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 _____	01/23/2015

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OSAWATOMIE STATE HOSPITAL PSYCHIATRIC	500 STATE HOSPITAL DRIVE OSAWATOMIE, KS 66064

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A 000	INITIAL COMMENTS The following citations represent the findings of health resurvey (ASPEN #15HF11) completed at the above named facility. The health resurvey resulted in non-compliance with five Conditions of Participation of Patient Rights 42 CFR 482.13; Governing Body 42 CFR 482.12; Condition of Participation of Quality Assessment and Performance Improvement Program 42 CFR 482.21; Condition of Participation of Nursing Services 42 CFR 482.23 and Discharge Planning 42 CFR 482.43. The survey resulted in Immediate Jeopardy with the Condition of Participation of Patient Rights 42 CFR 482.13 and Condition of Participation of Nursing Services 42 CFR 482.23 that were not removed on exit 1/23/15.	A 000		
A 043	482.12 GOVERNING BODY There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observation, document review, and staff interview, it was determined that the hospital's governing body failed to ensure the hospital met all Federal regulations and assumed full responsibility for determining, implementing, and monitoring policies governing the hospital's total operation. The governing body failed to provide a ligature risk free environment and provide for care in a safe setting (refer to A-0115 and A-0144). The governing body failed to	A 043	**A 043** **POC:** - Through implementation of the plan of correction for Patient Rights; Quality Assessment/Performance Improvement; Nursing Services; Nursing Care Plans; Organization & Staffing; Maintenance of the Physical Plant; Facilities, Supplies, Equipment Maintenance; Infection Control Program; Discharge Planning; Transfer & Referral; and Special Medical Record Requirements for Psychiatric Hospitals, the Governing Body will ensure that the hospital meets Federal regulations. - The Governing Body, Administrative Executive Team (AET), will provide the guiding force in ensuring the proper conduct for the hospital services - By transforming the Performance Improvement Council into the AET, the Governing Body will ensure the proper vision, guidance, and assurances that proper functions will occur within the hospital. - The implementation of preventive actions and mechanisms that include feedback and learning throughout the hospital will result in systemic changes to increase	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jerry Rea | Superintendent | 3-2-15

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 043	Continued From page 1 develop an ongoing program that shows measurable improvement in indicators for which there is evidence that will improve health outcomes and must measure analyze and track quality indicators that identify improvement projects for processes of care, hospital service and operations (refer to A-0273); failed to use data collection to identify opportunities for improvement and changes that will lead to improvement and must set priorities for its performance improvement activities that focus on problem prone areas (refer to A-0283); failed to include an ongoing program that shows measurable improvement in indicators for which there is evidence it will identify and reduce medical errors, measure and analyze and track adverse events in the pharmacy and failed to implement preventive actions and mechanisms that include feedback and learning throughout the hospital (refer to A-0286); failed to ensure all hospital departments and services participate in the QAPI (Quality Assurance and Performance Improvement) program and maintain and demonstrate evidence (refer to A-0308); and the hospital's governing body failed to ensure that an ongoing program for ongoing quality improvement and patient safety included the reduction of medical errors and failed to ensure the hospital wide quality assessment and performance improvement efforts addressed priorities for improved quality of care, patient safety and all improvement actions are evaluated (refer to A-0309).The governing body failed to ensure the hospital planned appropriately and provided staff in adequate numbers, according to the unit's patient census, to ensure nursing staff responded to each individual patient's nursing needs in a safe and effective manner around the clock; (refer to A-0392). provide ongoing nursing	A 043	quality improvement and patient safety through the reduction of medical errors. - As the hospital continues to recruit quality staff, it will continue to work with contractors to ensure continuity of adequate staffing to meet patient needs. - In order to ensure continuous growth of services, feedback from our most important resource, our staff, will be obtained through the Idea Exchange, the Franklin Covey process, face to face interactions with staff at all levels in the organization. - In order to increase the likelihood of successful discharge to the community, the hospital will evaluate all patients support needs ranging from social support to medical needs. Plans will be implemented to address these needs. - Finally through the implementation of this plan of correction, the Governing Body is committed to the delivery of safe and high quality services to individuals with mental illness. **How are we monitoring:** - AET will monitor activities of the oversight committees charged with producing services from the respective department. **Ensure Compliance:** - In its oversight, if care, treatment and services do not meet the established expectations, the Superintendent will require follow-up through the department head and other leaders. **Individual Responsible for Compliance:** Superintendent	

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A 043	Continued From page 2 assessments when a patient experiences changes in physical condition; complete ongoing assessments of patient responses to interventions; and notify physician of changes in patient's condition; (refer to A-0395).The governing body failed to ensure nursing staff followed their policy to update and keep a current nursing care plan; (refer to A-0396). The governing body failed to provide a designated professional responsible for maintaining the medical records (refer to A-0432).The governing body failed to develop and maintain an environment to ensure the safety and well-being for special needs of patients admitted to the psychiatric hospital (refer to A-0701). The governing body failed to ensure hospital staff maintain facility supplies and equipment to ensure safety and quality (refer to A-0724). The governing body failed to develop an active infection control system (refer to A-0749). The governing body failed to ensure the hospital establish in writing discharge planning policies and procedures planning (refer to A-0799, A-0800, A-0806, A-0807, A-0810, A-0811, A-0812, A-0818, A-0819, A-0820, A-0821, and A-0823). The governing body failed to ensure staff discharge patients when they transferred to another hospital for further care and/or treatment (refer to A-0837). The governing body failed to reassess its discharging process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs (refer to A-843).	A 043		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights.	A 115		

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A 115	Continued From page 3 This CONDITION is not met as evidenced by: Based on observation, document review, and staff interview the hospital failed to provide care in a safe setting to patients admitted to the hospital for 2 of 2 suicidal patients and 29 of 29 assaultive/violent patients in the MAPS A1 unit, 14 of 14 suicidal patients and 12 of 12 assaultive/violent patients in the MAPS A2 unit, 1 of 1 suicidal and 20 of 20 assaultive/violent patients in CCP unit B1, 3 of 3 suicidal patients and 25 of 25 assaultive/violent patients in the SSP unit B2, 24 of 24 suicidal patients and 19 of 19 assaultive/violent patients in the PLS unit C1, 6 of 6 suicidal patients and 15 of 15 assaultive/violent patients in the HOPE unit C2, and 17 of 17 suicidal patients and 5 of 5 assaultive/violent patients in the CSP unit EB by failing to : - Identify potential risks and conduct surveillance in the physical environment according to the " Safety Management Plan " Policy; - Provide non-suicide resistive shower and tub water control knobs, non-exposed plumbing on sinks and commodes, and non-hinged commode seats. The configuration of the water control knobs, exposed plumbing pipes, and hinged commode seats created a looping hazard (material or a device could be looped around the knobs or plumbing to be used for choking or strangulation) in all 30 bathrooms/shower rooms in seven of seven nursing units throughout the facility; - Secure heavy furniture which could provide dangerous projectiles or could easily be maneuvered and positioned under a protruding device as potential for hanging; - Remove metal closet doors with either a handle, latch hook, or a one-inch opening. The closet handles, latch hooks, or openings	A 115	**A 115 and A 144** **POC:** **Patient Assessments:** Supervision of patients is based on the assessed level of risk. Risk assessments are conducted upon admission and thereafter at varying intervals based on the current level of risk assigned to each individual patient. It is the primary objective of the hospital to ensure the level of supervision is adequate to meet the current needs of patients. (See Attachment 1, procedure PC-10.1, Therapeutic Observational Status). All Registered Nurses, Security Officers, and Admissions Clerks will be trained on the revised admissions process outlined in Attachment 2. Training will begin on March 2, 2015 and will be completed and implemented by March 11, 2015. The Program Nurse Manager will train all Registered Nurses on the revised admissions triage process including the initial Observational Status determination for all patients admitted to OSH. The Director of Quality Management will train all Admissions Clerks and Secuity Officers on the revised admissions process	

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A 115	Continued From page 4 potentially provide a hanging, choking, or strangulation hazard in all 138 patient rooms; - Provide door handles that prevent an anchor point. The door handles created a potential ligature attachment point affecting all patients admitted to the hospital at risk for suicide; - Secure pictures to the wall using tamper resistant screws or anchors. The picture frames have the potential to be used as a weapon on others affecting all patients admitted to the hospital at risk for harming themselves or others; - Secure heating/cooling vents to the ceiling and air exchange vents to the wall with tamper resistant screws or anchors creating an anchor for hanging or used as a weapon affecting 16 hallways, 138 patient rooms, seven day halls, 30 bathrooms/shower rooms throughout the facility; - Provide a non-tamper proof ceiling. The suspended ceiling with removable tiles expose pipes and wiring above the tiles that have the potential to provide a hanging, choking, or strangulation hazard in 132 patient rooms, 16 hallways, 4 comfort rooms, and seven day halls throughout the facility; - Remove, replace, or cover electrical outlets. The electrical outlets could be accessed with the potential to create a fire or electrical shock in 138 patient rooms, 30 bathrooms/shower rooms, 16 hallways, 4 comfort rooms, and 7 day halls throughout the facility; - Secure ceiling mounted florescent light fixtures. The light fixtures have the potential to provide an anchor for hanging in 138 patient rooms, 30 bathrooms/shower rooms, 16 hallways, 4 comfort rooms, and 7 day halls throughout the facility; - Remove hospital gowns with string closers and fitted sheets with elastic from patient use. The strings and elastic have the potential to provide a hanging, choking, or strangulation risk for all	A 115	including the Observational Status determination upon admission. The Director of Nursing is responsible for ensuring that all new and existing registered nureses have received this training. The Director of Quality Management is responsible for ensuring that all new and existing Admissions Clerks and Security Officers have received this training. The admissions process including the Mental Health Screening Form, the appropriateness of admission and unit placement , referral source, and patient Observational Status determination is reviewed by the Assistant Superintendent monthly and consists of 10% of all admissions. (See Attachment 3.) All data from this review is shared no less than quarterly with the Clinical Executive Team so that the Director of Nursing and the Director of Social Work can follow up as necessary with nursing staff and community mental health centers. The hospital has increased staffing levels to ensure there is continuous supervision in all areas where patients reside including common areas and patient rooms. All patients will be randomly checked on every 5 -10 minutes in addition to the checks required based upon the risk level assigned to each individual patient.	

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A 115	Continued From page 5 patients at risk for suicide in seven of seven nursing units throughout the facility; - Provide a barrier between the Mental Health Technician (MHT) station and patients in the day hall. Patients could reach the telephone and computer keyboard and cord to use for hanging, choking, or strangulation or as a weapon on three of seven patient units; - Secure laundry soap in patient ' s laundry room in two of seven laundry rooms. Laundry soap, when ingested, could be harmful; - Provide a patient lift for patients exceeding four hundred pounds. The lift had the potential for a fall hazard for one patient over four hundred pounds. Refer to A-0144 - The hospital admits patients with diagnosis of schizophrenia (mental disorder that makes it hard to: tell the difference between what is real and not real; think clearly; have normal emotional responses; act normally in social situations, psychotic disorders (loss of contact with reality that usually includes: false beliefs about what is taking place or who one is (delusions) ; seeing or hearing things that aren't there (hallucinations)), depressive disorders, bipolar disorders (condition in which a person has periods of depression and periods of being extremely happy or being cross or irritable), anxiety disorders, impulse-control disorders (characterized by failure to resist a temptation, urge or impulse that may harm oneself or others), and suicidal or homicidal thoughts. These deficient practices presented an immediate threat to the health and safety of the patients. The hospital administration was notified	A 115	All staff responsible for assessments have been retrained on the importance of the initial patient assessment upon admission. (See Attachments 1 and 4). The training involved reviewing the assessment tool and highlighting the significance of questions involving the risk of suicide and harm to self or others. Staff were instructed on about the importance of placing patients on the proper Observational Status Level to ensure patient safety at all times. **This training was completed on 2/12/15 by Clinical Program Director or designee.** The Supervisory Nurse on each unit will ensure that all patient assessments scheduled for that day have been completed and that each patient is assigned the appropriate level of observation. If an observational status needs to be modified, the nurse will contact the attending or on-call physician. The physician will review the assessment and determine whether a modification is appropriate. The Clinical Program Director or designee will review new patient assessments from a random sampling of 25% newly admitted patients each week to ensure that the assessments have been completed and that each patient has been assigned to the proper Observational Status. The "Safety Management Plan" policy (see Attachment 5) has been revised as of	

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A 115	Continued From page 6 of the Immediate Jeopardy (IJ) on 1/14/15 at 3:35 pm. The IJ was not removed on exit 1/23/15. The cumulative effect of the systematic failure to provide for the safety of patients resulted in the potential for harm to all patients admitted to the hospital at risk for suicide or harm to others.	A 115	2/10/2015. Those revisions are related to all changes made to the review and purchase of patient furnishings. All staff have been notified of the revised policy and asked to review the policy by email on 2/27/15. The revised policy is located on the OSH intranet site and is accessible to all staff.	
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to provide care in a safe setting to patients admitted to the psychiatric hospital for 2 of 2 suicidal and 29 of 29 assaultive/violent patients in the MAPS unit A1, 14 of 14 suicidal and 12 of 12 assaultive/violent patients in the MAPS unit A2, 1 of 1 suicidal and 20 of 20 assaultive/violent patients in CCP unit B1, 3 of 3 suicidal and 25 of 25 assaultive/violent patients in the SSP unit B2, 24 of 24 suicidal and 19 of 19 assaultive/violent patients in the PLS unit C1, 6 of 6 suicidal patients and 15 of 15 assaultive/violent patients in the HOPE unit C2, and 17 of 17 suicidal patients and 5 of 5 assaultive/violent patients in the CSP unit EB. The hospital census was 181. The hospital had 67 current patients assessed as a suicidal risk and 125 current patients assessed as assaultive/violent risk. Findings include:	A 144	Due to the identified environmental risks, the following enhanced safety precautions have been instituted to ensure patient safety. (Please see Attachment 6 for further explanation of these enhanced safety precautions). - Safety Round checks – All patients will be checked on randomly every 7-10 minutes in addition to the checks required based upon the risk level assigned to each individual patient - All staff assigned to conduct safety round checks will be re-trained on the safety round process including what to look for, how to report any patient concerns. This will be completed by March 12, 2015. - Preventative Maintenance Rounds— All Facility Services staff will be re-trained on the Preventative Maintenance Rounds check sheet. This training will include identification of repairs needed and potential hazards and steps to take to address them. This will be completed by March 12, 2015. - Environmental Rounds— All staff assigned to conduct Environmental	

