Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 010001	**(X3) Date Survey Completed** 08/24/2017
Name of Provider or Supplier Southeast Health Medical Center	**Street Address, City, State** 1108 Ross Clark Circle, Dothan, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0000	An abbreviated survey was conducted on 8/24/17 to investigate complaint number AL00035294. Patient Identifier (PI) # 1 presented to the Emergency Department (ED) on 5/14/17 at 3:21 AM with complaints of "... can't remember anything... back hurts so bad and I don't know if it is my body or just life in general..." The patient was subsequently admitted to the Behavioral Medicine Unit (BMU) with Auditory Hallucinations, Psychosis and Suicidal Ideations. On 5/30/17, PI # 1 was found hanging from the door to the patient bathroom door, cardiopulmonary resuscitation was initiated and the patient was pronounced dead. The hospital performed a Root Cause Analysis of the sentinel event, which indicated staff were not performing Q15 (Every 15) minute safety checks as ordered by the physician. Two Mental Health Technicians were fired and measures were put in place to protect other patients in the unit from immediate harm. There was no immediate threat to patient safety identified during the survey. The complaint was substantiated with conditions cited out of compliance at: 482.12, Governing Body; 482.13, Patient Rights; 482.21, Quality Assurance Performance Improvement and 482.23, Nursing Services. The state agency recommends the conditions at 482.13 (Patient Rights) and 482.23 (Nursing Services) be placed out of compliance.
A0043	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: This condition level deficiency was cited based on observations, review of facility policies, Facility Scope of Care Behavioral Health Services (BHS) / Behavioral

	Medicine Unit (BMU), facility work order maintenance requests, security video footage, Root Cause Analysis (RCA), medical records, Risk Management Worksheets, Unit Profile reports, Safety Checklist documentation, Minutes Houston County Health Care Authority Quality Committee, interviews and Facility's Corrective Action Plan submitted to the surveyors on 8/24/17, it was determined the governing body failed to ensure: 1. Psychiatric patients were provided care in a safe environment. 2. Mental Health Technicians (MHTs) performed patient safety rounds every 15 minutes. 3. The Registered Nurse (RN) conducted hourly rounds on patients and supervised the care provided by the MHTs to ensure patient observations were conducted every 15 minutes according to physician orders. 4. The BMU staff recognized the complexity of Patient Identifier (PI) #1's previous suicide attempts, including the attempt to self violence in the facility's Emergency Department (ED) and place the patient on 1:1 observation. 5. A treatment plan was implemented and updated for a suicidal patient to provide safe care and environment for PI # 1. 6. The BMU staff recognized PI # 2's self-destructive behaviors while in the BMU and was placed on 1:1 observation. 7. PI # 2's right to be free of restraint was not violated by placing the patient in a geri-chair (cardiac chair) for greater than 15 hours after being found trying to harm him/herself. 8. The BMU staff conducted environmental safety rounding each shift and ensure physical surroundings were safely maintained to protect patients and prevent potential harm. 9. Patient occurrences were reported, investigated, analyzed and preventative measures were implemented to prevent further occurrences. 10. The sentinel event involving PI # 1, a patient who successfully committed suicide while a patient in the BMU was reviewed in monthly quality meetings of the governing body. 11. Governing Body Quality Committee meetings were conducted for the months of July 2017 and as of the date of this survey (8/24/17) August 2017. 12. The BMU (2 North and 3 North) was staffed according to their budgeted target hours, which increased the patient work load for licensed, unlicensed and clerical staff caring for those patients. This affected 3 of 3 medical records (PI # 1, PI # 2, PI # 3) and 3 of 6 patients with adverse occurrences (PI # 4, PI # 6 and PI # 7). This also has the potential to negatively affect all patients admitted to this facility. Findings include: Refer to A0057, A115, A263, A309 and A385 for findings.
A0057	CHIEF EXECUTIVE OFFICER CFR(s): 482.12(b) The governing body must appoint a chief executive officer who is responsible for managing the hospital. This STANDARD is not met as evidenced by: Based on observations, review of facility policies, Facility Scope of Care Behavioral Health Services (BHS) / Behavioral Medicine Unit (BMU), facility work order maintenance requests, security video footage, Root Cause Analysis (RCA), medical records, Risk Management Worksheets, Unit Profile reports, Safety Checklist documentation, Minutes Houston County Health Care Authority Quality Committee, interviews and Facility's Corrective Action Plan submitted to the surveyors on 8 /24/17, it was determined the governing body failed to ensure: 1. Psychiatric patients were provided care in a safe environment. 2. Mental Health Technicians (MHTs) performed patient safety rounds every 15 minutes. 3. The Registered Nurse (RN) conducted hourly rounds on patients and supervised the care provided by the MHTs to ensure patient observations were conducted every 15 minutes according to physician orders. 4. The BMU staff recognized the complexity of Patient Identifier (PI)

	#1's previous suicide attempts, including the attempt to self violence in the facility's Emergency Department (ED) and place the patient on 1:1 observation. 5. A treatment plan was implemented and updated for a suicidal patient to provide safe care and environment for PI # 1. 6. The BMU staff recognized PI # 2's self-destructive behaviors while in the BMU and was placed on 1:1 observation. 7. PI # 2's right to be free of restraint was not violated by placing the patient in a geri-chair (cardiac chair) for greater than 15 hours after being found trying to harm him/herself. 8. The BMU staff conducted environmental safety rounding each shift and ensure physical surroundings were safely maintained to protect patients to prevent potential harm. 9. Patient occurrences were reported, investigated, analyzed and preventative measures were implemented to prevent further occurrences. 10. The sentinel event involving PI # 1, a patient who successfully committed suicide while a patient in the BMU was reviewed in monthly quality meetings of the governing body. 11. Governing Body Quality Committee meetings were conducted for the months of July 2017 and as of the date of this survey (8/24/17) August 2017. 12. The BMU (2 North and 3 North) was staffed according to their budgeted target hours, which increased the patient work load for licensed, unlicensed and clerical staff caring for those patients. This affected 3 of 3 medical records (PI # 1, PI # 2, PI # 3) and 3 of 6 patients with adverse occurrences (PI # 4, PI # 6 and PI # 7). This also has the potential to negatively affect all patients admitted to this facility. Findings include: Refer to A115, A263, A309 and A385 for findings.
A0115	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, review of facility policies, Facility Scope of Care Behavioral Health Services (BHS) / Behavioral Medicine Unit (BMU), facility work order maintenance requests, Safety Checklist documentation, security video footage, Root Cause Analysis (RCA), medical records, interviews and Facility's Corrective Action Plan submitted to the surveyors on 8/24/17, it was determined the facility failed to: 1. Ensure psychiatric patients were provided care in a safe environment. 2. Ensure Mental Health Technicians (MHTs) performed patient safety rounds every 15 minutes. 3. Ensure Licensed nursing staff performed patient rounds every hour. 4. Recognize the complexity of Patient Identifier (PI) #1's previous suicide attempts, including the attempt to self violence in the facility's Emergency Department (ED) and place the patient on 1:1 observation. 5. Ensure a treatment plan was implemented and updated for a suicidal patient to provide safe care and environment for PI # 1. 6. The BMU staff recognized PI # 2's self-destructive behaviors while in the BMU, PI # 2 was free from harm related to those self-destructive behaviors and placed the patient on 1:1 observation. 7. PI # 2's right to be free of restraint was not violated by placing the patient in a geri-chair (cardiac chair) for greater than 15 hours after being found trying to harm him/herself. 8. Conduct environmental safety rounding each shift and ensure physical surroundings were safely maintained to protect patients and prevent potential harm. This affected 2 of 3 medical records reviewed, including PI # 1, PI # 2 and has the potential to negatively affect all psychiatric patients admitted to this facility's BMU. Findings include: Refer to A144 and A154 for findings.
A0144	PATIENT RIGHTS: CARE IN SAFE SETTING

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, review of facility policies, Facility Scope of Care Behavioral Health Services (BHS) / Behavioral Medicine Unit (BMU), facility work order maintenance requests, Safety Checklist documentation, security video footage, Root Cause Analysis (RCA), medical records, interviews and Facility's Corrective Action Plan submitted to the surveyors on 8/24/17, it was determined the facility failed to: 1. Ensure psychiatric patients were provided care in a safe environment. 2. Ensure Mental Health Technicians (MHTs) performed patient safety rounds every 15 minutes. 3. Ensure Licensed nursing staff performed patient rounds every hour. 4. Recognize the complexity of Patient Identifier (PI) #1's previous suicide attempts, including the attempt to self violence in the facility's Emergency Department (ED) and place the patient on 1:1 observation. 5. Ensure a treatment plan was implemented and updated for a suicidal patient to provide safe care and environment for PI # 1. 6. The BMU staff recognized PI # 2's self-destructive behaviors while in the BMU and was placed on 1:1 observation. 7. Conduct environmental safety rounding each shift and ensure physical surroundings were safely maintained to protect patients and prevent potential harm. This affected 2 of 3 medical records reviewed, including PI # 1, PI # 2 and has the potential to negatively affect all psychiatric patients admitted to this facility's BMU. Findings include: Facility Policy: Behavioral Medicine Risk Analysis Effective Date: 6/21/2012, Revised 8/24/17 Policy: To provide for evaluation and inspection process to provide a safe environment for patients, staff and visitors within the Behavioral Medicine Unit. Purpose: The behavioral healthcare environment demonstrates that the physical surroundings help assure that the patient cannot harm himself/herself or others, and that staff are adequately protected from potential harm of patients. To purposefully identify and eliminate environmental risks for inpatient suicide and suicide attempts, heighten the awareness of clinical staff regarding environment, environmental hazards on locked psychiatric units and to focus specific attention on psychiatric unit safety. Procedure: The Director of Behavioral Medicine will implement a proactive BMU safety program to include safety responsibility assignments, safety rounding, risk analysis. 1. Assigned BMU staff will conduct safety rounding. Any safety findings noted will be documented on the form, entered electronically into an electronic work order for review by the Safety Coordinator. The room will remain closed until inspected by staff to assure safety findings have been resolved prior to further occupancy of the room... ****** Facility Policy: Observation with Documentation - Behavioral Medicine Effective Date: 9/1/2009 Policy: The Behavioral Health Services will provide a safe environment for patients admitted to the unit with suicidal /homicidal ideation (or who become suicidal after admission) impaired reality testing, potential withdrawal and patients in seclusion and/or restraints by appropriate observation and documentation on observation sheet. Purpose: To ensure patient and staff safety. Procedure: 1. Patient is placed on appropriate observation (as outlined below) with documentation in electronic record either by direct physician order or nursing order... 3. Notify physician of any significant change in patient's condition. Observation: 4. Close observation: A patient on close observation must be where staff can visualize see him/her at all times. Patient must have approximately one minute in bathroom with the door closed. 5. Q15 (Every 15) Minute Observation: All patient are on Q15 minute observation for the duration of their stay. 6. 1:1 Observation: A patient on 1:1 observation is to be no more than arm's length

away from staff member at all times. Staff member may not leave the patient at any time unless relieved by another staff member. Documentation will reflect Q15 minute observation. ****** Facility Policy: Rounds-Behavioral Medicine Effective Date: 9/1 /2009 Policy: Rounds on patients admitted to BHS (Behavioral Health Services) will be made by personnel to ensure appropriate patient records and care. Purpose: To evaluate the status of all patients, determine the overall status of the unit, and identify administrative needs. Procedure: ... B. Objectives of Rounds for Clinical Coordinator or Charge Nurse 1. To observe the condition of patients... 4. To observe nursing staff performance... 7. To observe safety measures C. Objectives for Rounds for Q15 minute observations 1. To evaluate the safety of the patient... ****** Facility Policy: Intensity of Care 1:1 Observation Criteria-Behavioral Medicine Effective Date: 1/1 /1989 Policy: At times patients on the BHS unit may verbalize or exhibit behaviors that require a more intense level of observation. The safety of all patients and staff is a major concern on the BHS unit. Purpose: Identify guidelines for 1:1 observation to ensure patient/staff safety. Procedure: 1. 1:1 observation will be initiated for one of the following: a. Patient is in immediate danger of harming self. b. Patient is in immediate danger of harming others. c. Active psychosis requiring constant redirection. 2. The charge nurse may initiate 1:1 observation but physician should be notified within one hour to obtain order. 3. One staff member will be assigned to be with the patient at all times... 5. Explain reason for 1:1 observation to patient in a calm and reassuring manner. Provide safety and support to the patient. 6. Document in patient's medical record the reason for the increase in observation and the interventions initiated. ****** Facility Policy: Rounding Policy Effective Date: 10/09 Policy: All nursing staff is required to complete hourly rounding on all patients and assess for pain, position, potty and possessions. Purpose: To improve patient satisfaction, patient trust, patient care, patient safety, and reduce the amount of call light interruptions. Procedure: ... All nursing staff is required to evaluate for pain, potty, position, and possessions on an hourly basis to ensure patient's needs are met. Nursing staff should initial hourly roundings checklist sheet in room to confirm rounding has been completed... ****** Facility Policy/Procedure: Treatment Planning-Behavioral Medicine Effective Date: 9/1/2009 Policy: Each patient admitted to the Behavioral Health Services (BHS) will have an Initial Treatment Plan initiated on admission. Each discipline will add their specific interventions. An Interdisciplinary Treatment Plan will be developed with the patient, physician, nurse and therapist. After the Interdisciplinary Treatment Plan is complete, a review will be held weekly to re-evaluate the patient's progress and update the Interdisciplinary Treatment Plan. Purpose: To identify the purpose of the multidisciplinary treatment planning team sessions and guidelines. Procedure: 1. The multidisciplinary treatment planning sessions meet three times a week. 6. Notes or updates of results of the discussion are documented on the interdisciplinary treatment review. ***** Facility Scope of Care Behavioral Health Services Revision Date: 1/17 The inpatient center is divided into specialty programs. Three North treats the most acute patients typically with diagnosis's of psychosis, schizophrenia, bipolar disorders, agitation, and other patients requiring a high level of supervision and redirection. The program consists of group process, education and activity therapy. Standard of Care (practice guidelines and professional performances). Patient care will be administered according to the nursing process outlined in the Patient Care Services Policy and Procedure Manual and Standards of Psychiatric Nursing as established by the American Nurses Association. The Master Treatment Plan is the center of the patient's treatment and shall be based on collected data, nursing assessments, social history, the physician's history and physical, psychological testing, etc. The Master Treatment Plan will be implemented using this information to identify patient problems, goals, objectives, treatment modalities utilized, and

