PRINTED: 11/24/2015 FORM APPROVED OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 174004		1.	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		B. WING			C 11/03/2015		
NAME OF PROVIDER OR SUPPLIER OSAWATOMIE STATE HOSPITAL PSYCHIATRIC				STREET ADDRESS, CITY, STATE, ZII 500 STATE HOSPITAL DRIVE OSAWATOMIE, KS 66064	P CODE		
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A 000	INITIAL COMMEN	ITS	A 00	00			
	complaint investig above named faci #3GD211) resulter Condition of Partic requirements for N The survey resulter with the Condition 482.23, requirement was not removed 482.23 NURSING The hospital must service that provid The nursing servic supervised by a result the nursing servic supervised by a result the nursing servic supervised by a result failed to ensure nut therapeutic observer failed to ensure nut in shower rooms a	ed in an Immediate Jeopardy of Participation, 42 CFR ents for Nursing Services that on exit 11/3/15. SERVICES have an organized nursing es 24-hour nursing services. tes must be furnished or	A 38	35			
	Medicaid Services immediate jeopard 1:19pm that was n at 6:30pm.	n the Centers for Medicare and notifying the facility of an y situation on 11/3/15 at ot removed on exit on 11/3/15 ect of the systemic failure to					
2	supervise the provi	ision of care, to perform ecks, and to protect suicidal					
BORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: M061101

PRINTED: 11/24/2015 FORM APPROVED OMB NO: 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	174004 B. WING			C 11/03/2015			
	ROVIDER OR SUPPLIER	TAL PSYCHIATRIC		50	REET ADDRESS, CITY, STATE, ZIP CODE 10 STATE HOSPITAL DRIVE SAWATOMIE, KS 66064		
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	receiving services	ing risks placed all patients		385 395			
	A registered nurse the nursing care for This STANDARD Based on observa document review, nursing staff provi of patient care, fai Staff performed a failed to ensure nu therapeutic obser failed to ensure nu in shower rooms risks. These defic at risk for harm al Medicare and Me facility of an imme November 3, 201	must supervise and evaluate or each patient. is not met as evidenced by: ation, staff interview, and the facility failed to ensure ded oversight for the provision led to ensure Security Rounds ppropriate safety round checks, ursing staff completed vation status level checks, and ursing staff supervised patients and bathrooms with ligature ident practices placed all patient nd resulted in the Centers for dicaid Services notifying the ediate jeopardy situation on 5 at 1:19pm that was not in November 3, 2015 at 6:30pm					
	with (Mental Hea revealed she was to 11:00pm) on 1 to Patient #3 ' s r 8:30pm and she that she was goi MHT Staff T said his hand on my r	rview on 10/30/15 at 1:15 pm Ith Technician) MHT Staff T s working evening shift (2:30pm 0/27/15. She was taking gowns oom on hallway B around had told the other MHT Staff H ng to the patient ' s room. The I Patient #3 grabbed me and pu mouth and I was trying to screar g on the walls and he raped me. d she doesn ' t believe anyone	t				

Facility ID: M061101

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		174004	B. WING	·		1	C 03/2015
NAME OF F	PROVIDER OR SUPPLIER	1		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	500 STATE HOSPITAL DRIVE		
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A 395	station. Two patien me. They came be opened the door ar (Patient #3) back o - Patient #2, intervi said he and a frien down hallway B an think much about t noises on the unit. down hallway B, Pa someone screamir Patient #2 said the #3 ' s room and sa her pants down an reported they pulle and threw Patient # him there while Pa screaming " he ray Staff H arrived and seclusion room. -MHT Staff H interv revealed he worket 10/27/15. MHT Sta heard a patient scr hallway B and they	ble to hear her from the tech ts (Patients #2 and #8) saved fore any staff did. Patient #8 nd Patient #2 shoved him	A	395			
	hallways because the MHT station do hear all the way do all the noise. - Review of the hos	t hear anything down the of the noise on the unit and if oors are closed, they could not own the hallways even without spital 's Safety and Security revealed East Biddle staff					
	called Security at 8	3:38pm reporting a staff d and Security responded at					