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A 144	Continued From page 7 - The hospital ' s form " Nursing Needs Assessment " states (in part): The data from this form will assist in evaluating the adequacy of 24-hr nursing personnel staffing, based on the identified care needs and acuity level of the patients ... This form shall be completed for each identified ward of the hospital by a registered profession nurse who has clinical knowledge of the patients ...Data should reflect the patients ' current needs/behaviors. V. Psychiatric Nursing Care Problems 1. Assaultive/violent: Number of patients who are: 1. Potentially assaultive (has occasionally demonstrated during hospitalization 2. Actively assaultive (has evidence physically/verbally within last 48 hrs. 2. Suicidal: Number of patient who are ...1. Low risk suicidal (requires some protection against impulses 2. Intermediate risk suicidal (high potential for self-injury; requires close observation) 3. Acute risk suicidal (in immediate danger of suicide) VII. Observations/Supervision: Number of patients who are on: 1. 1:1 supervision 2. Under constant/line-of-sight supervision 3. Every 15-30 minute supervision checks 4. Every 3-4 hour supervision checks. - Risk Manager Staff B interviewed on 1/12/15 at 2:20 pm indicated that the " Nursing Needs Assessment " form is completed daily by a nurse on each unit to help determine their staffing needs. The hospital ' s policy titled " Therapeutic Observational Status " dated 12/10/14 provided the following guidance (in part): The purpose of Therapeutic Observational Status is to maintain the safety of the patient and others. ...At admission and ongoing throughout hospitalization, patients are assessed for the level	A 144	Rounds will be re-trained identification of environmental issues and risk and actions to take to address any issues identified. This training will be completed by March 12, 2015. In addition, cameras will be installed for monitoring of common areas, hallways, and common areas with restricted views. The equipment has been ordered. This action is expected to be complete April 1, 2015. A General Maintenance Repair Technician (GMRT) will be assigned to each building to check the environment of each area daily and take action to address the issues identified or contact the Facility Services Office to request repair / replacement. Issues identified will be documented on a Repair Log. Copies will be maintained in the Facility Services Office. The Facility Services Director will provide training to the GMRTs. This training and implementation will be completed by March 4, 2015. **Physical Environment Improvements:** Completed Actions • Outlets – **2/4/15** • Light fixtures – inserted tamper-proof screws added – **2/4/15** • Pictures removed or tamper-proof screws were added – **2/4/15** • Closet doors removed – **2/3/15**	

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A 144	Continued From page 8 of risk of danger to self or others. Therapeutic Observational Status Categories: Red: 1. Unit Observation with 1:1 (Red High Alert) a. 1:1 requires a specific assigned clinical staff member to have constant 1:1 supervision of the patient. 2. Unit Observation (Red-High Alert) 15 minute Check b. The R.N. assigns staff to complete the Timed Check Sheet ...by entering the time of the check, initials, and appropriate codes at frequent, irregular intervals at least every fifteen minutes. 3. Unit Observation (Orange-Moderate Alert) a. Patients ...must remain on the unit with hourly checks being completed by Nursing Staff. 4. Escorted Observation Status (Moderate Alert) Yellow 2. A patient is accompanied by staff any time he/she leaves the building. 5. Standard Observation (Green) 1. A patient may leave the unit unescorted for up to 60 minutes during " Free Time " and must stay within the approved hospital boundaries. The hospital ' s " Patient Handbook " dated December 2014 states " Patients or their legal guardians have the following rights: To receive care in a safe setting " . - The hospital ' s policy " Safety Management Plan " dated 7/23/12 reviewed on 1/22/15 at 3:00 pm directed, " ...The Environment of Care Committee (EOCC) conducts quarterly rounds of buildings, grounds, equipment, and occupants to: c. Identify safety risks d. Conduct hazard surveillance. C. Safety Planning 1. The EOCC participates in performance improvement activities...monitoring performance regarding actual or potential risks ...Safety and Hazard Assessment, Identification of Processes, identify opportunities for improvement in order to ...establish and maintain a physical environment	A 144	• Door handles changed to storage handles (intermediate phase) – **2/6/15** • Unsecured furniture on units were either removed or weighted down – **2/5/15** • Secured heating ventilation and cooling (HVAC vents) by inserting tamper-proof screws – **2/4/15** • Patient gowns with ties removed – **1/29/15** • Fitted sheets removed – **1/20/15** • Secured laundry soap – **2/4/15** • Patient lift for patients up to 600lbs. We have secured a rental company should we require more than one lift – Re-training completed for all nursing staff on **2/12/15** • Water fountains removed and plumbing covered – **2/6/15** • Removed all cords and connected items in the nursing station – **2/4/15** • Patient telephone cords have been replaced with 12 inches or less cords – **2/4/15** • Cabinet handles – All cabinet handles were removed on **2/2/15**. The location of the handles was covered with a wooden plate and tamper proof screws. A key is required to open the cabinets, which may be opened without a handle. <u>On-going Actions</u> • Door handles (ligature free handles to be installed, 576 have been ordered) – The projected completion date is 4/3/15.	

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A 144	Continued From page 9 free of hazards ... " H. Environment 5. Facilities and grounds are maintained through collaborative efforts of Facility Services and program staff in order to create an environment that is comfortable, safe, clean and attractive. 6. Furnishings and equipment provided are safe and in good repair ...8. The EOCC reviews safety concerns submitted by employees, patient, visitors or other hospital committees/teams. The Director of Operations or designee, with the assistance of members of the EOCC, a. Directs ongoing performance improvement activities related to the environment of care; b. Directs the integration of environment of care monitoring and response activities into the hospital wide patient safety program; c. Reviews summaries of deficiencies, problems, failures and/or user errors related to managing, i. Safety; ii. Security; v. Fire Safety. Staff BB, Assistant Superintendent, interviewed on 1/22/14 at 2:00 pm was unable to provide documentation of any findings from the EOCC addressing safety issues or any potential or actual risks or hazards identified in the physical environment of the hospital. Managing and Preventing Symptoms (MAPS) unit (Individuals who are unable to manage behaviors and care for their well being due to an acute impairment in the ability to perceive reality) A1 building observed on 1/12/15 between 2:00 pm and 4:30 pm and 1/20/15 between 3:15 pm to 4:20 pm showed the following: - The MAPS unit A1 had a total of 30 beds with 29 current patients (2 patients at risk for suicide (2 intermediate risk suicidal) and 29 Assaultive/violent patients (27 potentially	A 144	• Patient beds have been ordered and purchased on **2/3/15.** Delivery is expected to be completed in three phases as product becomes available. The first delivery is scheduled to occur on 3/6/15 with 73 beds. The next is tentatively scheduled for 3/13/15 (another 73 beds) and the last on 3/27/15 (74 beds). The Action will be completed by 3/31/15. • Bathroom/Shower room renovations will be carried out in phases. The projected completion date is July 31, 2015. (See contract.) • Ceiling renovations will be carried out in phases by building. The projected completion is September 30, 2017. **Physical Environment** All areas accessible to patients will be updated and repaired to reflect current safety standards as outlined by the *Veteran's Health Administration (VHA) National Center for Patient Safety to reduce environmental factors for inpatient suicide attempts & self-injurious behaviors.* Completion dates are outlined within each of the following sections. **Closet Doors** All closet doors in patient rooms (approximately 250) were removed. **This action was completed by 2/3/15.**	

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A 144	Continued From page 10 assaultive/violent and 2 actively assaultive/violent). Therapeutic Observational Status for the 29 patients revealed: Red (15 minute) - 2 patients; Orange - 11 patients; Yellow - 16 patients. - Hallway A and hallway B revealed a total of 19 patient rooms including eight private and 11 semi-private rooms. All 19 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slats formed into a grid pattern to hold the mattress. The unsecured lightweight furniture in patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 2 of 2 patients on the unit assessed as a suicide risk. All rooms have a 6 inch door handle that protrudes 3 ½ inch out from the door. The door handles potentially provide a hanging, choking, or strangulation for 2 of 2 patients on the unit assessed as a suicide risk. All 19 patient rooms have a metal closet with either a handle, latch hook, or a one-inch opening. The closet handles, latch hooks, or openings potentially provide a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. All 19 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. All 19 patient rooms had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 19 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures	A 144	Any staff member who identifies an inappropriate or damaged structure or item in or around the closet area will submit a "work request" to have the issue addressed. Until the structure or item is repaired, the room will be locked and will not house patients or be accessible to them until the repairs have been completed. Facility Services will repair or replace structure or item within 24 hours of being identified. ***All staff were trained on the physical environment risks including those associated with closet doors, on 2/12/15 by the Assistant Risk Manager.*** Individual responsible for compliance: Director of Facility Services **Electrical Outlets** On 2/3/15, the Kansas State Fire Marshall approved the use of tamper-proof outlets for areas, in which patients' have access, ameliorating outlet safety concerns. All electrical outlets have been inspected and either replaced, repaired, or upgraded (approximately 300 outlets). Outlets not needed have been identified and covered with a steel plate (approximately 300 outlets were blanked). **This action was completed by 2/4/15.** Locked covers have been placed on the outlets in 8 rooms, which have been identified for use for patients assessed as high risk. Locked covers will be added in	

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A 144	Continued From page 11 have the potential to provide an anchor for hanging. All 19 patient rooms had one metal ceiling heating/cooling vent easily removed and one metal air exchange vent secured to the wall with non-tamper proof screws potentially creating an anchor for hanging or use as a weapon. All 19 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic has the potential to provide a hanging, choking, or strangulation risk for 2 of 2 patients on the unit assessed as a suicide risk. - Observation of room 143 revealed a displaced ceiling tile and room 144 revealed a missing ceiling tile. Above the ceiling tiles are plumbing and electrical wiring. Access to the plumbing pipes and electrical wiring has the potential to provide a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The shower room on hallway B revealed a metal vent with missing screws and room 143 revealed a displaced vent. The metal vent could easily be removed and create an anchor for hanging or be used as a weapon. - The Day Hall (the units living and dining area) revealed a suspended ceiling with approximately 20-inch by 20-inch ceiling tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The Day Hall contained two water fountains attached to the wall that could be pulled off of the wall and used for a weapon. Two telephones for patient use located beside the nurses station had a 29 inch cord providing a potential hazard for hanging, choking, or strangulation affecting 2 of 2 patients on the	A 144	additional rooms as needed based on the results of the individual patient risk assessment. Locking covers have been ordered but the manufacturing process and importation issues have slowed their arrival. It is anticipated that another 100 locking outlet covers will be on hand by 3/6/15 to complete the installation in the rooms designated for higher risk patients. Checks for hazardous electrical outlets will be conducted during the weekly Preventative Maintenance Rounds. If any are found, repairs or replacements will be made immediately. (Please see attachment 7 for further explanation). The Procurement Officer was trained on the process and the requirements of obtaining approval from the Environment of Care Committee's Safety Team before purchasing orders for gowns, sheets, beds, furniture, fixtures and other furnishings. ***All staff were trained on the physical environment risk, including those associated with electrical outlets, on 2/12/15 by the Assistant Risk Manager.*** Individual responsible for compliance: Director of Facility Services **Light Fixtures**	

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A 144	Continued From page 12 unit assessed as a suicide risk. The Day Hall had eight electrical outlets easily accessible with the potential to create a fire or electrical shock. The Day Hall had ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The day hall had eight metal ceiling vents easily removed creating an anchor for hanging or use as a weapon. One wall had four cabinets with C handles with the potential hazard for hanging, choking, or strangulation for 2 of 2 patients on the unit assessed as a suicide risk. The Mental Health Technician (MHT) station (desk area) in the day hall failed to have an adequate barrier enclosing the area from patients. The MHT station measured 42 ½ inches tall and had a 12 ¾ inch wide counter. Patients could easily reach the telephone and the telephone cord could be used as a strangulation device as well as the computer keyboard and cord to be used as a weapon. - MHT staff O interviewed on 1/13/15 at 2:00 pm indicated patients can and have reached over the MHT station to obtain the phone and keyboard. - The patient bathroom on hallway A had two commodes with a hinged seat and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. The bathroom had one urinal with exposed plumbing. Two sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The bathroom had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an	A 144	All light fixtures have been secured with tamper-proof screws. **This action was completed by 2/4/15.** Approximately 700 lens covers will be added to existing light fixtures. These lenses were due to be ordered from Stanion on 2/12/15. However, prior to placing the order, a representative from Stanion reviewed, on-site, the light fixtures and lenses required and reported that the hospital uses lighting fixtures from 3 different manufactures whose lenses and frames are not cross-compatible. Therefore, the hospital needs were re-evaluated with the conclusion being that given the age and indeterminate nature of many of the frames, proceeding in discreet phases is necessary to ensure that the appropriate frames/lenses are obtained. Based upon the above, the first set of lens/frames were ordered on 2/27/15 with an expected delivery date of 3/20/15. All fixtures in patient areas will be re-evaluated with details determined and orders placed by 3/27/15 and the lens/frames are to be installed by 4/24/15. Checks for hazardous light fixtures will be conducted during the weekly Preventative Maintenance Rounds. If any are found, repairs or replacements will be made immediately. If the light fixture cannot be fixed immediately, the room will be locked.	