estimated time frames. Treatment planning will be performed on all patients and updates to the Master Treatment Plan will be documented. 1. Patient Identifier (PI) # 1 was admitted to the facility on 5/14/17 with Auditory Hallucinations, Psychosis and Suicidal Ideations. PI # 1 presented to the Emergency Department (ED) on 5/14/17 at 3:21 AM with complaints of, "... can't remember anything... back hurts so bad and I don't know if it is my body or just life in general..." The patient stated he /she had suicidal ideation, security was notified and suicide precautions were in place. On 5/14/17 at 5:57 AM, while the patient was in the ED, the ED Technician was present in the room while security was called away when the patient grabbed (his/her) purse and began to put on makeup. The patient was digging through the purse and became upset when the Technician saw something silver that was concealed by the bag. The staff member called for help and the patient proceeded to try to put a pocket knife to his/her left wrist and cause harm to self. With security's help, all of the patient's belongings including the knife were removed and the patient was placed in a hospital gown. The patient was subsequently admitted to the facility in the Behavioral Medicine Unit (BMU). Review of the Psychiatric Evaluation History and Physical dated 5/14/17 revealed the patient's chief complaint was, "I hear him." The psychiatrist documented, "... Per ER (Emergency Room), patient complaining of hearing 2 or 3 different people inside of (him/her), the voices... are (his/her) own and is just different people that live in (him/her)... the voices tell (him/her) to kill (self). Patient has suicidal ideation. Patient reports multiple suicide attempts in the past and stated... had tried to overdose and has tried to hang (self) on 2 occasions. Patient denied any visual hallucinations... denied homicidal ideation... As of today... patient very irritable, we need to encourage (him/her) several times to finish the evaluation. Patient reported hearing all kinds of things, like... own voice telling (him/her) different things including telling (him/her) to kill (self)... Patient reported paranoia, said, "they are talking about me."... reported depression... no energy, poor appetite, and said, "he tells me don't eat."... said the person inside of (him/her) is with (him/her)... reported suicidal thought, said, "you don't need a plan, you just do it..." Further review of the Psychiatric History and Physical dated 5/14/17 revealed, "... Mental Status Examination: ... poorly groomed, not well cooperative, with poor eye contact... psychomotor agitation... Mood: Depressed. Affect: Very irritable, constricted, labile. Thought process and association: Illogical and loose. Thought content: ... reports auditory hallucinations, paranoia,,, suicidal thought. Insight: Poor. Judgement: Poor... Concentration and attention span: Poor... Differential Diagnoses: ... Substance-induced psychotic disorder... Methamphetamine abuse... Rule out gender identity disorder... Rule out schizophrenia... Rule out mood disorder... Treatment Plan: 1. Safety: Admit the patient to psych inpatient unit, start q15 minute observation, and monitor patient's vital signs closely..." Review of the medical record revealed physician orders dated 5/14/17 for Q 15 minute checks. Review of the Interdisciplinary Master Treatment Plan dated 5/14/17 and signed by the Interdisciplinary team on 5/17/17, revealed no documentation suicidal ideation was identified as a problem and there was no documentation of interventions related to suicidal ideation. The surveyor reviewed the patient's medical record on 8/21 /17 and there was no documentation Q 15 minute checks were completed. On 8/22/17 at 8:30 AM, the surveyor requested a copy of the patient's entire medical record and pointed out there was no documentation of Q 15 minute safety checks. On 8/22/17 at 10:00 AM, the patient's medical record was given to the surveyor and copies of documents entitled "Q 15 Minute Safety Rounding Sheet" for the entire time the patient was admitted to this facility. Review of the Psychosocial Assessment dated 5/18/17 revealed the Licensed Professional Counselor (LPC) documented, "... (patient) stated was feeling hopeless and suicidal on admission. Pt (patient) continues to report... is suicidal... having auditory hallucinations, reporting "they" won't

let (him/her) eat... Pt was seen by staff attempting to eat and having a verbal altercation with another personality (he/she) calls "William" in which "William" told (patient) not to eat and then pt hit self when attempting to take a bite... Pt did state if (he/she) left the hospital... would kill self..." Review of the Physician Progress Note dated 5/21/17 revealed the physician documented, "...Tells me (he/she) is not a danger to (self) or others. In group revealed when (he/she) came here (he/she) is going to kill (self)..." The patient denied suicidal ideation/homicidal ideation (SI/HI). The physician circled "SI with plan" and further documented, : told group (he/she) planned to kill (self) after d/c (discharge)..." Review of the Physician Progress Note dated 5/22/17 revealed the Psychiatrist documented, " ... Mental Status Examination ... mood depressed ... continued to have suicidal ideation ... had thoughts of trying to hang (self) ... asked (him/her) about voices ... denied that (he/she) heard voices and stated "they are my own stupid thoughts." (Patient) did make some self-deprecatory remarks ... reportedly made a comment in group therapy that (he/she) was going to kill (self) after ... got discharged ..." Review of the Physician Progress Note dated 5/23/17 revealed the Psychiatrist documented, " ... Subjective ... patient remains depressed ... continues to have suicidal thoughts which include sticking something in a light socket or throwing (his/her) blanket over the door and trying to hang (self) ... Mental Status Examination ... appeared depressed, though there was little mood reactivity. Speech was limited to answering questions ... There was no suicidal or homicidal ideation present ... was a little worried as to what was going to happen to (him/her) because ... was "homeless" ... On the one hand ... felt ...needed to be in a group home. "I do not trust myself. I make bad decisions..." Review of the Physician Progress Note dated 5/24/17 revealed the Psychiatrist documented, " ... the patient appears a little more depressed today than yesterday ... does show a little bit of mood reactivity ... is appearing more depressed ... affect was euthymic and mood depressed ... There was no suicidal or homicidal ideation present. When I asked ... about suicidal thought, (he/she) stated "I have put them on hold ... When I asked (him/her) what (he/she) meant by that ... (patient) indicated that previously (he/she) would kill (self) if HIV (human immunodeficiency virus) positive ... now ... willing to see what it is like living with HIV and taking medication, and not automatically stating (he/she) would kill (self) ..." Review of the Physician Progress Note dated 5/25/17 revealed the Psychiatrist documented, " ... Subjective ... affect is less flat, mood still depressed, but less so ... not psychotic ... does report having suicidal thoughts ... not sure whether (he/she) want to live or not ... denies, however, this has anything to do with being HIV positive and states ... has been feeling this was for some time ... at one point, (patient) indicated ... wanted to be discharged either today or tomorrow. I pointed out ... that first off, (he/she) was having suicidal thoughts, so I was not going to discharge (him/her). Secondly ... (patient) was court ordered and has to go back to court next week and the judge would have to release (him/her) ... (Patient) then looked at me and smirked and said "he did not tell me that" ... we did discuss it briefly yesterday ... (patient) was not interested in hearing about it and elected not to go to (his/her) court hearing ..." Review of the Physician Progress Note dated 5/26/17 revealed the Psychiatrist documented, " ... Subjective ... reports having had fleeting suicidal thoughts, but not having thoughts, but (he/she) did not want to live ... is not psychotic ..." Review of the Physician Progress Note dated 5/27/17 revealed the Psychiatrist documented, " ... came to meet with the patient, it was after lunch ... lying on ... bed and was teary ... did state ... had been hearing voices telling (him/her) to bust (his/her) way out of the hospital ... affect is euthymic, mood depressed and teary ... had been having suicidal thoughts. Though no specific plan or intent ... is feeling a little tired of being in the hospital ..." Review of the Physician Progress Note dated 5/28/17 revealed the Psychiatrist documented, " ... does feel a little anxious at times ... had a little more difficulty sleeping ... has not been hearing voices ... has not had any

suicidal ideation or behavior ... is agreeable to going to the group home when there is an opening ... is willing to "jump through the hoops" to get there ..." Review of the Physician Progress Note dated 5/29/17 revealed the Psychiatrist documented, " ... There was no suicidal or homicidal ideation present ... did report having a lot of difficulty sleeping last night and this is 2 nights in a row ... has had problems sleeping ..." There was no documentation in the medical record the patient's above documented behaviors were communicated to the nursing staff, addressed by the Interdisciplinary team, nor was there documentation additional safety interventions were implemented. A review of the Q 15 Minute Safety Rounding Sheet dated 5/30 /17 revealed multiple patients were listed, including PI # 1. On 8/22/17 at 10:00 AM, when questioned about the Q 15 Minute Rounding Sheet, Employee Identifier (EI) # 3, Nurse Manager stated the documents are not part of the patient's permanent medical record and are kept on the unit in a notebook. A review of the security video footage for 5/30/17 was conducted on 8/22/17 at 10:15 AM. A review of this video footage revealed at 9:29 AM, the patient was seen talking with a male and female at the end of the hallway, (identified as the Psychiatrist and Case Manager). The patient turned away from the Psychiatrist and Case Manager and walked toward his/her room. At 9:30 and 11 seconds (AM), the patient was visibly upset, placed his/her hands on the top of his/her head, walked into his/her room at 9:30 and 15 seconds (AM) and shut the door. None of the nursing staff entered the room or checked on the patient after he/she entered the room and closed the door. At 11:18 and 44 seconds (AM), a male staff member (identified as the MHT) was seen running down the hall from the nurse's station to the patient's room. The patient's door remained closed until 11:18 AM and 49 seconds (AM), when the MHT opened the door and found the patient hanging from the bathroom door by a bed sheet. A review of the Q 15 Minute Safety Rounding Sheet dated 5/30/17 revealed the Mental Health Technicians (MHTs) documented the patient was in his/her room from 9:30 AM to 2: 15 PM. There was no documentation the Registered Nurse (RN) completed hourly rounding on the patient. Cardiopulmonary Resuscitation was performed and the patient was pronounced dead on 5/30/17 at 11:39 AM. Review of the Therapist Documentation note dated 5/30/17 at 9:30 AM revealed, "Dr (doctor) and this writer met with pt (patient) in the hall... (patient) asked about court and this writer advised that (he/she) was not on the docket for today and pt responded with, "I am not going to stay here two more days"... This writer advised that I would contact the court and see if I could get (him/her) on the docket for this afternoon and would let (him/her) know if it changes..." This note was documented on 5/30/17 at 2:42 PM, after the patient expired. Review of the Physician Progress Note dated 5/30/17 revealed the Psychiatrist documented, " ... When I walked on the unit this morning, around 9:30 AM, the patient approached me to ask about court. I pointed out that (he/she) was not on the docket for today. The case manager indicated we could try to get (him/her) on the docket for today ... (Patient) indicated they would talk with (him/her) a little later ... (Patient) walked away and mumbled something about (he/she) was not going to spend 2 more days in the hospital. At 11:23 in the morning ... received a call from a case manager indicating that the patient had been found in (his/her) room in apparent hanging attempt, unresponsive. Resuscitation efforts were not successful and the patient was subsequently pronounced dead ..." This Physician Progress Note was dictated on 5/30/17 at 5:42 PM, after the patient expired. Review of the Root Cause Analysis (RCA) dated 5/30/17 related to PI # 1's successful suicide attempt revealed, "... Items Analyzed... What human factors were relevant to the outcome? Policy and procedure was not followed. Q15 minute rounds were not completed by staff... Action Required: Two employees terminated on 5/31/17. Education given again for standards for q 15 minute rounds. Met with each shift change and emphasized importance of rounding by nurses and MHT on 5/30/17 and 5/31/17.

Email to all staff for expectations for rounding... Controllable environmental factors... Only identified environmental factor is the doors in patient rooms can be closed and as in this case, sheet with knot in it thrown over door and patient able to hang self... Action Required... Re-evaluate if there are other ways for doors to be in patient room so that nothing can be thrown across the top and caught when door closed, i.e. slant top of door especially in private rooms. This is being evaluated currently, no answer to what changes will be made to doors, if any... Questions regarding future planning... If able to put the q 15 minute checks into electronic format would be better so the exact time the patient is seen would be captured... Need to explore being able to document q 15 minute observations in electronic format..." A tour of the BHU - 3 North was conducted on 8/22/17 at 12:30 PM with Employee Identifier (EI) # 1, Director Quality Management and EI # 2, Interim Director Behavioral Health. During this tour, the surveyor observed located in the unit were 5 private rooms, including room 330 (PI # 1's room at the time of death). Upon entering room 330, the surveyor observed the door to the patient's bathroom had been removed. On 8 /22/17 at 12:30 PM, the surveyor asked EI # 1 when the door had been removed and the reply was, "today." (8/22/17). EI # 1 stated all of the bathroom doors in the 5 private rooms had been removed on 8/22/17. 22965 2. PI # 2 was admitted to the facility on 6/8/17 with the diagnoses of Suicidal Ideations, Paranoid Schizophrenia, Hallucination and Panic Attack. Review of the Psychosocial Assessment performed on 6/8/17 revealed the patient was found "hanging in a tree and was cut down by the law enforcement and was taken to the hospital". Patient stated "lots of stressors in life that is why he decided to hang self." The patient was subsequently admitted to the hospital's BMU. During the staff's rounds on 6/9/17 at 10:28 PM, the staff who was making rounds checked on the patient who was "staying in the bathroom." The staff found strips of a torn gown made into a noose in the garbage can. Patient stated he/she was feeling suicidal and hearing voices. The psychiatrist was notified. At 2:30 AM on 6/10/17, the patient was placed in a cardiac chair (geri-chair) at the nursing station in full view of the staff at all times "related to his suicide attempt." There was no written order from the psychiatrist to place the patient in a cardiac chair (geri-chair) at the nursing station. At 7:26 AM on 6/10/17, the MHT noted the patient was noted as "covering his/her head with a blanket" while in the cardiac chair (geri-chair)in full view of the nursing station. The MHT redirected the patient a few times and asked what he/she was doing, the patient did not respond to the redirection, so the MHT pulled the blanket off of the patient and noted the patient was attempting to "chew on the water pitcher cover." The MHT then removed the water pitcher from the patient. Further review of the note revealed documentation the MHT relayed the "information was..." This documentation was incomplete and did not identify the staff member that the patient's behaviors were reported to or their reponse. Group Note on 6/10/17 at 9:07 AM revealed documentation the patient stated that he/she "moved to Andalusia to be near (his/her) brother and family". There was no documentation the brother and/or the family was notified of the suicidal ideations patient was having. Group Note on 6/10/17 at 9:07 AM, the Psychiatrist ordered to place the patient in a room by him/her self in the "Geri chair (cardiac chair) near the nurses desk." The documentation further described the patient as "does not maintain consistent eye contact but will answer questions and thanked the writer when (his/her) medicine was given. Patient remains very flat." During the group session on 6 /10/17 at 11:00 AM, patient was observed resting in the Geri chair (cardiac chair) and dozing at intervals. At 9:40 PM on 6/10/17, patient swallowed "markers" while in the dayroom. It was documented that when the staff turned, the patient "snatched marker and swallowed it." Nurse observed the patient "threw up marker." Further documentation stated the patient was unsure on how many markers he/she swallowed. Psychiatrist was notified and X-rays were taken. Patient was also place on 1:1

