STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	174004	A. BUILDING _____ B. WING _____	C 11/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAWATOMIE STATE HOSPITAL PSYCHIATRIC	500 STATE HOSPITAL DRIVE OSAWATOMIE, KS 66064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #93304 completed at the above named facility. The survey (ASPEN #3GD211) resulted in non-compliance with one Condition of Participation: 42 CFR 482.23, requirements for Nursing Services. The survey resulted in an Immediate Jeopardy with the Condition of Participation, 42 CFR 482.23, requirements for Nursing Services that was not removed on exit 11/3/15.	A 000		
A 385	482.23 NURSING SERVICES 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 observation, staff interview, and document review, the facility failed to ensure nursing staff provided oversight for the provision of patient care, failed to ensure Security Rounds Staff performed appropriate safety round checks, failed to ensure nursing staff completed therapeutic observation status level checks, and failed to ensure nursing staff supervised patients in shower rooms and bathrooms with ligature risks (refer to A-0395). This failure of Nursing services resulted in the Centers for Medicare and Medicaid Services notifying the facility of an immediate jeopardy situation on 11/3/15 at 1:19pm that was not removed on exit on 11/3/15 at 6:30pm. The cumulative effect of the systemic failure to supervise the provision of care, to perform required safety checks, and to protect suicidal	A 385		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 385	Continued From page 1 patients from hanging risks placed all patients receiving services at risk for harm.	A 385		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on observation, staff interview, and document review, the facility failed to ensure nursing staff provided oversight for the provision of patient care, failed to ensure Security Rounds Staff performed appropriate safety round checks, failed to ensure nursing staff completed therapeutic observation status level checks, and failed to ensure nursing staff supervised patients in shower rooms and bathrooms with ligature risks. These deficient practices placed all patient at risk for harm and resulted in the Centers for Medicare and Medicaid Services notifying the facility of an immediate jeopardy situation on November 3, 2015 at 1:19pm that was not removed at exit on November 3, 2015 at 6:30pm. Findings include: -A telephone interview on 10/30/15 at 1:15 pm with (Mental Health Technician) MHT Staff T revealed she was working evening shift (2:30pm to 11:00pm) on 10/27/15. She was taking gowns to Patient #3 ' s room on hallway B around 8:30pm and she had told the other MHT Staff H that she was going to the patient ' s room. The MHT Staff T said Patient #3 grabbed me and put his hand on my mouth and I was trying to scream and was banging on the walls and he raped me. MHT Staff T said she doesn ' t believe anyone	A 395		

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A 395	Continued From page 2	A 395		

would have been able to hear her from the tech station. Two patients (Patients #2 and #8) saved me. They came before any staff did. Patient #8 opened the door and Patient #2 shoved him (Patient #3) back off of me.

- Patient #2, interviewed on 10/30/15 at 12:15pm, said he and a friend (Patient # 8) were walking down hallway B and heard noises, but did not think much about them because there are always noises on the unit. When they got 3/4 of the way down hallway B, Patient #2 thought they heard someone screaming, crying, and the word rape. Patient #2 said they opened the door to Patient #3 ' s room and saw MHT Staff T on the bed with her pants down and legs spread. Patient #2 reported they pulled Patient #3 off of MHT Staff T and threw Patient #3 against the wall and held him there while Patient #8 was in the hallway screaming " he raped her, he raped her " . MHT Staff H arrived and took patient #3 to the seclusion room.

-MHT Staff H interviewed on 11/2/15 at 2:10pm revealed he worked on the East Biddle unit on 10/27/15. MHT Staff H said he and MHT Staff U heard a patient screaming for help from down hallway B and they both ran down to Patient #3 ' s room where the attack occurred. MHT Staff H said staff could not hear anything down the hallways because of the noise on the unit and if the MHT station doors are closed, they could not hear all the way down the hallways even without all the noise.

- Review of the hospital ' s Safety and Security Log from 10/27/15 revealed East Biddle staff called Security at 8:38pm reporting a staff member was raped and Security responded at

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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.

- 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 8:28:55pm. 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 8:32:22pm. 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 up the hallway. Two security officers are then seen coming down the hallway toward patient #3 ' s room at 8:38pm. RN Staff AA then appears at 8:47:13pm and is seen escorting police officers to the room at 8:52:36pm.