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A 144	Continued From page 13 anchor for hanging. The bathroom had one metal vent in the ceiling tiles and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or use as a weapon. The bathroom had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. - The shower room on hallway A had a bathtub with a water temperature dial with a 3 inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The plumbing is 28 inches from the floor and 5 inches from the wall. One sink has a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The shower room had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The shower room had one metal vent in the ceiling tiles easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - Hallway A revealed seven ceiling mounted florescent light fixtures with a plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as	A 144	Facility Services will repair or replace the light fixture within 24 hours of being identified. The Procurement Officer was trained on the process and the requirements of obtaining approval from the Environment of Care Committee's Safety Team before purchasing orders for gowns, sheets, beds, furniture, fixtures and other furnishings. ***All staff were trained on the physical environment risks, including those associated with light fixtures, on 2/12/15 by the Assistant Risk Manager.*** Individual responsible for compliance: Director of Facility Service **Pictures and Wall Items** All picture frames or other wall items in patient common areas on the units were removed or secured with tamper-proof screws (approximately 175 wall mounted items were removed and an additional 85 were secured with tamper-proof screws). **This action was completed by 2/4/15.** Checks for unsecured pictures or other wall items will be conducted during the weekly Preventative Maintenance Rounds. If any are found, repairs or replacements will be made immediately.	

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A 144	Continued From page 14 a suicide risk. Hallway A had four electrical outlets easily accessible with the potential to create a fire or electrical shock. - The comfort room revealed a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The comfort room had four electrical outlets easily accessible with the potential to create a fire or electrical shock or electrical shock. The comfort room had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The comfort room had one eraser board and five picture frames secured with non-tamper proof screws with the potential for removal and use as a weapon. - The patient bathroom on hallway B had two commodes with hinged seats and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The bathroom had one metal vent with non-tamper proof screws and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. The bathroom had two ceiling mounted florescent light	A 144	***All staff were trained on the physical environment risks, including pictures and other wall items, on 2/12/15 by the Assistant Risk Manager.*** Individual responsible for compliance: Director of Facility Services **Door Handles** All door handles in patient accessible areas will be replaced with ligature-free handles. After identification was made of an acceptable ligature resistant handle, an order was placed on 02/09/15 to obtain 466 door handles. A second order was placed on 02/23/15 for an additional 110 locksets. Upon receipt, the locksets will be replaced by unit to compliment the replacement of the bathroom fixtures. It is anticipated that the door handles in patient areas will be replaced by 04/03/15. All bathroom and shower room door handles in patient areas have all been replaced with self-locking handles that are only accessible with staff present to unlock the doors. However, the doors remain unlocked from the inside so the patient may freely exit the bathroom. This is an intermediate solution to ensure patient safety until the bathrooms and shower rooms renovations are complete. Until all door handles have been replaced with ligature free handles, Safety Rounds	

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A 144	Continued From page 15 fixtures with a plastic inserts covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - The shower room on hallway B had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The bathroom had one metal vent in the ceiling tiles easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets with the potential to create a fire or electrical shock. The shower room had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - Hallway B revealed six ceiling mounted florescent light fixtures with a plastic covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway B has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as suicidal risk. Hallway B had four electrical outlets easily accessible with the potential to create a fire or electrical shock.	A 144	will continue. (See attachment 7 for further explanation.) Individual responsible for compliance: Facility Services Director **Unsecured Furniture** All dressers have been removed from patient bedrooms. **This action was completed by 2/3/15.** There will be space for the storage of patient belongings in the polyurethane, molded beds discussed later under the "Beds" section. The unit furniture was weighted down with sand. **This process was completed by 2/3/15.** Observation of furniture is included as part of the Environment of Care rounds completed monthly. If unsecured or un-weighted furniture is discovered, Facility Services will be notified immediately for repairs, replacement or removal. (See Attachment 7.) Facility services will make any necessary repairs immediately, or if after regular business hours any repairs will be made by Security Services. The Procurement Officer was trained on the process and the requirements of obtaining approval from the Environment of Care Committee's Safety Team before purchasing	

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A 144	Continued From page 16 - Managing and Preventing Symptoms (MAPS) unit A1 building observed on 1/13/15 at 2:00 pm revealed a patient in the day hall wearing a hospital gown with strings for securing the gown. Mental Health Technician (MHT) staff D interviewed on 1/13/15 at 2:00 pm revealed patients wear hospital gowns when doing laundry and some wear them at night. Staff D acknowledged the use of hospital gowns with strings and the fitted bed sheets with elastic edging had the potential to be used by patients as a means of hanging or strangulation. Staff D acknowledged that all patients on the unit can request gowns or sheets from staff members regardless of whether they are a suicidal risk or at risk to harm others. Managing and Preventing Symptoms (MAPS) unit (Individuals who are unable to manage behaviors and care for their well-being due to an acute impairment in the ability to perceived reality) A2 building observed on 1/13/15 between 11:20 am to 12:30 pm and 1/20/15 between 4:20 pm and 5:15 pm showed the following: - The MAPS unit A2 had a total of 30 beds with 24 current patients (14 patients at risk for suicide (9 low risk suicidal; 4 intermediate risk suicidal; 1 acute risk suicidal risk) and 12 Assaultive/violent patients (11 potentially assaultive/violent; 1 actively assaultive/violent). Therapeutic Observational Status for the 24 patients revealed: Red (1:1) - 1 patient; Red (15 minute) - 4 patients; Orange - 9 patients; and Yellow-10 patients. - Hallway A and hallway B revealed a total of 18 patient rooms including six private and 12	A 144	orders for gowns, sheets, beds, furniture, fixtures and other furnishings. ***All staff were trained on the physical environment risks, including unsecured or un-weighted furniture, on 2/12/15 by the Assistant Risk Manager.*** Individual responsible for compliance: Director of Facility Services **Heating, Cooling and Air Exchange Vents (HVAC)** All vents (approximately 500) in patient accessible areas have been secured with tamper-proof screws. **This action was completed by 2/4/15.** Checks for unsecured tamper-proof screws in vents will be conducted during the weekly Preventative Maintenance Rounds. If any are found, repairs or replacements will be made immediately. ***All staff were trained on the physical environment risks, including ensuring that there are tamper-proof screws, on all vents at all times on 2/12/15 by the Assistant Risk Manager.*** Individual responsible for compliance: Director of Facility Services **Patient Gowns**	

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A 144	Continued From page 17 semi-private rooms. All 18 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slats formed into a grid pattern to hold the mattress. The unsecured lightweight furniture in patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 14 of 14 patients assessed at risk for suicide on the unit. All rooms have a 6 inch door handle that protrudes 3 ½ inch out from the door. The door handles potentially provides a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. All 18 patient rooms have a metal closet with either a handle, latch hook, or a one-inch opening. The closet handles, latch hooks, or openings potentially provide a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. All 18 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. All 18 patient rooms had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 18 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 18 patient rooms had one metal ceiling vent easily removed and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. All 18 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic on the fitted	A 144	Patient gowns with ties have been removed from the hospital. **This action was completed by 1/29/15.** The Procurement Officer was trained on the process and the requirements of obtaining approval from the Environment of Care Committee's Safety Team before purchasing orders for gowns, sheets, beds, furniture, fixtures and other furnishings. ***All staff were trained on the physical environment risks, including those associated with patient gowns, on 2/12/15 by the Assistant Risk Manager.*** Individual responsible for compliance: Director of Nursing **Unsecured "Tech Desk" Areas** "Tech Desks" in areas that are accessible to patients have had all cords and connected items removed. **This action was completed by 2/4/15.** As part of the weekly preventative maintenance rounds, facilities staff will check to ensure that the "tech desks" on the units are appropriate and safe. ***All staff have been trained on 2/12/15 by the Assistant Risk Manager to contact Informational Technology Services if any computer equipment is found in patient care areas.***	

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A 144	Continued From page 18 sheets provide a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. - The Day Hall (the units living and dining area) revealed a suspended ceiling with approximately 20-inch by 20-inch ceiling tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. The Day Hall contained two water fountains attached to the wall that could be pulled off of the wall and used for a weapon. Two telephones for patient use located beside the nurses station had a 29 inch cord providing a potential hazard for hanging, choking, or strangulation affecting 14 of 14 patients assessed at risk for suicide on the unit. The Day Hall had eight electrical outlets easily accessible with the potential to create a fire or electrical shock. The Day Hall had 17 ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The day hall had six cabinet doors with C handles with the potential hazard for hanging, choking, or strangulation. The Mental Health Technician (MHT) station (desk area) in the day hall failed to have an adequate barrier enclosing the area from patients. The MHT station measured 42 ½ inches tall and had a 12 ¾ inch wide counter. Patients could easily reach the telephone and the telephone cord which could be used as a strangulation device as well as the computer keyboard and cord for use as a weapon.	A 144	Individual responsible for compliance: Director of Nursing **Fitted Sheets** All fitted sheets were removed from the hospital. **This action was completed by 1/20/15.** The Procurement Officer was trained on the process and the requirements of obtaining approval from the Environment of Care Committee's Safety Team before purchasing orders for gowns, sheets, beds, furniture, fixtures and other furnishings. As part of the weekly preventative maintenance rounds, facilities staff will check to ensure that there are no fitted sheets on the beds or in the linen closet. If fitted sheets are found, they will be removed from the room immediately and reported to the Director of Nursing. The Director of Nursing will follow up with all staff. ***All staff were trained on the physical environment risks, including those associated with fitted sheets, on 2/12/15 by the Assistant Risk Manager.*** Individual responsible for compliance: Director of Nursing **Laundry Soap**	

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A 144	Continued From page 19 - The patient bathroom on hallway A had two commodes with a hinged seat and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. The bathroom had one urinal with exposed plumbing. Two sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. The bathroom had one metal vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathroom had two electrical outlets easily accessible with the potential to create a fire or electrical shock. The bathroom had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - The shower room on hallway A had a bathtub and shower stall with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with hinged seat and exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. One sink has a 10-inch protruding water faucet. The toilet seat and exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. The shower room had two ceiling mounted florescent light fixtures with a plastic insert easily removed. The light fixtures have the potential to provide an anchor for hanging.	A 144	Laundry soap was placed under lock and key on each unit. **This action was completed by 2/4/15.** Individual responsible for compliance: Director of Nursing As part of the weekly preventative maintenance rounds, facilities staff will check to ensure that all laundry soap on the units is stored in a locked area. If any laundry soap is found outside the locked area, the Director of Nursing will take immediate action to secure the soap and report the issue to the Program Nurse Manager to follow up with staff. Individual responsible for compliance: Director of Nursing **Patient Lifts** A patient lift that can accommodate an individual who weighs up to 600 lbs has been secured and is stored in the PLS building. All patients who may need this lift will be assigned to the PLS unit. **This action was completed by 2/12/15.** A copy of the operation manual is attached to the lift and has also been posted on the hospital intranet. A list of medical equipment available for use including patient lists has been developed and placed in each of the hospital	

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A 144	Continued From page 20 - Hallway A revealed seven ceiling mounted florescent light fixtures with a plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. Hallway A had five electrical outlets easily accessible with the potential to create a fire or electrical shock. - The comfort room revealed a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. The comfort room had four electrical outlets easily accessible with the potential to create a fire or electrical shock. The comfort room had five picture frames secured with non-tamper proof screws with the potential for removal and use as a weapon. - The patient bathroom on hallway B had two commodes with hinged seats and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 14 of 14 patients on the unit assessed as a suicide risk. The bathroom had one metal ceiling vent easily removed from	A 144	treatment rooms. This list is also available on the hospital intranet site as part of a new procedure, Durable Medical Equipment (NUR-5.2) (See Attachment 8). Program Nurse Managers and Nursing Shift Supervisors will ensure that an appropriate, functional lift remains available and is being correctly utilized by trained staff for patients requiring it. Nursing staff have been made aware of the availability of the lift and of its location as of 2/12/15 by the LPN responsible for arranging Durable Medical Equipment for the hospital. ***All nursing staff were trained on the proper use of the lift on 2/12/15 by Nursing Education.*** **Individual responsible for compliance:** Director of Nursing **Water Fountains** All water fountains in areas accessible to patients have been removed. **This action was completed by 2/6/15.** Due to the unavailability of free access to water, nursing staff have been instructed to make water available upon request. Each unit has a kitchenette stocked with Styrofoam cups for distribution to patients.	

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A 144	Continued From page 21 the tiles and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. The bathroom had two ceiling mounted florescent light fixtures with a plastic inserts covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - The shower room on hallway B had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with a hinged seat and exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 7 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The toilet seat and exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. The bathroom had one metal vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets with the potential to create a fire or electrical shock. The shower room had three ceiling mounted florescent light fixtures with a plastic covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - Hallway B revealed six ceiling mounted florescent light fixtures with a plastic covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical	A 144	The hospital has met with a manufacturing representative (Sexauer) and a new fountain that is ligature-free is being designed. These fountains will be custom built to meet the needs of the hospital and are expected to be ready for installation by 3/27/15. Prior to the new fountains being installed, the walls will be remodeled to provide a more secure anchor (steel plate) for the fountain. Monitoring of the drinking fountain areas will be a regular part of the Preventative Maintenance Rounds. During these rounds, the location of the fountain (as they are now and then as they will be once fountains are installed) will be monitored for missing or damaged hardware. If problems are found, they will be fixed immediately or steps will be taken to secure the area from patient access until Facility Services can make the necessary repair(s). Individual responsible for compliance regarding areas where the water fountains were removed: Director of Facility Services Individual responsible to ensure the safe handling of water: Director of Nursing **Patient Telephone Cords** All telephone cords in areas that are accessible to patients have been replaced with cords that are 12 inches or less in	

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A 144	Continued From page 22 wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 14 of 14 patients on the unit assessed as a suicide risk. Hallway B had four electrical outlets easily accessible with the potential to create a fire or electrical shock. Hallway B had three pictures attached to the wall with non-tamper proof screw. Continuing Care (CCP) unit (Individuals whose psychiatric symptoms have contributed to their involvement with the courts; and individuals who are referred by law enforcement for Detox, care and treatment (DCT)) B1 building observed on 1/12/15 between 2:00 pm and 4:30 pm showed the following: - The CCP unit B1 had a total of 30 beds with 28 current patients - (1 patient assessed as risk for suicide (1 low risk suicidal) and 20 patients assessed as risk for assaultive/violent (16 potentially assaultive/violent and 4 actively assaultive/violent). Therapeutic Observational Status for the 28 patients revealed: Red (15 minute) - 3 patients; Orange - 12 patients; Yellow - 8 patients and Green - 5 patients. - Hallway A and hallway B revealed a total of 18 patient rooms including seven private and 11 semi-private rooms. All 18 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slats formed into a grid pattern to hold the mattress. The unsecured lightweight furniture in patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 1 of 1 patient on the unit. All rooms have a 6 inch door handle that protrudes 3 ½ inch	A 144	length. **This action was completed by 2/4/15.** The telephone cords will be checked as part of the Environment of Care Rounds completed monthly. If broken cords are found, staff will remove the cord and submit a Technology Request to have the cord repaired or replaced within 24 hours. ***The Director of Information and Technology (IT) provided training to all IT staff of the necessity of using phone cords 12 inches or less in length on all phones accessible to patients on 2/2/15.*** ***All staff were trained on the physical environment risks, including those associated with telephone cords, on 2/12/15 by the Assistant Risk Manager.*** Individual responsible for compliance: Director of Facility Services **<u>More Extensive Building Renovations</u>** **Beds** All beds will be replaced with polyurethane, molded beds that include storage space for patient belongings, which are free of ligature points. **220 patient beds have been purchased on 2/3/15** from Dallas Midwest with a projected delivery date of approximately 4-6 weeks.	