precautions in full view of the nursing station. On 6/11/17 at 1:16 AM Group Note: patient asleep in cardiac chair (geri-chair) at the nursing station with 1:1 sitter in attendance. Review of Group Note on 6/12/17 at 2:00 PM, staff spoke with patient who was in a cardiac chair (geri-chair) with 1:1 precautions in the hall. Patient stated that he/she has just had "enough and tried to hang (him/herself) but the officer cut (him /her) down." The staff further documented the patient "seems hopeless about (his/her) future." Patient reports hallucinations. Patient is also homeless. Review of the Group Note on 6/12/17 at 7:36 PM revealed the patient verbalized being "OK" and denied any current thoughts of suicidal ideations. Review of the Daily Focus Assessment Report revealed no clear indication when the patient was released from the geri-chair (cardiac chair) to a regular bed with 1:1 precautions until 6/13/17 at 12:37 AM In an interview conducted on 8/24/17 at 2:45 PM with EI # 2, Interim Director Behavioral Health, EI # 2 confirmed the above mentioned findings. 30952 During a tour of the 2 North (N) BMU (Behavioral Medical Unit) on 8/22/17 at 12:35 PM, the surveyors observed two loose hand rails with anchors visible located between the geriatric dayroom and the nurses station. During a tour of the 3 N BMU on 8/22/17 at 12:35 PM, the surveyors observed a rusted air grill (vent)in room 349, a cracked bathroom mirror in room 348, sheet rock damage with a screw visible in room 350 and peeling paint around the shower in room 342. Following the unit tours on 8/24/17 at 2:05 PM, EI # 3, Nurse Manager reported to the surveyors the safety/risk assessment rounds were completed by the Mental Health Technician's every shift. Review of the facility 3 N BMU Safety Checklist documentation provided to the surveyors failed to include May 2017 daily safety checks. There was no documentation 3 N BMU daily safety rounds were performed May 1 to May 31, 2017. Review of the 3 N BMU Safety Checklist documentation provided, revealed no daily safety checks were performed from July 6 to July 12, on July 14, and no daily safety check documentation was provided from July 17 to July 31. There was no documentation that daily safety checks were performed on 3 N BMU from August 1 to August 18, 2017. Further review of the 3 North BMU Safety Checklist documentation completed on the 3-11 shift on 6/21/17 revealed the following: "room 349 panel chip." The staff documented the discrepancy was reported to proper personnel and a work order was sent for damage. Review of the 3 North BMU Safety Checklist documentation on the 11-7 shift on 6/30, (the year was left blank) revealed "room 330 base of the bathroom sink need (s) to be pulled up closer theirs a inch gap between base and sink." There was no documentation the staff completed work order documentation for damage repair. There was no documentation the damage was repaired. On 8/23/17 at 5:26 PM, the surveyors met with administrative staff of the facility to outline the identified concerns noted above. The survey team requested a corrective action plan to address the identified concerns. On 8/24/17 at 1:45 PM, the staff provided the surveyors with the facility Corrective Action Plan documentation which included "My Maintenance Requests" printed on 8/24/17 at 11:08 AM for BMU 2 and 3 North for June and July 2017. There was no documentation repairs were completed on room 349-panel chip and room 330-bathroom sink repair. Review of the facility Corrective Action Plan documentation submitted on 8/24/17 at 7:00 PM included documentation repairs to the above observed areas were completed as of 8/24/17 at 1:45 PM with the exception of room 342's peeling paint. Review of the Corrective Action Plan documentation submitted to the surveyors on 8/24/17 at 7:00 PM revealed the following corrective actions: "... Finding 1: Observations every 15 minutes not done: Organization Corrective Action Plan: ... The documentation tool was reviewed and updated August 23, 2017. The tool now is patient specific and has the actual time the patient was observed by the MHT. The patient's behavior and location was added to the tool. The MHTs were educated on the new tool starting August 23, 2017. The current education to the MHTs is 1:1 and will be completed by August 28, 2017.

MHTs are being educated as they return to work regarding the new observation tool. The tool is patient specific and is for the MHTs to document the patient's location & behavior every 15 minutes. The tool covers a 24 hour time period. At the end of the 24 hours time period the tool is reviewed by the Clinical Nurse Manager or Charge Nurse and placed in the patient's medical record... Date for implementation of Corrective Action Plan: Immediate: August 23, 2017. Organization method for follow-up: On August 24, 2017 the Clinical Nurse Manager or Charge Nurse on 2 North and 3 North will monitor each MHTs documentation by direct observation 2 times each shift for a total of 6 observations per day. The Clinical Nurse Manager or Charge Nurse will document on the same tool that the MHT uses to document every 15 minute observations, which will validate the patient's observations. Non-compliance will be communicated to Director of the Unit. Non-compliance result in immediate education and/or progressive discipline. Results will be communicated weekly at Improving Patient Outcomes (IPO) and monthly to Continuous Survey Readiness (CSR). Target 90%. Will monitor for 3 consecutive months and re-evaluate monitoring status at CSR... Finding 2: Observations every hour not done... Organization Corrective Action Plan: ... A Every One Hour Safety Precaution form was developed August 23, 2017. The form is patient specific and has the actual time the patient was observed, the patient's location & patient's behavior by the licensed staff. The licensed staff was educated on the new form starting August 23, 2017. The current education to the licensed staff is 1:1 and will be completed by August 28, 2017. Licensed staff is being educated as they return to work regarding the new observation form. The form covers a 24 hour time period. At the end of the 24 hour time period the form is reviewed by the Clinical Nurse Manager or Charge Nurse and placed in the patient's medical record...Date for implementation of Corrective Action Plan: Immediate: August 23, 2017. Policy updated August 24, 2017. Organization method for follow-up: On August 24, 2017 the Clinical Nurse Manager and/or Charge Nurse on 2 North & 3 North will monitor each licensed staff's documentation by direct observation 2 times each shift for a total of 6 observations per day. The Clinical Nurse Manager will document on the same tool that the licensed staff used to document every one hour observations, which will validate the time, patient's location & behavior. Non-compliance will be communicated to Director of the Unit. Non-compliance result in immediate education and/or progressive discipline. Results will be communicated weekly at Improving Patient Outcomes and monthly to Continuous Survey Readiness. Target 90%. Will monitor for 3 consecutive months and re-evaluate monitoring status at CSR... Finding 3: Safety rounds not being done consistently on 2 North (N) and 3 N BMU Nonconformity with safety rounds completed on 2 N and 3 N BMU The Organization Corrective Plan documentation outlined the following actions: August 24, 2017, review of the facility policy, Behavioral Medicine Risk Analysis, and the facility safety rounding process by the Director of Behavioral Medicine and Vice President of Patient Care Services. Policy revised. Process changed, Clinical Nurse Manager and /or Charge Nurse complete daily inspections of 2 N and 3 N BMU for any actual or potential safety concerns. Identified concerns result in immediate notification of Plant Services and Life Safety. Work order generated, room closed if determined necessary. When corrected, plant services and nursing will inspect/agree the concern was corrected, and if agreed room re-opened. August 24, 2017, education on the Daily Safety Inspection form and process for all Clinical Nurse Manager and charge nurses. August 24, 2017, Safety Officer/Safety Coordinator conduct and document monthly safety inspections using the Hazard Surveillance report, implement corrective actions. August 24-August 28, 2017, Safety Coordinator conducts education, train "the trainer" for all Clinical Nurse Manager and charge nurses. August 28, 2017, Director of Behavioral Medicine and Safety Coordinator conduct annual BMU Risk Analysis,

	submit report to Improving Patient Outcomes (IPO) The Interim Director of Behavioral Medicine, Vice President of Patient Care Services, Safety Coordinator is responsible for activities, implementation and adherence to the Behavioral Medicine Risk Analysis policy. August 24, 2017, Director of 2 N and 3 N BMU monitor daily (Monday-Friday, upon return from the weekend review of the weekend inspections) each units Daily Safety Inspection form, to verify daily inspections and safety concerns not corrected within 72 hours. Non-compliance result in immediate education and/or progressive discipline. Results communicated at Improving Patient Outcomes (IPO) and monthly to Continuous Survey Readiness (CSR), target 90 % with 3 consecutive month monitoring and re-evaluate monitoring status at CSR. Environmental Concerns: Door Modification: History May 30, 2017, Root Cause Analysis (RCA) initiated, identified the need to "re-evaluate doors within the patient rooms so that nothing can be thrown across the top and caught when door closed" June 8, 2017, assessment complete, follow-up action at 9:30 AM, 6 staff attended. Discussion included cutting off tops of doors, use of door alarms, roton hinges and removal of tops of doors, privacy curtains/magnetic latches across door frames. Review of 2014 Hospital and Outpatient design and construction with Life Safety consultant. August 22, 2017, all private room bathroom doors removed with evaluation of long-term plan discussion. September 1, 2017, completion date for action plan, all 2 N and 3 N BMU bathroom doors have latching mechanisms removed, replaced with a blank latching plate, preventing the doors from being securely closed. Director of Plant Services responsible. In-Visit Physical Environment Concerns: Addressed/Completed August 22, 2017, 2 N BMU: 7 bathrooms doors removed, handrails tightened, bad anchors replaced. 3 N BMU: 7 bathrooms doors removed, room 349 rusted air grill replaced, hand rails tightened, bad anchors replaced. August 23, 2017, 3 N BMU, handrails tightened, bad anchors replaced, room 348 replaced cracked mirror in bathroom, room 350 wall repairs made, replaced stained ceiling tile in soiled utility room. 2 N, In-Visit Physical Environment Concerns: Work order entered, rooms 250, 251 wood exposed/chipped formica, rooms 238, 239, 250 insulation/wallpaper ripped, room 241 cabinet wood exposed /chipped. **** Finding 6: Numerous documented patient hanging attempts during hospitalization. Cause of nonconformity was failure of BMU staff to report documented suicide attempts by hanging (Patient Identifier # 2) during hospitalization. Administration with no knowledge of the safety concern prior to August 23, 2017. The Organization Corrective Plan documentation outlined the following actions: Staff audited facility email communication (during the onsite survey visit), determined previous Director of Behavioral Medicine was aware of the safety concerns on June 10, 2017. Noncompliance with occurrence reporting identified. Quality Management completed an occurrence report, requested root cause analysis (RCA), due September 22, 2017. RCA will be presented to the Adverse Outcomes Committee, interventions implemented. In May and June 2017, the organization had one successful hanging and several attempts. Decision made to remove all latches from semi-private bathroom door on 2 N and 3 N BMU. August 22, 2017 (after surveyors entered the facility), 2 N and 3 N BMU private patient bathroom doors removed. August 25, 2017, staff "updated" on change in patient bathroom doors on 2 N and 3 N BMU. September 1, 2017, bathroom door latch removal completed. Director of Plant Services and Interim Director of Behavioral Medicine responsible for implementation. Organization follow-up: RCA interventions implemented which may result in ongoing monitoring, process to be determined.
A0154	USE OF RESTRAINT OR SECLUSION CFR(s): 482.13(e)

Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

This STANDARD is not met as evidenced by:
Based on review of medical records, facility policy and interview it was determined in 1 of 3 patient medical records reviewed, the patient's right to be free of restraint was violated by placing a patient in a geri-chair (cardiac chair) for greater than 15 hours after being found trying to harm him/herself. This affected Patient Identifier (PI) # 2 and has the potential to affect all patients receiving care in the facility. Findings include: Facility Policy: Restraints and Seclusion Utilization Effective Date: 2/1/1980 Policy Southeast Alabama Medical Center (SEAMC) in accordance with its mission and core values, respect the rights of our patients and thereby strives to provide them with the safest possible environment. ... When restraint/ seclusion is necessary, the rights and dignity of the patient are respected, and when appropriate, family involvement in the treatment is attempted and documented. Purpose 2. To establish guidelines that protect patient rights and dignity with regards to the use of restraints and seclusion in the therapeutic environment. General Guidelines for Restraint and Seclusion 1. Generally, restraint(s) and seclusion is used if less restrictive measures have proven unsuccessful. ... 4. ... The order should be reviewed daily according to the reason for restraints or seclusion, non violent, violent/ aggressive behavior. 7. Implementation of restraints and or seclusion should be accompanied by a modification to the patient's plan of care within 8 hours of restraint application. Thereafter, the plan of care would be updated daily with the care plan evaluation. 9. Restraint/seclusion should be discontinues as soon as possible after the patient meets the criteria for discontinuation. Violent and/or Self- destructive Patient (Behavior that jeopardized the immediate physician safety of the patient, staff or others). 4. Orders for restraint and/or seclusion for patients exhibiting violent and /or self destructive behaviors should be limited to: 1. Four (4) hours for adults age 18 and older. ... 5. When patient is placed on restraint/seclusion: 1. Pockets, socks, etc., should be checked for dangerous items and such items should be removed. 2. The patient should be made aware that he/she is involved in determining his/her length of stay and be made aware that he/she must do to get out of seclusion. The procedure and expectation of care should be explained to the patient and documented in the medical record. 10. The patient exhibiting violent and /or self destructive behavior and in restraints or seclusion should be observed at least every fifteen (15) minutes. Such observation should include efforts to interact verbally with the patient. Observation should be documented on the FREQUENT OBSERVATION FLOWSHEET: BEHAVIORAL MEDICINE. 12. Range of Motion should be performed every two (2) hours or more frequently unless contraindicated by patient's condition or behavior. If range of motion is not performed, reason should be documented in the patient record. Quality Monitoring 1. The use of restraint and seclusion is monitored and evaluated on an ongoing basis and is reported to the patient Safety Committee and Quality Safety Committee. 2. Any occurrences of prolonged restraints are identified and actions taken to reduce or eliminate the use of restraints are evaluated/analyzed by the treatment team. Prolonged restraints for violent and/ or self-destructive patients is defined as 24 hours .... 1. PI # 2 was admitted to the facility on 6/8/17 with the diagnoses of Suicidal Ideations, Paranoid Schizophrenia, Hallucination and Panic Attack. Review of the Psychosocial Assessment performed on 6/8/17 revealed the

