174004
12/18/2015
R-C

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

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5)
COMPLETION
DATE
ID
PREFIX
TAG
(X4) ID
PREFIX
TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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INITIAL COMMENTS

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The following report represents the findings of an immediate jeopardy revisit survey (ASPEN #3GD212).

The survey resulted in representatives of the Centers for Medicare and Medicaid Services (CMS) notifying the hospital administration on December 18, 2015 at 4:46 pm that the immediate jeopardy situation had not been removed and that termination of the hospital's Medicare participation would take place as scheduled on December 21, 2015.

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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:

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Based on observation, staff interview, and document review, and medical record review, the facility failed to ensure nursing staff provided oversight for the provision and evaluation of patient care (refer to A-0395).

This failure of Nursing services resulted in the Centers for Medicare and Medicaid Services notifying the facility that the immediate jeopardy situation still existed on 12/18/15 at 4:46pm and that termination of their Medicare participation would take place on 12/21/15 as scheduled.

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482.23(b)(3) RN SUPERVISION OF NURSING CARE

A registered nurse must supervise and evaluate

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the nursing care for each patient.

This STANDARD is not met as evidenced by:
Based on record review, document review, and staff interview, the facility's nursing staff failed to: protect patients from other patients' aggressive/assaultive behaviors (patient #1, patient #2, and patient #3); supervise a patient closely enough to prevent self harm including a suicide attempt (patient #1), prevent two patients from having sexual relations with each other (patient #1 and patient #2); respond to staff concerns about the room placement of patients (patient #1 and patient #2); respond to treatment teams warnings regarding the relationship forming between two patients (patient #1 and patient #2); change observation status level in a timely manner after patient #2 admitted to having sexual relations with another patient (#1); and recognize escalating aggressive behaviors not responding to interventions (patient #3).

Findings include:

Patient #1

Patient #1 was admitted on 5/21/14 with diagnoses of posttraumatic stress disorder (a mental health condition triggered by experiencing or seeing a terrifying event), Bipolar I disorder with psychotic features (a mood disorder characterized by unusually euphoric or agitated moods, along with depression which can severely impact a person ' s ability to function), and borderline personality disorder (mental disorder characterized by unstable moods, behavior, and relationships).

Record review revealed the patient participated in

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self-harm by placing objects like coins, pens, spoons, knives, and safety pins in her eyes, ears, and vagina and attempted suicide while on 15 minute observation checks:

12/9/15 Gynecology consult ordered as patient stuck 2 quarters and a penny in her vagina.
12/9/15 X-ray ordered; patient swallowed a pen.
12/13/15 Patient reports placing safety pins in her vagina.
12/13/15 Patient stuck a self-dissolving pen in inner aspect of right eye.
12/14/15 Medical consult due to patient sticking objects up vagina and ear including an insulin cap, spoon, serrated knife, and coins into her vagina and a color pencil in her right ear.
12/15/15 Patient placed spoon in her vagina.
12/16/15 Patient attempted suicide by tying a pair of pants around her neck and banging her head on the wall.

Record review revealed the patient participated in assaultive/aggressive acts against other patients or staff including choking, pulling handfuls of hair out, kicking, and throwing coffee while on every 15 minute observation checks:

12/9/15 Patient grabbed another patient's hair (#6) and put her fingers in his mouth and stretched it outward.
12/9/15 Patient dug her nails in a staff member's arm and kicked staff in upper thigh.
12/10/15 Patient choked peer (#6).
12/13/15 Patient choked peer (#6). Patient threw hot coffee on a staff member. Forcibly pulled hair out of peer's head (#5).
12/15/15 Patient choked peer (#6).
12/16/15 Patient ripped a handful of peer's hair out (#8) and then came back a few minutes later

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and attempted to choke her.

LMSW Staff G on 12/7/15 documented in communication to treatment team members that since patient #1 was purposefully attacking others and voicing that she will continue to do so until she gets what she wants, which at this time is 1:1 status and due to this being behavioral and done purposefully, a request to follow the procedure and file police reports when patient #1 attacks others as this behavior is unacceptable. LMSW Staff G said in an interview on 12/17/15 that local authorities would not press charges against patient #1.