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A 144	Continued From page 23 out from the door. The door handles potentially provides a hanging, choking, or strangulation hazard for 1 of 1 patient on the unit. All 18 patient rooms have a metal closet with either a handle, latch hook, or a one-inch opening. The closet handles, latch hooks, or openings potentially provide a hanging, choking, or strangulation hazard for 1 of 1 patient on the unit. All 18 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 1 of 1 patient on the unit. All 18 patient rooms had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 18 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 18 patient rooms had one metal ceiling vent easily removed and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. All 18 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic on the fitted sheets provide a hanging, choking, or strangulation hazard for 1 of 1 patient assessed at risk for suicide on the unit. - The bathroom on hallway A had two commodes with a hinged seat and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. The bathroom had one urinal with exposed plumbing. Two sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 1 of 1 suicidal patients on	A 144	(See Attachment 9 - Invoice for beds) Shipment phases are as follows: - 1st shipment is scheduled to arrive 3/6/15 - 2nd shipment to arrive 3/13/15 - Final shipment to arrive 3/27/15 Upon receipt, priority of bed replacement will be based on the patient's assessed risk. Custom designed anti-ligature mattresses have been ordered from the Kansas Department of Corrections to fit the new beds. The initial delivery of 126 mattresses occurred on 2/24/15, and will continue as they become available, but should correlate with the bed deliveries (of precede them). Medical hospital beds are being provided for patients who need them. All cords have been secured to the bedframe with zip ties. Safety Rounds will verify that no loose cords or hazardous zip ties exist. In the event that a loose cord or hazardous zip tie is found, the Safety Rounds person will secure the room if unoccupied or notify nursing staff to remain with the patient until the loose cord can be secured or hazardous zip tie can be replaced. Any time a medical hospital bed is unoccupied, the bedroom door is kept locked. Any new beds ordered will be reviewed and approved by the Safety Team of the Environment of Care Committee. Purchases	

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A 144	Continued From page 24 the unit. The bathroom had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathroom had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. - The shower room on hallway A had a bathtub with a water temperature dial with a 3 inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. One sink has a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. The shower room two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - Hallway A revealed seven ceiling mounted florescent light fixtures with a plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the	A 144	will only be made upon the approval of this team. The Procurement Officer was trained on the process and the requirements of obtaining approval from the Environment of Care Committee's Safety Team before purchasing orders for gowns, sheets, beds, furniture, fixtures and other furnishings. ***All staff were trained on the physical environment risks, including those associated with beds and medical hospital beds, on 2/12/15 by the Assistant Risk Manager.*** Individual responsible for compliance: Assistant Superintendent **Cabinet Handles** All cabinet door handles in patient accessible areas were removed. For those removed, a wooden plate was installed over the holes of the handle. **This action was completed by 2/2/15.** Checks for damaged cabinet doors are included as part of the Environment of Care Rounds completed monthly. If a damaged cabinet door is found, it will be repaired within 24 hours. ***All staff were trained on the physical environment risks, including those***	

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A 144	Continued From page 25 potential for hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. Hallway A had four electrical outlets easily accessible with the potential to create a fire or electrical shock. - The comfort room revealed a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. The comfort room had four electrical outlets easily accessible with the potential to create a fire or electrical shock. The comfort room had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The comfort room had one eraser board and five picture frames secured with non-tamper proof screws with the potential for removal and use as a weapon. - The patient bathroom on hallway B had two commodes with hinged seats and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 1 of 1 patient on the unit. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. The bathroom had two ceiling mounted florescent light fixtures with a plastic inserts covering easily	A 144	***associated with damaged cabinet doors, on 2/12/15 by the Assistant Risk Manager.*** Individual responsible for compliance: Director of Facility Services **Bathroom/Shower Rooms** A contract was executed with American Boiler on 12/23/14. (See Attachment 10). American Boiler had agreed to provide two on-site crews to renovate the following areas identified below beginning on 2/23/15. The hospital has met with a manufacturing representative (Sexauer) and they will be designing new toilet paper holders (design completed and approved on 2/20/15), soap dispensers and forced air drying systems that are ligature resistant for the new bathrooms. - Sinks - Plumbing - Commodes - Showers - Mirrors - Metal vents – tamper-proof screws installed 2/6/15 - Light fixtures – tamper-proof screws installed 2/6/15 - Toilet paper dispensers - Soap dispensers - Paper towel dispensers	

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A 144	Continued From page 26 removed. The light fixtures have the potential to provide an anchor for hanging. - The shower room on hallway B had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets with the potential to create a fire or electrical shock. The shower room had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - Hallway B revealed six ceiling mounted florescent light fixtures with a plastic covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. Hallway B had four electrical outlets easily accessible with the potential to create a fire or electrical shock. - The Day Hall (the units living and dining area) revealed a suspended ceiling with approximately	A 144	This work will be done in the following phases: - Work began at CSP on 2/16/15, a week ahead of schedule. It is anticipated that it will take approximately three weeks to complete - MAPS A beginning 3/16/15 approximately three weeks to complete - MAPS B beginning 3/30/15 approximately three weeks to complete - CCP beginning 4/20/15 approximately three weeks to complete - SSP beginning 5/4/15 approximately three weeks to complete - PLS beginning 5/18/15 approximately three weeks to complete - HOPE beginning 6/8/15 approximately three weeks to complete **Project completion date is no later than 6/30/15.** **All bathroom doors have been replaced with self-locking handles as of 2/6/15.** Until new fixtures are installed, nursing staff will supervise any and all patient use of bathrooms.	

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A 144	Continued From page 27 20-inch by 20-inch ceiling tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. The Day Hall contained two water fountains attached to the wall that could be pulled off of the wall and used for a weapon. Two telephones for patient use located directly across from the nurse ' s station had a 29 inch cord providing a potential hazard for hanging, choking, or strangulation affecting 1 of 1 suicidal patient. The Day Hall had six electrical outlets easily accessible with the potential to create a fire or electrical shock. The Day Hall had ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The day hall had eight metal ceiling vents easily removed creating an anchor for hanging or used as a weapon. One wall had five cabinets with C handles with the potential hazard for hanging, choking, or strangulation. Stepping Stones Program, (SSP) (Individuals who have met their discharge criteria but have barriers to placement in the community) unit B2 building toured on 1/12/15 between 1:55 pm to 4:47 pm and on 1/13/15 between 2:10 pm and 3:00 pm showed the following: - The SSP unit B2 had a total of 26 beds with 25 current patients (3 patients assessed as risk for suicide (1 low risk suicidal and 2 intermediate risk suicidal) and 25 patients assessed as risk for assaultive/violent (24 potentially assaultive/violent and 1 actively assaultive/violent). Therapeutic Observational Status for the 25 patients revealed: Red (15 minute) - 2 patients; Orange - 8 patients;	A 144	All mirrors have been removed from the bathrooms. **This action was completed by 2/1/15.** Any staff member who identifies an inappropriate or damaged fixture will submit a "work request" to have the issue addressed and until the fixture is repaired, the bathroom will be closed. Facility Services will repair or replace fixtures within 24 hours of being identified. To ensure that there are sufficient staff to monitor an individual every 4-5 minutes while using the restroom, 20 additional staff are being recruited to be assigned to the 7:00am – 3:00pm and 3:00pm-11:00pm shifts to increase core staffing levels. ***All nurses have been trained to check bathrooms every 4-5 minutes. This training was completed on 2/11/15 and will continue on an on-going basis by Nurse Managers.*** Individual responsible for compliance: Director of Nursing **Ceilings** In order to correct the deficiencies related to the ceilings, census will be reduced by 30 patients within the next 60 days. At that time, one 30 bed unit will be closed and renovations will begin. It will take	

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A 144	Continued From page 28 Yellow - 13 patients; and Green - 2 patients. - Hallways A and B revealed a total of 15 patient rooms including four private and 11 semi-private rooms. All 15 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slates formed into a grid pattern to hold mattress. The unsecured lightweight furniture in the patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 3 of 3 patients assessed at risk for suicide on the unit. All rooms have a six-inch door handle that protrudes three and one-half inches out from the door. The door handles potentially provides a hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. All 15 patient rooms have a metal closet with a latch hook. The closet latch hooks potentially provide a hanging, chocking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. All 15 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide. All 15 rooms had one to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 15 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 15 patient rooms had one metal ceiling vent easily removed and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a	A 144	approximately 5 months for each of the following units to be renovated: - CSP - MAPS A - MAPS B - CCP - SSP - PLS - HOPE KDADS will secure four contractors to work on this project. The projected completion date is September of 2017. Upon completion of the renovated units, those patients identified as being at the highest risk level will be given priority for placement in those units. **Documentation:** - Attachment 1: Therapeutic Observational Status Policy (PC-10.1) - Attachment 2: Training Content for Initial Therapeutic Observation Status - Attachment 3: New Admission Assessment/Observational Status Review - Attachment 4: Assessment of Patients and Therapeutic Observational Status a. Mental Health Screening Form b. Timed Check Sheet c. Initial Assessment d. Review of Systems e. Behavioral Assessment f. Psychiatric Evaluation-Admission g. Assessment of Dangerousness to Self or Others	

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A 144	Continued From page 29 weapon. All 15 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic has the potential to provide a hanging, choking, or strangulation risk for 3 of 3 patients at risk for suicide. - Observation of room 154 revealed a displaced ceiling tile. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide. - The men ' s bathroom on hallway A had one porcelain commode with a hinged seat and exposed plumbing pipes on the toilet and one metal commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and approximately seven inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing pipes and hinged toilet seat potentially provide a hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. The bathroom had two ceiling mounted florescent light fixtures and a florescent light fixture mounted above each sink on the wall with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. - Observation in the men ' s bathroom on hallway A on 1/14/15 at 9:20 am revealed three florescent light fixtures mounted on the wall above the sinks. A screw was missing from each of the light fixtures, indicating tampering of the light fixtures.	A 144	h. Comprehensive Assessment of Dangerousness to Self or Others - Attachment 5: Safety Management Plan Policy (EC-1.0) - Attachment 6: Explanation of Patient and Environment Observational Check - Attachment 7: Environment of Care Monthly Rounds Checklist - Attachment 8: Durable Medical Equipment Policy (Nur-5.2) - Attachment 9: Invoice for Purchase of Patient Beds - Attachment 10: American Boiler & Mechanical Contract **Individual Responsible for Compliance:** Superintendent	

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A 144	Continued From page 30 The screws could be used as weapons or to inflict self-harm or the easy access to the electrical wiring creates a potential for fire or electrical shock. Staff N, Physical Plant Supervisor Specialist, interviewed on 1/14/15 at 9:20 am verified the missing screws for each of the light fixtures above the sinks. Staff N explained the light fixtures were secured with screws that were supposed to be tamper proof. " I guess we ' ll need to get some screws back in there " . - The shower room on hallway A had a bathtub with a water temperature dial with a three inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and five inches from the wall. One sink had a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. The shower room had two ceiling mounted florescent light fixtures with plastic inserts covering easily removed and above the sink there was a wall mounted florescent light fixture. The light fixtures have the potential to provide an anchor for hanging. The shower room had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or use as a weapon. - Observation in the men ' s shower room on hallway A on 1/14/15 at 9:20 am revealed the one florescent light fixture mounted on the wall above the sink. A screw was missing from the light fixture, indicating tampering of the light fixture. The screws could be used as weapons or to inflict	A 144		

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A 144	Continued From page 31 self-harm or the accessibility to the electrical wiring creates a potential for fire or electrical shock. - The Arjo tub room (a special kind of bathtub) had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and five inches from the wall. One sink had a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, chocking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. The shower room had four ceiling mounted florescent light fixtures with plastic inserts covering easily removed and above the sink they had a wall mounted florescent light fixture. The light fixtures have the potential to provide an anchor for hanging. - Hallway A revealed seven ceiling mounted florescent light fixtures with plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has a suspended ceiling with approximately 20 inch by 20-inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit Hallway A had seven electrical outlets easily accessible with the potential to create a fire or electrical shock. - Observation of hallway A on 1/14/15 at 9:20 am revealed that one side of the hallway is not visible to the staff at the " aide " station on the Day Hall between hallway A and B potentially leaving patients unobserved and 3 of 3 suicidal patients at risk for harming themselves or 25 of 25	A 144		