Facility ID: M061101

If continuation sheet Page 3 of 8

	PRINTED: 11/24/2015 FORM APPROVED OMB NO. 0938-0391
STRUCTION	(X3) DATE SURVEY COMPLETED

STATEMENT OF DEFICIENCIES (X1) PROVDERSUPPLIERULA 0x3 MULTIPLE CONSTRUCTION 0x3 MULT	CENTER	to i oit mebior ate	d MEDIONE CENTICEO			Contraction of the second s	OIND NO	. 0000 0001
174004 B. WING 11/03/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 500 STATE HOSPITAL PSYCHIATRIC STREET ADDRESS, CITY, STATE, ZIP CODE 500 STATE HOSPITAL DRIVE OSAWATOMIE, KS 66064 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY NUES TERRETCEDED BYTULL TAG D PREVINCENT NO. STATE HOSPITAL DRIVE OSAWATOMIE, KS 66064 A 395 Continued From page 3 8:33pm. The local police were called at 8:45pm per request from the East Bildel RN Staff Y with police arriving on grounds at 8:51pm. A 395 - Review of video camera recordings of the East Bildel unit from Stopm to 9:00pm to 10/27/15 (from the B Hall Begin Camera View) revealed MHT Staff T walking with gowns down the B hallway at 8:28:55pm. MHT Staff T entered patient #3 is room rear the end of the hall at 8:20:14pm. An arm is seen reaching out to shut the door at 8:29:20pm. Patient #2 and Patient #8 are seen walking down the hallway and are seen opening up Patient 3 's room at 8:32:12pm. Patient #2 enters the room and Patient #8 is seen reaching out of the foron naked and holding a gown up against the froot naked an								
NMME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE, ZIP CODE OSAWATOMIE STATE HOSPITAL PSYCHIATRIC STREET ADDRESS, CITY. STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES BOD STATE HOSPITAL DRIVE PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX A 395 Continued From page 3 A 395 8:39pm. The local police were called at 8:45pm per request from the East Biddle RN Staff V with police arriving on grounds at 8:51pm. A 395 - Review of video camera recordings of the East Biddle unit from 8:00pm to 9:00pm on 10/27/15 (from the B Hall Begin Camera View) revealed MHT Staff T walking with gowns down the B halkway at 8:28:55pm. MHT Staff T entered patient #3's room near the end of the hall at 8:29:14pm. An arm is seen reaching out to shut the door at 8:29:26pm. Patient #2 and Patient #8 are seen opening up Patient 3's door at 8:32:12pm. MHT U is seen enuming down the hallway towards patient #3's room at 8:33:21pm. MHT Staff H and U are seen running down the hallway. Two security officers are then seen coming out of the room maked and holding a gown up against the front side of his body at 8:33:22pm. MHT Staff H escorted Patient #3 is then seen coming down the hallway. Two security officers are then seen coming down the hallway. Two toward patient #3's room at 8:53:25pm. • Video camera recordings of the East Biddle unit from 8:00pm to 9:00pm to 10/27/15 revealed for the maginty of the first 30 minutus of the recording MHT Staff H, MHT Staff Y, emailed in the tech station occasionally coming out to gett linens for patients, open bath			174004	D WINC				-
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 per request from the East Biddle RN Staff V with police arriving on grounds at 8:51pm. Review of video camera recordings of the East Biddle unit from 8:00pm to 9:00pm on 10/27/15 (from the B Hall Begin Camera View) revealed MHT Staff T walking with gowns down the B hallway at 8:26:55pm. MHT Staff T entered patient #3 's room near the end of the hall at 8:29:14pm. An arm is seen reaching out to shut the door at 6:29:26pm. Patient #2 and Patient #8 are seen walking down the hallway and are seen opening up Patient 3 's door at 8:32:12 pm. Patient #2 enters the room and Patient #8 is seen yealing and waving her arms up and down toward the MHT desk area at 8:32:14pm. MHT Staff H and U are seen running down the hallway and is seen running down the hall to Patient #3 's room at 8:32:22pm. MHT U is seen yelling towards the MHT desk and Nursing Staff V appears and is seen running down the hall to Patient #3 's room at 8:33:19pm. Patient #3 is then seen coming out