteria): - Q15 min checks in person when awake, via camera when asleep - Bathroom lockouts (for high risk patients) - Paper scrubs	{A 144}		

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{A 144}	Continued From page 17 and suicide blanket at staff discretion." The orders were unclear and contained direction contradictory to other written policies and procedures. For example: The standardized orders were not consistent with the suicide precautions described in the policy and procedure referred to above and did not ensure patients identified at risk for suicide would be continuously monitored or placed under constant observation. In addition, the "checks...via camera when asleep" was a lesser degree of observation than the adult and adolescent unit standards of care policies and procedures referred to above; It was not clear what "per CSSRS protocol only (discontinue if pt does not meet criteria)" meant; It was not clear who would determine "high risk" and how that would be communicated; It was not clear what "at staff discretion" meant in terms of paper scrubs and suicide blankets. b. Review of the medical record of Patient 50 reflected that he/she presented to the PES with a chief complaint of "Suicidal" on 07/04/2018 and was subsequently admitted as a psychiatric inpatient. The record reflected the following: * On 07/04/2018 at 2226 the ED MD ordered a "Hospital Hold (Notice of Mental Illness)" specified as "Continuous." There was no order to discontinue the hold during the patient's hospitalization. * On 07/04/2018 at 2234 the ED MD initiated a standardized order for "Initiate suicide precautions per CSSRS protocol only (discontinue if pt does not meet criteria): - Q15 min checks in person when awake, via camera when asleep - Bathroom lockouts (for high risk	{A 144}		

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{A 144}	Continued From page 18 patients) - Paper scrubs and suicide blanket at staff discretion." The generic orders were not consistent with the suicide precautions described in the policy and procedure referred to above and did not ensure this patient identified at high risk for suicide would be continuously monitored or under "constant observation." It was not clear what "per CSSRS protocol only (discontinue if pt does not meet criteria) meant; It was not clear who would determine "high risk" and how that would be communicated; It was not clear what "at staff discretion" meant in terms of paper scrubs and suicide blankets. * On 07/04/2018 at 2321 the ED MD's "Psychiatric ED Initial Evaluation" reflected the chief complaint was "Suicidal." The evaluation included "Since 11/2017 [patient] has had multiple suicide attempts including overdosing on opioids, overdosing on acetaminophen, hanging, drowning and recently a penetrating neck injury requiring surgery...Interestingly, until these recent attempts, the patient previously had only on (sic) suicide attempt in the remote past and had functioned well...[Patient] endorses occasional AH including the voice of [his/her parent] telling [the patient] to kill [him/herself]...[Patient] stated that if [he/she] is discharged [he/she] would just kill [him/herself]...Depressive Symptoms:...suicidal thoughts...Suicide Risk Assessment: Columbia Suicide Severity Rating Scale 1. Wish to be Dead: Yes; 2. Suicidal Thoughts: Yes...5. Suicide Intent with Specific Plan: Yes; 6. Suicide Behavior Question: Yes How long ago did you do any of these?: Within the last three months...This patient is at high risk of imminent suicide, if discharged. Patient endorses thoughts, intent, or plan for harm to self or others...Plan: PES interventions: safe/locked	{A 144}		

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{A 144}	Continued From page 19 environment...ongoing observation and assessment...transfer to Inpatient Psychiatry..." * On 07/05/2018 at 1901 a psychiatrist recorded in an inpatient admission evaluation that the patient was at high risk for suicide attempts and required close monitoring. * On 07/05/2018 at 2314 a 1E RN note reflected "Patient reported to staff that pain was intolerable to the level where [he/she] regrets that the suicide attempt failed, but then very upset when bathroom door was locked by staff, 'NO, I cannot have it locked, I'm not going to do anything'. Suicide precautions, with BR door locked, maintained..." * On 07/07/2018 at 1100 a NP discontinued the suicide precautions ordered on 07/04/2018. There were no new orders for suicide precautions or observation written at that time or during the patient's hospitalization. * On 07/07/2018 at 1116 a NP note was not clear in relation to the patient's suicide risk, in conjunction with the order to discontinue suicide precautions 16 minutes prior to this note, as it reflected "No behavioral problems on unit and feels safe (no SI or violent ideation)...Thought Content: endorses SI, denies SI/HI/AH/VH...Insight: poor; Judgment: poor...Plan: Continue current level of care." The note contained contradictory assessment findings related to the patient's SI and the justification for discontinuing suicide precautions was not clear. * On 07/07/2018 at 1653 a 1E RN note reflected "[Patient] endorses SI, but says [he/she] feels safe in the hospital. [He/she] is unclear on how	{A 144}		

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{A 144}	Continued From page 20 Unity Behavioral Health will help and is not willing to participate in treatment." There was no change ordered or planned related to suicide precautions and patient monitoring. * On 07/08/2018 at 1005 a NP note was not clear in relation to the patient's suicide risk as it reflected "Thought Content: endorses SI, denies SI/HI/AH/VH..." There was no change ordered or planned related to suicide precautions and patient monitoring. * On 07/09/2018 at 0229 a 1E RN note reflected "[Continued] with SI..." There was no change ordered or planned related to suicide precautions and patient monitoring. * On 07/09/2018 at 1316 a 1E RN note reflected "Doesn't want to return home to care for self which [patient] thinks will happen. Says that [he/she] would just try to kill [him/herself] again...states [he/she] can't concentrate...dreads having to face each new day..." There was no change ordered or planned related to suicide precautions and patient monitoring. * On 07/09/2018 at 1756 a psychiatrist progress note reflected "[Patient] continues to be utterly hopeless and that [he/she] is better off dead...Mental Status Exam...Thought Content: endorses SI...Patient is able to understand and adhere to treatment plan: No..." There was no change ordered or planned related to suicide precautions and patient monitoring. * On 07/10/2018 at 1512 a psychiatrist progress note reflected "[Patient] wonders and hopes that [he/she] has metastatic cancer so that [he/she] can die with dignity...Mental Status	{A 144}		

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{A 144}	Continued From page 21 Exam...Thought Content: endorses SI and no delusions noted. Wants desperately to end [his/her] life as [he/she] is afraid of living in pain and sees no hope...Today patient is looking much worse, [he/she] is restless, unable to safety plan. Patient risk of suicide is high and it is unclear if the hospitalization will be able to mitigate such risk as he (sic) picture is complicated by depressed bipolar state, somatization, personality pathology and a complete shut down and unwillingness on [his/her] part to assume an active role in [his/her] care. Will need more time in hospital to engage psychotherapeutically while treated depressed state as part of a bipolar spectrum disorder...Patient is able to understand and adhere to treatment plan: No. Plan:...Assist with finding home health supports while family works on exploring retirement homes with patient..." There was no change ordered or planned related to suicide precautions and patient monitoring. * On 07/11/2018 at 0644 a 1E RN note reflected "[Patient] endorses SI...feels [he/she] cannot manage [his/her] life alone and needs to be in a care home but then wan't (sic) to die in the same sentence..." There was no change ordered or planned related to suicide precautions and patient monitoring. * The patient's care plan was not individualized and did not clearly address the patient's suicide risk and did not include clear, patient specific interventions. The "Potential for self harm" problem recorded on the care plan dated 07/05/2018 contained the following non-specific interventions: "Provide safe and supportive environment PRN...Assess risk of self harm every shift while awake PRN...Monitor for safety and	{A 144}		

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{A 144}	Continued From page 22 need for increased observation level..." * Documentation on the EHR Q15 minute check flow sheet reflected that the Q15 minute checks ordered by the ED MD on 07/04/2018 were not carried out. There were no 15 minute checks documented: On 07/05/2018 between 0545 and 0730; On 07/06/2018 between 0400 and 0430; On 07/06/2018 between 1330 and 1415; and On 07/07/2018 between 0815 and 0900. * During interview with the DPCS on 07/24/2018 at 1445 he/she stated that when the suicide precautions orders were discontinued the "unit standard" for observation would be followed. The observation protocol between 0700 and 2300 was in-person observations every hour, and between 2300 and 0700 observations every half hour by camera monitoring or in-person, but at least once an hour in-person was required. * Documentation on the "Safety Rounding Forms" between 07/07/2018 and 07/11/2018 reflected numerous gaps where the "unit standard" observation protocol was not documented as followed, and numerous of the hand-written entries were illegible. For example: On 07/07/2018 no observations are documented between 1800 and 1953; On 07/08/2018 no observations are documented between 1615 and 1744; on 07/09/2018 no observations are documented between 1701 and 1831; On 07/09/2018 between 2300 and 0700 at least 7 of the 16 time entries were illegible and the times of observations could not be discerned; On 07/10/2018 no observations are documented between 1800 and 1950; On 07/10/2018 no observations are documented between 0000 and 0050; On 07/11/2018 the last fully documented	{A 144}		

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{A 144}	Continued From page 23 observation is at 0803. Although there is a time entry for 0900 the entry was not complete as the "Location" of the observation and "Status" of the patient was blank. * Documentation of observations on the "Safety Rounding Forms" was not consistent with observations observed during video review. On 07/26/2018 at 1240 video of Patient 50's room on 07/09/2018 between 2300 and 0700 was reviewed. The video reflected that in-person observations were not made between 0159 and 0327, however, staff documented on the rounding form that an in-person observation was made at 0300. The video reflected that no in-person observations were made between 0403 and 0525, however, staff documented on the rounding form that an in-person observation was made at 0500. * Documentation on the EHR flowsheets of the CSSRS reflected the patient's suicide risk was evaluated in accordance with that suicide risk tool only one time after the patient's admission as an inpatient. The CSSRS was documented as completed on 07/05/2018 at 0314. Based on the patient's "Yes" responses to questions 5 and 6 as described in the policy and procedure referred to above, the patient was considered "HIGH RISK" for suicide. Although RN and medical staff notes reflected the patient was expressing suicidal ideation as the hospitalization progressed, there was no evidence that the CSSRS was conducted again contrary to the policy and procedure. *The last entry on the "Suicide Precautions" EHR flowsheet was recorded on 07/07/2018 at 1128. *Documentation on the EHR flowsheets of the	{A 144}		