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A 144	Continued From page 32 assaultive/violent patients at risk for harming others. - The women ' s bathroom on hallway B had two porcelain commodes with hinged seats and exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and approximately seven inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit The bathroom had two ceiling mounted florescent light fixtures and a florescent light fixture mounted above each sink on the wall with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. - Observation in the women ' s bathroom on 1/14/15 at 9:20 am revealed the three florescent light fixtures mounted on the wall above the sinks. A screw was missing from each of the light fixtures, indicating tampering of the light fixtures. The screws could be used as weapons or to inflict self-harm or the easy access to the electrical wiring creates a potential for fire or electrical shock. Staff N, Physical Plant Supervisor Specialist, interviewed on 1/14/15 at 9:20 am verified the missing screws for each of the light fixtures above the sinks. Staff N explained the light fixtures were secured with screws that were supposed to be tamper proof. " I guess we ' ll need to get some screws back in there " .	A 144		

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A 144	Continued From page 33 - Hallway B revealed seven ceiling mounted florescent light fixtures with plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway B has a suspended ceiling with approximately 20 inch by 20-inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit Hallway B had three electrical outlets easily accessible with the potential to create a fire or electrical shock. - The Day Hall (the units living and dining area) revealed a suspended ceiling with approximately 20 inch by 20-inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. The Day Hall contained one drinking fountain attached to the wall that could be pulled off of the wall and used as a weapon. One telephone for patient use located against the wall in a corner of the Day Hall had a 29 inch cord providing a potential hazard for hanging, choking, or strangulation affecting 3 of 3 patients assessed at risk for suicide on the unit. The Day Hall had 11 electrical outlets easily accessible with the potential to create a fire or electrical shock. The Day Hall had 12 ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The linen room contained shelves of clean linen accessed only by staff. The linen closet revealed patient gowns with cloth ties	A 144		

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A 144	Continued From page 34 attached for patients to secure the gown closed and fitted sheets with elastic around the sheet to hold the sheet on the beds. The patient gowns and elastic sheets are made available to all patients on the unit upon request. The patient gowns with ties and the elastic on the fitted sheets provide a hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. The Mental Health Technician (MHT) station (desk area) in the Day Hall failed to have an adequate barrier enclosing the area from the patients. The MHT station measured 42 ½ inches tall and had a 12 ¾ inch wide counter. Patients could easily reach the telephone and the telephone cord could be used as a strangulation device as well as the computer keyboard and cord be used as a weapon. Staff R Mental Health Technician interviewed on 1/12/15 at 3:30 pm explained they try to have a staff member in the Day Hall at all times, but there are times they need to attend to several patients at the same time, which makes the Day Hall unattended. Staff R, Mental Health Technician interviewed on 1/12/15 at 3:30 pm explained the patients can reach over the counter and have reached over the counter before to grab things off of the desk area. Staff C, Mental Health Technician interviewed on 1/21/15 at 8:00 am verified the patients do reach over the counter to grab stuff and also jump over it, into the station (desk area). Staff C explained they have asked to have a barrier put up so the patients could not reach or jump over the counter.	A 144		

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A 144	Continued From page 35 - Observation of the laundry room used by the patients to wash their personal laundry on 1/12/15 at 3:45 pm revealed an unlocked cabinet containing a pan of laundry soap packets. Patient T, demonstrated how they do their laundry and explained the staff open the cabinet that contains the soap because they are to keep it locked, however on this day the cabinet was open. Patient T explained the staff let the patients in the laundry room but do not stay with them at all times when they are in the room. All patients on the unit had the potential to access the unattended laundry room and the unlocked cabinet containing a potentially harmful substance. - The Material Safety Data Sheet (MSDS) for the laundry soap packets reviewed on 1/22/15 at 3:00 pm directed, " Ingestion: May be harmful if swallowed. Drink large amounts of water or milk. DO NOT induce vomiting. Get medical attention immediately. " Staff U, Mental Health Technician (MHT) interviewed on 1/12/15 at 3:45 pm acknowledged the unlocked cabinet containing the soap packets and stated staff are to keep the soap packets locked at all times. Positive Living Skills (PLS) unit C1 observed on 1/13/15 between 12:30 pm and 2:45 pm, 1/14/15 between 9:00 am and 4:30 pm, and 1/21/15 between 7:40 am and 9:00 am showed the following: - The PLS unit C1 had a total of 30 beds with 24 current patients (24 patients assessed as risk for suicide (22 low risk suicidal and 2 acute risk suicidal) and 19 patients assessed as risk for	A 144		

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A 144	Continued From page 36 assaultive/violent (16 potentially assaultive/violent and 3 actively assaultive/violent). Therapeutic Observational Status for the 24 patients revealed: Red (15 minute) - 1 patient; Orange - 10 patients; and Yellow - 13 patients. - Hallway A and hallway B revealed a total of 19 patient rooms including eight private and 11 semi-private rooms. All 19 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slats formed into a grid pattern to hold the mattress. The unsecured lightweight furniture in patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 24 of 24 patients assessed at risk for suicide on the unit. All rooms have a 6 inch door handle that protrudes 3 ½ inch out from the door. The door handles potentially provide a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. All 19 patient rooms have a metal closet with either a handle, latch hook, or a one-inch opening. The closet handles, latch hooks, or openings potentially provide a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. All 19 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. All 19 patient rooms had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 19 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert	A 144		

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A 144	Continued From page 37 covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 19 patient rooms had one metal ceiling vent easily removed and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. All 19 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic on the fitted sheets provide a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. - The Day Hall (the units living and dining area) revealed two telephones for patient use located near the entry door. Each phone had a 24 inch cord providing a potential hazard for hanging, choking, or strangulation affecting 24 of 24 patients assessed at risk for suicide on the unit. The Day Hall had seven electrical outlets easily accessible with the potential to create a fire or electrical shock. One wall had cabinet doors with six C handles with the potential hazard for hanging, choking, or strangulation for 24 of 24 patients assessed at risk for suicide on the unit. The Day Hall had one Mental Health Tech (MHT) station with a barrier and locking doors. Observation on 1/14/15 at 10:20 am revealed MHT station door unlocked and open. The unlocked door allows patients access to telephone and cord, computer keyboard, pen and pencils to use as potential strangulation hazard or weapons affecting all 24 of 24 patients on the unit. Mental Health Technician Staff P interviewed on 1/15/15 at 11:00 am revealed the MHT station doors should remain closed and locked at all times.	A 144		

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A 144	Continued From page 38 - Observation on 1/14/15 at 10:25 am revealed two patients wearing hospital gowns with strings attached at the neck and lower back for securing the gown. The hospital gown strings provide a risk for hanging, choking, or strangulation affecting all 24 of 24 patients on the unit. Registered Nurse Staff H interviewed on 1/14/15 at 10:25 am indicated the two patients wearing hospital gowns with strings are currently washing their dirty laundry. - Hallway A revealed seven ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. Hallway A had three electrical outlets easily accessible with the potential to create a fire or electrical shock. - Observation of rooms 123 and 161 revealed each room had a hospital bed with an unsecured coil style cord measuring greater than 12 inches in length. Room 123 also contained a Manual hydraulic patient lift (a patient lifting device) and sit- to- stand style lift with an unsecured power cord plugged into the electrical outlet. The unsecured cord measures greater than 12 inches in length. Unsecured cords measuring greater than 12 inches in length have the potential to provide a looping and hanging hazard for 24 of 24	A 144		

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A 144	Continued From page 39 patients assessed at risk for suicide on the unit. - Observation of hallway A on 1/13/15 at 12:30 pm and 1/14/15 at 9:20 am revealed an unlocked and unattended bathroom door. Unlocked bathrooms provide 24 of 24 patients assessed at risk for suicide on the unit access to potential anchor points for hanging, choking, or strangulation hazards. Sign placed on outside of door stated, " Restrooms will remain locked when not in use. Staff will unlock the door and monitor every 4-5 minutes for safety while in use " . Registered Nurse Staff H interviewed on 1/14/15 at 9:25 am indicated that the bathroom was unlocked in preparation for bringing a patient from his/her room. RN Staff H indicated multiple staff members were assisting with using a hydraulic patient lift to transfer the patient to the bathroom and revealed the Manual hydraulic patient lift used for patient #24 has a maximum weight lifting capacity of 400 pounds evidenced by the manufacturer ' s warning sticker placed on the lift. Patient #24 ' s weight recorded on 12/4/14 was 440 pounds. Staff H revealed that staff must stand on the legs of the Manual hydraulic patient lift to keep it from tipping over. The use of the Manual hydraulic patient lift beyond its stated maximum weight lifting capacity placed patient #24 at risk for injury from a fall. Administrative Staff BB on 1/14/15 when told about the use of the lift on a patient exceeding the weight limit said: " Well, they are not supposed to do that. " - The patient bathroom on hallway A had two commodes with a hinged seat and exposed	A 144		

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	174004	A. BUILDING _____ B. WING _____	01/23/2015

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A 144	Continued From page 40 plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. The bathroom had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - The shower room on hallway A had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. The shower room had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The shower room had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or use as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock.	A 144		

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A 144	Continued From page 41 - Observation of room 157 and 159 revealed multiple displaced ceiling tiles. The exposed pipes and wiring above the displaced tiles have the potential for hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. Mental Health Technician staff P interviewed 1/15/15 at 11:15 am revealed that patients do remove the ceiling tiles and ceiling mounted florescent light fixtures with a plastic insert covering. Review of the facility ' s work order logs for the Carpenter Shop from 6/29/14-1/29/15 revealed at least 20 requests to replace ceiling tiles that were damaged by patients, pulled down by patients, missing, pushed in, and some ceiling vents knocked out of position. - Observation of room 162 revealed one displaced ceiling mounted florescent light fixture with plastic insert easily removed. The light fixtures have the potential to provide an anchor for hanging. - Hallway B revealed seven ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. Hallway B had four electrical outlets. The electrical outlets easily accessed with the potential to create a fire	A 144		

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A 144	Continued From page 42 or electrical shock. - Observation of hallway B on 1/21/15 at 8:20 am revealed an unlocked and unattended patient bathroom door. Unlocked bathrooms provide 24 of 24 patients assessed as risk for suicide on the unit access to potential anchor points for hanging, choking, or strangulation hazards. Sign placed on outside of bathroom door stated " Restrooms will remain locked when not in use. Staff will unlock the door and monitor every 4-5 minutes for safety while in use " . - The patient bathroom on hallway B had one commode with a hinged seat and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. The bathroom had one urinal with exposed plumbing. The bathroom had two commodes with exposed pipes on the toilets. The piping is 28 inches from the floor and 5 inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathroom had two covered electrical outlets with non-tamper proof screws. The electrical outlet covers easily accessible with the potential to create a fire or electrical shock. - The shower room on hallway B had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with a hinged seat and exposed	A 144		

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A 144	Continued From page 43 plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. One sink has a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or use as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. Healthy Options, Plans, and Experiences (HOPE) unit C2 building observed on 1/12/15 between 2:00 pm and 4:30 pm, 1/13/15 between 8:00 am and 12:00 pm, and 1/21/15 between 8:30 am and 9:30 pm of the HOPE C2 showed the following: - The HOPE unit C2 had a total of 30 beds with 26 current patients - (6 patients assessed as risk for suicide (3 low risk suicidal; 1 intermediate risk suicidal; and 2 acute risk suicidal) and 15 patients assessed as risk for assaultive/violent (11 potentially assaultive/violent and 4 actively assaultive/violent). Therapeutic Observational Status for the 26 patients revealed: Red (15 minute) -2 patient; Orange - 14 patients; Yellow - 8 patients and Green - 2 patients. - Hallway A and hallway B revealed a total of 19 patient rooms including eight private and 11 semi-private rooms. All 19 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slats formed into a grid pattern to hold the mattress. The unsecured	A 144		

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A 144	Continued From page 44 lightweight furniture in patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 6 of 6 patients assessed at risk for suicide on the unit. All rooms have a 6 inch door handle that protrudes 3 ½ inch out from the door. The door handles potentially provide a hanging, choking, or strangulation hazard. All 19 patient rooms have a metal closet with either a handle, latch hook, or a one-inch opening. The closet handles, latch hooks, or openings potentially provide a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. All 19 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. All 19 patient rooms had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 19 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 19 patient rooms had one metal ceiling vent easily removed and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. All 19 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic on the fitted sheets provide a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. - The Day Hall (the units living and dining area) revealed two telephones for patient use located	A 144		

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A 144	Continued From page 45 near the entry door. Each phone had a 24 inch cord providing a potential hazard for hanging, choking, or strangulation for 6 of 6 patients assessed at risk for suicide on the unit. The Day Hall had six electrical outlets easily accessible with the potential to create a fire or electrical shock. The Day Hall had one Mental Health Tech (MHT) station with a barrier and locking doors. Observation on 1/13/15 at 9:05 am revealed MHT station door unlocked and open. The unlocked door allows patients access to the telephone and telephone cord which can be used as a strangulation hazard, computer keyboard, pens and pencils to use as weapons affecting 6 of 6 patients assessed at risk for suicide and 15 of 15 patients assessed as at risk of harming others. Registered Nurse staff Q interviewed on 1/13/15 at 9:35 am revealed the MHT station doors should remain closed and locked at all times. - Observation on 1/12/15 at 10:15 am revealed two patients wearing hospital gowns with strings attached at the neck and lower back for securing the gown. One of the patients (patient #20) observed wearing the hospital gown with ties was assessed as a patient at risk for suicide. The hospital gown strings provide a risk for hanging, choking, or strangulation for patient # 20. - Hallway A revealed seven ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 6 of 6	A 144		