Violence Risk Screening Assessment (VRA) completed on 12/9/15 by LMSW (Licensed Master Social Worker) Staff scored the patient in the Moderate Risk range (7-13 points). Further, it documented "No More Detailed Violence Risk Assessment was needed". The box indicating the need for the Implementation of Preventive Measures was left blank.

Interview on 12/17/15 with the Director of Psychology and Therapy Services regarding the Violence Risk Screening Assessment tool, "the violence risk assessment is meant to be done for all new admissions, not for current patients. Current patients have treatment plans in place to address their identified needs. I would not recommend redoing the VRA during a patient's stay, it is meant to tell us what kind of issues a patient has coming through the door, so teams can prepare." We do not have a policy and procedure in place for this tool, but it comes with instructions for scoring the patient.

LMSW Staff G on 12/11/15 documented in

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communication to treatment team members that patient #1 has attacked two peers over the past few days. She choked patient #6 and put her fingers inside another peers mouth to stretch it out. Patient #1 is doing this purposefully and team is requesting she be held accountable for this. Licensed Professional Counselor (LPC) Staff H questioned whether placement at hospital CC (a psychiatric hospital with greater restrictions) would be an option for placement since she is not getting better here. Director of Psychology and Therapy Services indicated that hospital CC's sexual behavioral unit was not an option for patient #1 as it is a male only program. RN Staff L sent communication to treatment team on 12/14/15 indicating that patient #1 was targeting patient #5 (her roommate) and this is not the first time she has done this to patient #5 who is vulnerable (patient #5 is in a wheelchair and unable to defend herself). They are roommates so we are going to move patient #5 out of that room today but staff feel like patient #1 will continue behavior toward patient #5. (Patient #5 was not moved out of the room on 12/14/15 due to her being a target. However, later on this day, patient #1 was transferred to another unit due to a consensual sexual incident with patient #2).

Interview with LPC Staff H on 12/17/15 revealed that the Mental Health technician (MHT) staff were telling the nurses it is not appropriate for patient #1 to be with patient #5, who is wheelchair bound. Treatment team staff noted Patient #1 and Patient #2 sitting together and told nursing staff " to watch them " on 12/13/15. "They had been warned that patient #1's behaviors were escalating".

Record review revealed the treatment team noted

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on 12/14/15 (a week after the last note), patient "is acting aggressively in a malicious and purposeful manner, laughing and mocking those she harms. She is non-chalant about her self-harming behaviors and reports she will continue them as well. Silver status (one on one observation) is not recommended at this time as this is what (the patient) wants and serves as secondary gain and reinforces her actions." So, patient remained on 15 minute observation checks.

Record review revealed on 12/14/15, Staff caught Patient #1 and Patient #2 kissing in the TV room. Patient #1 and #2 report that they had sex earlier in the day. Patient #1 then transferred to a different unit by APRN staff B " for safety of other peers " . No changes made to treatment plan or orders to keep patients in the new unit safe from patient #1 or to keep her safe from herself until about 24 hours later when an order is written by APRN staff B to search the patient's room now and as needed for objects the patient might use to self-harm.

Record review showed even after the transfer on 12/14/15, Patient #1 continued her self-harming behavior by inserting objects into her ear and vagina and continued her aggressive assaultive behaviors by choking and pulling another patient's hair.

Record review showed even after Patient #1 attempted suicide on 12/16/15 by tying her pants around her neck and banging her head against the wall, Patient #1 remained on 15 minute observation status (RED) checks.

Interview with LMSW staff G on 12/17/15 when

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asked about patient #1's aggressive acts and her 15 minute observation status said, "a 1:1 would help prevent harm to others".