of the room naked and holding a gown up against the front side of his body at 8:33:22pm. MHT Staff H escorted Patient #3 's room at 8:33:00m. No security officers are then seen coming down the hallway toward patient #3 's room at 8:33:00m. Video camera recordings of the East Biddle unit from 8:00pm to 9:00pm on 10/27/15 revealed for the majority of the first 30 minutes of the recording. MHT Staff H, MHT Staff I ends: some secorting police officers to the room at 8:38pm. Video camera recordings of the East Biddle unit from 8:00pm to 9:00pm on 10/27/15 revealed for the majority of the first 30 minutes of the recording. MHT Staff H, MHT Staff T, and MHT Staff L and Security condes Staff Y remained in the tech station occasionally coming out to get linens for patients, open bathroom doors, and do unit observation checks. RN Staff V is not seen 	A 395	Continued From pa	age 3	A	395			
 Biddle unit from 8:00pm to 9:00pm on 10/27/15 (from the B Hall Begin Camera View) revealed MHT Staff T walking with gowns down the B hallway at 8:28:55pm. MHT Staff T entered patient #3's room near the end of the hall at 8:29:14pm. An arm is seen reaching out to shut the door at 8:29:26pm. Patient #2 and Patient #8 are seen walking down the hallway and are seen opening up Patient 3's door at 8:32:12 pm. Patient #2 enters the room and Patient #8 is seen yelling and waving her arms up and down toward the MHT desk area at 8:32:14pm. MHT Staff H and U are seen running down the hallway towards patient #3's room at 8:33:22pm. MHT U is seen yelling towards the MHT desk and Nursing Staff V appears and is seen running down the hall to Patient #3's room at 8:33:19pm. Patient #3 is then seen coming out of the room naked and holding a gown up against the front side of his body at 8:33:22pm. MHT Staff H escorted Patient #3's room at 8:33:19pm. Patient #3 is then seen coming out of the room naked and holding a gown at 8:33:6pm. Video camera recordings of the East Biddle unit from 8:00pm to 9:00pm on 10/27/15 revealed for the majority of the first 30 minutes of the recording. MHT Staff Y remained in the tech station occasionally coming out to get linens for patients, patients, or MAIT Staff Y remained in the tech station occasionally coming out to get linens for patients, path baltwords of the recording. MHT Staff Y is not seen 		per request from th	e East Biddle RN Staff V with					
linens for patients, open bathroom doors, and do unit observation checks. RN Staff V is not seen		Biddle unit from 8:0 (from the B Hall Be MHT Staff T walkin hallway at 8:28:55p patient #3 ' s room 8:29:14pm. An arm the door at 8:29:26 are seen walking d opening up Patient Patient #2 enters th yelling and waving the MHT desk area and U are seen run towards patient #3 is seen yelling towa Nursing Staff V ap down the hall to Pa Patient #3 is then so naked and holding side of his body at escorted Patient # officers are then so toward patient #3 ' then appears at 8: police officers to th - Video camera re from 8:00pm to 9:0 the majority of the recording, MHT St Staff U and Securi	20pm to 9:00pm on 10/27/15 egin Camera View) revealed by with gowns down the B om. MHT Staff T entered near the end of the hall at n is seen reaching out to shut pm. Patient #2 and Patient #8 lown the hallway and are seen a 's door at 8:32:12 pm. he room and Patient #8 is seen her arms up and down toward a at 8:32:14pm. MHT Staff H nning down the hallway 's room at 8:32:22pm. MHT U ards the MHT desk and pears and is seen running atient #3 's room at 8:33:19pm. seen coming out of the room a gown up against the front 8:33:22pm. MHT Staff H 3 up the hallway. Two security een coming down the hallway s room at 8:38pm. RN Staff A4 47:13pm and is seen escorting he room at 8:52:36pm. ecordings of the East Biddle uni 00pm on 10/27/15 revealed for first 30 minutes of the taff H, MHT Staff T, and MHT ity Rounds Staff Y remained in					
	EORM CMS /	unit observation cl	hecks. RN Staff V is not seen	211	Fa	cility ID: M061101 If con	tinuation sl	heet Page 4 of f