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A 144	Continued From page 46 patients assessed at risk for suicide on the unit. Hallway A had three electrical outlets easily accessible with the potential to create a fire or electrical shock. - The patient bathroom on hallway A had one commode with a hinged seat and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. The bathroom had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - Observation of hallway A on 1/12/15 at 9:00 am revealed an unlocked and unattended bathroom door. Unlocked bathrooms provide 6 of 6 patients assessed as risk for suicide on the unit access to potential anchor points for hanging, choking, or strangulation hazards. Sign placed on outside of door stated, " Restrooms will remain locked when not in use. Staff will unlock the door and monitor every 4-5 minutes for safety while in use " . Registered Nurse staff Q interviewed on 1/13/15 at 9:35 am verified the bathroom doors should remain locked when not in use.	A 144		

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A 144	Continued From page 47 - The shower room on hallway A had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with a hinged seat with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. The shower room had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The shower room had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - Observation of rooms 127 and 140 revealed a solid ceiling with ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Room 140 revealed two electric radios with unsecured cords greater than 12 inches in length. Unsecured cords measuring greater than 12 inches in length have the potential to provide a looping and hanging hazard for 6 of 6 patients assessed at risk for suicide on the unit. - Hallway B revealed seven ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with	A 144		

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A 144	Continued From page 48 approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. Hallway B had one electrical outlet easily accessible with the potential to create a fire or electrical shock. Hallway B had three picture frames secured with non-tamper proof screws. Picture frames secured with non-tamper proof screws have the potential for removal and use as a weapon for 15 of 15 patients assessed as risk to harm others. - Hallway B revealed an " L " shape with a section unobservable from the main hallway with two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The blind hallway leaves patients unobserved creating the potential for 6 of 6 patients at risk for suicide and 15 patients assessed as assaultive/violent at risk for harming others. The light fixtures have the potential to provide an anchor for hanging. Hallway B has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. - The patient bathroom on hallway B had two commodes with hinged seats and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. The bathroom had one urinal with exposed plumbing. Two sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged	A 144		

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A 144	Continued From page 49 toilet seat potentially provides a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. The bathroom had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - The shower room on hallway B had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with a hinged seat with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. The shower room had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The shower room had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - The comfort room revealed a suspended ceiling with 12-inch tiles easily removed. Above the ceiling tiles are plumbing and electrical wiring.	A 144		

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A 144	Continued From page 50 The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. The comfort room had three electrical outlets easily accessible with the potential to create a fire or electrical shock. The comfort room had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The comfort room had one picture frame secured with non-tamper proof screws. The picture frame could be easily removed and used as a weapon. Crisis Stabilization Program (CSP) (Individuals in crisis who are experiencing a critical disruption in their ability to function in the community and will likely be stabilized within two weeks) East Biddle (EB) building toured on 1/15/15 between 8:10 am to 12:00 am showed the following: - The CSP unit EB had a total of 30 beds with 25 current patients - (17 patients assessed as risk for suicide (12 low risk suicidal; 4 intermediate risk suicidal; and 1 acute risk suicidal) and 5 patients assessed as risk for assaultive/violent (5 potentially assaultive/violent). Therapeutic Observational Status for the 26 patients revealed: Red (15 minute) - 3 patients; Orange - 6 patients; Yellow - 16 patients. - Hallways A, B, and C revealed a total of 30 patient rooms including all private rooms. All 30 patient rooms have furniture including dressers with removable drawers, wooden beds with legs and flat metal springs with metal slates formed into a grid pattern to hold mattress. The unsecured lightweight furniture in the patient rooms moved easily with the potential for	A 144		

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A 144	Continued From page 51 placement under a protruding device or propped up as a potential for hanging for 17 of 17 patients assessed as risk for suicide on the unit. All rooms have a six-inch door handle that protrudes three and one-half inches out from the door. The door handles potentially provides a hanging, choking, or strangulation hazard for 17 of 17 patients assessed as risk for suicide on the unit. All 26 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 17 of 17 patients assessed as risk for suicide on the unit. Four of the patient rooms have a solid ceiling above the tiles, and affects two patients in these rooms. All 30 rooms had one to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 30 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 30 patient rooms had one metal ceiling vent easily removed and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. - Observation of rooms 227, 220, 203, 209, 213, and 215, showed blackened areas around the electrical outlets indicating they had been tampered with. Staff AA, Registered Nurse (RN) interviewed on 1/15/15 at 8:10 am explained patients pick up cigarette butts outside and bring them in. They get paper clips and put in the outlet to light their cigarettes. Now we are doing checks on patients when they come in to make sure they don ' t have any cigarettes.	A 144		

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A 144	Continued From page 52 Review of the facility ' s maintenance log for the electric shop from 6/29/14 to 1/29/15 revealed the following: 1. At least 6 requests to fix electrical outlets which had been pulled away from the wall exposing wires. 2. At least 2 requests for outlets to be replaced due to foreign objects (pencils/graphite) stuck in them. 3. At least two requests for broken light fixtures and covers to be reattached/replaced. 4. Request to replace missing screws on electrical outlets. - Hallway B and A had seven bathroom/showers and one tub room. The bathroom/shower rooms each had one commode with a hinged seat and exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and five inches from the wall. One bathroom/shower room had a sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 17 of 17 patients on the unit. The bathroom/shower rooms each had one ceiling mounted florescent light fixture in the shower and one in the rooms with plastic inserts with coverings easily removed. The light fixtures have the potential to provide an anchor for hanging. - Hallways A, B, and C revealed ceiling mounted florescent light fixtures with plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallways A, B, and C have a suspended ceiling with approximately 20 inch by 20-inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 17 of 17 patients assessed as risk for suicide on the unit.	A 144		

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A 144	Continued From page 53 - The Day Hall (the units living and dining area) revealed a suspended ceiling with approximately 20 inch by 20-inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 17 of 17 patients assessed as risk for suicide on the unit. The Day Hall contained two drinking fountains attached to the wall that could be pulled off the wall and used as a weapon. Two telephones for patient use located in the area of the TV room had a 29 inch cord providing a potential hazard for hanging, choking, or strangulation for 17 of 17 patients assessed as risk for suicide on the unit. The Day Hall had ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - The linen room contained shelves of clean linen accessed only by staff. The patient gowns and fitted sheets are made available for all patients upon request and revealed cloth ties attached to the gowns for patients to secure the gown closed, and fitted sheets with elastic around the sheet to hold the sheet on the beds. The patient gowns with ties and the elastic on the fitted sheets provide a hanging, choking, or strangulation hazard for 17 of 17 patients on the units assessed as risk for suicide. - Observation of the laundry room used by the patients to wash their personal laundry on 1/14/15 at 5:10 pm revealed a pan of laundry soap packets placed on the counter. Staff AA, RN explained they are to be kept at the nurses ' station. The laundry room was unattended providing the potential for 17 of 17 suicidal	A 144		

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A 144	Continued From page 54 patients to have access to a harmful substance. - The Material Safety Data Sheet (MSDS) for the laundry soap packets reviewed on 1/22/15 at 3:00 pm directed, " ...Ingestion: May be harmful if swallowed. Drink large amounts of water or milk. DO NOT induce vomiting. Get medical attention immediately ... " Review of the facility ' s maintenance log for the paint shop from 6/29/14 to 1/29/15 revealed: at least 6 requests to repair holes due to patients punching holes in the wall and at least two requests to repair wall where patient had carved or etched writing into the wall. Review of the facility ' s maintenance log for the plumbing shop from 6/29/14 to 1/29/15 revealed at least 10 requests to repair water fountains due to patients pulling them off the wall, kicking them, shaking them or vandalizing them. The log indicates the facility repaired or replaced them. Staff N, Physical Plant Supervisor Specialist, interviewed on 1/14/15 at 9:20 am during tour of B2 unit explained all of the nursing units throughout the facility have the following: · The electrical outlets are " hot " - the patients can receive a jolt or start a potential fire if they are tampered with. · The vent covers are possible to remove and patients often remove the ones in their room. · The tiles in the suspended ceilings are movable and above the ceiling there is plumbing, electrical wiring, and pipes for the sprinkler system. · The drinking fountains are pulled off the walls by the patients; the facility keeps a supply of them in stock to replace them.	A 144		

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A 144	Continued From page 55 · The plastic covering over the fluorescent lights in the patient rooms, bathrooms, and hallways are removable. · The furniture in the patient rooms is movable and patients often move the furniture in their room. Recognized standards of practice for a psychiatric facility include: The Veteran's Health Administration (VHA) National Center for Patient Safety formed a national committee that developed The Environment of Care Checklist for the purpose of reducing environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors. This initiative is consistent with current literature on prevention of suicidal behaviors (Suicide Prevention Strategies: A systematic review. The Journal of the American Medical Association, (JAMA), 2005, v 294, 2064-2074). JAMA, published continuously since 1883, is an international peer-reviewed general medical journal published 48 times per year. JAMA is the most widely circulated medical journal in the world. The VHA and JAMA have all established accepted standards of practice for psychiatric inpatient facilities in the United States. The VHA committee developed the Mental Health Environment of Care Checklist (MHEOCC) with the goal to prospectively identify and eliminate environmental risks for inpatient suicide and suicide attempts. The following are some of the	A 144		

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A 144	Continued From page 56 items included on the MHEOCC to reduce environmental risks for inpatient suicide: - Faucets and water faucets in sinks and showers should be an institutional type. There should be no handheld shower devices and no temperature adjusting devices within the showers (unless recessed). Institutional faucets will not provide an anchor point for hanging exposed plumbing pipes created a looping hazard. -Furniture should be free of anchor points. -Closet doors should be free of anchor points. -Door handles should be free of anchor points. -Pictures and wall hanging should be tamper resistant screws or anchors. -Vents should be secured to the wall or ceiling with tamper resistant screws or anchors. -Ceilings should be constructed of solid materials. -Electrical outlets should be protected and tamper resistant. -Light fixtures should be flush mounted and tamper resistant. -Hospital gowns should have no strings and fitted sheets should not have elastic.	A 144	**A 263** **POC:** - Hospital procedure LD-1.5, Quality Assessment and Performance Improvement Program (formerly PI-1, Performance Improvement Plan), was revised and approved by Administrative Executive Team (AET) on February 26, 2015, to be effective immediately. (See Attachment 11.) A key change in this procedure was identification of the AET, which is chaired by the Superintendent, as the oversight committee for the hospital's Quality Assessment and Performance Improvement Program. - On February 27, 2015, the hospital selected a new Performance Improvement Director to fill the position that has been vacant since December 1, 2014. - On February 24, 2015, Service and Program Directors and Committee Chairs were notified that a meeting would be scheduled with each of them to review and discuss any QAPI measures / projects that are currently in progress and to determine what QAPI activities need to be developed to improve health outcomes and to prevent and / or reduce medical errors. These meetings will occur between March 2 and 11, 2015. - Each Service and Program Director and Committee Chair will present the identified QAPI measures / projects to the AET on March 5 or 12, 2015 to obtain feedback, make adjustments based on the feedback and gain approval. These presentations will include how each indicator will be measured, analyzed, and tracked.	
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention	A 263		

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A 263	Continued From page 57 and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on the Performance Improvement Committee plan review, meeting minutes, and staff interview the hospitals Executive Compliance Committee and Performance improvement Committee (PI) failed to develop an ongoing program that shows measurable improvement in indicators for which there is evidence that will improve health outcomes and must measure analyze and track quality indicators that identify improvement projects for processes of care, hospital service and operations (refer to A-0273); failed to use data collection to identify opportunities for improvement and changes that will lead to improvement and must set priorities for its performance improvement activities that focus on problem prone areas (refer to A-0283); failed to include an ongoing program that shows measurable improvement in indicators for which there is evidence it will identify and reduce medical errors, measure and analyze and track adverse events in the pharmacy and failed to implement preventive actions and mechanisms that include feedback and learning throughout the hospital (refer to A-0286); failed to ensure all hospital departments and services participate in the QAPI (Quality Assurance and Performance Improvement) program and maintain and demonstrate evidence (refer to A-0308); and the hospital's governing body failed to ensure that an ongoing program for ongoing quality improvement and patient safety included the reduction of	A 263	- On March 12, 2015, the AET will review currently established priorities and identify other priorities for problem prone areas based on the presentations made. Following this meeting, a "Summary of Priorities and Indicators" will be written to include the process being measured; why monitoring this process is important; how it will be measured (including sources of data); frequency of data collection; sample size; oversight group that will analyze and take action; threshold (expected range) for the process; frequency of presentation to oversight committee; and frequency of presentation to AET. - Beginning March 12, 2015, all programs, services, and committees will submit QAPI reports to the Performance Improvement Director at the frequency specified for presentation to the oversight committee identified. The Performance Improvement Director will contact the individual responsible for the report if not received. - Beginning March 12, 2015, upon receipt of a report from a program / service / committee, the Performance Improvement Director will review the report to determine if there are any areas that need to be further addressed and assessed by the individual or oversight committee as determined necessary. The Performance Improvement Director will keep Superintendent or designee informed of any issues that need to be resolved (e.g. untimely reports, data issues) **How are we monitoring:**	

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A 263	Continued From page 58 medical errors and failed to ensure the hospital wide quality assessment and performance improvement efforts addressed priorities for improved quality of care, patient safety and all improvement actions are evaluated (refer to A-0309). The cumulative effect of the systemic failure to identify improvement projects, to develop programs that focus on problem prone areas, to track medical errors, to ensure all hospital departments and services participate in the QAPI program, and the hospital's governing body's failure to ensure comprehensive and ongoing QAPI program that focused on quality of care and patient safety resulted in the hospital's inability to provide care in a safe effective manner.	A 263	- The Performance Improvement Director will monitor the minutes of the oversight committee to ensure timely presentation and thorough review of the QAPI reports occurred. Any issues identified will be addressed with the individual responsible prior to the next meeting. **Ensure Compliance:** - If discrepancies are noted in the presentation or review of QAPI reports, the PI Director will notify the Superintendent for individual action and follow-up. **Documentation:** - Attachment 11: Quality Assessment and Performance Improvement Program (LD-1.5)	
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of	A 273	**Individual Responsible for Compliance:** Superintendent **A 273** **POC:** - The hospital reviewed contributing factors to the PI Council's failure to develop an ongoing QAPI program to improve health outcomes by measuring, analyzing and tracking quality indicators and incorporating quality indicators for high risk or problem prone areas identified. These issues were identified during recent CMS and The Joint Commission (TJC) surveys as well as other hospital performance improvement activities. This review identified a lack of a current Performance Improvement Director,	