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{A 144}	Continued From page 24 patient's self-injurious behaviors was inconsistent. On 07/05/2018 the flowsheets reflected the patient was evaluated for self-injurious behaviors on two occasions at 0806 and 1629 and none were observed. On 07/06/2018 the flowsheets reflected the patient was evaluated for self-injurious behaviors on 24 occasions between 0753 and 1915 and none were observed. On 07/07/2018 the flowsheet reflected that patient was evaluated for self-injurious behaviors on one occasion at 0545. That was the last EHR flowsheet entry related to self-injurious behaviors in the patient's record. *Documentation on the EHR flowsheets of "Room Checks" was inconsistent and unclear. On 07/05/2018 the flowsheet reflected nine entries between 0806 and 1632 recorded as "Room Checks - Yes." On 07/06/2018 the flowsheet reflected 22 entries between 0852 and 1915. Four of those entries were recorded as "Room Checks - Yes," 16 of those entries were recorded as "Room Checks - No," and entries recorded at 1633 and at 1707 reflected both "Room Checks - Yes" and "Room Checks - No." There was one "Room Check" recorded on 07/07/2018 at 1545, which was the last "Room Check" flowsheet entry of that type in the patient's record. *Documentation on the EHR flowsheets that the patient was checked for contraband was recorded on one occasion, 07/05/2018 at 1629, during the hospitalization. That entry reflected "Patient Checked for Contraband - Body Checked; Clothing Checked." *There was no documentation to reflect that the patient was assessed for the use of paper scrubs and/or suicide blankets. Documentation on the	{A 144}		

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{A 144}	Continued From page 25 EHR flowsheets related to patient clothing was recorded only as "Clothing Checked" on 07/05/2018 at 1629 and on 07/07/2018 at 0545. Other references related to clothing were recorded under the "Appearance" section of the EHR flowsheet. Those entries were recorded on 13 occasions between 07/05/2018 at 0257 and 07/11/2018 at 0417 and denoted only "Clothing - Unremarkable." * On 07/24/2018 at approximately 1700 video of Patient 50's room on 07/11/2018 was reviewed. It revealed that an individual entered the room at 0804 on 07/11/2018 who handed the patient an item that was not identifiable on the video. The patient was observed focusing on and handling that item for some time, although it was not clear what the patient was doing as his/her back was facing the camera view in the room. However, Nurse management staff who reveiwed the video were unable to definitively identify the person that entered the room as either staff or patient, and were unable to identify the object as well. The video reflected that at 0935 on 07/11/2018 the last staff person to enter the room was an RN identified by nurse management staff during the review. The RN entered the room briefly and then left. The video reflected that between 0959 and 1005 the patient made multiple trips in and out of the room, and between the closet and the BR in the room. Patient 50 is seen to retrieve and carry and move garments and linen items in and out of the BR. At 1005 the patient entered the BR for the final time. At 1006 a garment or linen item was observed to be thrown from the inside of the BR through the slanted opening at the top of the closed BR door. There is no activity until a housekeeper entered the patient's room at 1019.	{A 144}		

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{A 144}	Continued From page 26 Four minutes later at 1023 the housekeeper opened the BR door and caused Patient 50's body to fall to the floor. The housekeeper left the room and staff are observed to respond to the scene. * On 07/11/2018 at 1327 a 1E RN note reflected "Pt was up in [his/her] room at the shift start...Pt said, 'I wish I did not survive my suicidal attempt'...Pt said that [he/she] always has SI but contracted for safety...Pt said, 'I am not human any more'...At around 1020hr, a BHT staff called for help while doing CPR. Pt was lying on the floor unresponsive half way [between his/her] room and bathroom when this writer responded to the call. Code M cart brought in to the room and AED attached and O2 with ambu-bag initiated. At 1025hr, providers responded to the code. EMS called and arrived to the unit at around 1035hr. Pt transferred out to LEMC ED at around 1045hr." * On 07/12/2018 at 1022 the LIP "Discharge Summary" reflected "This is patient's 7th admission to hospital in the last year for psychiatric concerns, prior to this [patient] had none. [Patent] has had at least 6 [suicide attempts] since depression ranging from overdoses to stabbing...In April 2018 [patient] was admitted again after an intentional overdose...In May [patient] was admitted...for SI with plan to OD...In early June [patient] was readmitted...after going missing...found by [family] standing by the pool with rocks...[found in assisted living facility making a noose]...On June 25th, patient cut [his/her] neck and was admitted...On 07/30 (sic) [patient used a screw driver to...puncture [his/her] right jugular vein. Patient describes that [he/she] was hoping to see the light...On 7/10 (sic) [patient] went to the bathroom and hung	{A 144}		

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{A 144}	Continued From page 27 [him/herself]...when found CPR was initiated...EMS arrived...pulse obtained...then transferred to [LEMC ED]." * Review of Patient 50's LEMC medical inpatient record reflected that he/she arrived at the LEMC ED on 07/11/2018 at 1058 and was subsequently transferred to the NTICU where he/she died on 07/12/2018 at 0550. * Review of the facility's untitled, undated physical environment risk assessment document received on Day 1 of the revisit survey revealed that "Bedding" and patient "Scrubs/clothes" were identified as risk items and were "allowed unmonitored unless an extreme risk has been identified by staff or provider." What was meant by "extreme risk" was not clear. Review of incident/event documentation for Patient 50 revealed that the patient had used his/her personal thin fabric bathrobe as a ligature around his/her neck. * The physical environment risk assessment received on Day 1 also revealed that "Bathroom door hinges" were identified as a ligature risk and that "Patient restrooms will be secured at all times when not in use. Staff will be present in patient room when in use." However, review of the video of Patient 50 revealed that the BR door was not locked and he/she had free access to the BR. * The findings in Patient 50's record were confirmed during interviews with the DPCS at the times of the reviews of the records and video on 07/24/2018, 07/25/2018 and 07/26/2018. c. Review of the medical record of Patient 57	{A 144}		

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{A 144}	Continued From page 28 reflected that he/she presented to the PES with a chief complaint of "Suicide Attempt" and "Depression" on 07/23/2018 and was subsequently admitted as a psychiatric inpatient. The record reflected the following: * On 07/23/2018 at 1824 a PES RN recorded the following note which described events on a timeline beginning at 1600: "16:00-Pt laying in recliner at this time with blanket over [him/herself]...Pt now punching wall...Pt yelling...16:10-Pt continuing to scream and yell loudly in the milieu. RN offered pt calming room...offer alternatives...however, pt was unable to redirect or engage in these options. At this time security was called, restraint chair brought to outside room...Pt moved from restraint chair into hold room willingly...Seclusion door was locked...16:38-RN returned to PES milieu and opened camera view to visualize patient. At this point RN saw pt awake and banging hand on door. RN to hold room where pt was screaming...it was at this point that RN assessed that pt had sock tied around [his/her] neck...RN unlocked seclusion door and untied sock from pt's neck...Pt crying...Red ligature marks present on front of neck...Increased monitoring to 1 to 1, took pt's socks. PT IS ALLOWED TO HAVE PILLOW CASE AND BLANKET ONLY WITH 1-TO-1 SUPERVISION." * On 07/23/2018 at 1720 the ED MD initiated a standardized order for "Initiate suicide precautions per CSSRS protocol only (discontinue if pt does not meet criteria): - Q15 min checks in person when awake, via camera when asleep - Bathroom lockouts (for high risk patients) - Paper scrubs and suicide blanket at staff discretion." The generic orders were not	{A 144}		

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{A 144}	Continued From page 29 consistent with the suicide precautions described in the policy and procedure referred to above, and further did not ensure this patient who had attempted suicide in the PES within an hour prior to the order would be continuously monitored per the "1 to 1" monitoring planned at the time of the suicide attempt. It was not clear what "per CSSRS protocol only (discontinue if pt does not meet criteria) meant; It was not clear who would determine "high risk" and how that would be communicated; It was not clear what "at staff discretion" meant in terms of paper scrubs and suicide blankets. * On 07/23/2018 at 2118 the ED MD's "Psychiatric ED Initial Evaluation" reflected the patient presented to PES as result of an intentional overdose of insulin and "is high utilizer of hospitals with 30 plus presentations this year often following overdoses." The note reflected that while in the PES the patient was screaming and yelling and "was escorted to seclusion and required IM Geodon...was then observed tying a sock around [his/her] neck in attempts to strangle [him/herself]." The ED MD documented a CSSRS that reflected the patient answered "Yes" to question #6. The MD's assessment included "Due to repeated suicide attempts and highly emotional dysregulation pt requires inpatient admission for safety and stabilization...Plan: safe/locked environment...ongoing observation and assessment...Transfer to Inpatient Psychiatry." Although Patient 57 was considered "HIGH RISK" based on responses to the CSSRS, and an attempted suicide in the PES, the evaluation did not identify the patient as such in accordance with the policy and procedure referred to above.	{A 144}		

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{A 144}	Continued From page 30 * On 07/24/2018 at 1906 the "Suicide Precautions" order was modified to add "Frequency: Continuous 07/24/2018 1906 - Until Specified." The order was not discontinued until the patient's discharge from the hospital on 07/26/2018 at 2119. * On 07/25/2018 at 1738 a 1W MHT note reflected "Staff observed [patient] walk down the hall and punch the wall...became increasingly agitated and loud...spent time in [his/her] room yelling and intermittently banging the right side of [his/her] head on the wall...short time later staff observed via monitor [patient] sitting with a bed sheet tied around [his/her] neck. Upon entering the room [patient] was sitting quietly with arms at [his/her] sides and sheet around neck. After a discussion with this staff [patient] untied the sheet and gave it to staff...Q15 safety checks are being done." * On 07/25/2018 at 1837 a 1W RN note described the sheet ligature incident above and in addition "All linens removed from Pts room along with shower curtain...safety blanket was provided for comfort." * The patient's care plan was not individualized and did not clearly address the patient's suicide risk and did not include clear, patient specific interventions. The "Potential for self harm" problem contained the following non-specific interventions: "Provide safe and supportive environment PRN...Assess risk of self harm every shift while awake PRN...Monitor for safety and need for increased observation level..." * Documentation on the EHR flowsheets of the CSSRS reflected the patient's suicide risk was	{A 144}		