	patient was found "hanging in a tree and was cut down by the law enforcement and was taken to the hospital." Patient stated "lots of stressors in life that is why (he/she) decided to hang self." The patient was subsequently admitted to the hospital's Behavioral Medicine Unit (BMU). During staff rounds on 6/9/17 at 10:28 PM, the staff who was making rounds checked on the patient who was "staying in the bathroom." The staff found strips of torn gown made into a noose in the garbage can. Patient stated he/she was feeling suicidal and hearing voices. The psychiatrist was notified. At 2:30 AM on 6/10/17, the patient was placed in a cardiac chair (geri-chair) at the nursing station in full view of the staff at all times "related to his/her suicide attempt." There was no written order from the psychiatrist to place the patient in a cardiac chair (geri-chair) at the nursing station. At 7:26 AM on 6/10/17, the Mental Health Technician (MHT) noted the patient was covering his/her head with a blanket while in the cardiac chair (geri-chair) in full view of the nursing station. The MHT redirected the patient a few times and asked what he/she was doing, the patient did not respond to the redirection, so the MHT pulled the blanket off and the patient was noted attempting to "chew on the water pitcher cover." The MHT then removed the water pitcher from the patient. Review of the daily Focus Assessment Report revealed documentation "this information was..." The staff failed to complete his/her documentation. Group Note on 6/10/17 at 9:07 AM, Psychiatrist ordered "patient not to be in (his/her) room alone and to sleep in Geri-chair near the nurses desk." The Group Note further described the patient as "does not maintain consistent eye contact but will answer questions and thanked the writer when (his/her) medicine was given. Patient remains very flat." During the group session on 6/10/17 at 11:00 AM, patient was observed resting in the Geri-chair and dozing at intervals. On 6/11/17 at 1:16 AM Group Note: patient asleep in cardiac chair (geri-chair) at the nursing station with 1:1 sitter in attendance. On 6/12/17 at 3:46 AM Group Note: It was documented the patient was "laying in cardiac chair (geri-chair) in hallway with 1:1 sitter." Review of Group Note on 6/12/17 at 2:00 PM, staff spoke with patient who was in a cardiac chair (geri-chair) with 1:1 precautions in the hall. Patient stated that he/she has just had "enough and tried to hang himself but the officer cut (him/her) down." The staff further documented the patient "seems hopeless about (his/her) future." Patient reports hallucinations. Patient is also homeless. Further review of the Daily Focus assessment Report dated 6/9/17 to 6/12/17 the time the patient was restrained in the cardiac/geri-chair revealed no documentation that range of motion was performed according to the facility policy. Review of the nurse notes from 6/10/17 to 6/14/17 revealed no documentation range of motion was performed every two (2) hours or more frequently. There was no documentation form labeled Frequent Observation Flowsheet: Behavioral Medicine given to the surveyor regarding patient observation. An interview conducted on 8/24/17 at 2:45 PM with Employee Identifier (EI) # 2, Interim Director Behavioral Health, who confirmed the staff failed to follow the facility's policy for restraints (cardiac/geri-chair), physician orders for restraints, observations of the patient in restraints and documentation related to those observations.
A0263	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 evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on review of the facility policy, medical records, Occurrence Report summary, Risk Management Worksheets, Minutes Houston County Health Care Authority Quality Committee, Facility's Corrective Action Plan and interviews with facility staff, it was determined the facility failed to ensure: 1. Patient occurrences were reported, investigated, analyzed and preventative measures were implemented to prevent further occurrences. 2. The sentinel event involving Patient Identifier (PI) # 1, a patient who successfully committed suicide while a patient in the Behavioral Medicine Unit (BMU) was reviewed in monthly quality meetings of the governing body. 3. Governing Body Quality Committee meetings were conducted for the months of July 2017 and as of the date of this survey (8/24/17) August 2017. This affected 2 of 3 medical records (PI # 1, PI # 2) and 3 of 6 patients with adverse occurrences (PI # 4, PI # 6 and PI # 7). This also has the potential to negatively affect all patients admitted to this facility. Findings include: Refer to A286 and 309 for findings.
A0286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on review of the facility policy, medical records, Risk Management Worksheets, interviews and the Facility's Corrective Action Plan, it was determined the facility failed to ensure patient occurrences were reported, investigated, analyzed and preventative measures were implemented to prevent further occurrences. This affected 1 of 3 medical records (Patient Identifier (PI) # 2) and 3 of 6 patients with adverse occurrences (PI # 4, PI # 6 and PI # 7). This also has the potential to negatively affect all patients admitted to this facility. Findings include: Facility Policy: Quality Plan Effective Date: 1/1/2002 Policy: ... The hospital's governing body will provide oversight 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. Purpose: 1. To establish organizational guidelines for developing, implementing and maintaining an ongoing system for managing quality and patient safety... 5. To demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risks ... ... The Governing Board has defined the scope of organizational performance improvement

as an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided, and promoting patient safety practices throughout the Hospital and its entities... ... Every member of the organization has a role in providing quality, safe care. Leaders play a role in fostering improvement. 1. ... leaders including the governing board, the chief executive officer, and other senior management, the elected officers of the medical staff, department directors, and directors of nursing units... 3. Department managers and their staff ... under the direction of their administrative contact are responsible for quality activities ... 5. The department manager or his/her designee should review and report the status and results of quality activities to the Quality Management Department ... ... Clinical Practice Guidelines, based on evidenced based medicine, are considered when designing or improving processes. The hospital leaders identify criteria for the selection and implementation of clinical practice guidelines ... Collections and analysis of certain data is required. These are: ... 7. Adverse events/ near misses a. Quality Management monitors level of harm and near misses as it relates to reported medication variances... ... Certain analyses have specific defined timeframes such as Root Cause Analysis, 30 days from event... ... The hospital has the following committees that provide oversight of the quality requirements by reviewing and acting on reports and recommendations from: 1. Quality Safety Council is to incorporate the organization's Mission... Responsibilities is to assist with determining targets and ensure corrective and preventive actions are taken by the organization are implemented, measured and monitored... 2. Adverse Outcomes is to provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety. This is accomplished through mechanisms that support effective response to potential or actual Patient Safety concerns or near misses or hazardous conditions, ongoing proactive reduction in medical/health care errors, and integration of patient safety priorities into new design and redesign of relevant organization processes, functions, and services. 3. Patient Safety Committee is to improve patient safety and reduce risks to patients through an environment that encourages: recognition and acknowledgement of risks to patient safety... and initiation of actions to reduce these risks. The internal reporting of possible risks and any action taken. A focus on processes and systems ... 4. Physical Environment Committee is to adopt, implement and monitor a comprehensive hospital wide safety program, designed to produce safe characteristics and practices for the elimination and /or reduction, to the greatest extent possible, hazards to patients, visitors and staff... A root cause analysis (RCA) shall be conducted on all incidents that impact or threaten patient safety and close calls involving a recipient of care... A patient safety concern is an unexpected occurrence involving death, permanent harm or severe temporary harm of a patient or the risk thereof... The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. To identify, analyze for root cause, and improve to the extent possible, the following events will always have a root cause analysis: 1. Suicide of a patient in a setting where the patient receives around the clock care, treatment or services or within 72 hours of discharge... 12. Any elopement (that is, unauthorized departure) of a patient from a staffed around-the clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient... Upon notification of a patient safety concern or near miss, an administrative leader or his/her designee will initiate an immediate investigation involving appropriate department head and appropriate personnel. The basics of the RCA are: 1. Assign a team, including personnel closest to the occurrence along with supervisory staff to investigate the event immediately. 2. Set the goal of thirty (30) days for completion of the RCA. 3. Clearly define the event or near miss and brainstorm all possible causes. Focus on processes, not people... 5. Redesign the process that will eliminate the risk of the root

cause occurrence. 6. Complete the RCA form and submit to Quality Management within 30 days of the event. Include the number, skill mix and competency of all staff on duty in the area of the occurrence. 7. Quality Management staff will assign a date and time for the team to meet and discuss the RCA with Adverse Outcomes Committee. 8. Follow up to the RCA will be required by the Adverse Outcomes Committee. Follow up should address the interventions put into place to avoid another occurrence. The Quality Management staff will assign dates for follow up ... The organization recognizes the impact of effective communication in the promotion of safety and quality. Effective communication is measured by timeliness, accuracy and use by the audience. Leadership roles in providing effective communication are: ... 2. Assessment of internal and external needs ... 4. Assess environmental changes as they relate to communication needs of the patients, community, physicians, staff and management... ... The organization will adhere to all requirements for mandatory reporting of adverse events and will meet requirements for voluntary program for patient safety concern reporting ... The Governing Board, Senior Leadership and the organized Medical Staff will collaborate and manage conflicts that may hinder the delivery of quality safe patient care ... ... The Adverse Outcomes Committee reviews the organization's initial management of Patient Safety concerns... Occurrence reporting is a key part of the management information system, provides support and assistance in the overall institutional objective of improved patient care ... Any hospital employee who becomes aware of an incident must report that incident by completing an Occurrence Report. The Occurrence Report consists of two components, an Incident Report and a Quality Assurance narrative, which provided in-depth detail. The Occurrence Report is to be completed online... To complete an on-line Occurrence Report you must access Inside SAMC and do the following: ... 7. Complete the Incident Report by filling in all required fields ... 8. The next section is the Quality Assurance Narrative; this section provides in-depth details about the incident ... 10. Quality Management will receive immediate notification that an incident report has been submitted. 11. After being reviewed by Quality Management the occurrence Report will be forwarded to the appropriate Department Head for follow up/investigation by placing it on the Department Head's Midas work list. The Department Head will receive notification by e-mail that an incident report had been placed on their work list. The Department Health should complete the follow up/investigation within 72 hours ... 14. Department Investigations - The extent of investigation will depend on the seriousness of the event. The department head or designee shall investigate all incidents. Based on severity or trend direction, formal investigation will be performed by the department head or designee and/or Risk Management. 15. Analysis - The Quality Management Department is responsible for producing a monthly analysis of incidents by type, location and time to appropriate committees and administration for review. 22965 1. See A144 related to the self-destructive behaviors and occurrences for PI # 2. The surveyor requested information related to those occurrences and none was provided. At 3:00 PM on 8/24/17 an Occurrence report was requested by the surveyor, EI # 4, Quality Outcomes Team Leader and was informed there was no report submitted to Quality Outcomes. 32470 On 8/23/17 the Occurrence Report summary was requested, received and reviewed by the surveyor. The surveyor chose 6 occurrences between the months of March 2017 and August 2017 and requested the documentation which was submitted for each occurrence. 2. Review of the Risk Management Worksheet presented to the surveyor on PI (Patient Identifier) # 4 revealed the nurse documented on the worksheet (occurrence) report he/she was making hourly rounds and knocked on the patient's door and entered room. Upon entering the room the patient jumped down off the toilet in the bathroom where he/she had partially removed the vent over the toilet. Further review of the documentation revealed maintenance was notified and

remounted the grill with zipit mounts. Review of the Risk Management Worksheet documentation provided revealed no documentation as to what actions were taken and what preventive measures were taken to prevent the occurrence from happening again. Further review of the worksheet revealed on 7/24/2017: Ref. (refer) to Emp. (employee) EI # 10, Director of Behavioral Medicine (no longer employed), Ref. to Dept (department): Behavioral Medicine Unit, Reason: need follow up and preventive measure, Comment: area is blank, Action: area is blank, Disposition: area is blank and Date Closed: no date was documented. Review of the documentation revealed no documentation the incident was taken to the Root Cause Analysis (RCA) Committee for review. The surveyor asked several times for any other information including the RCA information for the incident and was provided no other documentation. An interview was conducted on 8/23/17 at 3:10 PM with Employee Identifier (EI) # 1, Director of Quality Management, and EI # 4, Quality Outcomes Teamleader, who confirmed the incident was not presented to the RCA committee for evaluation. 3. Review of the documentation dated 7/18/17 presented to the surveyor on PI # 6 revealed the patient was taken down to 1 North for court and was sitting in the waiting area. Patient stood up and ran out the glass doors leading to the outside and eloped. The police department was notified and the patient was found by the local police. According to interviews conducted on 8/23/17 with the staff several staff reported the patient was brought back to the hospital approximately 30 minutes to 1 hour later. Review of the RCA documentation dated 7/18/17 revealed security did not assist with escorting patients from the unit to court unless called by the staff. Security was not called to assist with escorting this patient. Further review of the RCA report revealed as of 7/19/17 security was notified by the Director of the Behavioral Medicine Unit (BMU) who informed the Director, security they should arrive prior to (the) patient being taken to the court room. A meeting was held on 8/14/17 with the head of security and the Director of the BMU to discuss and review the process. Review of the RCA dated 8/14/17 revealed the occurrence was discussed and it was decided to attempt to move the court room to 3 north or to lock the doors leading to the outside during court. Further review of the RCA revealed on 8/16/17, EI # 2, Interim Director Behavioral Health, met with the judge after the court session and court was relocated to 1 North beginning 8/22/17 and the door to the outside would be locked during court sessions. Review of the 8/21/17 RCA documentation revealed the Director of security notified the day shift security staff of the new process. Further review of the RCA documentation revealed during court hearings, the glass doors leading to the hospital's exterior will be locked by security officer. Entrance from the outside is attained, however inadvertent exiting prevented and the security director informed all day shift security personnel of the new process. An interview with EI # 3, Nurse Manager, was conducted on 8/24/17 at 10:30 AM who reported the court hearing was moved to 3 north on a trial basis for one court session on 8/15/17. On 8/24/17 at 8:30 AM the surveyors observed the area on 1 North where the court hearing was in session. EI # 2 was present along with the fire Marshall, security and EI # 7, Director of Safety. EI # 2 was asked if the glass doors were locked since court was in session. EI # 2 replied "yes they are". The surveyor opened the first glass door leading to the outside of the hospital. EI # 2 stated "yes you can open the first door, but the second door will not open as long as the first door is still open". The surveyor held open the first door and opened the second door and was able to exit to the outside of the hospital. EI # 7 and the fire Marshall were discussing the actual locking of the glass doors on 8/24/17 at 8:30 AM while the surveyors were present. The incident occurred on 7/18/17 when PI # 6 exited the hospital waiting for court and no actions or preventive measures were taken until 8/24/17 when the surveyors were present. An interview was conducted on 8/24/17 at 9:00 AM with EI # 1 and EI # 2, who confirmed no actions had taken place until 8/24/17. 4. Review of the occurrence