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A 273	Continued From page 59 services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: Based on the Performance Improvement Committee plan review, meeting minutes, and staff interview the hospitals Executive Compliance Committee and Performance Improvement Committee (PIC) failed to develop an ongoing program that shows measurable improvement in indicators for which there is evidence that will improve health outcomes and must measure analyze and track quality indicators that identify improvement projects for processes of care, hospital service and operations. Failure to incorporate previously identified quality indicators and measure, analyze, and track high risk and problem prone areas including nursing assessments and services, infection control, pharmacy, and ligature risks has the potential to affect health outcomes, patient safety, and quality of care for all patients admitted to the hospital. Findings include: - Policy titled "Performance Improvement Plan (PI-1.0)" dated 7/30/12 reviewed on 1/27/15 at 12:20 pm directed staff," ...performance improvement activities help us identify and implement opportunities ..." - The hospitals policy "Safety Management Plan"	A 273	dwindling attendance at Performance Improvement Council Meetings and lack of participation by programs / services / committees in the process. As a result of the findings, the hospital redesigned the QAPI process (see response to A263). Effective February 26, 2015, AET serves the role of oversight of the QAPI process. - During the month of December 2014, priorities related to issues identified during recent CMS and TJC survey were established. There were five (5) teams identified to address priorities identified and discussed during the December 17, 2015 AET meeting. Each team was assigned priorities as follows: 1) nursing assessments, services and safe medication administration; 2) pharmacy services and Pharmacy & Therapeutics Committee; 3) environmental safety involving ligature risks; 4) patient rights; and 5) infection control. The multi disciplinary teams consist of non licensed and licensed staff from the services involved in each project. This enables invaluable input from members who know the patients and the processes to affect greater change in providing quality services. - On January 6, 2014, the identified teams met and received training on the Franklin Covey Four Disciplines of Execution and to further refine the established goals and plan strategies to meet the goals. The teams continue to meet to address the priorities identified. Attachment 12 reflects a current project addressing timeliness of meal trays.	

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A 273	Continued From page 60 reviewed on 1/22/15 at 3:00 pm directed, "...The Environment of Care Committee participates in performance improvement activities...monitoring performance regarding actual or potential risks ...Safety and Hazard Assessment, Identification of Processes, of this procedure outlines processes used to identify opportunities for improvement in order to ...establish and maintain a physical environment free of hazards ..." - Review of the statement of deficiency for two surveys by CMS State Agency on 10/30/14 and Joint Commission survey on 12/23/14 identified the hospital's high risk, problem prone processes that resulted in three immediate jeopardy's (IJ's). The 10/30/14 survey resulted in two IJ's involving nursing services and pharmacy. The nursing IJ identified the nursing staff lacked appropriate physical assessments for medical interventions that resulted in harm to a patient. The pharmacy IJ identified the pharmacy failed to identify patients on high-risk medications and failed to obtain medication clarifications in a timely matter that resulted in harm to a patient. The Joint Commission survey on 12/23/14 resulted in a physical environment IJ due to ligature risks, (anchor points that included: beds, cords that had length enough to secure them to the frame of the bed, bathrooms and fixtures with anchor points, and oxygen tubing and power cords that can be used for strangulation/hanging). The survey on 10/30/14 identified problems with the condition of participation for infection control including hand hygiene, laundry handling, cleaning, and point of care testing. - The Performance Improvement Committee (PIC) minutes reviewed on 1/28/15 at 1:50 pm revealed minutes for meetings held on 10/17/14	A 273	- As part of addressing data collection and analysis, the leader of each of these teams, and other members as appropriate, will meet with the Performance Improvement Director between March 2 and 11, 2015 to further define the priorities and present to AET no later than March 12, 2015 for approval. - Ongoing results (data collection and analysis) of these teams' activities are reflected in minutes or supporting materials of Environment of Care Committee, Infection Control Committee, Nursing Administrative Committee, Medical Staff Committee, and AET. The teams will present to the designated oversight committee in addition to the AET as specified in the "Summary of Priorities and Indicators." The AET has oversight of the ongoing Quality Assessment and Performance Improvement Program effective February 26, 2015. - Beginning March 12, 2015, upon receipt of a report from a program / service / committee, the Performance Improvement Director will review the report to determine if the data collection and analysis has occurred and identify if any areas need to be further addressed and assesses by the individual or oversight committee as determined necessary. **How are we monitoring:** - The Performance Improvement Director will monitor the minutes and supporting documentation of the oversight committee	

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A 273	Continued From page 61 and 11/6/14 and lacked minutes for December or January. The minutes revealed the hospital PIC lacked quality data or discussion of indicators relating to nursing assessments, pharmacy, infection control, or patient safety related to ligature risks and the committee failed to meet after the facility had knowledge of issues affecting patient outcomes. - The PIC's project data reviewed on 1/22/15 at 2:00 pm with administrative staff BB revealed "Quality Indicator Tracer" and "Patient Safety Tracers" and lacked evidence the hospital incorporated data collection on physical nursing assessments, infection control, pharmacy, and ligature risks. - Performance Improvement program review on 1/22/15 between 2:00 pm to 3:00 pm revealed the PIC lacked evidence of data collection from nursing services, environmental assessments and failed to measure, analyze, and track data from the pharmacy and therapeutics committee. Administrative staff BB interviewed on 1/22/15 between 2:00 and 3:00 pm verified the hospital lacked evidence of data collection and analysis for nursing assessments, pharmacy services, and environmental assessments recently identified as high risk and problem processes.	A 273	to ensure data collection and analysis is completed and documented. **Ensure Compliance:** - If discrepancies are noted in the minutes and supporting documentation, the PI Director will notify the Superintendent for individual action and follow-up. **Documentation:** - Attachment 12: Foodservice Example of Franklin Covey Process in Use **Individual Responsible for Compliance:** Superintendent	
A 283	482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement.	A 283	**A 283** **POC:** - See response to A263 for redesign of the QAPI process. - Beginning March 12, 2015 the Performance Improvement Director will review the QAPI reports to determine if there are any areas that need to be further addressed and assessed by the individual or oversight committee as determined necessary. Any opportunities for improvement identified should be addressed by the oversight committee or designee. In the event improvement is needed and there is no plan to address the lack of progress, the Performance Improvement Director will provide feedback to those involved and assist as appropriate (e.g. utilizing tools for performance improvement develop and implement a plan). - At the present time, members of the AET are utilizing review of current hospital	

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A 283	Continued From page 62 (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on the Performance Improvement Committee plan review, meeting minutes, and staff interview the hospital's Director of Performance Improvement (PI) failed to use data collection to identify opportunities for improvement and changes that will lead to improvement and set priorities for its performance improvement activities that focus on problem prone areas that affected health outcomes, patient safety and quality of care. Findings include: - Policy titled "Performance Improvement Plan (PI-1.0)" dated 7/30/12 reviewed on 1/27/15 at 12:20 pm revealed the Director of Performance Improvement (PI) is available to provide consultation in data issues sources, collection, verification, interpretation, presentation and report	A 283	QAPI data, findings from recent surveys, guidelines for infection control and environmental design, nursing services and risk management activities in an effort to identify priorities. These priorities will be identified based on an assessment of risk, volume and problems associated with the process. - Priorities will be established for, but are not limited to, the following: o Nursing physical assessments and services o Infection control o Safe use of high risk medications o Adverse drug events (adverse drug reactions, medication errors) o Medication reconciliation o Environmental safety (including ligature risks) o Use of seclusion and restraint o Patient falls - These priorities will be established by AET on March 12, 2015. Hospital procedure LD-1.5, Quality Assessment and Performance Improvement Program (formerly PI-1, Performance Improvement Plan), was revised and approved by Administrative Executive Team (AET) on February 26, 2015, to be effective immediately. (See Attachment 11.) A key change in this procedure was identification of the AET, which is chaired by the Superintendent, as the oversight committee for the hospital's Quality Assessment and Performance Improvement Program. **How are we monitoring:**	

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A 283	Continued From page 63 writing. The Director of PI assures monthly reporting to the PI council and assures projects are on track. "High risk, high volume, and problem prone processes are considered when determining improvement priorities." The Performance Improvement Council "Assesses the status and performance improvement projects through timely reports", and "Monitors implementation of action plans from Failure Modes and Effects analysis." - The Performance Improvement Committee's project data reviewed on 1/22/15 at 2:00 pm with administrative staff BB revealed "Quality Indicator Tracer" and "Patient Safety Tracers" and lacked data and project improvement activities for nursing assessments, pharmacy services, and environmental assessments recently identiied as high risk, problem prone processes. Administrative staff BB interviewed on 1/22/15 between 2:00 and 3:00 pm verified the hospital lacked evidence of data collection and analysis for nursing assessments, pharmacy services, and environmental assessments recently identified as high risk and problem processes.	A 283	- The Performance Improvement Director will monitor that data on established priorities is collected analyzed and tracked and that opportunities for improvement identified and addressed. **Ensure Compliance:** - If discrepancies are noted in the data collection, analysis or tracking, the PI Director will notify the Superintendent for individual action and follow-up. **Documentation:** - Attachment 11: Quality Assessment and Performance Improvement Program (LD-1.5) **Individual Responsible for Compliance:** Superintendent	
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities	A 286	**A 286** See response to A263 for redesign of the QAPI process.	

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A 286	Continued From page 64 (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on the Performance Improvement Committee plan review, meeting minutes, and staff interview the hospital's Executive Compliance Committee and Performance improvement Committee (PI) failed to include an ongoing program that shows measurable improvement in indicators for which there is evidence it will identify and reduce medical errors, measure and analyze and track adverse events in the pharmacy and failed to implement preventive actions and mechanisms that include feedback and learning throughout the hospital.. Failure to measure, analyze, and track high risk and problem prone areas has the potential to affect health outcomes, patient safety, and quality of care for all patients admitted to the hospital. Findings include: - Policy titled "Performance Improvement Plan	A 286		

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A 286	Continued From page 65 (PI-1.0)" dated 7/30/12 reviewed on 1/27/15 at 12:20 pm revealed the Director of Performance Improvement (PI) is available to provide consultation in data issues sources, collection, verification, interpretation, presentation and report writing. The Director of PI assures monthly reporting to the PI council and assures projects are on track. "High risk, high volume, and problem prone processes are considered when determining improvement priorities." The Performance Improvement Council "Assesses the status and performance improvement projects through timely reports", and "Monitors implementation of action plans from Failure Modes and Effects analysis." - Pharmacy Director staff QQ Interviewed on 1/14/15 at 1:50 pm revealed the pharmacy is currently monitoring the types and amounts of medication clarification needed, medication errors, monitoring high-risk medications, and medications requiring laboratory monitoring for patient safety. Staff QQ revealed they report to the Pharmacy and Therapeutics committee and Risk management. - The Performance Improvement Committee minutes reviewed on 1/28/15 at 1:50 pm revealed the committee met on 10/17/14 and 11/6/14. The hospital lacked evidence of meeting minutes from the PI committee for December and January. The meeting minutes dated 11/6/14 failed to include data or discussion related to the identified problem prone areas in nursing assessments, pharmacy services, found. Administrative staff BB, Performance Improvement Committee designee, interviewed on 1/22/15 in their office between 2:00 and 3:00	A 286		

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A 286	Continued From page 66 pm verified the hospital ' s PI Committee is scheduled to meet on a monthly basis. Staff BB lacked evidence of data and analysis collection concerning problems identified during the 10/30/14 survey for pharmacy services. Staff BB confirmed the committee failed to meet because the staff in charge of keeping the data for the performance improvement committee left their employment at the hospital in October.	A 286	**A 308** See response to A263, A273, and A283.	
A 308	482.21 QAPI GOVERNING BODY, STANDARD TAG ... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This STANDARD is not met as evidenced by: Based on the Performance Improvement Committee plan review, meeting minutes, and staff interview the hospital's governing body failed to ensure all hospital departments and services participate in the QAPI (Quality Assurance and Performance Improvement) program and maintain and demonstrate evidence of its QAPI program. The failure to ensure all hospital services maintain and demonstrate evidence of participation in the QAPI program placed all patients admitted to the hospital as risk for harm. Findings include: - The Performance Improvement Committee data, analyis and meeting minutes reviewed on	A 308		

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A 308	Continued From page 67 1/28/15 at 1:50 pm lacked evidence of data and analysis from the hospital departments of laundry, dietary and laboratory. The minutes for 10/17/14 and 11/6/14 failed to include data or discussion relating to laundry, dietary, and laboratory. The committee lacked evidence of data collection and meeting minutes in December. - Laundry staff HH interviewed on 1/13/15 at 8:10 am indicated the laundry does not have a QAPI project. - Dietary staff OO interviewed on 1/13/15 at 11:30 am indicated they lack a QAPI project and do not send reports to QAPI. - Laboratory Director staff PP interviewed on 1/13/15 at 9:30 am indicated they have not reported data to QAPI. The plan failed to include all departments in their QAPI program.	A 308	**A 309** See response to A263, A273, and A283.	
A 309	482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address	A 309		

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A 309	Continued From page 68 priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This STANDARD is not met as evidenced by: Based on the Performance Improvement Committee plan review, meeting minutes, and staff interview the hospital's governing body failed to ensure that an ongoing program for ongoing quality improvement and patient safety included the reduction of medical errors and failed to ensure the hospital wide quality assessment and performance improvement efforts addressed priorities for improved quality of care, patient safety and all improvement actions are evaluated. Failure to develop and maintain an ongoing program for quality improvement and patient safety, identify and address priortities for improved quality of care and patient safety previously identified has the potential to affect health outcomes, patient safety, and quality of care for all patients admitted to the hospital. - Policy titled "Performance Improvement Plan (PI-1.0)" dated 7/30/12 reviewed on 1/27/15 at 12:20 pm revealed the Director of Performance Improvement (PI) is available to provide consultation in data issues sources, collection, verification, interpretation, presentation and report writing. The Director of PI assures monthly reporting to the PI council and assures projects are on track. "High risk, high volume, and problem prone processes are considered when determining improvement priorities. "The	A 309		