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174004 B. WING 11/103/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 600 STATE HOSPITAL DSYCHIATRIC STREET ADDRESS, CITY, STATE, ZIP CODE 600 STATE HOSPITAL DSYCHIATRIC SOMMAT VALUE, VIS SEG044 O(A) ID TAG SUMMARY STATEMENT OF DEFICIENCIES EXCURPTIONS INSTITUTE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION D D PARNOERS PLAN OF CORRECTION EACH ORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY A 395 Continued From page 4 until about 30 minutes into the recording when she comes out of the nurses' office behind the lech station and gives linens to MHT Staff T. RN Staff AA is not seen on the unit until about 47 minutes into the recording. LPN Staff D is present in the medication room for the majority of the time, occasionally seen in day hall and going down hallways to patient rooms. Despite the staff were not appropriately stationed to provide patient safety and oversight. A 395 - Administrative Staff X interviewed on 10/29/15 at 5:28 pm with a diagnosis of psychosis (a serious mental disorder characterized by thinking and emotions that are so impaired, the person experiencing them has lost contact with reality. People who are psychotic have false thoughts (delusions) and/or see or hear things that are not there fallucinations), and danger to sefi and others. Patient #3's medical record also showed a history of multiple attempts to strangle his spouse. Qualified mental health professional staff NN completed Patient #3's medical record also showed a history of multiple attempts to this nospital in partoue to the likelih							COMPLETED		
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PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSSREPTERNCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DEFICIENCY A 395 Continued From page 4 until about 30 minutes into the recording when she comes out of the nurses' office beind the tech station and gives linens to MHT Staff T. RN Staff AA is not seen on the unit until about 47 minutes into the recording. LPN Staff D is present in the medication room for the majority of the time, occasionally seen in day hall and going down hallways to patient rooms. Despite the presence of staff members in the tech station, the nurses' station and the medication room, the staff were not appropriately stationed to provide patient safety and oversight. - Administrative Staff X interviewed on 10/29/15 at 9:45pm revealed the hospital has failed to conduct a root cause analysis for the rape that occurred on 10/27/15. - Patient #3's medical record review on 10/29/15 revealed a 42 year-old male admitted on 10/27/15 at 5:28 pm with a diagnosis of psychosis (a serious mental disorder characterized by thinking and emotions that are so impaired, the person experiencing them has lost contact with reality. People who are psychotic have false thoughts (delusions) and/or see or hear things that are not there [hallucintons]), and danger to self and others. Patient #3's medical record also showed a history of multiple attempts to strange his spouse. Qualified mental health professional staff NN completed Patient #3's Mental Health Screening Form on 10/27/15 and recommended involuntary admission to this hospital in part due to the likelihood patient with cause substantial	OSAWAT	OMIE STATE HOSPIT	AL PSYCHIATRIC						
 until about 30 minutes into the recording when she comes out of the nurses 'o ffice behind the tech station and gives linens to MHT Staff T. RN Staff AA is not seen on the unit until about 47 minutes into the recording. LPN Staff D is present in the medication room for the majority of the time, occasionally seen in day hall and going down hallways to patient rooms. Despite the presence of staff members in the tech station, the nurses' station and the medication room, the staff were not appropriately stationed to provide patient safety and oversight. Administrative Staff X interviewed on 10/29/15 at 9:45pm revealed the hospital has failed to conduct a root cause analysis for the rape that occurred on 10/27/15. Patient #3's medical record review on 10/29/15 revealed a 42 year-old male admitted on 10/27/15 at 5:28 pm with a diagnosis of psychosis (a serious mental disorder characterized by thinking and emotions that are so impaired, the person experiencing them has lost contact with reality. People who are psychotic have false thoughts (delusions) and/or see or hear things that are not there [hallucinations]), and danger to self and others. Patient #3's medical record also showed a history of multiple attempts to strangle his spouse. Qualified mental health professional staff NN completed Patient #3's medical record also showed a history of multiple attempts to strangle his spouse. Qualified mental health professional staff NN completed Patient #3's medical record substantial 	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION	
others. - Patient #3 was placed on unit observation status red with 15 minute checks for suicidal ideation on	A 395	until about 30 minur she comes out of the tech station and giv Staff AA is not seen minutes into the react in the medication ro- time, occasionally seed down hallways to pa- presence of staff minurses ' station and staff were not appro- patient safety and of - Administrative Sta at 9:45pm revealed conduct a root cause occurred on 10/27/ - Patient #3's medic revealed a 42 year- at 5:28 pm with a di- serious mental diso and emotions that a experiencing them I People who are psy (delusions) and/or se there [hallucinations others. Patient #3's history of multiple a spouse. Qualified r staff NN completed Screening Form on involuntary admission to the likelihood pat physical injury or pho- others. - Patient #3 was plated	tes into the recording when he nurses ' office behind the res linens to MHT Staff T. RN on the unit until about 47 cording. LPN Staff D is present bom for the majority of the seen in day hall and going atient rooms. Despite the embers in the tech station, the d the medication room, the opriately stationed to provide oversight. Iff X interviewed on 10/29/15 the hospital has failed to be analysis for the rape that 15. cal record review on 10/29/15 old male admitted on 10/27/15 agnosis of psychosis (a rder characterized by thinking are so impaired, the person has lost contact with reality. rchotic have false thoughts be or hear things that are not s]), and danger to self and medical record also showed a ttempts to strangle his nental health professional Patient #3's Mental Health 10/27/15 and recommended on to this hospital in part due ient will cause substantial sysical abuse to himself or	A	395				