report dated 7/26/17 revealed PI # 7 eloped (ran out) from 3 North Behavioral Unit by kicking the door, which released the magnet on the door and the patient ran through the doors and headed to the 3 East area. BMU staff ran out of the unit and caught PI # 7 and escorted PI # 7 back to the unit and placed him/her in seclusion and restraints. Review of the occurrence report revealed the following documentation: Ref to Emp: EI # 10, Former Director of Behavioral Health (no longer employed), Reason: need follow up and preventive measure, Comments: area is blank, Action: area is blank. Further review of the documentation reveled no other documentation as to what the follow up or the preventive measure was or that the incident was referred to the RCA for review. When the surveyor asked for the RCA report, the surveyor was told by EI # 4, the team has 30 days to complete and as of the survey date the report was not complete. Review of the Risk Management Worksheet dated 7/27/17 revealed PI # 7 was given a court order and PI # 7 became upset broke the unit door and eloped. The staff called a Brubaker (an announcement over head to call for assistance with a person out of control). Further review of the occurrence report revealed no other documentation as to whether PI # 7 left the unit once the door was opened or the end result. The only other documentation was the staff documenting on whether the police should deliver the court order instead of the staff in the Risk Management Worksheet. Review of the documentation on the Risk Management Worksheet revealed the following: Ref. to Dept: Security Services, Reason: need follow up and preventive measure, Comment: area is blank, Action: area is blank and Disposition: area is blank. Further review revealed the following documentation: Ref. to Dept: Case Management, Reason: need follow up and preventive measure, Comments: area is blank, Action: area is blank and Disposition: area is blank. The surveyor asked EI # 4 if there was an RCA report for each of these occurrences and EI # 4, Quality Outcomes Team Leader, replied " no, not yet they have 30 days to complete the report". After review of the Risk Management Worksheet documentation it was documented PI # 7 eloped 2 days in a row by kicking the locked door of the unit and running out. Further review of the Risk Management Worksheet revealed no documentation by each department as to what the follow up or preventive measure was, any actions that were taken and no documentation the occurrences were taken to the RCA committee with a Organizational Response or Findings or the Action required. An interview was conducted on 8/24/17 at 11:00 AM with EI # 4 who confirmed the above mentioned findings. On 8/23/17 at 5:26 PM, the surveyors met with administrative staff of the facility to outline the identified concerns noted above. The survey team requested a corrective action plan to address the identified concerns. Review of the Corrective Action Plan documentation submitted to the surveyors on 8 /24/17 at 7:00 PM revealed the following corrective actions: Finding 4: Risk for elopement of patients attending court inside the facility. Cause of nonconformity was egress area not secured on 1st floor where patients are taken for court hearings. The Organization Corrective Plan documentation outlined the following actions: August 24, 2017, City Fire Marshall review of egress area, recommendations for keyed mag (magnetic) lock to the egress door in the BMU 1st floor, locked 24-7. All employees in this unit will have a mag lock key. Remove exit sign. August 25, 2017, transport procedure updated. Court proceedings currently held in the North building, 1st floor. The court room/conference room is accessed by an interior door with dual wing access doors. Prior to the first patient transport, the exterior door will be locked and remain locked throughout the proceedings. Each patient transported from their assigned unit is accompanied by security personnel to the court room, one officer per patient transport. August 25, 2017, educate all security officers and BMU clinical staff on the new transport procedure. All employees in the BMU 1st floor have key to mag lock and educated regarding door lock. August 25, 2017, recommendations of City Fire Marshall implemented. Transport procedure change implemented. BMU 1st floor

egress removed. August 25, 2017, Director of Security and Interim Director of Behavioral Medicine implement fire marshall recommendations. Monitor twice weekly the escort of patients by a Security Office (from the BMU unit to court). Weekly results reported at IPO and monthly CSR. Target 90 %, monitor 3 consecutive months, re-evaluate status at CSR. Finding 6: Numerous documented patient hanging attempts during hospitalization. Cause of nonconformity was failure of BMU staff to report documented suicide attempts by hanging (Patient Identifier # 2) during hospitalization. Administration with no knowledge of the safety concern prior to August 23, 2017. The Organization Corrective Plan documentation outlined the following actions: Staff audited facility email communication (during the onsite survey visit), determined previous Director of Behavioral Medicine was aware of the safety concerns on June 10, 2017. Noncompliance with occurrence reporting identified. Quality Management completed an occurrence report (Patient Identifier # 2), requested root cause analysis (RCA), due September 22, 2017. RCA will be presented to the Adverse Outcomes Committee, interventions implemented. In May and June 2017, the organization had one successful hanging and several attempts... Organization follow-up: RCA interventions implemented which may result in ongoing monitoring, process to be determined.

A0309

QAPI EXECUTIVE RESPONSIBILITIES
CFR(s): 482.21(e)(1), (e)(2), (e)(5)

The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually.

This STANDARD is not met as evidenced by:
Based on review of facility policy, Minutes Houston County Health Care Authority Quality Committee, medical records and interviews, it was determined the hospital's governing body failed to: 1. Review the sentinel event involving Patient Identifier (PI) # 1, a patient who successfully committed suicide while a patient in the Behavioral Medicine Unit (BMU). 2. Conduct monthly meetings for the months of July 2017 and as of the date of this survey (8/24/17) August 2017. 3. Ensure staff completed occurrence reports for PI # 2 with documented self-destructive behaviors. 4. Patient occurrences that were reported were investigated, analyzed and preventative measures were implemented to prevent further occurrences. This affected 2 of 3 medical records (Patient Identifier (PI) # 1, PI # 2) and 3 of 6 patients with adverse occurrences (PI # 4, PI # 6 and PI # 7). This also has the potential to negatively affect all patients admitted to this facility. Findings include: Facility Policy: Quality Plan Effective Date: 1/1/2002 Policy: ... The hospital's governing body will provide oversight 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. Purpose: 1. To establish organizational guidelines for developing, implementing and maintaining an ongoing system for managing quality

and patient safety... 3. To reflect the oversight mechanism of the governing body, regarding direct supervision, support, and participation of the quality activities performed by the hospital and its affiliates and network ... 5. To demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risks ... ... The Governing Board has defined the scope of organizational performance improvement as an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided, and promoting patient safety practices throughout the Hospital and its entities... 1. The Governing Board monitors quality and safety through a monthly dashboard of quality/safety indicators and a quarterly report discussing specific issues related to quality and safety... ...Quality Improvement minutes should contain conclusions that have been reached as result of quality investigations, recommendations that the committee makes to address the conclusions reached, actions taken to follow through on the recommendations made and evaluations of the effectiveness of the actions taken... Every member of the organization has a role in providing quality, safe care. Leaders play a role in fostering improvement. 1. At Southeast Alabama Medical Center ... leaders including the governing board, the chief executive officer, and other senior management, the elected officers of the medical staff, department directors, and directors of nursing units. 2. Leaders may foster performance improvement through planning, educating, setting priorities, providing support such as time and resources, and empowering staff as appropriate. 3. Department managers and their staff ... under the direction of their administrative contact are responsible for quality activities ... 5. The department manager or his/her designee should review and report the status and results of quality activities to the Quality Management Department ... ... Clinical Practice Guidelines, based on evidenced based medicine, are considered when designing or improving processes. The hospital leaders identify criteria for the selection and implementation of clinical practice guidelines ... Collections and analysis of certain data is required. These are: 1. Threats to patient safety (i.e. falls, patient identification, injuries) a. Quality Management monitors all reported falls and falls with injury... 7. Adverse events/ near misses a. Quality Management monitors level of harm and near misses as it relates to reported medication variances... 15. Physical Environment Management Systems... ... Certain analyses have specific defined timeframes such as Root Cause Analysis, 30 days from event. Quality indicators on the organization scorecard are reported to the Governing Board... The Houston County Healthcare Authority Governing Board is ultimately responsible for the provision of the performance improvement process at Southeast Alabama Medical Center ... ... The hospital's executive team's primary responsibility is to plan, review, analyze data, approve and evaluate quality and safety activities that relate to patient care provided throughout the organization. The hospital's executive team responds to performance improvement team requests and recommendations, quality measurement reports and other issues from the clinical practice improvement teams, hospital departments, clinical benchmarking and team tracking ... The hospital has the following committees that provide oversight of the quality requirements by reviewing and acting on reports and recommendations from: 1. Quality Safety Council is to incorporate the organization's Mission... Responsibilities is to assist with determining targets and ensure corrective and preventive actions are taken by the organization are implemented, measured and monitored... 2. Adverse Outcomes is to provide a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety. This is accomplished through mechanisms that support effective response to potential or actual Patient Safety concerns or near misses or hazardous conditions, ongoing proactive reduction in medical/health care errors, and integration of patient safety priorities into new design and redesign of relevant organization processes, functions,

and services. 3. Patient Safety Committee is to improve patient safety and reduce risks to patients through an environment that encourages: recognition and acknowledgement of risks to patient safety... and initiation of actions to reduce these risks. The internal reporting of possible risks and any action taken. A focus on processes and systems ... 4. Physical Environment Committee is to adopt, implement and monitor a comprehensive hospital wide safety program, designed to produce safe characteristics and practices for the elimination and/or reduction, to the greatest extent possible, hazards to patients, visitors and staff... A root cause analysis (RCA) shall be conducted on all incidents that impact or threaten patient safety and close calls involving a recipient of care... A patient safety concern is an unexpected occurrence involving death, permanent harm or severe temporary harm of a patient or the risk thereof... The phrase "risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. To identify, analyze for root cause, and improve to the extent possible, the following events will always have a root cause analysis: 1. Suicide of a patient in a setting where the patient receives around the clock care, treatment or services or within 72 hours of discharge... 12. Any elopement (that is, unauthorized departure) of a patient from a staffed around-the clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient... Upon notification of a patient safety concern or near miss, an administrative leader or his/her designee will initiate an immediate investigation involving appropriate department head and appropriate personnel. The basics of the RCA are: 1. Assign a team, including personnel closest to the occurrence along with supervisory staff to investigate the event immediately. 2. Set the goal of thirty (30) days for completion of the RCA. 3. Clearly define the event or near miss and brainstorm all possible causes. Focus on processes, not people... 5. Redesign the process that will eliminate the risk of the root cause occurrence. 6. Complete the RCA form and submit to Quality Management within 30 days of the event. Include the number, skill mix and competency of all staff on duty in the area of the occurrence. 7. Quality Management staff will assign a date and time for the team to meet and discuss the RCA with Adverse Outcomes Committee. 8. Follow up to the RCA will be required by the Adverse Outcomes Committee. Follow up should address the interventions put into place to avoid another occurrence. The Quality Management staff will assign dates for follow up ... The organization recognizes the impact of effective communication in the promotion of safety and quality. Effective communication is measured by timeliness, accuracy and use by the audience. Leadership roles in providing effective communication are: ... 2. Assessment of internal and external needs ... 4. Assess environmental changes as they relate to communication needs of the patients, community, physicians, staff and management... ... The organization will adhere to all requirements for mandatory reporting of adverse events and will meet requirements for voluntary program for patient safety concern reporting ... The Governing Board, Senior Leadership and the organized Medical Staff will collaborate and manage conflicts that may hinder the delivery of quality safe patient care ... ... The Adverse Outcomes Committee reviews the organization's initial management of Patient Safety concerns... Occurrence reporting is a key part of the management information system, provides support and assistance in the overall institutional objective of improved patient care ... Any hospital employee who becomes aware of an incident must report that incident by completing an Occurrence Report. The Occurrence Report consists of two components, an Incident Report and a Quality Assurance narrative, which provided in-depth detail. The Occurrence Report is to be completed online... To complete an on-line Occurrence Report you must access Inside SAMC and do the following: ... 7. Complete the Incident Report by filling in all required fields ... 8. The next section is the Quality Assurance Narrative; this section provides in-depth details about the incident ... 10. Quality Management

will receive immediate notification that an incident report has been submitted. 11. After being reviewed by Quality Management the occurrence Report will be forwarded to the appropriate Department Head for follow up/investigation by placing it on the Department Head's Midas work list. The Department Head will receive notification by e-mail that an incident report had been placed on their work list. The Department Health should complete the follow up/investigation within 72 hours ... 14. Department Investigations - The extent of investigation will depend on the seriousness of the event. The department head or designee shall investigate all incidents. Based on severity or trend direction, formal investigation will be performed by the department head or designee and/or Risk Management. 15. Analysis - The Quality Management Department is responsible for producing a monthly analysis of incidents by type, location and time to appropriate committees and administration for review. Refer to A144 and A286 for individual information related to PI # 1, PI # 2, PI # 4, PI # 6 and PI # 7. 30952 On 8/24/17 at 1:00 PM the surveyor reviewed a facility document titled, "Minutes Houston County Health Care Authority Quality Committee, June 14, 2017. Included in the June 2017 Quality Committee (QC) Meeting was documentation a DNV (Det Norske Veritas) (accrediting organization) survey visit occurred in May at the end of Southeast Alabama Medical Centers' optimization process ($30 million operating expense reduction). The documented finding was the Safety Council failed to meet to evaluate Quality Improvement of corrective action plans during the optimization process. Further review of the June 2017 QC Meeting documentation was QPRC (Quality Peer Review Committee) /Adverse Outcomes Case Presentation by the Chief Medical Officer concerning 2 patients with suspected cancer and questionable biopsy reports. Pathology was notified, results reviewed and confirmed as reported. The physician remained unconvinced, repeated the biopsies. The repeat biopsy results confirmed the mistake. Additionally, the QC meeting documentation revealed the pathologists attended the June QC meeting, reported on the root cause analysis results and new process implemented. There was no documentation the 5/30/17 patient suicide in the 3 North Behavioral Medical Unit was reviewed during the June 14, 2017 in the Quality Committee meeting. In an interview on 8/24/17 at 1:29 PM, the surveyor requested the July 2107 Quality Committee Meeting documentation from Employee Identifier (EI) # 1, Director of Quality Management. EI # 1 confirmed the QC Committee meetings were monthly. EI # 1 reported the committee did not meet in July and had not met in August as of August 24. The surveyor asked EI # 1 why the QC committee had not met in July? EI # 1 responded, I honestly do not know.