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{A 144}	Continued From page 31 evaluated in accordance with that suicide risk tool on 07/24/2018 at 1949. Based on the patient's "Yes" response to question #6 as described in the policy and procedure referred to above, the patient was considered "HIGH RISK" for suicide. Although the record reflected the patient continued to express suicidal ideation, and exhibited additional self-harm/suicide behaviors on 07/25/2018, there was no evidence that the CSSRS was conducted again during the hospitalization until discharge, contrary to the policy and procedure. * The record of Patient 57 contained similar findings to that of Patient 50, including in the area of unclear, inaccurate and inconsistent observation. For example: - Documentation of 1:1 or continuous observation was not recorded or not clear. The EHR flowsheet included an entry field for "Restraint/Seclusion Monitoring Q15 mins - Continuous observation." On 07/23/2018 at 1718 an entry was recorded as "Yes" and a second entry at that same time reflected "No." Entries recorded at 1720, 1724, 1733, and 1746 reflected "No" that continuous observation was not provided. - In addition, during video review on 07/27/2018 at 1335 it was observed that the ordered suicide precaution Q15 min checks were not done in person as required by policy and procedure referred to above. The video revealed that staff opened the door of the patient's room for very brief moments, or entered the room at the following times between 07/24/2018 at 2104 and 07/25/2018 at 0455: 2104, 2120, 2209, 2303, 0203, 0310, 0354, and 0455, revealing up to three-hour intervals for the observations. It was noted on the video that the staff entering the	{A 144}		

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{A 144}	Continued From page 32 room at 0203 and 0310 didn't look in the direction of patient 57, but rather looked at the opposite side of the room where another patient was in bed. Review of the "Rounding Form" also revealed that staff recorded "in-person" observations at 0000 and 0100. However, the video review revealed that no staff opened the room door at those times. * The record of Patient 57 contained similar findings to that of Patient 50, including that there was no clear assessment and consistent interventions related to clothing/linens. This failure resulted in the patient's ability to access linens for self-harm on the inpatient unit after he/she had already exhibited self-injurious behaviors with clothing items in the PES, and after Patient 50 had successfully committed suicide using clothing/linen items just 12 days prior to Patient 57's admission. * The findings in Patient 57's record were confirmed during interview with the DPCS at the time of the review on 07/27/2018. d. Review of Patient 61's medical record reflected that he/she presented to the PES on 07/24/2018 with suicidal ideation and thoughts of wanting to harm others and was subsequently admitted as a psychiatric inpatient. * An MD conducted a CSSRS on 07/24/2018 at 1655. Although the patient replied "yes" to questions #5 and #6, which reflected HIGH RISK according to the policy and procedure, the MD note reflected "Patient is at medium risk of imminent suicide, if discharged." The last CSSRS documented at the time of the review of this record on 07/27/2018 was recorded on	{A 144}		

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{A 144}	Continued From page 33 07/25/2018 at 1827 and reflected the patient answered "yes" to question #6, and again reflected HIGH RISK for suicide. * Incident/event documentation reflected that on 07/26/2018 at 1757 he/she was observed by staff through the camera to be in his/her room on Unit 2 laying on his/her bed with his/her head hanging off the bed and with socks tied around his/her neck. The patient's face was observed to be purple and a Code M was initiated. The documentation reflected that the following orders were initiated at that time: paper scrubs, 1:1 until the morning, and all items removed from the room. An entry describing the event in the medical record recorded at 07/26/2018 at 2039 by an LIP reflected that patient stated to the LIP during examination after the event "I want to die." * The review of the medical record revealed similar findings to those identified for Patient 50 and Patient 57 related to lack of clear and consistent assessments and suicide precaution and observation orders, lack of documented observations, and failure to carry out interventions to ensure protection of the patient from self-harm and suicide. * Review of additional incident/event documentation for Patient 61 reflected that orders for paper scrubs only and suicide blanket only were not followed and on 07/27/2018 at 1930 the patient was found to be wearing hospital scrubs, white ankle socks, and boxer shorts. * The findings in Patient 61's record were confirmed during interview with the DPCS at the time of the review on 07/27/2018.	{A 144}		

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{A 144}	Continued From page 34 e. Similar failures to those for Patients 50, 57 and 61 above were identified in incident and medical record documentation for Patient 48 who exhibited suicide gestures and self-harm on 07/05/2018 and 07/07/2018 with items he/she was able to access; and for Patient 65 admitted on 07/24/2018 who scored at high risk for suicide on the CSSRS conducted on 07/28/2018 at 1035 and was identified as "high risk for suicide and requires continuous monitoring" by the MD on the same date at 1708. 2. The environment contained ligature risks that had not been identified or mitigated. In addition, the facility's identification of ligatures on the untitled, undated physical environment risk assessment received on Day 1 of the revisit survey, were not consistent with surveyors' observations. For example the following ligature risks observed were not included on the risk assessment document: * On Unit 1E, observation of patient room 101 on 07/23/2018 at 1640 revealed the window cabinet hinges had gaps at the upper portion of the hinge sufficient to insert a lanyard or other string-like material. This created a ligature risk. Similar gaps were observed at the window cabinet hinges in room 102 on 07/24/2018 at 1525. Those same hinges were observed on 07/24/2018 at 1445 in numerous patient rooms throughout Unit 1E including rooms 109 and 111. * On Unit 2, observations on 07/24/2018 at 1005 of patient rooms 207, 208, 209, 211, 213, 214, and 215 revealed the same window cabinet hinges used as those identified on Unit 1E. * On Unit 5, observations on 07/24/2018 at 1550 of patient rooms 506 and 509 revealed the same window cabinet hinges used as those identified	{A 144}		

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{A 144}	Continued From page 35 on Unit 1E. * On Unit 6, observations on 07/24/2018 at 1110 of patient rooms 612 and 616 revealed the same window cabinet hinges used as those identified on Unit 1E. * On Unit 1E, observation of patient room 101 on 07/23/2018 at 1640 revealed a tall storage unit with a locked cabinet at the upper portion. The cabinet had a gap between the door and the cabinet sufficient to insert a lanyard or other string-like material. This created a ligature risk. * On Unit 2, observations on 07/24/2018 at 1005 of patient rooms 210, 211, 213 and 215 revealed the same storage units with locking upper storage cabinet doors used as those identified on Unit 1E. * On Unit 1E, observation of seclusion room H1 on 07/24/2018 at 1135 revealed six thick metal rings mounted into recessed metal mountings in the floor for the purpose of tying of restraints. The rings were mounted in such a way so that they were moveable in their mounting and could be vertically positioned so the top of the ring was flush with the floor or extended slightly above the level of the floor. During interview with hospital staff during the initial survey they reported that a patient harmed him/herself by banging his/her head on similar metal rings while in seclusion on another unit. * On Unit 6, observations of seclusion rooms H1 and H2 on 07/24/2018 at 1110 revealed the same six thick metal rings mounted into recessed metal mountings in the floor. * In the PES, observations on 07/26/2018 at 1430 revealed patient recliner chairs in the main milieu and in "calming rooms." Calming rooms were small rooms with a door used to provide lower	{A 144}		

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{A 144}	Continued From page 36 stimulation. Each of those rooms had one recliner chair in it. The design of the arms of the recliner chairs was such that there was a large open space between the arm rests and the chair seat. Sheets, blankets, clothing, and other ligature items could be tied around the arm rest and used as a ligature. * In the outdoor patient garden areas, observations on 07/26/2018 at 1525 revealed the following ligature risks: Two tall, parking lot type steel emergency fixtures, cemented into the ground, had a curved ligature point several feet high where steel extensions were welded on; Garden benches were designed with vertical and horizontal slats where ligatures could be tied; and the joint between the basketball backboard and the basketball hoop was a ligature risk. On the last day of the revisit survey a document titled "Unity Therapeutic Garden Risk Mitigation Plan" dated as "June 05, 2018 DRAFT" was provided. That document also did not identify the risks listed in this finding. 3. There were unsafe items in the environment that had not been identified or mitigated: * The policy and procedures titled "Psychiatric Emergency Services (PES) Standard of Care," "Unity Adult Inpatient Psychiatric Services Standard of Care" and "Standard of Care...Adolescent Psychiatry Inpatient" all three dated as reviewed "Jul 2018" stipulated "Assure safe environment: Remove potentially harmful items. Check new patients for unsafe items; Inform all visitors of restrictions and monitor all items being brought onto unit." * The policy and procedure titled "Personal	{A 144}		

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{A 144}	Continued From page 37 belongings and unsafe items on inpatient psychiatric unit (Adult and Adolescent)" dated as last revised "May 2018" reflected: "Patients shall be allowed to wear their own clothing and to retain possession of personal items except when this poses a threat to safety...Items which pose an obvious threat to safety will be declared as unsafe items...Appendix A outlines examples of Unsafe items which will be deemed as never available, available only in a therapeutic group setting, and available under supervision." Appendix A contained a table with four columns. Items listed in the "Never" column included "Intentionally sharp items (knives, straight razors, metal nail files)." Items in the "Unmonitored Unless an Extreme Risk" column included "Bedding" and "Scrubs/clothes." * On Unit 1W in Room 111, observations on 07/26/2018 at 1430 revealed a thin fabric shower curtain in place of a BR door. The shower curtain was hanging from the door jamb with small pieces of Velcro that allowed the curtain to pulled down with little effort. However, there was no documentation to reflect that the thin fabric shower curtains had been identified and addressed in the physical environment risk assessment received on Day 1 of the revisit survey. * Refer to the findings for Patients 50, 57 and 61 in this Tag that reflect that bedding and clothing items were accessible to patients identified at risk for suicide and were used as ligatures by those patients on 07/11/2018, 07/23/2018, 07/25/2018, and 07/26/2018. * Review of incident/event documentation and the medical record for Patient 52 reflected that on	{A 144}		