Patient #2

Patient #2 was admitted from Hospital CC due to recent history of 3 weeks with no aggression or sexual activity. The patient was admitted to this hospital for a less restrictive environment and for discharge planning. The patients diagnosis included antisocial personality disorder (a mental health disorder characterized by disregard for other people) and major depressive disorder with psychotic features (a mental disorder in which a person has depression along with loss of touch with reality). The patient was identified at risk for sexual aggression due to his history of criminal sodomy. The patients history included sexual abuse from his mother and brother. The patient is a registered sex offender. Hospital staff placed the patient on every 60 minute therapeutic observation status checks.

A "Violence Risk Screening Assessment" tool, completed on 12/3/15 by PhD staff K, scored patient #2 in the High range. "No More Detailed Violence Risk Assessment" was checked. The box indicating the need for the" Implementation of Preventive Measures" was blank.

Record Review showed patient #2 displayed inappropriate sexual behaviors including kissing other patients, attempting to kiss other patients, hugging and inappropriately touching other patients, and having another female patient place her hands down his pants:
12/9/15 Patient approached patient #9 from behind, grabbed her hair, and attempted to kiss

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her.
12/10/15 Patient extremely close to patient # 9. Sat with blanket over their laps. In day hall, pushed brown chairs together like a couch where he and patient # 10 sat most of the day. Seen holding hands.
12/10/15: Review of observational status. Patient #2 had a verbal outburst, destroyed property and threatened a peer with a broken toothbrush. He has been sexually inappropriate, touching and kissing female peers despite numerous education and redirection. He will remain on unit observation, 60 minute checks.
12/10/15: Patient #2 was transferred to B1 unit with his belongings because of an alleged incident that occurred with another male peer. He was placed in a room that is predominantly a female hallway. Nursing staff placed him in a room next to patient #1 and he remained on 60 minute observation checks.

An interview with LMSW Staff G on 12/17/15 revealed that nurses's make the decision about where patient's go, nursing made the decision to put patient #2 on the female hallway.

An interview with LPC Staff H on 12/17/15 revealed treatment team staff felt like this was a poor room assignment due to patient's history of inappropriate sexual behaviors and recent aggression and indicate that nursing makes the decision about bed placement. Patient #2 remained in this room until after he reported that he had sex with patient #1 a few days later. The Interdisciplinary team (IDT) can't have a RN (registered nurse)at team meetings-they have to be communicated with via phone. RN supervision is terrible. Yesterday there was a tech at the desk and a nurse in the office. Patient #3 took a swing

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at me and missed. The nurse rolled her eyes and the tech did nothing.

Record review from 12/14/15 showed Patient #2 continued flirting with female patients in the B1 unit and making inappropriate sexual gestures. Treatment team staff noted Patient #1 and Patient #2 sitting together and told nursing staff " to watch them " .

Record review from 12/14/15: Staff caught patient #1 and patient #2 kissing in the TV room. Patient #1 and #2 reported that they had sex earlier in the day. The next day, the treatment team placed patient #2 on 15 minute checks related to the inappropriate sexual behavior the day before and had him moved to the A (" Male ") hallway.

An interview with LPC Staff H on 12/17/15 revealed the treatment team indicated the nursing staff should have placed patient #2 on 15 minute checks at the time when they discovered the reported sex with patient #1.

Record review revealed on 12/16/15, patient #2 made sexually inappropriate comments to patient #8. He made explicit threats to kill a staff member. Patient #2 reported to housekeeper that he had sex with another patient but was not caught. Also told her he had contraband in his room and " if you find it, hide it again. " When questioned, denied having sex with anyone other than patient #1.

In an interview with LMSW Staff G on 12/17/15 at 3:00, "patient #2 is not in the right environment. The case mix in this unit is loaded so heavy with high risk patients that it is the "perfect storm".

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Patient #3

Patient #3 was admitted on 12/17/14 with diagnosis of schizophrenia (a serious disorder which affects how a person thinks, feels and acts. Someone with schizophrenia may have difficulty distinguishing between what is real and what is imaginary; may be unresponsive or withdrawn; and may have difficulty expressing normal emotions in social situations).

A "Violence Risk Screening Assessment" tool, completed on 12/3/15 by LPC staff H, scored patient #3 in the High range. "No More Detailed Violence Risk Assessment" was checked. The box indicating the need for " Implementation of Preventive Measures" was blank.