A0385

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 review of facility policies, medical records, security video footage, Root Cause Analysis (RCA), Unit Profile reports, interviews and the Facility's Corrective Action Plan submitted to the surveyors on 8/24/17, it was determined the facility failed to ensure: 1. The Behavioral Medicine Unit (BMU) (2 North and 3 North) was staffed according to their budgeted target hours, which increased the patient work load for licensed, unlicensed and clerical staff caring for those patients. 2. The Registered Nurse (RN) supervised the care provided by the Mental Health Technicians (MHT) to ensure patient observations were conducted every 15 minutes

	according to physician orders. 3. A treatment plan was implemented and updated for a suicidal patient according to the facility policy. This affected 3 of 3 medical records reviewed, including Patient Identifier (PI) # 1, PI # 2, PI # 3 and has the potential to negatively affect all patients admitted the the facility's BMU. Findings include: Refer to A392, A395 and A396 for findings.
A0392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on review of facility policies, Unit Profile reports and interviews, it was determined the facility failed to ensure 2 North and 3 North were staffed according to their budgeted target hours, which increased the patient work load for licensed, unlicensed and clerical staff caring for those patients. This had the potential to negatively affect all patients admitted to the facility. Findings include: Facility Policy: Staffing and Scheduling Guidelines Effective Date: 1/11/2006 Purpose: ... it is essential to provide skilled staff at budgeted levels on all shifts to care for our patients. The following delineates a proactive staffing process utilizing OptiLink software (Scheduling and Workload) to allocate nursing resources based on the constantly changing volume and severity levels of our patients. Procedure: Applicability I. These guidelines are applicable to all Patient Care Services personnel involved in: A. Planning staffing prior to the start of a shift. B. Reallocation of staffing during the shift. C. Monitoring staffing levels to the approved budget. II. This includes the: A. Vice President of Patient Care Services/ Chief Nursing Officer and Associate Chief Nursing Officer. B. Nursing Coordinators, Directors and Charge Nurses who are responsible for planning staffing levels based on patient needs. C. Nursing Resources staff that handles the day-to-day input of staff specific into the OptiLink software. The procedure for ensuing that appropriate staffing by skill level is in place for a shift requires advanced planning. Having appropriate staffing levels requires the balancing of the time off needs of staff with the knowledge of expected census and acuity for each unit. I. Scheduling of Staff Prior to Publishing Schedules: ... Each Director is responsible for completing the schedule(s) for his/her assigned unit(s) and ensuring that it is appropriately "balanced" based on the type of unit and patient population... Staffing Oversight:Actual staffing to budgeted levels by unit will determine how closely and how well each unit is balancing staff to patient needs. It is the responsibility of the individual Director to manage the staffing on his/her unit(s). There are a number of tools/reports available in OptiLink to assist the Director in achieving this goal. ****** Facility Policy: Position Control Plan Effective Date: 1/1 /1980 Policy: The Position Control Plan is based on scientific principles and an organized nursing process that shall be used to establish staffing levels for each nursing unit based on past trends and projections of future changes in patient load. Purpose:To establish staffing allocation for each nursing unit based on an average daily census, acuity of patients, care hours per day, skill mix, and standards of care that provide safe care for our patients. To provide a computation of required full time equivalents (FTE's) by employee type and shift. Procedure: The Position Control Plan is a delineation of the professional and no-professional division, shift

	division, FTE composite, average occupancy, bed capacity, and fiscal year of each designated unit. In order to derive the Position Control Plan for each designated nursing unit, the Master Staffing Pattern for said unit shall be adhered to in its entirety. FTEs may not be added nor may the average occupancy be changed unless approval has been granted by the Vice President/Patient Care Services to change the Master Staffing Pattern... Review of the Unit Profile reports for 2 North revealed the following: 5/30/17: Patient census: 21 Day Shift: Targeted hours for Licensed staff: 24.0 hours Actual staffed hours: 16.05 hours Hours Variance: -7.95 hours Staff: Patient Ratio, Targeted: 1:6.67 (1 Licensed staff member to 6.67 patients) Staff: Patient Ratio, Actual: 1:9.97 (1 Licensed staff member to 9.97 patients) Evening Shift: Targeted hours for Licensed staff: 24.0 hours Actual staffed hours: 16.60 hours Hours Variance: -7.10 hours Staff: Patient Ratio, Targeted: 1:6.67 (1 Licensed staff member to 6.67 patients) Staff: Patient Ratio, Actual: 1:9.64 (1 Licensed staff member to 9.64 patients) 6/8/17: Patient census: 23 Day Shift: Targeted hours for Licensed staff: 24.0 hours Actual staffed hours: 16.05 hours Hours Variance: -7.95 hours Staff: Patient Ratio, Targeted: 1:6.33 (1 Licensed staff member to 6.33 patients) Staff: Patient Ratio, Actual: 1:9.47 (1 Licensed staff member to 9.47 patients) Evening Shift: Targeted hours for Licensed staff: 24.0 hours Actual staffed hours: 16.05 hours Hours Variance: -7.95 hours Staff: Patient Ratio, Targeted: 1:7.67 (1 Licensed staff member to 7.67 patients) Staff: Patient Ratio, Actual: 1:11.46 (1 Licensed staff member to 11.46 patients) 6/9/17: Patient census: 23 Evening Shift: Targeted hours for Licensed staff: 24.0 hours Actual staffed hours: 16.05 hours Hours Variance: -7.95 hours Staff: Patient Ratio, Targeted: 1:7.67 (1 Licensed staff member to 6.67 patients) Staff: Patient Ratio, Actual: 1:11.46 (1 Licensed staff member to 11.46 patients) The actual licensed staff members present to care for patients on 2 North for 5/30/17, 6/8 /17 and 6/9/17 were below the budgeted expectations for the unit for those dates. Review of the Unit Profile reports for 3 North revealed the following: 6/8/17: Patient census: 22 Day Shift Targeted hours for Licensed staff: 24.0 hours Actual staffed hours: 15.95 hours Hours Variance: -8.05 hours Staff: Patient Ratio, Targeted: 1:7 (1 Licensed staff member to 7 patients) Staff: Patient Ratio, Actual: 1:10.53 (1 Licensed staff member to 10.53 patients) Targeted hours for unlicensed staff: 24.0 hours Actual staffed hours: 23.95 hours Hours Variance: -.05 hours Staff: Patient Ratio, Targeted: 1: 7 (1 unlicensed staff member to 7 patients) Staff: Patient Ratio, Actual: 1:7.01 (1 unlicensed staff member to 7.01 patients) Targeted hours for Clerical: 8.0 hours Actual staffed hours: 7.60 hours Hours Variance: -.40 hours Staff: Patient Ratio, Targeted: 1:21 (1 clerical staff member to 21 patients) Staff: Patient Ratio, Actual: 1: 22.11 (1 clerical staff member to 22.11 patients) 6/9/17 Patient census: 23 Day Shift: Targeted hours for Licensed staff: 24.0 hours Actual staffed hours: 21.75 hours Hours Variance: -2.25 hours Staff: Patient Ratio, Targeted: 1:7.33 (1 Licensed staff member to 7.33 patients) Staff: Patient Ratio, Actual: 1:8.09 (1 Licensed staff member to 8.09 patients) The actual licensed, unlicensed and clerical staff members present to care for patients on 3 North for 6/8/17 and the licensed staff members present to care for patients 6/9/17 were below the budgeted expectations for the unit for those dates. An interview was conducted on 8/24/17 at 10:45 AM with Employee Identifier # 2, Interim Director Behavioral Health verified the above.
A0395	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 review of facility policies, medical records, security video footage, Root Cause Analysis (RCA), interviews, Facility's Corrective Action Plan received from the facility on 8/24/17 prior to the surveyor's departure, it was determined the Registered Nurse (RN) failed to supervise the care provided by the Mental Health Technicians (MHT) to ensure patient observations were conducted every 15 minutes according to physician orders. This affected 3 of 3 medical records reviewed, including Patient Identifier (PI) # 1, PI # 2, PI # 3 and has the potential to negatively affect all patients admitted to the facility's Behavioral Medicine Unit (BMU). Findings include: Facility Policy: Observation with Documentation - Behavioral Medicine Effective Date: 9/1/2009 Policy: The Behavioral Health Services will provide a safe environment for patients admitted to the unit with suicidal/homicidal ideation (or who become suicidal after admission) impaired reality testing, potential withdrawal and patients in seclusion and/or restraints by appropriate observation and documentation on observation sheet. Purpose: To ensure patient and staff safety. Procedure: 1. Patient is placed on appropriate observation (as outlined below) with documentation in electronic record either by direct physician order or nursing order... 3. Notify physician of any significant change in patient's condition. Observation: 4. Close observation: A patient on close observation must be where staff can visualize see him/her at all times. Patient must have approximately one minute in bathroom with the door closed. 5. Q15 (Every 15) Minute Observation: All patient are on Q15 minute observation for the duration of their stay. 6. 1:1 Observation: A patient on 1:1 observation is to be no more than arm's length away from staff member at all times. Staff member may not leave the patient at any time unless relieved by another staff member. Documentation will reflect Q15 minute observation. ****** Facility Policy: Rounds-Behavioral Medicine Effective Date: 9/1/2009 Policy: Rounds on patients admitted to BHS (Behavioral Health Services) will be made by personnel to ensure appropriate patient records and care. Purpose: To evaluate the status of all patients, determine the overall status of the unit, and identify administrative needs. Procedure: ... B. Objectives of Rounds for Clinical Coordinator or Charge Nurse 1. To observe the condition of patients... 4. To observe nursing staff performance... 7. To observe safety measures C. Objectives for Rounds for Q15 minute observations 1. To evaluate the safety of the patient... ****** Facility Policy: Intensity of Care 1:1 Observation Criteria-Behavioral Medicine Effective Date: 1/1 /1989 Policy: At times patients on the BHS unit may verbalize or exhibit behaviors that require a more intense level of observation. The safety of all patients and staff is a major concern on the BHS unit. Purpose: Identify guidelines for 1:1 observation to ensure patient/staff safety. Procedure: 1. 1:1 observation will be initiated for one of the following: a. Patient is in immediate danger of harming self. b. Patient is in immediate danger of harming others. c. Active psychosis requiring constant redirection. 2. The charge nurse may initiate 1:1 observation but physician should be notified within one hour to obtain order. 3. One staff member will be assigned to be with the patient at all times... 5. Explain reason for 1:1 observation to patient in a calm and reassuring manner. Provide safety and support to the patient. 6. Document in patient's medical record the reason for the increase in observation and the interventions initiated. ****** Facility Policy: Rounding Policy Effective Date: 10/09 Policy: All nursing staff is required to complete hourly rounding on all patients and assess for pain, position, potty and possessions. Purpose: To improve patient satisfaction, patient trust, patient care, patient safety, and reduce the amount of call light interruptions. Procedure: ... All nursing staff is required to evaluate for pain, potty, position, and possessions on an hourly basis to ensure patient's needs are met. Nursing staff should initial hourly roundings checklist sheet in room to confirm rounding has been completed... 1. Patient Identifier (PI) # 1 was admitted to the facility on 5/14/17 with Auditory Hallucinations, Psychosis and Suicidal Ideations. PI

1 presented to the Emergency Department (ED) on 5/14/17 with complaints of, "... can't remember anything... back hurts so bad and I don't know if it is my body or just life in general..." The patient stated he/she had suicidal ideation, security was notified and suicide precautions were in place. On 5/14/17 at 5:57 AM, while the patient was in the ED, the ED Technician was present in the room while security was called away when the patient grabbed (his/her) purse and began to put on makeup. The patient was digging through the purse and became upset when the Technician saw something silver that was concealed by the bag. The staff member called for help and the patient proceeded to try to put a pocket knife to his/her left wrist and cause harm to self. With security's help, all of the patient's belongings including the knife were removed and the patient was placed in a hospital gown. The patient was subsequently admitted to the facility in the BMU. Review of the Psychiatric Evaluation History and Physical dated 5/14/17 revealed the patient's chief complaint was, "I hear him." The psychiatrist documented, "... Per ER (Emergency Room), patient complaining of hearing 2 or 3 different people inside of (him/her), the voices... are (his/her) own and is just different people that live in (him/her)... the voices tell (him/her) to kill (self). Patient has suicidal ideation. Patient reports multiple suicide attempts in the past and stated... had tried to overdose and has tried to hang (self) on 2 occasions. Patient denied any visual hallucinations... denied homicidal ideation... As of today... patient very irritable, we need to encourage (him/her) several times to finish the evaluation. Patient reported hearing all kinds of things, like... own voice telling (him/her) different things including telling (him/her) to kill (self)... Patient reported paranoia, said, "they are talking about me."... reported depression... no energy, poor appetite, and said, "he tells me don't eat."... said the person inside of (him/her) is with (him/her)... reported suicidal thought, said, "you don't need a plan, you just do it..." Further review of the Psychiatric History and Physical dated 5/14/17 revealed, "... Mental Status Examination: ... poorly groomed, not well cooperative, with poor eye contact... psychomotor agitation... Mood: Depressed. Affect: Very irritable, constricted, labile. Thought process and association: Illogical and loose. Thought content: ... reports auditory hallucinations, paranoia,,, suicidal thought. Insight: Poor. Judgement: Poor... Concentration and attention span: Poor... Differential Diagnoses: ... Substance-induced psychotic disorder... Methamphetamine abuse... Rule out gender identity disorder... Rule out schizophrenia... Rule out mood disorder... Treatment Plan: 1. Safety: Admit the patient to psych inpatient unit, start q15 minute observation, and monitor patient's vital signs closely..." Review of the medical record revealed physician orders dated 5/14/17 for Q 15 minute checks. The surveyor reviewed the patient's medical record on 8/21/17 and there was no documentation Q 15 minute checks were completed. On 8/22/17 at 8:30 AM, the surveyor requested a copy of the patient's entire medical record and pointed out there was no documentation of Q 15 minute safety checks. On 8/22/17 at 10:00 AM, the patient's medical record was given to the surveyor and copies of documents entitled "Q 15 Minute Safety Rounding Sheet" for the entire time the patient was admitted to this facility. A review of the Q 15 Minute Safety Rounding Sheet dated 5 /30/17 revealed multiple patients were listed, including PI # 1. On 8/22/17 at 10:00 AM, when questioned about the Q 15 Minute Rounding Sheet, Employee Identifier (EI) # 3, Nurse Manager stated the documents are not part of the patient's permanent medical record and are kept on the unit in a notebook. A review of the security video footage for 5/30/17 was conducted on 8/22/17 at 10:15 AM. A review of this video footage revealed at 9:29 AM, the patient was seen talking with a male and female at the end of the hallway, (identified as the Psychiatrist and Case Manager). The patient turned away from the Psychiatrist and Case Manager and walked toward his/her room. At 9:30 and 11 seconds (AM), the patient was visibly