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{A 144}	Continued From page 38 07/12/2018 the patient approached a SSO on Unit 5 and voluntarily surrendered a P38 can opener (small folding metal opener with a sharp pointed blade for piercing a metal can) the patient removed from his/her wallet. The documentation reflected that Patient 52 stated to the SSO that he/she shouldn't keep the item right now and wanted it locked up. Documentation in the patient's record reflected he/she was admitted to the PES on 06/28/2018 and then to Unit 5 as an inpatient on 06/29/2018. Documentation on the "Patient Valuables/Belonging Checklist - Initial," dated 06/29/2018 reflected that the patient had only 2 shirts, 1 pant and $10.00 cash in his/her possession upon admission to the facility. There were no other personal belongings or possessions recorded and the checkbox next to "Wallet" was unmarked. In addition, review of the EHR patient belonging flowsheet dated 06/29/2018 revealed only "1" personal belonging and that item was unspecified. * Observation of Unit 1E open dining/activity area on 07/24/2018 at 1510 revealed a cup that contained approximately 25 black plastic coffee stir sticks/straws accessible to patients. The facility's physical environment risk assessment document failed to identify any information related to plastic coffee stirring sticks/straws. * On 07/24/2018 at 1105 in Unit 2, a sachet bag with a thin satin ribbon closure was observed on one of the two beds in room 215. 4. Blind spots identified during the initial complaint survey concluded on 05/22/2018 had not been removed or mitigated as of this revisit survey. In addition, the facility's identification of blind spots on the "ASG Unity Addressing Blind Spot and	{A 144}		

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{A 144}	Continued From page 39 Security" document dated 07/10/2018 submitted with the POC for the initial complaint survey, and the "Blind Spots and Camera Monitoring: Risk Assessment and Plan" document received during the revisit survey on 07/24/2018, were not consistent with surveyors' observations during the initial survey and confirmed on this revisit survey. For example: * For Unit 1E the "Blind Spots and Camera Monitoring: Risk Assessment and Plan" reflected that there were "none" for patient rooms on that unit. However, observations on 07/23/2018 at 1700 revealed camera blind spots in rooms 101, 102, 103, 105, 106, 107, 108, 109, 110, 111, 112 and 113. * For Unit 2 the ASG report failed to identify any camera blind spots. However, observations on 07/24/2018 at 1000 revealed camera blind spots in patient rooms 201, 204, 205, 210, 211, 213, 214 and 215. * For Unit 6 the ASG report failed to identify the camera blind spots observed on the initial survey and again on 07/24/2018 at 1115 in patient rooms 611 and 616. 5. The policy and procedure titled "General RN Station Guideline" dated as last reviewed "Jul 2018" stipulated "Every staff member is expected to wear a Vocera badge while on duty." * Incident/Event documentation dated 07/27/2018 at 1930 reflected that upon staff arrival to the 1E unit for the night shift on 07/27/2018 there were no available Vocera badges. Two Voceras were located however, contrary to the policy and procedure four staff persons had no Vocera	{A 144}		

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{A 144}	Continued From page 40 badge to be able to call for assistance or help in event of emergency. This was confirmed during interview with the DPCS at the time of the review on 07/30/2018 at approximately 1330. 6. Elopement prevention, and staff awareness and alertness to potential hazards and risks were lacking. * The policy and procedure titled "Safe Transportation of Patients and Prevention of Elopement" dated as reviewed "May 2018" reflected "Prevention of Elopement. When moving through a locked door, all staff and service providers with badge access will ensure door is clear of patients prior to opening and stay until door is completely closed." * Review of incident/event documentation for Patient 71 reflected that on 06/25/2018 at 1040 the patient was identified as missing from unit 1E having been last seen on that unit at approximately 0900. The patient's location was unknown until he/she was found at approximately 1110 on unit 1W in a patient room. The documentation reflected that staff believed the patient to be attending a garden group that morning. 1W is immediately adjacent to unit 1E and the two units are separated at one entry/exit point by only one door that requires badge access. Unit 1W was closed to patients and vacant at that time which left the patient entirely isolated and unsupervised in that environment. This incident demonstrates a lack of awareness and alertness by staff to ensure patient safety. * During tour of the facility on 07/26/2018 at 1505 a patient being escorted by staff off of a patient unit was observed exhibiting escalating physical	{A 144}		

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{A 144}	Continued From page 41 and verbal behaviors in the corridor outside of elevator C. A staff person in the presence of the patient was observed holding in front of him/herself a large beverage container with one of his/her hands and a pen loosely between two fingers in the same hand. The pen and/or beverage were easily accessible to the patient, and the pen particularly had the potential to be used by the patient for harm to self or others. The staff person demonstrated a lack of awareness of the possible risk during the patient's escalating behaviors as there was no effort to free his/her hand of those objects or to move the pen to a more secure location not within reach of the patient. 7. The system to ensure the safety and availability of equipment and supplies for Code M responses to urgent and emergent medical conditions was not fully implemented. * During tour of unit 1W on 07/26/2018 at 1545 observations of the "Code M Supply Cart Checklist" reflected that checklist entries had not been completed on 06/02/2018, 06/04/2018, 06/06/2018, 07/12/2018, 07/13/2018, 07/16/2018, 07/17/2018, 07/18/2018, and 07/19/2018. Items not checked on those dates included, but were not limited to: AED present, portable suction machine working, required supplies present, glucometer test strips labeled and in date, and oxygen tank full. * Similar omissions were identified on the unit 1E "Code M Supply Cart Checklist" observed on 07/24/2018 at approximately 1445. This was confirmed with the NEBHS and DPC at the time of the observation.	{A 144}		

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{A 144}	Continued From page 42 * During tour of the PES on 07/26/2018 at 1430 a portable suction machine with Serial Number M34934 was observed on the PES Code M cart. During tour of unit 1W on 07/26/2018 at 1545 a portable suction machine with Serial Number M34874 was observed on the 1W Code M cart. There was no evidence on those suction machines, as there were in the form of stickers observed on the AED machines, to reflect whether equipment preventive maintenance had been conducted and during interview with unit staff at those times they indicated they were unaware of the preventive maintenance status. During interview with the DPCS on 07/30/2018 at 1630 he/she confirmed that equipment preventive maintenance for the suction machines "brought on board" in May was "missed." 8. Refer to findings at Tag A405, CFR 482.23(c), Administration of Drugs, that reflect medication errors were made for Patients 47, 51, 58, 59, 60, 66, 73 and 74. Patient 58 experienced a change of condition and required EMS transfer and medical hospitalization as a result of receiving another patient's medications.	{A 144}		
{A 145}	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) 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 observations, interviews, review of incident/event documentation for 6 of 10 patients who experienced actual or potential self-harm between 06/25/2018 and 07/29/2018 (Patients 48, 50, 52, 57, 61 and 71), and incident/event	{A 145}		

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{A 145}	Continued From page 43 documentation for 8 of 8 patients who were reviewed for medication errors that occurred between 07/04/2018 and 07/27/2018 (Patients 47, 51, 58, 59, 60, 66, 73 and 74), it was determined that the hospital failed to ensure patient's rights to be free from all forms of abuse, including neglect, as all components of an effective abuse prevention program were not evident, including complete investigation of, and response to, actual neglect that resulted in patient harm, including a patient death, from an unsafe physical environment, lack of patient monitoring and observation, and medication errors. The CMS Interpretive Guideline for this requirement at CFR 482.13(c)(3) reflects "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one patient by another. Neglect, for the purpose of this requirement, is considered a form of abuse and is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Further, the CMS Interpretive Guideline reflects that components necessary for effective abuse protection include, but are not limited to: o Prevent. o Identify. The hospital creates and maintains a proactive approach to identify events and occurrences that may constitute or contribute to abuse and neglect. o Investigate. The hospital ensures, in a timely and thorough manner, objective investigation of all allegations of abuse, neglect or mistreatment. o Report/Respond. The hospital must assure that	{A 145}		

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{A 145}	Continued From page 44 any incidents of abuse, neglect or harassment are reported and analyzed, and the appropriate corrective, remedial or disciplinary action occurs, in accordance with applicable local, State, or Federal law. Findings include: 1. Refer to the findings cited under Tag A115, CFR 482.13 - CoP: Patient's Rights. Those findings reflect the hospital's failure to ensure investigations of neglect for Patients 48, 50, 52, 57, 61 and 71 that resulted in actual or potential patient self-harm were timely and complete to prevent recurrence. a. Review of incident/event documentation for Patient 48 reflected that on 07/05/2018 at 1930 the patient made a suicidal gesture and self-harm when he/she put a "chew OT device shaped like long LEGO piece in back of throat" to the point of gagging, and then "wrapped stretchy plastic string (that was connected to chew toy) around [his/her] hands so tight that it caused [him/her] pain ...' The investigation and follow-up was not clear or complete. A note recorded on 07/06/2018 reflected: "Reviewed. OT removed toy from unit and will not bring toys like it back to unit. Patient placed on 15 min checks/suicide precautions for extra monitoring. Contributing factors: Patient has difficulties being by [him/herself] and utilizing coping skills. Patient condition: No harm to patient, staff present during entire event. Care plan opened: no. CSSR documented pre- and post- event: No, event assessed to be suicidal gesture by RN in progress not. Progress note written: yes. Provider notified: yes, in am. Family/guardian notified: yes." There was no further investigation, clarification, or follow-up. For	{A 145}		

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{A 145}	Continued From page 45 example: It incorrectly concluded that the patient experienced "no harm" when the patient was described as gagging and in pain. It was not clear what the relevance was to this incident that the "Patient has difficulties being by [him/herself]" when other information in the note indicated that "staff present during entire event." It was additionally not clear why the patient was allowed to perform those self-harm acts if staff was "present during entire event." Further, it was not clear how one OT's removal of "toy from unit and will not bring toys like it back to unit" ensured that that item and similar unsafe items would not be available and accessible to patients. b. Incident/event documentation was reviewed for Patient 50 who died as a result of suicide by hanging in his/her patient room on 07/11/2018. The documentation reflected that the patient had used his/her personal thin fabric bathrobe as a ligature around his/her neck. Refer also to the findings for Patient 50 under Tag A115, CFR 482.13 - CoP: Patient's Rights. At the time of this survey the investigation had been initiated but not completed. Although some physical environment changes had been made to reduce ligature risks, not all immediate actions to mitigate harm to other suicidal patients had been considered or taken. For example: Restricted access to, or removal of garments and linens; and constant observation. c. Review of incident/event documentation for Patient 52 reflected that on 07/12/2018 the patient approached a SSO on Unit 5 and voluntarily surrendered a P38 can opener (small folding metal opener with a sharp pointed blade for piercing a metal can) the patient removed from his/her wallet. The investigation and	{A 145}		

