

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  010001	<b>(X3) Date Survey Completed</b>  08/24/2017
<b>Name of Provider or Supplier</b>  Southeast Health Medical Center	<b>Street Address, City, State</b>  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.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>  (Each deficiency should be preceded by full regulatory or LSC identifying information)
<b>A0144</b>	<p><b>PATIENT RIGHTS: CARE IN SAFE SETTING</b> CFR(s): 482.13(c)(2)</p> <p>The patient has the right to receive care in a safe setting.</p> <p>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</p>

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 response. 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 placed 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.