upset, placed his/her hands on the top of his/her head, walked into his/her room at 9:
30 and 15 seconds (AM) and shut the door. None of the nursing staff entered the room or checked on the patient after he/she entered the room and closed the door. At 11:18 and 44 seconds (AM), a male staff member (identified as the MHT) was seen running down the hall from the nurse's station to the patient's room. The patient's door remained closed until 11:18 AM and 49 seconds (AM), when the MHT opened the door and found the patient hanging from the bathroom door by a bed sheet. A review of the Q 15 Minute Safety Rounding Sheet dated 5/30/17 revealed the Mental Health Technicians (MHTs) documented the patient was in his/her room from 9:30 AM to 2:15 PM. There was no documentation the Registered Nurse (RN) completed hourly rounding on the patient. Cardiopulmonary Resuscitation was performed and the patient was pronounced dead on 5/30/17 at 11:39 AM. Review of the Root Cause Analysis (RCA) dated 5/30/17 related to PI # 1's successful suicide revealed, "... Items Analyzed... What human factors were relevant to the outcome? Policy and procedure was not followed. Q15 minute rounds were not completed by staff... Action Required: Two employees terminated on 5/31/17. Education given again for standards for q 15 minute rounds. Met with each shift change and emphasized importance of rounding by nurses and MHT on 5/30/17 and 5
/31/17. Email to all staff for expectations for rounding... Questions regarding future planning... If able to put the q 15 minute checks into electronic format would be better so the exact time the patient is seen would be captured... Need to explore being able to document q 15 minute observations in electronic format..." An interview was conducted on 8/22/17 at 9:52 AM with Employee Identifier (EI) # 1, Director Quality Management who verified the above findings. 22965 2. PI # 2 was admitted to the facility on 6/8/17 with the diagnoses of Suicidal Ideations, Paranoid Schizophrenia, Hallucination and Panic Attack. Review of the Psychiatric Evaluation History and Physical Treatment Plan/ Safety: Admit patient to psych inpatient unit, start every 15 minute observation and monitory patient's vital signs closely. Review of the Q 15 Minute Safety Rounding Sheet (Q 15 Min SRS) 6/8/17 revealed the following codes: Location : Dayroom (D), Patient Room (P), Group Room (G), Hallway (H) and Unassigned Patient Room (UPR). Review of the 6/9/17, 6/10/17, 6/12/17 Q 15 Min SRS at 2 North (N) from 11:15 AM to 3:00 PM revealed the MHT documented the location code and the letter "A." There was no documentation on the Q 15 Min SRS of a legend for "A". When EI # 3, Nurse Manager was asked by the surveyor of what "A" meant, EI # 3 stated that it "probably meant alert/awake", but was not sure. Review of the 6/8/17, 6/9/17, 6/10/17 Q 15 Min SRS at 2N from 7:15 PM to 11:00 PM revealed the MHT documented the location code and the letter "S." There was no documentation on the Q 15 Min SRS of a legend for "S". When EI # 3, Nurse Manager was asked by the surveyor of what "S" meant, EI # 3 stated that it "probably meant sleeping", but was not sure. Review of the 6/11/17 Q 15 Min SRS from 3N revealed from 3:15 PM to 7:00 PM, there was no documented patient observation and
/or where the patient was located. Review of the 6/12/17 Q 15 Min SRS from 3N revealed from 11:15 AM to 3:00 PM, the patient was located in the hallway, but no patient behaviors were documented. Review of the Daily Focus Assessment Report revealed no documented of the reason the patient was in the hallway. There was no documentation of the patient behavior. Review of the 6/13/17 and 6/14/17 Q 15 Min SRS revealed from 7:15 AM to 11:00 AM revealed the patient in an Unassigned Patient Room (UPR). There was no documentation of the patient's behavior. Review of the 6/15/17 Q 15 Min SRS from 7:15 AM to 11:00 AM, revealed no documentation of where the patient was located or the patient's behavior. In an interview conducted on 8/24/17 at 2:45 PM, EI # 2, Interim Director of Behavioral Health confirmed the aforementioned findings. 30952 2. PI # 3 was presented to the ED on 3/8/17 with reports of increased depression and thoughts of suicide which

included a plan.. PI # 3 was admitted to the 2N BMU on 3/8/17 with diagnoses including Suicidal Ideations, Depressive Disorder, Chronic Pain and Polysubstance Abuse. Review of the physician history and physical documentation included every 15 minute safety checks. There was no Q 15 Minute Safety Rounding Sheet documentation received in the certified medical record documentation requested by the surveyor. In an interview on 8/22/17 at 10:09 AM, EI # 3, Clinical Nurse Manager, verified safety rounds completed were documented in a multi-patient format which included all patients on the unit and was not part of the patient medical record. The surveyors requested PI # 3's safety round documentation. Review of the facility document titled, Q (every) 15 Minute Safety Rounding Sheet dated 3/8/17 and 3/9/17 revealed the MHT documented the patient location using a location code (abbreviation) every 15 minutes. There was no code for patient behavior. Review of PI # 3's Q 15 Minute Safety Rounding Sheet for 3/8/17 from 11:15 PM through 3/9/17 at 7:00 AM failed to include documentation of PI # 3's behaviors or activity. There was no documentation the nurse completed safety rounds verification every hour on PI # 3 per facility policy from admission on 3/8/17 to discharge on 3/9/17. In an interview on 8/24/17 at 10:30 AM, EI # 2 reported MHTs complete the rounding sheets every 15 minutes and the documentation should include the patient location and activity. EI # 2 confirmed on 3/8/17 from 11:15 PM to 3/9/17 at 7:00 AM, the 15 minute safety rounding sheet documentation did not reveal PI # 3's activity as requested by physicians. Staff should document for patient awake, "A" and patient sleeping, "S". EI # 2 confirmed the nurse should document safety rounds hourly using his/her tool. No hourly safety nurse rounding documentation or nurse tool was provided. The above findings were confirmed. On 8 /23/17 at 5:26 PM, the surveyors met with administrative staff of the facility to outline the identified concerns noted above. The survey team requested a corrective action plan to address the identified concerns. Review of the Organization Corrective Action Plan submitted to the surveyors on 8/24/17 at 7:00 PM revealed the facility identified the following: Finding 1: Observations every 15 minutes not completed (by Mental Health Technician's [MHT]) Nonconformity with the organization policy, Observation with Documentation-Behavioral Medicine. Every 15 minute observations were not completed by the MHT which impacted PI # 1's suicide by hanging on 5/30/17 on 3 N BMU. The Organization Corrective Plan documentation outlined the following actions: May 30, 2017, team member discussion of the 5/30/17 events. May 31, 2017, dismissal of 2 MHT for falsification of medical records. May 31, 2017, 2 N and 3 N BMU staff education on Observation with Documentation-Behavioral Medicine policy, use of the multi-patient, pre-filled time slot for patient observations documentation, compliance would be monitored. July 7, 2017, documentation tool, (Q 15 Minute Safety Rounding Sheet) updated to require the MHT to document the correct (actual) time the patient was observed. August 23, 2017, tool reviewed and updated, begin use of updated documentation, patient specific,with actual time observed to include patient behavior and location. August 23, 2017 to August 28, 2017, staff training is 1:1 (one to one), MHT education on updated Q 15 Minute Safety Rounding Tool, patient specific, completed every 15 minutes for the actual time staff observed the patient behavior and location during a 24 hour period. Review of the MHT documentation on the Q 15 Minute Safety Rounding Sheet is to be completed by the Clinical Nurse Manager or Charge Nurse every 24 hours. The documentation is then placed in the patient medical record. The Interim Director of Behavioral Medicine and Vice President of Patient Care Services is responsible for implementation and adherence to the corrective action plan and organization policy. August 24, 2017, Organization followup begins, Charge Nurse or Charge Nurse on 2 N and 3 N BMU monitor each MHT's documentation by direct observation 2 times each shift, total of 6 observations per day. Validation of the observation is

documented on the tool. Non-compliance action is immediate education and/or progressive discipline. Weekly results communicated at Improving Patient Outcomes (IPO) and monthly to Continuous Survey Readiness (CSR), target 90 % with 3 consecutive month monitoring and re-evaluate monitoring status at CSR. Finding 2: Observations every one hour not completed (by licensed staff). Nonconformity with licensed nurses documenting observations every one hour as indicated on Observation with Documentation-Behavioral Medicine. (The surveyors observed noncompliance with completing the hourly safety rounds as evidenced in facility video monitoring of the 5/30/17 event). The Organization Corrective Plan documentation outlined the following actions: May 30, 2017, team member discussion of the 5/30/17 events, PI # 1's, suicide by hanging on 5/30/17 on 3 N BMU. The Registered Nurse (RN) admitted to not observing PI # 1 every hour. June 5, 2017, 2 N and 3 N BMU staff education on the expectation of hourly nurse round completion. August 23, 2017, an Every One Hour Safety Precaution form was developed, patient specific, requires actual observation time, patient behavior and location over a 24 hour period, documented by licensed staff. August 23, 2017, use of new observation tool, the Every One Hour Safety Precaution form began. August 23 to August 28, 2017, licensed staff training is 1:1, for use of the Every One Hour Safety Precaution form. Review of the Every One Hour Safety Precaution form is to be completed by the Clinical Nurse Manager or Charge Nurse every 24 hours. The documentation is then placed in the patient medical record. August 24, 2017-The Observation with Documentation-Behavioral Medicine policy was updated to reflect licensed staff monitoring of the patient behavior and location hourly. The Interim Director of Behavioral Medicine and Vice President of Patient Care Services is responsible for implementation and adherence to the corrective action plan and organization policy. August 24, 2017, Organization followup begins, Charge Nurse or Charge Nurse on 2 N and 3 N BMU monitor each licensed staff's documentation by direct observation 2 times each shift, a total of 6 observations per day. Validation of the observation is documented on the tool. Non-compliance action is immediate education and/or progressive discipline. Weekly results communicated at IPO and monthly to CSR, target 90 % with 3 consecutive month monitoring and re-evaluate monitoring status at CSR.

A0396

NURSING CARE PLAN
CFR(s): 482.23(b)(4)

The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan

This STANDARD is not met as evidenced by:
Based on review of facility policy, medical records and interview with staff, it was determined the facility failed to ensure an updated treatment plan was implemented and updated for a suicidal patient according to the facility policy. This affected 1 of 3 medical records reviewed, including Patient Identifier (PI) # 1 and has the potential to negatively affect all patients admitted to the Behavioral Medicine Unit (BMU) / Behavioral Health Services (BHS). Findings include: Facility Policy/Procedure: Treatment Planning-Behavioral Medicine Effective Date: 9/1/2009 Policy: Each patient admitted to the Behavioral Health Services (BHS) will have an Initial Treatment Plan initiated on admission. Each discipline will add their specific interventions. An Interdisciplinary Treatment Plan will be developed with the patient, physician, nurse and therapist. After the Interdisciplinary Treatment Plan is complete,

a review will be held weekly to re-evaluate the patient's progress and update the Interdisciplinary Treatment Plan. Purpose: To identify the purpose of the multidisciplinary treatment planning team sessions and guidelines. Procedure: 1. The multidisciplinary treatment planning sessions meet three times a week. 6. Notes or updates of results of the discussion are documented on the interdisciplinary treatment review. ****** Facility Scope of Care Behavioral Health Services Revision Date: 1 /17 The inpatient center is divided into specialty programs. Three North treats the most acute patients typically with diagnosis's of psychosis, schizophrenia, bipolar disorders, agitation, and other patients requiring a high level of supervision and redirection. The program consists of group process, education and activity therapy. Standard of Care (practice guidelines and professional performances). Patient care will be administered according to the nursing process outlined in the Patient Care Services Policy and Procedure Manual and Standards of Psychiatric Nursing as established by the American Nurses Association. The Master Treatment Plan is the center of the patient's treatment and shall be based on collected data, nursing assessments, social history, the physician's history and physical, psychological testing, etc. The Master Treatment Plan will be implemented using this information to identify patient problems, goals, objectives, treatment modalities utilized, and estimated time frames. Treatment planning will be performed on all patients and updates to the Master Treatment Plan will be documented. 1. Patient Identifier (PI) # 1 was admitted to the facility on 5/14/17 with Auditory Hallucinations, Psychosis and Suicidal Ideations. PI # 1 presented to the Emergency Department (ED) on 5/14/17 with complaints of, "... can't remember anything... back hurts so bad and I don't know if it is my body or just life in general..." The patient stated he/her had suicidal ideation, security was notified and suicide precautions were in place. On 5 /14/17 at 5:57 AM, while the patient was in the ED, the Technician was present in the room while security was called away when the patient grabbed (his/her) purse and began to put on makeup. The patient was digging through the purse and became upset when the Technician saw something silver that was concealed by the bag. The staff member called for help and the patient proceeded to try to put a pocket knife to his /her left wrist and cause harm to self. With security's help, all of the patient's belongings including the knife were removed and the patient was placed in a hospital gown. The patient was subsequently admitted to the facility in the BMU. Review of the Psychiatric Evaluation History and Physical dated 5/14/17 revealed the patient's chief complaint was, "I hear him." The psychiatrist documented, "... Per ER (Emergency Room), patient complaining of hearing 2 or 3 different people inside of (him/her), the voices... are (his/her) own and is just different people that live in (him/her)... the voices tell (him/her) to kill (self). Patient has suicidal ideation. Patient reports multiple suicide attempts in the past and stated... had tried to overdose and has tried the hang (self) on 2 occasions. Patient denied any visual hallucinations... denied homicidal ideation... As of today... patient very irritable, we need to encourage (him/her) several times to finish the evaluation. Patient reported hearing all kinds of things, like... own voice telling (him/her) different things including telling (him/her) to kill (self)... Patient reported paranoia, said, "they are talking about me."... reported depression... no energy, poor appetite, and said, "he tells me don't eat."... said the person inside of (him/her) is with (him/her)... reported suicidal thought, said, "you don't need a plan, you just do it..." Further review of the Psychiatric History and Physical dated 5/14/17 revealed, "... Mental Status Examination: ... poorly groomed, not well cooperative, with poor eye contact... psychomotor agitation... Mood: Depressed. Affect: Very irritable, constricted, labile. Thought process and association: Illogical and loose. Thought content: ... reports auditory hallucinations, paranoia,,, suicidal thought. Insight: Poor. Judgement: Poor... Concentration and attention span: Poor... Differential Diagnoses: ... Substance-