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{A 145}	Continued From page 46 follow-up was not clear or complete. A follow-up note dated 07/24/2018 at 0954 reflected that an RN " ...did hand [Patient 52 his/her] wallet on a previous date. [RN] reports taking the wallet out of [his/her] belongings, which were in the patient belonging storage room, looking briefly in the wallet, as is [his/her] standard practice. [He/she] did not see any weapon in the wallet at that time. [he/she] reports that there was significant time, ie: days that passed by between patient being handed [his/her] wallet, and the weapon being discovered. It is not clear if the can opener was in the wallet to begin with, or if it was hidden on the patient's person at time of transfer from PES." The next note dated 07/24/2018 at 1052 by the RM reflected "Have reviewed circumstance with security and unit manager; this ICARE can be CLOSED." This did not constitute a complete investigation. It consisted of only an interview with one staff person. That interview resulted in more questions that needed to be explored and answered about the lack of systems that allowed that P38 to be in the patient's possession. There was no further investigation or follow-up. d. Review of incident/event documentation for Patient 71 reflected that on 06/25/2018 at 1040 the patient was identified as missing from unit 1E having been last seen on that unit at approximately 0900. The patient's location was unknown until he/she was found at approximately 1110 on unit 1W in a patient room. On 06/28/2018 extensive investigation documentation identified that the patient eloped because a nurse failed to ensure a door was shut as the nurse " ...reported that [he/she] had been preoccupied ..." The investigation and follow-up was not clear or complete. For example: It reflected "Two barriers identified that need to be evaluated" were related	{A 145}		

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{A 145}	Continued From page 47 to visualization barriers and camera views. That was followed by "This I-Care will be closed." There was no further information about the evaluation of the "barriers" identified. Nor was there information or actions related to the nurse's failure to ensure a door was shut that allowed the patient to elope. e. Similar findings were identified for investigation documentation for Patient 57 who attempted suicide and self-harm on 07/23/2018 in the seclusion room and who attempted suicide again on 07/25/2018; and for Patient 61 who attempted suicide on 07/27/2018. 2. Refer to the findings cited under Tag A405, CFR 482.23(c) - Standard: Preparation and Administration of Drugs. Those findings reflect the hospital's failure to ensure investigations of neglect that resulted in actual or potential harm secondary to medication errors for Patients 47, 51, 58, 59, 60, 66, 73 and 74, and investigation of repeated medication errors by RN 36 and RN 39, were timely and complete to prevent recurrence.	{A 145}		
{A 175}	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD is not met as evidenced by: Based on interview, documentation reviewed in the medical record of 2 of 2 patients (Patients 53	{A 175}		

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{A 175}	Continued From page 48 and 55) who were placed in seclusion by hospital staff, and review of policies and procedures, it was determined the hospital failed to ensure ongoing assessment and monitoring of patients who were in seclusion in accordance with hospital policies and procedures as follows: * Patients with violent or self-destructive behaviors were not assessed and monitored when seclusion was used in accordance with hospital policies and procedures; and restraint and seclusion policies and procedures were not fully developed and implemented. Findings include: 1. The policy and procedure titled "Restraint and Seclusion for Patient Safety" dated last revised "Jul 2018" was reviewed. It stipulated: *Section G.1. reflected "...Non-Behavioral or Non-Violent Behavior: The RN will assess every 2 hours to address specific needs, which may include The behavior exhibited by the patient indicating the need for restraint or seclusion...Status of restraint (device type and # of points)...Signs of any injury associated with applying restraint or seclusion...Nutrition and hydration needs...Circulation and range of motion in extremities...Elimination needs...Physical and psychological status and comfort; and...Readiness for discontinuing restraint use or seclusion." *Section G.2. reflected "...Violent or Self-Destructive Behavior...All violent or self-destructive restraint patients shall be assessed in person every 2 hours, which may include...The behavior exhibited by the patient indicating the need for restraint or seclusion...Status of restraint (device type and # of points)...Signs of any injury associated with	{A 175}		

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{A 175}	Continued From page 49 applying restraint or seclusion...Nutrition and hydration needs...Circulation and range of motion in extremities...Elimination needs...Physical and psychological status and comfort; and...Readiness for discontinuing restraint use...3. Additionally, all VSD patients shall be monitored every 15 minutes to evaluate...Safety, psychological & emotional status, comfort, and signs of injury from restraint and/or seclusion." *"As soon as possible after the implementation of restraint or seclusion, the patient's plan of care shall be modified to address appropriate interventions implemented to assure the patient's safety and encourage the prompt discontinuation of restraint and/or seclusion." *"...Documentation will be completed in the medical record and include the following...restraint use assessment, monitoring and interventions (as outlined in G.1. and G.2 above) additional documentation as patient condition warrants." * The "Definitions" section reflected "...Restraint Event...The time from application to discontinuation of restraints." The policy did not include who was required to complete the every 2 hour assessment of patients with violent or self destructive behaviors who were in restraints or seclusion, whereas it reflected that an RN was required to complete the every 2 hour assessment of patients with nonviolent behaviors. The policy was unclear related to the elements that were required to be completed every 2 hours as it stated the every 2 hour assessment "may include" the individual assessment areas listed and "...vital signs as warranted by patient condition, as ordered, and per nursing judgement." The policy additionally failed to	{A 175}		

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{A 175}	Continued From page 50 include who was required to complete the every 15 minutes monitoring of patients with violent or self destructive behaviors who were in restraint or seclusion. 2. The medical record of Patient 55 was reviewed and reflected the patient was admitted on 07/11/2018 with diagnoses including schizophrenia and agitation. The record reflected the following: *The flowsheet notes dated 07/20/2018 at 1030 reflected the patient's behaviors were threatening and aggressive, and seclusion was initiated. *The initial RN assessment for the seclusion event on the "Restraint/Seclusion Monitoring Q 2 Hours" flowsheet dated 07/20/2018 at 1030 did not include an assessment of the patient's nutrition, hydration and elimination needs as required by hospital policy. *The flowsheet notes dated 07/20/2018 at 1900 reflected "Seclusion...Discontinued not sure what time d/c'd, out already." There was no definitive documentation reflecting when the seclusion event ended. *There was no documentation reflecting a Q 2 hours assessment of the patient between 07/20/2018 at 1030 when the seclusion event started and 07/20/2018 at 1900, a period of nearly 9 hours, including no assessment of the behavior exhibited by the patient indicating the need for seclusion, status of restraint, signs of injury associated with seclusion, nutrition and hydration needs, circulation and range of motion in extremities, elimination, physical and physiological status and comfort, and readiness for discontinuing seclusion. *There was no documentation reflecting the patient was monitored Q 15 minutes between 07/20/2018 at 1030 and 07/20/2018 at 1900 to	{A 175}		

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{A 175}	Continued From page 51 evaluate safety, psychological and emotional status, comfort, and signs of injury from the seclusion. 3. The medical record of Patient 53 was reviewed and reflected the patient was admitted on 07/07/2018 with a diagnosis of psychosis. *The flowsheet notes dated 07/13/2018 at 1515 reflected seclusion was initiated. The patient's behaviors were reflected as "Unable to plan for safety; Imminent risk of harm to self and others; Impulsive behaviors; Red faced, perspiring heavily, rapid breathing; Unable to redirect." *The record reflected the seclusion event ended on 07/13/2018 at 1645. *The RN assessment on the "Restraint/Seclusion Monitoring Q 2 Hours" flowsheet dated 07/13/2018 at 1645 at the time the restraint event ended did not include an assessment of the patient's range of motion and comfort. In addition, there was no documentation reflecting the patient's care plan was modified related to the seclusion event. 4. An interview was conducted with the DPC and Unit 1E/2 ANM on 07/26/2018 at 1600 during review of the medical record of Patients 53 and 55. The DPC and Unit 1E/2 ANM confirmed the records contained no documentation reflecting the RN assessed and monitored Patients 53 and 55 as reflected in findings 2 and 3. They also confirmed the record of Patient 53 contained no documentation reflecting the care plan was modified related to the seclusion event. During the interview on 07/26/2018 at 1620 the Unit 1E/2 ANM stated an RN was required to conduct an assessment at the start of restraint and seclusion, every 2 hours during restraint and	{A 175}		

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{A 175}	Continued From page 52 seclusion, and at the end of restraint and seclusion.	{A 175}		
{A 202}	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(2)(iv) [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia). This STANDARD is not met as evidenced by: Based on interview, review of restraint and seclusion training documentation for 16 of 16 hospital staff (Employees 6, 10, 20, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, and 35), review of policies and procedures, and review of other documentation it was determined that the hospital failed to fully develop and implement its restraint and seclusion policies and procedures to ensure staff were trained and demonstrated knowledge and competency in the use of restraints and seclusion in the following areas: * Staff were not trained in the safe application and use of all types of restraints used in the hospital. Findings include: 1. The policy and procedure titled "Restraint and Seclusion for Patient Safety" dated last revised "JUL 2018" was reviewed. It stipulated: *"Education and Training: Patients have the right	{A 202}		

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{A 202}	Continued From page 53 to safe implementation of restraint or seclusion by trained staff. Hospital and medical staff shall receive focused education as appropriate to perform assigned duties under this policy. Such education shall take place upon hire, prior to the new staff member being asked to implement the provisions of this policy and shall be repeated annually...Staff Education Content (may vary by department and clinical position)...The safe application and use of all types of restraint or seclusion used in the hospital, including education in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia); (Attachment 2 Approved Restraint Devices)..." *Attachment #2 included a list of 8 approved restraint types/devices for non-violent behaviors. Those devices were Limb holder: soft fabric, mitt; Limb holder: neoprene; Waist belt, soft fabric; Roll belt, soft fabric; Seat belt; Vest/Jacket; Enclosure Bed; and Spit mask. *"Attachment #2 included a list of 11 approved restraint types/devices for violent/self-destructive behaviors. Those devices were Limb holder: soft fabric, mitt; Limb holder: neoprene; Limb holder: neoprene locking; Waist belt, soft fabric; Roll belt, soft fabric; Seat belt; Vest/Jacket; Ambulatory Restraint Belt; Restraint Chair; Physical Holding; and Spit mask. * Attachment #2 additionally included a list of 3 approved restraint types/devices identified as "Limited to use at Unity." Those devices were Ambulatory Restraint Belt; Restraint Chair; and Physical holding. 2. During tour of Unit 5 on 07/30/2018 at 1300 with the ACC and Unit 1W/5 NM, a General Purpose Belt restraint was observed in the nursing unit available for use.	{A 202}		