LMSW Staff G documented a review of the patient's observational status on 12/10/15: Patient #3 suffers from severe psychosis (a serious mental disorder characterized by thinking and emotions that are so impaired, that they indicate that the person experiencing them has lost contact with reality), even with medications, often resulting in him being irritable or acting out aggressively. Patient #3 is currently on orange (60 minute) monitoring.

Documentation in the medical record between 12/10/15 and 12/13/15 revealed two instances of disruptive behaviors: 12/10/15 yelling, spitting and disrobing during a group and 12/12/15 yelling at his peers.

RN staff MM documented in the record on 12/13/15, Patient #3 at approximately 11:25 am went up to peer #6 and hit peer in the arm. Patient #3 has been loud - pretend "shooting"

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people all morning long. He has been trying to get food from the trash can and was putting his fists up to certain peers as if inviting them to fight, this (happened) multiple times.

The next day 12/14/15 at 5:55 am, MHT Staff YY documented in the record that, "patient #3 was on the dayhall shadow boxing with unseen others...I asked him if he was okay, he then turned around and punched me in the jaw...He then proceed to do more shadow boxing and yelling.

Later the morning of 12/14/15 at 9:00, LMSW Staff G documented in the record that during Group therapy, patient #3 was irritable and paced in and out of group. He mumbled several statements that sounded hostile in nature.

Later in the afternoon of 12/14/15 at 12:44 pm, MHT Staff ZZ documented in the record, "patient #3 was verbally hostile this shift...after lunch he threw all the trays and started screaming."

Later in the evening of 12/14/15, video footage review between 7:00pm and 9:00pm showed patient #3 pacing around the dayhall, pulling stuff out of the trash, "shadow" boxing with unseen others and seen going up to several peers like he was inviting them to fight with him. Patient appeared agitated and irritable. Patient #3 seen talking with another patient, pointing his finger and moving his arms around. At 8:22 pm, patient #3 seen talking to patient #12, close to his face and pointing his finger at patient #12. At 8:24 pm, patient #3 stabbed patient #5 who is confined to a wheelchair with a plastic utensil that he had found on the table earlier and he kicked one of the staff members. He was then redirected by staff to a different area of the dayhall. At 8:26 pm, patient

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#3 stands up from the chair, appearing upset, mad and moving his arms around again like he is boxing. He moves to another chair and begins talking to patient #12 again and is pointing his finger at him. Patient #3 continues to alternately pace and sit at different places around the dayhall, also seen crawling on the floor under the table where patient #5 is seated. At 8:36 pm, patient walks around the table and hits patient #5 in the back and head multiple times with his fist. Patient #3 is escorted to his room, but comes back out and spit on a patient and threw a trash can lid at a staff member. Patient was then escorted by staff to another area of the dayhall to sit where he proceeded to disrobe.

Nursing Staff failed to recognize patient #3's aggressive behaviors were escalating beginning on 12/13/15 and that he was on the verge of a physical outburst. Nursing staff failed to recognize that patient #3 did not respond to interventions like moving him to another area of the dayhall or to his room. Nursing Staff failed to intervene early enough when patient #3 showed these increasing signs of aggression and violence and thus failed to protect a vulnerable patient (#5) from patient 3's aggressive/violent behavior twice in a fifteen minute period of time. Nursing staff failed to document the patient's hourly observation status between 7:10pm and 8:53pm (103 minutes) on 12/14/15.

On 12/15/15, LPC staff H documented that "patient #3 was in seclusion (12/14/15)due to throwing things, hitting peers, stripping naked, and yelling. He was difficult to redirect. Patient #3's treatment plan includes interventions for aggression, no changes are needed at this time".

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No changes were made to patient #3's treatment plan. Record review showed that on 12/15/15 and 12/16/15 patient #3 continued his aggressive behaviors including cursing, yelling, spitting and attempting to hit peers and staff. It was not until the afternoon of 12/16/15 (2 days after patient #3's aggressive/disruptive behaviors escalated) that the treatment team recommended a psychiatrist review for possible medication changes.