induced psychotic disorder... Methamphetamine abuse... Rule out gender identity disorder... Rule out schizophrenia... Rule out mood disorder... Treatment Plan: 1. Safety: Admit the patient to psych inpatient unit, start q15 minute observation, and monitor patient's vital signs closely..." Review of the Interdisciplinary Master Treatment Plan dated 5/14/17 and signed by the Interdisciplinary team on 5/17/17, revealed no documentation suicidal ideation was identified as a problem and there was no documentation of interventions related to suicidal ideation. Review of the Psychosocial Assessment dated 5/18/17 revealed the Licensed Professional Counselor (LPC) documented, "... (patient) stated was feeling hopeless and suicidal on admission. Pt (patient) continues to report... is suicidal... having auditory hallucinations, reporting "they" won't let (him/her) eat... Pt was seen by staff attempting to eat and having a verbal altercation with another personality (he/she) calls "William" in which "William" told (patient) not to eat and then pt hit self when attempting to take a bite... Pt did state if (he/she) left the hospital... would kill self..." Review of the Physician Progress Note dated 5/21/17 revealed the physician documented, "...Tells me (he/she) is not a danger to (self) or others. In group revealed when (he/she) came here (he/she) is going to kill (self)..." The patient denied suicidal ideation/homicidal ideation (SI/HI). The physician circled "SI with plan" and further documented, : told group (he/she) planned to kill (self) after d/c (discharge)..." Review of the Physician Progress Note dated 5/22/17 revealed the Psychiatrist documented, " ... Mental Status Examination ... mood depressed ... continued to have suicidal ideation ... had thoughts of trying to hang (self) ... asked (him/her) about voices ... denied that (he/she) heard voices and stated "they are my own stupid thoughts." (Patient) did make some self-deprecatory remarks ... reportedly made a comment in group therapy that (he/she) was going to kill (self) after ... got discharged ..." Review of the Physician Progress Note dated 5/23/17 revealed the Psychiatrist documented, " ... Subjective ... patient remains depressed ... continues to have suicidal thoughts which include sticking something in a light socket or throwing (his/her) blanket over the door and trying to hang (self) ... Mental Status Examination ... appeared depressed, though there was little mood reactivity. Speech was limited to answering questions ... There was no suicidal or homicidal ideation present ... was a little worried as to what was going to happen to (him/her) because ... was "homeless" ... On the one hand ... felt ...needed to be in a group home. "I do not trust myself. I make bad decisions"..." Review of the Physician Progress Note dated 5/24/17 revealed the Psychiatrist documented, " ... the patient appears a little more depressed today than yesterday ... does show a little bit of mood reactivity ... is appearing more depressed ... affect was euthymic and mood depressed ... There was no suicidal or homicidal ideation present. When I asked ... about suicidal thought, (he/she) stated "I have put them on hold ... When I asked (him/her) what (he/she) meant by that ... (patient) indicated that previously (he/she) would kill (self) if HIV (human immunodeficiency virus) positive ... now ... willing to see what it is like living with HIV and taking medication, and not automatically stating (he/she) would kill (self) ..." Review of the Physician Progress Note dated 5/25/17 revealed the Psychiatrist documented, " ... Subjective ... affect is less flat, mood still depressed, but less so ... not psychotic ... does report having suicidal thoughts ... not sure whether (he/she) want to live or not ... denies, however, this has anything to do with being HIV positive and states ... has been feeling this was for some time ... at one point, (patient) indicated ... wanted to be discharged either today or tomorrow. I pointed out ... that first off, (he/she) was having suicidal thoughts, so I was not going to discharge (him/her). Secondly ... (patient) was court ordered and has to go back to court next week and the judge would have to release (him/her) ... (Patient) then looked at me and smirked and said "he did not tell me that" ... we did discuss it briefly yesterday ... (patient) was not interested in hearing about it and elected not to go to (his/her) court hearing ..." Review of the

	Physician Progress Note dated 5/26/17 revealed the Psychiatrist documented, " ... Subjective ... reports having had fleeting suicidal thoughts, but not having thoughts, but (he/she) did not want to live ... is not psychotic ..." Review of the Physician Progress Note dated 5/27/17 revealed the Psychiatrist documented, " ... came to meet with the patient, it was after lunch ... lying on ... bed and was teary ... did state ... had been hearing voices telling (him/her) to bust (his/her) way out of the hospital ... affect is euthymic, mood depressed and teary ... had been having suicidal thoughts. Though no specific plan or intent ... is feeling a little tired of being in the hospital ..." Review of the Physician Progress Note dated 5/28/17 revealed the Psychiatrist documented, " ... does feel a little anxious at times ... had a little more difficulty sleeping ... has not been hearing voices ... has not had any suicidal ideation or behavior ... is agreeable to going to the group home when there is an opening ... is willing to "jump through the hoops" to get there ..." Review of the Physician Progress Note dated 5/29/17 revealed the Psychiatrist documented, " ... There was no suicidal or homicidal ideation present ... did report having a lot of difficulty sleeping last night and this is 2 nights in a row ... has had problems sleeping ..." There was no documentation in the medical record the patient's above documented behaviors were communicated to the nursing staff. Nor was there documentation those behaviors were addressed by the Interdisciplinary team in the treatment plan or that additional safety interventions were implemented. Review of the Therapist Documentation note dated 5/30/17 at 9:30 AM revealed, "Dr (doctor) and this writer met with pt (patient) in the hall... (patient) asked about court and this writer advised that (he/she) was not on the docket for today and pt responded with, "I am not going to stay here two more days"... This writer advised that I would contact the court and see if I could get (him/her) on the docket for this afternoon and would let (him/her) know if it changes..." This note was documented on 5/30/07 at 2:42 PM. Review of the Physician Progress Note dated 5/30 /17 revealed the Psychiatrist documented, " ... When I walked on the unit this morning, around 9:30 AM, the patient approached me to ask about court. I pointed out that (he/she) was not on the docket for today. The case manager indicated we could try to get (him/her) on the docket for today ... (Patient) indicated they would talk with (him/her) a little later ... (Patient) walked away and mumbled something about (he /she) was not going to spend 2 more days in the hospital. At 11:23 in the morning ... received a call from a case manager indicating that the patient had been found in (his /her) room in apparent hanging attempt, unresponsive. Resuscitation efforts were not successful and the patient was subsequently pronounced dead ..." This Physician Progress Note was dictated on 5/30/17 at 5:42 PM.
A0724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(c)(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observations, review of facility policies, facility work order maintenance requests, Safety Checklist documentation, Root Cause Analysis (RCA) for the sentinel event involving Patient Identifier (PI) # 1, interviews and Facility's Corrective Action Plan submitted to the surveyors on 8/24/17, it was determined the facility failed to conduct environmental safety rounding each shift and ensure physical surroundings were safely maintained to protect patients and prevent potential harm. This has the potential to negatively affect all psychiatric patients admitted to this facility's Behavioral Medical Unit (BMU). Findings include: Facility Policy:

Behavioral Medicine Risk Analysis Effective Date: 6/21/2012, Revised 8/24/17 Policy: To provide for evaluation and inspection process to provide a safe environment for patients, staff and visitors within the Behavioral Medicine Unit. Purpose: The behavioral healthcare environment demonstrates that the physical surroundings help assure that the patient cannot harm himself/herself or others, and that staff are adequately protected from potential harm of patients. To purposefully identify and eliminate environmental risks for inpatient suicide and suicide attempts, heighten the awareness of clinical staff regarding environment, environmental hazards on locked psychiatric units and to focus specific attention on psychiatric unit safety. Procedure: The Director of Behavioral Medicine will implement a proactive BMU safety program to include safety responsibility assignments, safety rounding, risk analysis. 1. Assigned BMU staff will conduct safety rounding. Any safety findings noted will be documented on the form, entered electronically into an electronic work order for review by the Safety Coordinator. The room will remain closed until inspected by staff to assure safety findings have been resolved prior to further occupancy of the room... Review of the Root Cause Analysis (RCA) dated 5/30/17 related to Patient Identifier # 1's successful suicide attempt revealed, "... Items Analyzed... Controllable environmental factors... Only identified environmental factor is the doors in patient rooms can be closed and as in this case, sheet with knot in it thrown over door and patient able to hang self... Action Required... Re-evaluate if there are other ways for doors to be in patient room so that nothing can be thrown across the top and caught when door closed, i.e. slant top of door especially in private rooms. This is being evaluated currently, no answer to what changes will be made to doors, if any... " A tour of the BHU - 3 North was conducted on 8/22/17 at 12:30 PM with Employee Identifier (EI) # 1, Director Quality Management and EI # 2, Interim Director Behavioral Health. During this tour, the surveyor observed located in the unit were 5 private rooms, including room 330. Upon entering room 330, the surveyor observed the door to the patient's bathroom had been removed. On 8/22/17 at 12:30 PM, the surveyor asked EI # 1 when the door had been removed and the reply was, "today." (8/22/17). EI # 1 stated all of the bathroom doors in the 5 private rooms had been removed on 8/22/17. During a tour of the 2 North (N) BMU (Behavioral Medical Unit) on 8/22/17 at 12:35 PM, the surveyors observed two loose hand rails with anchors visible located between the geriatric dayroom and the nurses station. During a tour of the 3 N BMU on 8/22/17 at 12:35 PM, the surveyors observed a rusted air grill (vent)in room 349, a cracked bathroom mirror in room 348, sheet rock damage with a screw visible in room 350 and peeling paint around the shower in room 342. Following the unit tours on 8/24/17 at 2:05 PM, EI # 3, Nurse Manager reported to the surveyors the safety/risk assessment rounds were completed by the Mental Health Technician's every shift. Review of the facility 3 N BMU Safety Checklist documentation provided to the surveyors failed to include May 2017 daily safety checks. There was no documentation 3 N BMU daily safety rounds were performed May 1 to May 31, 2017. Review of the 3 N BMU Safety Checklist documentation provided, revealed no daily safety checks were performed from July 6 to July 12, on July 14, and no daily safety check documentation was provided from July 17 to July 31. There was no documentation that daily safety checks were performed on 3 N BMU from August 1 to August 18, 2017. Further review of the 3 North BMU Safety Checklist documentation completed on the 3-11 shift on 6/21/17 revealed the following: "room 349 panel chip." The staff documented the discrepancy was reported to proper personnel and a work order was sent for damage. Review of the 3 North BMU Safety Checklist documentation on the 11-7 shift on 6/30, (the year was left blank) revealed "room 330 base of the bathroom sink need (s) to be pulled up closer theirs a inch gap between base and sink." There was no documentation the staff completed work order documentation for damage repair. There was no documentation

the damage was repaired. On 8/23/17 at 5:26 PM, the surveyors met with administrative staff of the facility to outline the identified concerns noted above. The survey team requested a corrective action plan to address the identified concerns. On 8 /24/17 at 1:45 PM, the staff provided the surveyors with the facility Corrective Action Plan documentation which included "My Maintenance Requests" printed on 8/24/17 at 11:08 AM for BMU 2 and 3 North for June and July 2017. There was no documentation repairs were completed on room 349-panel chip and room 330-bathroom sink repair. Review of the facility Corrective Action Plan documentation submitted on 8/24/17 at 7:00 PM included documentation repairs to the above observed areas were completed as of 8/24/17 at 1:45 PM with the exception of room 342's peeling paint. Review of the Corrective Action Plan documentation submitted to the surveyors on 8/24/17 at 7:00 PM revealed the following corrective actions: "... Finding 3: Safety rounds not being done consistently on 2 North (N) and 3 N BMU Nonconformity with safety rounds completed on 2 N and 3 N BMU The Organization Corrective Plan documentation outlined the following actions: August 24, 2017, review of the facility policy, Behavioral Medicine Risk Analysis, and the facility safety rounding process by the Director of Behavioral Medicine and Vice President of Patient Care Services. Policy revised. Process changed, Clinical Nurse Manager and/or Charge Nurse complete daily inspections of 2 N and 3 N BMU for any actual or potential safety concerns. Identified concerns result in immediate notification of Plant Services and Life Safety. Work order generated, room closed if determined necessary. When corrected, plant services and nursing will inspect/agree the concern was corrected, and if agreed room re-opened. August 24, 2017, education on the Daily Safety Inspection form and process for all Clinical Nurse Manager and charge nurses. August 24, 2017, Safety Officer/Safety Coordinator conduct and document monthly safety inspections using the Hazard Surveillance report, implement corrective actions. August 24-August 28, 2017, Safety Coordinator conducts education, train "the trainer" for all Clinical Nurse Manager and charge nurses. August 28, 2017, Director of Behavioral Medicine and Safety Coordinator conduct annual BMU Risk Analysis, submit report to Improving Patient Outcomes (IPO) The Interim Director of Behavioral Medicine, Vice President of Patient Care Services, Safety Coordinator is responsible for activities, implementation and adherence to the Behavioral Medicine Risk Analysis policy. August 24, 2017, Director of 2 N and 3 N BMU monitor daily (Monday-Friday, upon return from the weekend review of the weekend inspections) each units Daily Safety Inspection form, to verify daily inspections and safety concerns not corrected within 72 hours. Non-compliance result in immediate education and/or progressive discipline. Results communicated at Improving Patient Outcomes (IPO) and monthly to Continuous Survey Readiness (CSR), target 90 % with 3 consecutive month monitoring and re-evaluate monitoring status at CSR. Environmental Concerns: Door Modification: History May 30, 2017, Root Cause Analysis (RCA) initiated, identified the need to "re-evaluate doors within the patient rooms so that nothing can be thrown across the top and caught when door closed" June 8, 2017, assessment complete, follow-up action at 9:30 AM, 6 staff attended. Discussion included cutting off tops of doors, use of door alarms, roton hinges and removal of tops of doors, privacy curtains/magnetic latches across door frames. Review of 2014 Hospital and Outpatient design and construction with Life Safety consultant. August 22, 2017, all private room bathroom doors removed with evaluation of long-term plan discussion. September 1, 2017, completion date for action plan, all 2 N and 3 N BMU bathroom doors have latching mechanisms removed, replaced with a blank latching plate, preventing the doors from being securely closed. Director of Plant Services responsible. In-Visit Physical Environment Concerns: Addressed/Completed August 22, 2017, 2 N BMU: 7 bathrooms doors removed, handrails tightened, bad anchors replaced. 3 N BMU: 7 bathrooms doors

	removed, room 349 rusted air grill replaced, hand rails tightened, bad anchors replaced. August 23, 2017, 3 N BMU, handrails tightened, bad anchors replaced, room 348 replaced cracked mirror in bathroom, room 350 wall repairs made, replaced stained ceiling tile in soiled utility room. 2 N, In-Visit Physical Environment Concerns: Work order entered, rooms 250, 251 wood exposed/chipped formica, rooms 238, 239, 250 insulation/wallpaper ripped, room 241 cabinet wood exposed /chipped. **** Finding 6: Numerous documented patient hanging attempts during hospitalization. Cause of nonconformity was failure of BMU staff to report documented suicide attempts by hanging (Patient Identifier # 2) during hospitalization. Administration with no knowledge of the safety concern prior to August 23, 2017. The Organization Corrective Plan documentation outlined the following actions: Staff audited facility email communication (during the onsite survey visit), determined previous Director of Behavioral Medicine was aware of the safety concerns on June 10, 2017. Noncompliance with occurrence reporting identified. Quality Management completed an occurrence report, requested root cause analysis (RCA), due September 22, 2017. RCA will be presented to the Adverse Outcomes Committee, interventions implemented. In May and June 2017, the organization had one successful hanging and several attempts. Decision made to remove all latches from semi-private bathroom door on 2 N and 3 N BMU. August 22, 2017 (after surveyors entered the facility), 2 N and 3 N BMU private patient bathroom doors removed. August 25, 2017, staff "updated" on change in patient bathroom doors on 2 N and 3 N BMU. September 1, 2017, bathroom door latch removal completed. Director of Plant Services and Interim Director of Behavioral Medicine responsible for implementation. Organization follow-up: RCA interventions implemented which may result in ongoing monitoring, process to be determined.