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{A 202}	Continued From page 54 3. During an interview on 07/25/2018 at approximately 1500, the Unit 1W/5 NM stated the General Purpose Belt restraints were recently made available on units for patient use. 4. Manufacturer application instructions for General Purpose Belt restraint dated "2009" were provided and reviewed. The indications for use included "Patients assessed to be at risk of injury from a fall...Patients who are aggressive and attempt to 'buck' up and down, risking potential self-injury or disruption of treatment...Patients who need a supplemental restraint (5th point) of the thighs, pelvis, or chest, and who are already restrained at all four extremities." The instructions included contraindications to use such as "Do Not use this device on a patient who is or becomes: suicidal; highly aggressive or combative; self-destructive; or deemed to be an immediate risk to others , UNLESS the patient is under constant supervision...Do not use on patients with: ostomy, colostomy, or G-tubes; hernias...NEVER use a 5th point restraint on a patient...With supra-pubic catheter, ostomy...recent incision...a history of cardiac or pulmonary disorders...To restrain head or neck." 5. During tour of Unit 6 on 07/30/2018 at approximately 1325 with the ACC and Unit 6 NM, a TransBoard restraint was observed in the nursing unit available for use. During an interview with the Unit 6 NM at the time of the observation, he/she stated the TransBoard was used to restrain adolescent patients during transport from one location to another location within the unit. 6. Review of restraint competency checklists used to provide staff training reflected they did not	{A 202}		

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{A 202}	Continued From page 55 include all restraints approved for use as identified in finding 1. Examples include: *The "Restraint Training Checklist Unity BHT, BHA" form dated "CPS 06.18.2018" was reviewed. The checklist included demonstrated competency of the application/use for 4 restraint types as follows: Soft belt/abdominal belt; neoprene limb holder; Ambulatory Restraint Belt; and Restraint Chair. However, it did not include all restraints identified as approved for use at the hospital. For example, it did not include Limb holder: soft fabric, mitt; Physical Holding; Vest/Jacket; and Spit mask. Additionally, the competency training did not include all restraints used at the hospital. For example, it did not include General Purpose Belt restraint and TransBoard restraint identified in findings 2 and 5. *The "Unity Restraint Training Checklist RN" form dated "CPS 06.18.18" was reviewed. The checklist included demonstrated competency of the application/use for 4 restraint types as follows: Soft belt/abdominal belt; neoprene limb holder; Ambulatory Restraint Belt; and Restraint Chair. Similarly, it did not include all restraints identified as approved for use at the hospital. Additionally, the competency training did not include all restraints used at the hospital. For example, it did not include General Purpose Belt restraint and TransBoard restraint. 7. Training documentation titled "Provider Training: Restraints & Seclusion, and Medication Orders" dated "July 2018" included a list of "Restraint Devices used at Legacy". It included 11 restraints types/devices identified as Soft limb holder; Soft mitt; Waist/wheelchair belt; Roll belt; Mesh Vest; Jacket; Enclosure bed (used only in acute care units for non-violent behaviors); Neoprene limb holder; Locking neoprene limb	{A 202}		

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{A 202}	Continued From page 56 holder; Ambulatory Restraint Belt; and Restraint Chair. The training documentation did not include all restraints used at the hospital. For example, it did not include General Purpose Belt restraint or TransBoard restraint. 8. Review of employee training documentation reflected it failed to include demonstrated competency and training for all types of restraints approved and used at the hospital. Examples include but are not limited to: * Employee 23, SSO with hire date 10/31/2016 reflected no evidence of demonstrated restraint competency or any other training for General Purpose Belt restraint and TransBoard restraint; and no demonstrated restraint competency for Limb holder: soft fabric, mitt, Vest/Jacket, Physical holding, and Spit mask. * Employee 32, RN with hire date 01/09/2017 reflected no evidence of demonstrated restraint competency or any other training for General Purpose Belt restraint and TransBoard restraint; and no demonstrated competency for Vest/Jacket, Seatbelt, Physical holding, and Spit mask. * Employee 28, BHT with hire date 01/31/2017 reflected no evidence of demonstrated restraint competency or any other training for General Purpose Belt restraint and TransBoard restraint; and no demonstrated competency for Vest/Jacket, Seatbelt, Spit mask, Physical holding, and Limb holder: soft fabric, mitt. * Similar findings were identified related to lack of training and demonstrated restraint competency during review of training documentation for: Employee 6, SSO with hire date 10/16/2017; Employee 10, BHT with hire date 01/23/2017; Employee 20, RN with hire date 01/08/2018; Employee 24, BHT with hire date 01/31/2017;	{A 202}		

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{A 202}	Continued From page 57 Employee 25, BHT with hire date 12/12/2016; Employee 26, BHT with hire date 01/31/2017; Employee 27, BHT with hire date 01/31/2017 Employee 29, RN with hire date 01/02/2017; Employee 30, RN with hire date 01/31/2017; Employee 31, RN with hire date 02/05/2018; Employee 33, RN with hire date 02/05/2018; Employee 34, RN with hire date 07/11/2016; and Employee 35, RN with hire date 01/09/2017. 9. During an interview with DPCS on 07/30/2018 at approximately 1500, he/she confirmed General Purpose Belt restraint and TransBoard restraint were not included in the hospital's policy and procedure and list of approved restraint devices in finding 1. He/she also confirmed General Purpose Belt restraint and TransBoard restraint were not included in staff training and competency documents identified in findings 6 and 7.	{A 202}		
{A 263}	QAPI CFR(s): 482.21 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 arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate	{A 263}		

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{A 263}	Continued From page 58 evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on observations, interviews, review of incident/event and medical record documentation for 7 of 10 patients who experienced actual or potential self-harm between 06/25/2018 and 07/29/2018 (Patients 48, 50, 52, 57, 61, 65 and 71), incident/event and medical record documentation for 8 of 8 patients who were reviewed for medication errors that occurred between 07/04/2018 and 07/27/2018 (Patients 47, 51, 58, 59, 60, 66, 73 and 74), review of medical record documentation for 2 of 2 patients who were placed in seclusion (Patients 53 and 55), review of restraint and seclusion training documentation for 16 of 16 staff (Employees 6, 10, 20, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34 and 35), review of policies and procedures, and review of other documentation related to safety and physical environment risk, it was determined that the hospital failed to develop, implement, and maintain an effective QAPI program to ensure the provision of safe and appropriate care to patients in the hospital that complied with the Conditions of Participation in the following areas: * Patients identified at risk for suicide were not protected from self-harm and suicide attempts. Patient 50 committed suicide by hanging and died. * The physical environment contained ligature risks that resulted in actual patient harm. * The physical environment contained unsafe items that resulted in actual patient harm. * The physical environment contained blind spots that created the opportunity for patient self-harm or suicide without immediate detection.	{A 263}		

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{A 263}	Continued From page 59 * Communication safety devices required for staff use were not available. * Elopement prevention, and staff awareness and alertness to potential hazards and risks were lacking. * Systems to ensure that equipment and supplies necessary for response to urgent and emergent medical conditions were available and in safe working condition were not fully implemented. * Medication errors occurred when RNs failed to administer the right medication to the right patient, in the right dose, by the right route and at the right time. Patient 58 experienced a change of condition and required EMS transfer and medical hospitalization as a result of receiving another patient's medications. * Seclusion requirements were not met for those patients placed in seclusion. * Restraint and seclusion were not implemented by staff who met the restraint and seclusion training requirements. * Investigations of and response to patient incidents/events were not timely or complete to prevent recurrence. This Condition-level deficiency was uncorrected and represents a limited capacity on the part of the hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited under Tag A043, CFR 482.12 - CoP Governing Body. 2. Refer to the findings cited under Tag A115, CFR 482.13 - CoP Patient's Rights. 3. Refer to the findings cited under Tag A385, CFR 482.23 - CoP Nursing Services.	{A 263}		

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{A 263}	Continued From page 60 4. Refer to the findings cited under Tag A700, CFR 482.41 - CoP Physical Environment.	{A 263}		
{A 385}	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observations, interviews, review of incident/event and medical record documentation for 7 of 10 patients who experienced actual or potential self-harm between 06/25/2018 and 07/29/2018 (Patients 48, 50, 52, 57, 61, 65 and 71), incident/event and medical record documentation for 8 of 8 patients who were reviewed for medication errors that occurred between 07/04/2018 and 07/27/2018 (Patients 47, 51, 58, 59, 60, 66, 73 and 74), review of medical record documentation for 2 of 2 patients who were placed in seclusion (Patients 53 and 55), review of policies and procedures, and review of other documentation related to safety and physical environment risk, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured nursing services were provided in a safe and appropriate manner in the following areas: * Patients identified at risk for suicide were not protected from self-harm and suicide attempts. Patient 50 committed suicide by hanging and died. * Communication safety devices required for staff use were not available. * Elopement prevention, and staff awareness and	{A 385}		

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{A 385}	Continued From page 61 alertness to potential hazards and risks were lacking. * Systems to ensure that equipment and supplies necessary for response to urgent and emergent medical conditions were available and in safe working condition were not fully implemented. * Medication errors occurred when RNs failed to administer the right medication to the right patient, in the right dose, by the right route and at the right time. Patient 58 experienced a change of condition and required EMS transfer and medical hospitalization as a result of receiving another patient's medications. * Seclusion requirements were not met for those patients placed in seclusion. * Investigations of and response to patient incidents/events were not timely or complete to prevent recurrence. This Condition-level deficiency was uncorrected and represents a limited capacity on the part of the hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited under Tag A395, CFR 482.23(b) - Standard: Delivery of care, RN supervision and evaluation. Those findings reflect the hospital's failure to ensure an RN was responsible to ensure that patients' conditions were assessed and care planned, and that patients were monitored and observed to ensure their safety. 2. Refer to the findings cited under Tag A405, CFR 482.23(c) - Standard: Preparation and Administration of Drugs. Those findings reflect the hospital's failure to ensure that drugs were administered in accordance with physician's	{A 385}		