Facility ID: M061101

If continuation sheet Page 5 of 8

CENTERS FOR MEDICAR	E & MEDICAID SERVICES					0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			TIPLE CON		(X3) DATE SURVEY COMPLETED	
	174004	B. WING				C /03/2015
NAME OF PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CO	DDE	
OSAWATOMIE STATE HOSP	ITAL PSYCHIATRIC			ATE HOSPITAL DRIVE ATOMIE, KS 66064		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
Check Sheet from required 15 minut documented a ch patient was in the Video camera rec on 10/27/15 from MHT Staff U did required 15 minu as documented of - Video camera r from 8:00pm to 9 Rounds Staff Y fa 10-minute safety until the 8:57pm failed to perform safety rounds ch recordings. Patie the end of this ha failed to perform safety rounds ch recordings. - Administrative 4:30pm acknowl staff complaints not performing t rounds in the da sitting in the MH - Administrative 1:40pm, reveale Staff had been i not been provide	on 10/27/15. Review of a Timed h 10/27/15 revealed a log of the ise checks. MHT Staff U eck at 8:30pm indicating the ir room resting or sleeping. cordings of the East Biddle unit 8:00pm to 9:00pm revealed hot perform Patient #3 's te observation check at 8:30pm in the Timed Check Sheet log. ecordings of the East Biddle unit 1:00pm revealed Security ailed to perform the required rounds checks on Hallway A check. Security Rounds Staff Y any of the required 10 minute ecks on Hallway B during the ent #3 's room was located near allway. Security Rounds Staff Y any of the required 10 minute ecks on Hallway C during the Staff N interviewed on 11/3/15 at edged previous MHT and RN that Security Rounds Staff were he required 10-minute safety y halls of the unit and had been T staff area. Staff X, interviewed on 11/3/15 at ed concerns with Security Rounds dentified, but re-education had ed prior to MHT Staff T being East Biddle unit on 10/27/15.	t	395			