- 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 U and Security Rounds 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

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A 395	Continued From page 4 until about 30 minutes into the recording when she comes out of the nurses ' office 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 Mental Health Screening Form on 10/27/15 and recommended involuntary admission to this hospital in part due to the likelihood patient will cause substantial physical injury or physical abuse to himself or others. - Patient #3 was placed on unit observation status red with 15 minute checks for suicidal ideation on	A 395		

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A 395	Continued From page 5 arrival to the unit on 10/27/15. Review of a Timed Check Sheet from 10/27/15 revealed a log of the required 15 minute checks. MHT Staff U documented a check at 8:30pm indicating the patient was in their room resting or sleeping. Video camera recordings of the East Biddle unit on 10/27/15 from 8:00pm to 9:00pm revealed MHT Staff U did not perform Patient #3 ' s required 15 minute observation check at 8:30pm as documented on the Timed Check Sheet log. - Video camera recordings of the East Biddle unit from 8:00pm to 9:00pm revealed Security Rounds Staff Y failed to perform the required 10-minute safety rounds checks on Hallway A until the 8:57pm check. Security Rounds Staff Y failed to perform any of the required 10 minute safety rounds checks on Hallway B during the recordings. Patient #3 ' s room was located near the end of this hallway. Security Rounds Staff Y failed to perform any of the required 10 minute safety rounds checks on Hallway C during the recordings. - Administrative Staff N interviewed on 11/3/15 at 4:30pm acknowledged previous MHT and RN staff complaints that Security Rounds Staff were not performing the required 10-minute safety rounds in the day halls of the unit and had been sitting in the MHT staff area. - Administrative Staff X, interviewed on 11/3/15 at 1:40pm, revealed concerns with Security Rounds Staff had been identified, but re-education had not been provided prior to MHT Staff T being attacked on the East Biddle unit on 10/27/15. - Administrative Staff R, interviewed on 11/3/15 at 3:35pm, revealed they had received reports from	A 395		

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A 395	Continued From page 6 the hospitals supervisory staff, prior to MHT Staff T being attacked, that they had concerns with Security Rounds Staff incorrectly performing the required 10-minute security rounds. Administrative Staff R acknowledged some of the concerns were that security round staff are standing around talking with MHT staff, not performing their rounds, and leaving the unit before their replacement arrives. - Administrative Staff Q interviewed on 11/3/15 at 4:50pm revealed security round checks are not being done consistently, they are currently working on training the security personnel. Administrative Staff Q said that hospital staff complained to them that security rounds staff leave food on unit, place their I-Pad down without securing it, open bathrooms doors for patients to use without monitoring outside of door, and leave unit without notifying the units staff. Administrative Staff Q stated they have notified Security Supervisor Staff Z of these complaints. Administrative Staff Q revealed there are currently not enough RN ' s to supervise the floor, provide patient interactions, and do patient charting. - Video camera recordings of the East Biddle unit from 8:00pm to 9:00pm revealed the day hall with an open and unsupervised bathroom containing ligature hazards and that was available to all patients on the unit. The video further revealed an unidentified patient leaving an unsupervised bathroom/shower room down the A Hallway. The video revealed MHT staff U unlocking another bathroom door down the A hallway for an unidentified patient. MHT Staff U walked away leaving the patient unattended in a bathroom that contained ligature hazards. The unidentified	A 395		

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A 395	Continued From page 7 patient then leaves the bathroom door open and available for all patients. The video revealed an unattended bathroom down Hallway C open and available for use by any patient on the unit. Leaving bathrooms/shower rooms that have potential anchors for hanging open and unsupervised placed patients with suicidal thoughts at risk for harming themselves. Policy titled " Therapeutic Observation Status (PC 10.1) dated September 18, 2015 read in part: 1. Policy. The purpose of Therapeutic Observation Status is to maintain the safety of the patient and others. E. Standard Observation -Three Types. 2. Unit Observation (Red -High Alert) 15 minute check. a. Some individuals who are newly admitted and/or not well known to hospital staff; have the potential to become an imminent threat of harm as evidence by having recently engaged in such behavior, but who are not currently communicating threats to self or others, and are cooperative with staff requests to avoid harm to self or others; or anyone assessed by the interdisciplinary team as requiring close monitoring should be placed on Unit Observation with 15 minute checks. c. The R.N. Assigns: i. Staff to complete the Timed Check Sheet. II The patient to a room as close to the nursing station as possible. e. Nursing Staff: i. Periodically interacts with the patient to ascertain mental status and potential risk to self or others. g. ii. During checks, 1) Determines the patient ' s location, activity and behavior.	A 395		