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{A 385}	Continued From page 62 orders, facility policies and standards of practice.	{A 385}		
{A 395}	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on observations, interviews, review of incident/event and medical record documentation for 7 of 10 patients who experienced actual or potential self-harm between 06/25/2018 and 07/29/2018 (Patients 48, 50, 52, 57, 61, 65 and 71), incident/event and medical record documentation for 8 of 8 patients who were reviewed for medication errors that occurred between 07/04/2018 and 07/27/2018 (Patients 47, 51, 58, 59, 60, 66, 73 and 74), review of medical record documentation for 2 of 2 patients who were placed in seclusion (Patients 53 and 55), review of policies and procedures, and review of other documentation related to safety and physical environment risk, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured that the RN supervised and evaluated the care of patient to ensure the provision of safe and appropriate care in the following areas: * Patients identified at risk for suicide were not protected from self-harm and suicide attempts. Patient 50 committed suicide by hanging and died. * Communication safety devices required for staff use were not available. * Elopement prevention, and staff awareness and alertness to potential hazards and risks were lacking. * Systems to ensure that equipment and supplies	{A 395}		

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{A 395}	Continued From page 63 necessary for response to urgent and emergent medical conditions were available and in safe working condition were not fully implemented. * Medication errors occurred when RNs failed to administer the right medication to the right patient, in the right dose, by the right route and at the right time. Patient 58 experienced a change of condition and required EMS transfer and medical hospitalization as a result of receiving another patient's medications. * Seclusion requirements were not met for those patients placed in seclusion. * Investigations of and response to patient incidents/events were not timely or complete to prevent recurrence. Findings include: 1. Refer to the findings cited under Tag A115, CFR 482.13 - CoP: Patient's Rights. Those findings reflect the hospital's failure to ensure nursing staff provided appropriate assessment, care planning, monitoring and observation to ensure patient safety and prevent patient self-harm. 2. Refer to the findings cited under Tag A405, CFR 482.23(c) - Standard: Preparation and Administration of Drugs. Those findings reflect the hospital's failure to ensure nursing staff provided appropriate patient assessment, monitoring and observation after medication errors had been made.	{A 395}		
{A 405}	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and	{A 405}		

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{A 405}	Continued From page 64 State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on interview, incident/event and medical record documentation for 8 of 8 patients who were reviewed for medication errors that occurred between 07/04/2018 and 07/27/2018 (Patients 47, 51, 58, 59, 60, 66, 73 and 74), and review of policies and procedures it was determined that the hospital failed to ensure that drugs were administered in accordance with physician's orders, facility policies and standards of practice. Medication administration policies and procedures and standards of practice were not followed and enforced, and investigation and follow-up of medication errors was not timely and complete and resulted in repeated errors. Patient 58 experienced a change of condition and required EMS transfer and medical hospitalization as a result of receiving another patient's medications	{A 405}		

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{A 405}	Continued From page 65 Findings include: 1. The policy and procedure titled "Medications: Administration" dated as originated "Mar 1997" and last revised "Apr 2018" reflected it's purpose included "To describe a safe process for medication administration." The policy stipulated: "Medications are administered in accordance with the orders of a prescriber who is responsible for the patient's care and in accordance with law, regulation and hospital standards." The policy stipulated under the section "Medication Administration...Two identifiers will be checked prior to medication administration...In behavioral health, if the patient is unable or unwilling to wear patient identification wristband and/or provide patient identifiers, a photograph in the EHR may be used to identify the patient. Barcode scanning: The patient's wristband and medications will be barcode scanned immediately prior to administration. If the correct patient medication has an unreadable barcode, the nurse proceeds with verifying the 6 rights of correct medication administration and documentation of the administration by performing a medication scanning override and selecting the appropriate reason for not scanning...Key Point: Verifying the patient and identification through the patient stating their name and date of birth and scanning of the patient's wristband should be attempted prior to considering other options to verify patient identity. Key Point: The nurse must verify that the [EHR] medication order description matches the medication package label at the bedside when barcode scanning." Recognized standards of practice for the "rights of correct medication administration" are	{A 405}		

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{A 405}	Continued From page 66 referenced on the Lippincott Nursing Center website on 08/06/2018 and are identified as the "Right patient...Right medication...Right dose...Right route...Right time...Right documentation." 2. During observations at the 1E nurse's station on 07/24/2018 at 1135 a staff person was overheard on the telephone making arrangements to transfer a patient to the ED who was experiencing "tachycardia" as a result of an "overdose." During interview with nursing staff at that time in regards to the information heard during that phone call it was disclosed that a "medication error" had occurred at 2130 the evening before when Patient 58 was given Patient 59's medications in error. a. Review of Patient 58's medical record revealed the following in relation to the medication error: * On 07/23/2018 at 2202 a note by an MD reflected "Called by RN re: pt received 300mg of Clozapine + 600mg Lithium - pt supposed to receive Geodon 40mg BID + Lithium 300mg TID. Reviewed MAR. Thus, received extra dose of Lithium 300mg and Clozapine 300mg. Recommended to monitor for dizziness, HA, visions changes, falls or altered mentation. Monitor VS. On q15min checks. EKG..." * On 07/24/2018 at 0319 a note by RN 36 reflected "Patient was admitted during the later part of day shift. [He/she] was cooperative with care and medications. At 2137 [Patient 58] was given another patient's medications in error. MD was immediately notified and staff was told to watch patient closely for dizziness or falls...Vital signs were taken per MD and were stable as was standing ortho BP. [Patient] continues to be dizzy and complains of drooling but no other symptoms	{A 405}		

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{A 405}	Continued From page 67 were reported. Patient was informed of the medication error but was not in a state [he/she] would remember." There was no other documentation by RN 36 between 2137 and 0319, and none after 0319 except an "addendum" note timed at 0455 that was identical to the 0319 note. * Review of the MAR for 07/23/2018 reflected that the patient was "given" Geodon 40 mg by mouth on 07/23/2018 at 1730 by a day shift RN. The MAR reflected that on 07/23/2018 at 2137 the patient was "given" melatonin tablet 6 mg by mouth, lithium 300 mg by mouth, and Minipress 4 mg by mouth by night shift RN 36. There are no notes in the record to reflect that staff identified that in addition to receiving Patient 59's medications, Patient 58's MAR reflected that he/she had received the scheduled Geodon, melatonin, lithium and Minipress. * On 07/23/2018 at 2143 VS documentation reflected that the patients VS were taken and the patient's pulse was high at 98. (The VS record reflected the patient's pulse taken previously at 1014 that day had been 58.) The next VS were not taken for over 11 hours until 07/24/2018 at 0852 and the patient's pulse was recorded as 124. The patient's pulse was not taken again for almost 2 1/2 hours until 1112 and remained at 124 at that time. Contrary to RN 36's note that vitals signs were taken and were stable, including "standing ortho BP," there was no documentation in the record to reflect that the patient's VS were taken and monitored by RN 36 during the remainder of the night shift, and including the orthostatic BP. These findings were confirmed during interview with the DPCS at the time of the record review on 07/24/2018 at 1545. * The next RN note was recorded on 07/24/2018 at 1249 and reflected "[Patient 58] has been	{A 405}		

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{A 405}	Continued From page 68 confused and having visual hallucination, Observed [him/her] crawling on the floor...Pressured and slurred in [his/her] speech, up walking with [his/her] trunk of [his/her] body leaning forward, unsteady in [his/her] gait...LIMS was notified of the change in [his/her] mental status and decided to have pt sent to Good Sam ER which [he/she] was transported by AMR at 1220." * On 07/24/2018 at 1304 a not by an LIP reflected "On 07/22/18 (sic) patient received medication not prescribed to [him/her] thought a medication error, and on 07/23/18 (sic) was having an adverse reaction warranting increased medical monitoring and transfer to the emergency department...Received medication amount larger then (sic) scheduled lithium dose and unexpected medication: 7/23 22:16 Clozaril 300 mg Lithium 600 mg Ativan 1 mg and Zyprexa - [he/she] is niave (sic) to Clozaril. Discussed with poison control, concern for potential QTC prolongation, potential for seizure, K+, Mag and Ca+ needs to be maximized. Discussed w ED, will transfer for labs, cardiac monitoring and seizure precautions. A wake (sic) and alert, Tachycardic, feels dizzy, drooling, in no acute distress, airway is protected, without pain. LIMS will follow when [patient] returns..." b. Review of a report generated from the Pyxis revealed the following medications were removed from the machine for Patient 59 on 07/23/2018 at 2125 and were subsequently administered erroneously to Patient 58, and they were removed again at 2212 for late administration to Patient 59: * Clozaril 100 mg, 3 tablets * Lithium 300 mg, 2 tablets * Ativan 1 mg, 1 tablet * Zyprexa 5 mg, 1 tablet	{A 405}		

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{A 405}	Continued From page 69 * Pericolace 50 mg, 1 tablet c. Video of the medication administration to Patient 58 by RN 36 was reviewed on 07/25/2018 at 1445. The video showed that RN 36 entered the patient's room at 2136 carrying something small in his/her hand. RN 36 turned the room lights on and handed Patient 58 the item identified as a medication cup which the patient took and ingested the contents of. The RN was observed to not carry a "Rover" device used to scan the patient's wrist band and to scan the medications to ensure the right patient was receiving the right medications, nor was the RN observed to check the patient's wrist band as a secondary way to confirm the patient's identity. d. During interview with the DPCS and the 1E ANM on 07/25/2018 at 1445 they revealed that RN 36 had been interviewed about the medication error and had reported the following: * During the evening on 07/23/2018 RN 36 pulled both Patient 58's and Patient 59's medications, that were scheduled to be given at 2100, from the Pyxis machine at the same time. * A patient wrist band label for patient 58 was laying on the desk at the nurses' station. RN 36 scanned the wrist band label that was at the desk and then scanned each of the medications while he/she was at the desk, which generated electronic entries on the MAR to reflect the patient received the medications. * RN 36 then took one of the two cups of medications at the desk to Patient 58's room and gave the cup to Patient 58 who took them. * When RN 36 returned to the nurse's station desk he/she saw the other medication cup that had Patient 58's medications and realized he/she had given Patient 58 the medication cup that	{A 405}		