CENTER	SFOR MEDICARE	& MEDICAID SERVICES					. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 174004			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING	G		11	C (03/2015	
	PROVIDER OR SUPPLIER		1	500	REET ADDRESS, CITY, STATE, ZIP CO STATE HOSPITAL DRIVE AWATOMIE, KS 66064		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC	-IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 395	T being attacked, t Security Rounds S required 10-minute Administrative Stat concerns were tha standing around ta performing their ro before their replace - Administrative St 4:50pm revealed s being done consis working on training Administrative Stat complained to ther leave food on unit, securing it, open b use without monitor unit without notifyin Administrative Stat Security Superviso Administrative Stat security Superviso	rvisory staff, prior to MHT Staff hat they had concerns with taff incorrectly performing the e security rounds. If R acknowledged some of the t security round staff are alking with MHT staff, not unds, and leaving the unit ement arrives. aff Q interviewed on 11/3/15 at security round checks are not tently, they are currently g the security personnel. If Q said that hospital staff m that security rounds staff place their I-Pad down withou bathrooms doors for patients to pring outside of door, and leave	t	395			
	 Video camera refrom 8:00pm to 9: an open and unsuligature hazards a patients on the un an unidentified pa bathroom/shower video revealed Mil bathroom door do unidentified patier leaving the patien 	ecordings of the East Biddle un 00pm revealed the day hall wit pervised bathroom containing nd that was available to all it. The video further revealed tient leaving an unsupervised room down the A Hallway. The HT staff U unlocking another wh the A hallway for an ht. MHT Staff U walked away t unattended in a bathroom that hazards. The unidentified	h				
FORM CMS-	2567(02-99) Previous Versio	ns Obsolete Event ID: 3GI	0211	Fac	ility ID: M061101	If continuation s	heet Page 7 o

	S FOR MEDICARE	a MEDICAID SERVICES				ONID NO. 0930-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MUL A. BUILD	TIPLE CONSTRUCTIO	(X3) DATE SURVEY COMPLETED		
		174004	B. WING			C 11/03/2015
	PROVIDER OR SUPPLIER	TAL PSYCHIATRIC		STREET ADDRESS 500 STATE HOSP OSAWATOMIE,		1 1100/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CO	IDER'S PLAN OF CORREC ORRECTIVE ACTION SHO FERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
A 395	available for all pat unattended bathroo available for use by Leaving bathrooms potential anchors fu unsupervised place thoughts at risk for Policy titled " Ther (PC 10.1) dated Se 1. Policy. The purp Observation Status patient and others. -Three Types. 2. U Alert) 15 minute ch are newly admitted hospital staff; have imminent threat of recently engaged in not currently commothers, and are coo avoid harm to self by the interdiscipline monitoring should with 15 minute che Staff to complete the patient to a room a as possible. e. Nur interacts with the p status and potentia	the bathroom door open and ients. The video revealed an om down Hallway C open and y any patient on the unit. s/shower rooms that have or hanging open and ed patients with suicidal harming themselves. apeutic Observation Status eptember 18, 2015 read in part: ose of Therapeutic s is to maintain the safety of the E. Standard Observation nit Observation (Red -High neck. a. Some individuals who and/or not well known to the potential to become an harm as evidence by having n such behavior, but who are nunicating threats to self or operative with staff requests to or others; or anyone assessed hary team as requiring close be placed on Unit Observation tocks. c. The R.N. Assigns: i. he Timed Check Sheet. II The is close to the nursing station sing Staff: i. Periodically natient to ascertain mental al risk to self or others. g. ii. Determines the patient ' s	A3	95		
FORM CMS-25	567(02-99) Previous Version	s Obsolete Event ID: 3GD21	1	Facility ID: M061101	If cor	ntinuation sheet Page 8 of 8