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{A 405}	Continued From page 70 contained Patient 59's medications. * Patient 59 was not administered Patient 58's medications and did get his/her ordered medications later after the error was identified. During the interview the DPCS and 1E ANM further disclosed that RN 36 had been responsible for four previous known medication errors at UCBH: * One error was nearly identical to the error on 07/23/2018 where medication was administered to the wrong patient because he/she had not scanned the patient's wrist band at the time of administration. * On one occasion he/she gave medication early. * On another occasion he/she gave both oral AND injectable routes of a medication ordered to be given orally OR by injection. * Most recently in May of 2018 RN 36 had administered a supplemental amount of insulin to a patient using another patient's insulin pen. The DPCS stated that RN 36 "did not follow our process." He/she stated that hospital procedures required that only one patient's medication be removed from the Pyxis at a time and administered. The DPCS also disclosed that RN 36 had been placed on paid administrative leave as a result of the 07/23/2018 error. e. Review of incident/event documentation for the previous medication errors reflected: * On 02/20/2017 at 2145 RN 36 erroneously administered Trazadone to Patient 78, the wrong patient, as the Trazadone was ordered for Patient 78's roommate, because "Both patients in same room had unreadable wristbands." Follow-up documentation reflected that "[RN 36] did not ask for name and birthdate of either patient...coached	{A 405}		

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{A 405}	Continued From page 71 about the mandatory requirement for two identifiers and not taking two patients meds in at one time." * On 04/10/2017 at 0137 RN 36 erroneously administered Benztropine to Patient 77 both by injection AND by mouth instead of by injection OR by mouth. Follow-up documentation reflected only "Reviewed. That night the unit had enough bodies for the census but was short one RN. No harm came to the patient. Employee had no intent to hurt patient." * On 04/24/2017 at 0200 for Patient 76, RN 36 "made the decision to give a medication 6 hours before it was due, instead of contacting the provider at the time [RN 36] felt the med was needed." Follow-up documentation dated 05/15/2017 included "[RN 36] did violate elements of the Legacy Policy - Standard Medication Administration times...I am waiting to hear [his/her] rationale to decide the appropriate corrective action. I do not see that we need to report to the board of nursing." The next follow-up entry was dated 05/24/2017 and reflected "[RN 36] understand that [he/she] violated the medication administration policy...I believe that this was not a reckless error and coaching was done in the meeting." * On 05/14/2018 at 2230 RN 36 determined that Patient 75 was "Out of Lantus insulin in Pyxis. Patient needed more than was available in [his/her] insulin pen. Lantus pen borrowed from another patient and given." Follow-up documentation dated 05/16/2018 reflected "[RN 36] walked through the error and [his/her] steps afterward. Per [his/her] report it does appear to be a human error, with an identified knowledge gap among other nurses. This was the charge nurse on shift. After realization of the error, [he/she] collected the nurses on shift & explained	{A 405}		

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{A 405}	Continued From page 72 the error while doing a just-in-time teaching of why we don't use insulin pens on more than one patient. [He/she] also informed the day shift oncoming nurses; [he/she] reports that the nurses [he/she] spoke with were all unaware of the potential for exposure. Also, [he/she] called the house supervisor immediately after [his/her] conversation with pharmacy. All paper work was done; both patients were notified of the need for blood work follow up & why...encouraged to contact staff if concerns arose. Labs were returned negative, the patient at risk for exposure was discharged 5/15/18. Gaps were identified with RN & NM, will discuss putting education together to provide broadly. Feel this report can be closed." In spite of repeated medication errors and ineffective follow-up, RN 36 continued to administer medications which resulted in another medication error on 07/23/2018 that resulted in the patient's change of condition that had not been monitored by RN 36 and the patient was subsequently transferred for medical hospitalization. 3. Review of documentation for medication error incidents/events since 07/01/2018 reflected the following medication errors had occurred: a. On 07/04//2018 Patient 47 was given PRN olanzapine, an antipsychotic, at 0720 which resulted in a total dosage of 40 mg/24 hrs when the ordered dosage was maximum 30 mg/24 hrs. This error was made by RN 39. There was no follow-up documentation related to the RN's practice until 07/24/2018 and it only reflected "No harm came to patient. Following up with staff upon return to work..." There was no	{A 405}		

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{A 405}	Continued From page 73 documentation to reflect any further investigation or actions. b. On 07/04/2018 Patient 47 was given his/her scheduled omeprazole at 0719 when it had already been given at 0647. This resulted in a double dose given of the ordered medication. This error was made by RN 39. Follow-up documentation dated 07/05/2018 reflected "Per policy, all medications will be either administered, returned, or wasted within 30 minutes of vending. It appears the initial dose was vended about 6 hours before due." There was no further follow-up documentation until 07/24/2018 and it reflected "No harm came to patient. Will interview staff involved..." There was no documentation to reflect any further investigation or actions. c. On 07/11/2018 at 2133 Patient 51 received a double dose of lorazepam by injection. RN 39 wrote "I did not look at the order on the MAR or the dose on the Pyxis, and incorrectly assumed it was a 2 mg. dose...I did not take the time to verify the dose...I was in the med room, and did not verify the dose in person...When I discovered at about 2145 that I had given twice the ordered dose, I immediately notified the provider, charge RN, and pt's primary RN...Med admin documented in MAR as two different admins because no options exists to document an error such as this." The only follow-up documentation related to the RNs practice was dated 07/23/2018 and reflected "Coaching meeting completed with RN involved. Medication administration policy reviewed..." There was no evidence that the previous two medication errors made by RN 39 were identified, investigated and considered in the follow-up actions.	{A 405}		

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{A 405}	Continued From page 74 RN 39 made two wrong dose medication errors on 07/04/2018 for which there was no investigation or follow-up, and seven days later RN 39 made another wrong dose medication error. d. On 07/23/2018 at 1800 Patient 60 "...missed the warfarin dose...The omitted dose was discovered during the anticoagulation hand off to the patient's OP anticoagulation clinic." There was no investigation and the only follow-up documentation recorded was on 07/27/2018 and reflected "Reviewed. May close from my perspective." e. On 07/27/2018 at 1800 Patient 66's "...Combivent [inhaler] not given or charted on. This happened on dayshift." Follow-up documentation dated 07/29/2018 reflected that the reviewer/investigator concluded that the medication had actually been given and "I reviewed the chart and it is in fact charted as given...It shows this charted as such for 1800." However, review of the patient's MAR on 07/30/2018 at 1300 revealed that in fact the medication was not documented as given on 07/27/2018 at 1800, but was documented as given on 07/28/2018 at 1800. During interview with the DPCS at the time of the review he/she confirmed that the MAR reflected the medication was not given on 07/27/2018 at 1800. The reviewer/investigator of this error was incorrect in his/her review which did not ensure that appropriate actions and follow-up related to the RNs practice would occur. f. On 07/05/2018 at 1130 Patient 73's "antifungal powder was applied earlier than it was scheduled...accidentally applied at the wrong	{A 405}		

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{A 405}	Continued From page 75 time." There was no follow-up documentation until 07/24/2018 and the note written at that time reflected "Contributing factors: Human error. Patient condition: No harm to patient. Mitigation plan: None needed. Just Culture findings: Human error, and writer self-reported. Patient has anti-fungal cream ordered in the morning, and powder ordered at HS. Same medication name." Contrary to the finding that the medication ordered in two forms, powder and cream, had the same name, the reviewer/investigator of this error concluded that no investigation or action was needed, and the RN's practice was not addressed. g. On 07/15/2018 Patient 74 "was given Ativan at 1151 and at 1842 (less than 8hrs apart)." There was no documentation of investigation or follow-up related to this wrong time error.	{A 405}		
{A 700}	PHYSICAL ENVIRONMENT CFR(s): 482.41 The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observations, interviews, review of incident/event and medical record documentation for 7 of 10 patients who experienced actual or potential self-harm between 06/25/2018 and 07/29/2018 (Patients 48, 50, 52, 57, 61, 65 and 71), review of policies and procedures, and review of other documentation related to safety and physical environment risk, it was determined that the hospital failed to fully develop and	{A 700}		

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{A 700}	Continued From page 76 implement policies and procedures that ensured the physical environment was arranged and maintained for the safety of patients in the following areas: * Patients identified at risk for suicide were not protected from self-harm and suicide attempts. Patient 50 committed suicide by hanging and died. * The physical environment contained ligature risks that resulted in actual patient harm. * The physical environment contained unsafe items that resulted in actual patient harm. * The physical environment contained blind spots that created the opportunity for patient self-harm or suicide without immediate detection. * Communication safety devices required for staff use were not available. * Elopement prevention, and staff awareness and alertness to potential hazards and risks were lacking. * Systems to ensure that equipment and supplies necessary for response to urgent and emergent medical conditions were available and in safe working condition were not fully implemented. This Condition-level deficiency represents a limited capacity on the part of the hospital to provide safe and adequate care. Findings include: 1. Refer to the findings cited under Tag A701, CFR 482.41(a) - Standard: Buildings. Those findings reflect the hospital's failure to ensure care in a safe physical environment.	{A 700}		
{A 701}	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a)	{A 701}		

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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
{A 701}	Continued From page 77 The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observations, interviews, review of incident/event and medical record documentation for 7 of 10 patients who experienced sustained actual or potential self-harm between 06/25/2018 and 07/29/2018 (Patients 48, 50, 52, 57, 61, 65 and 71), review of policies and procedures, and review of other documentation related to safety and physical environment risk, it was determined that the hospital failed to fully develop and implement policies and procedures that ensured the physical environment was arranged and maintained for the safety of patients in the following areas: * Patients identified at risk for suicide were not protected from self-harm and suicide attempts. Patient 50 committed suicide by hanging and died. * The physical environment contained ligature risks that resulted in actual patient harm. * The physical environment contained unsafe items that resulted in actual patient harm. * The physical environment contained blind spots that created the opportunity for patient self-harm or suicide without immediate detection. * Communication safety devices required for staff use were not available. * Elopement prevention, and staff awareness and alertness to potential hazards and risks were lacking. * Systems to ensure that equipment and supplies necessary for response to urgent and emergent medical conditions were available and in safe working condition were not fully implemented.	{A 701}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	380007	A. BUILDING _____ B. WING _____	R-C 07/30/2018

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{A 701}	Continued From page 78 Findings include: Refer to the findings cited under Tag A115, CFR 482.13 - CoP: Patient's Rights. Those findings reflect the hospital's failure to ensure the provision of care in a safe physical environment.	{A 701}		