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A 309	Continued From page 69 Performance Improvement Council "Assesses the status and performance improvement projects through timely reports", and "Monitors implementation of action plans from Failure Modes and Effects analysis." - The Performance Improvement Committee's project data reviewed on 1/22/15 at 2:00 pm with administrative staff BB provided "Quality Indicator Tracer" and "Patient Safety Tracers" that lacked data and project improvement activities for previously identified problem prone process of nursing services, pharmacy services, and and patient safety. Administrative staff BB interviewed on 1/22/15 between 2:00 and 3:00 pm verified the hospital lacked evidence of data and analysis collection for nursing services, pharmacy services, and data from patient safety ligature risk assessments identified as high risk and problem processes.	A 309	**A 385** POC: - **Nursing Services and RN Supervision of Nursing Care** - **Increase in Supervision and Case Management** - To augment increased supervision of Nursing Services and to provide additional guidance, resources, and assistance to staff, two additional Program Nurse Managers have been assigned to the patient care units (one to MPA and MPB and one to CCP and SSP). The Program Nurse Managers are "hands on" Registered Nurses who are out on the units, assisting the unit nurses with patient care, evaluating the nursing care provided by unit nurses, providing 1:1 training and feedback as performance needs are identified when delivery of care and documentation deficits are found. All Program Nurse Managers are actively engaged in monitoring patient care, assisting the unit nurses with patient care needs, and provide training to reinforce the need for ongoing assessments, including gastrointestinal assessment, of patients when there is a change in condition, evaluating the patient's response to interventions, and ensuring that the physician is notified when a patient's condition changes. - One additional Nursing Supervisor has been added to oversee all patient care units on the evening shift to supplement existing supervision of the over-night and weekend shifts. - Beginning on March 4, 2015, the Director of Nursing, Program Nurse Managers,	
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 medical record review, document review, and staff interview the hospital's nursing staff failed to: follow the policy for supervision and evaluation of care for each patient; provide ongoing nursing assessments when a patient experiences changes in physical condition; complete ongoing assessments of patient responses to interventions; and notify physician of changes in patient's condition; (refer to A-0395).	A 385		

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A 385	Continued From page 70 The hospital failed to ensure nursing staff followed their policy to update and keep a current nursing care plan; (refer to A-0396). The failure of nursing service to ensure they supervised and re-evaluated patient ' s current physical condition and update the current nursing care plan resulted in an Immediate Jeopardy identified by the Centers for Medicare/Medicaid Services on 1/23/15 at 11:30am and not removed on exit 1/23/15. The cumulative effect of the systemic failure to: supervise and evaluate the care for each patient; provide ongoing nursing assessments when patients experience a change in condition; complete ongoing assessments of patient responses to interventions; notify the physician of changes in the patient ' s condition; and keep a current nursing care plan after a patient ' s physical condition changes resulted in a patient ' s death and placed all patients admitted to the hospital at risk.	A 385	and Nurse Supervisors will meet with unit Registered Nurses and Licensed Practical Nurses on a weekly basis. This will enhance communication with the unit nurses and provide opportunity to find out from OSH's strong clinical nurses what changes need to be made, what's working, and what needs revision or improvement. - A Registered Nurse Patient Care Coordinator and a LPN have also been added to provide patient case management in the Coordinated-Care Clinic (see page 60). **Program Nurse Managers**: - The Registered Nurses hired for the two Program Nurse Manager positions are individuals with knowledge of the hospital's policies and procedures but prior to assuming the Program Nurse Manager positions had not been working as full time nurses for the hospital. One of the individuals was not in a Nursing Services position and has since been promoted to a Program Nurse Manager position. The second individual who has been hired as a Program Nurse Manager has worked for the hospital as a "prn" nurse most recently, but now works full time as a Nurse Program Manager. **Nursing Supervisor:** - The new Nursing Supervisor had been on Medical Leave and has now returned to work on the evening shift as the Nurse Supervisor. **Registered Nurse Patient Care Coordinator and LPN (for the Coordinated-Care Clinic):**	
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on observation, policy review and interviews the hospital failed to plan appropriately and provide staff in adequate numbers, according to the unit's patient census, to ensure nursing	A 392		

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A 392	Continued From page 71 staff responded to each individual patient's nursing needs in a safe and effective manner around the clock for one of 32 patient's sampled (Patient #1) and 2 of 7 nursing units (PLS/C1 and HPE/C2). This deficient practice resulted in the death of patient #1 and had the potential to cause harm to all patients due to inadequate staffing for the patient acuity and census on the psychiatric unit. Findings: - The hospital's policy titled " Nursing Services (LD-3.21) dated 8/13/12" reviewed on 1/29/15 at 9:45 am directed" ...Staffing is reviewed on an ongoing basis to ensure appropriate staff mix and number." and "... nursing staff will be evaluated and adjusted by the nursing supervisor or designee ...A core number of staff per skill level has been determined per unit, per shift as outlined below as related to acuity ...Hope (C2) unit/Positive Living Skills (C1) unit (PLS), CAPACITY & OVERFLOW, 30 plus three." - Review of "Core Staffing" on 1/21/15 listed the PLS/C1and Hope/C2 unit nurse staffing requirements as the following: * Day, (AM) shift= 5 staff that includes one registered Nurse (RN), one Licensed Practical Nurse/Licensed Mental Health Technician (LPN/LMHT), and three (Mental Health Technicians/ Mental Health Technician Trainee)MHT/MHTT: * Afternoon/evening (PM) shift=5 staff (one RN, one LPN, and three MHT/MHTT): * and night shift=4 staff (one RN and three MHT/MHTT). - Review of the hospital's "Staffing Schedule" on	A 392	- The Patient Care Coordinator is a newly created Registered Nurse position which is solely responsible for the supervision of the Coordinated-Care Clinic and provides Patient Case Management for inpatients. Her strong medical-surgical background enables her to focus on patient's physical needs as well as provide training and direction to the unit nurses and physicians in order to meet the needs of the patients. - Additionally, a LPN works full-time in the Coordinated-Care Clinic to assist the physicians and the Registered Nurse Patient Care Coordinator. The LPN takes patients' vital signs, documents symptoms or patient complaints, readies the patient in the exam room to be seen by the physician, stays with the patient during the physician exam, obtains urine specimens as ordered, ensures that any ordered lab work or tests are processed, completes a Report of Infection if an infection is involved, performs wound preparation for the physician to exam as indicated, completes progress notes regarding each patient's encounter, communicates patient concerns and issues to the unit Registered Nurse, and flags the chart for any new physician orders. - This LPN is supervised by the Registered Nurse Patient Care Coordinator. - The Registered Nurse Patient Care Coordinator is supervised by the Director of Nursing. **Partnership with Viola Riggin Consulting** - Kansas Department for Aging and Disability Services (KDADS) and Osawatomie State Hospital (OSH) have taken significant steps to rectify issues in	

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A 392	Continued From page 72 1/21/15 listed patient census on PLS/C1 unit: * 12/4/14 patient census as 31, * 12//5/14 patient census as 31, * 12/6/14 patient census as 32, * 12/7/14 patient census as 32, * 12/8/14 patient census as 30, * 12/9/14 patient census as 29, * and 12/10/14 patient census as 28. - Patient #1's medical record review on 1/13/15 revealed an admission date of 11/9/14 to the PLS unit (identified as a 30 bed unit) with an Axis I diagnosis of major depressive disorder (MDD), moderate, recurrent, and an Axis III diagnosis of hypertension (HTN). Weekly nursing assessment dated 12/4/14 documented patient #1's "Elimination" assessment as, "no reported problems". The assessment lacked yes; no; or descriptive responses to the following items on the physical assessment: Bowels sounds present X 4 quadrants; Abdomen-hard, distended, pain; Nausea/vomiting/heartburn; Constipation/diarrhea; difficulty chewing or swallowing; and date of last bowel movement. Supervisor registered nursing staff H on 12/6/16 at 8:00am documented they notified the physician and received a one-time order for "Mag Citrate (a laxative) " and "docusate sodium (a laxative). Medical record review lacked any nursing documentation of follow up nursing assessment of the patient's gastrointestinal system including bowel sounds, patient complaints of constipation, pain or distention, or bowel movements on 12/7/14, 12/8/14, and 12/9/14. Nursing staff J, on 12/10/14 at 7:58 pm documented they received a physician telephone order for Mag Citrate for constipation. Nursing staff J obtained a	A 392	the area of nursing assessments, lack of nursing skills, and impeded access to timely and appropriate health care services. - In January OSH began working with Viola Riggin Consulting, to provide guidance in the area of risk reduction and clinical compliance. The Riggin Group's Program Manager is experienced in health care restructuring and systems management. She brings with her a team of PsyDs, BSNs, MSNs, APRNs, MDs and DOs. - During the month of January, the Riggin Group evaluated our patient population for clinical needs and system weaknesses. They also focused on system improvements and infrastructure development. During the first week of February the Riggin Group evaluated our Coordinated Care Clinic and approved that program as a standard community and hospital practice (refer to "Coordinated Care Clinic," page 60 for additional details). - The facility is working to incorporate APRN's into the clinical evaluation process to ensure Master's level Nurses are available on the unit and as part of the oversight and management process of physical / medical conditions. This process began in January by requesting and implementing a new contract for hiring quality staff outside of the normal State process to expedite clinical physician and nursing services. - In order to achieve appropriate health care services and management for our patient population, OSH will implement Clinical Pathways, a tool to manage quality of	

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A 392	Continued From page 73 physician's order for Milk of Magnesia (a laxative) for constipation on 12/10/14 at 11:20 pm. The medical record lacked evidence of a complete gastrointestinal assessments that included listening to the bowel sounds of the abdomen, observation/feeling the abdomen, documenting bowel movements and vital signs including the patient's temperature prior to calling medical staff for the patient's continued complaint of constipation. The medical record lacked evidence of nursing's gastrointestinal assessment after the administration of the Milk of Magnesia medication that included bowel sounds, observation/feeling the abdomen, a bowel movement, and vital signs or notified the physician regarding the patient's response to the interventions. Supervisory nursing staff H documented on 12/11/14 at 12:06 pm in patient #1's medical record that the patient was "unable to respond to her, eyes rolling back into head, abdomen was extremely distended and hard." Nursing staff documented they notified the medical staff and the physician ordered patient #1 transferred by ambulance to hospital B emergency department (ED) at 11:50 am for possible bowel impaction. The patient expired at hospital B at 2:40 pm, two hours and fifty minutes later and the patient's cause of death was ileus (the absence of movement in the intestine) with sepsis (infection). Review of the "Nurse Staffing Schedule" from 12/4/14 to 12/10/14 revealed the following: 1) On 12/4/14 evening shift, a MHT from the day shift worked over until 4:30pm on the evening shift until 11:pm. 2) On 12/6/14 evening shift, a MHT from Hope-C2 was pulled to worked the PLS/C1 unit 3) On 12/7/14 evening shift, a C-1 day shift RN,	A 392	health care concerning the standardization of care processes based on evidence-based practice. Clinical Pathways optimize patient outcomes in the acute care setting. During the months of February and March, OSH will begin the process of implementing nursing clinical guidelines for 61 medical conditions that will include one template for each medical condition. (See Attachment13-Clinical Pathways Appendix). All nursing and medical staff will be trained on this process and guidelines by March 31, 2015. This process will be comprehensive and proactive. - The Director of Nursing and Assistant Director of Nursing will oversee the completion of training to ensure that all nursing and medical staff have received training. - On February 3rd, the Riggin Group assisted in the development of a plan for unimpeded and timely access to appropriate care for every patient within our hospital. The process allows each patient access to daily nursing evaluations upon request. Each unit has a Registered Nurse on duty 24 hours a day, 7 days a week who is available to perform a nursing assessment and provide follow-up intervention for patient complaints by contacting the on-call physician or utilizing therapies already prescribed by the physician. If the patient condition or complaint has not improved or is of a reoccurring nature (concern voiced three {3} times), referral will be made to the Coordinated-Care Clinic. - During the week of February 17th OSH and Riggin Group enhanced our program	

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A 392	Continued From page 74 volunteered to work a double shift until 11:00pm and an evening shift RN from C2 was pulled to work the C1 unit until 11:00pm. 4) On 12/10/14 a morning/day shift (AM) MHT from the Managing and Preventing Symptoms (MAPS) A-I unit worked C-1 to provide patient care. Nursing supervisor staff H interviewed on 1/13/15 at 1:30 pm reported they were on duty 12/6/14 when patient #1 complained of constipation. Staff H verified they failed to document a complete nursing gastrointestinal assessment that included the bowel sounds, observation/feeling the abdomen, patient bowel movements, vital signs, failed to complete written progress notes for the newly ordered mag citrate and docusate sodium laxative and a nursing assessment with results of the laxative medication. Staff H confirmed the medical record lacked evidence of a nursing assessment of the patient's abdomen and elimination status including bowel sounds, observation/feeling the abdomen, bowel movements, or vital signs between the dates of 12/6/14 to 12/10/14 when nursing staff obtained another order for Mag citrate due to patient #1's continued complaint of constipation. Staff H shared the high census of patients on the unit and patient's medical needs contributed to nursing's failure to document assessments and follow up assessments in the medical record. Nursing staff J interviewed on 1/13/15 at 3:30 pm shared they worked a double shift the evening of 12/10/14 and the night shift into the morning of 12/11/14. Staff J acknowledged at shift report (day to evening shift) nursing had failed to communicate to them patient #1's complaints of constipation. Staff J verified the high census on	A 392	of identifying clinical weaknesses within the nursing staff. This assessment was managed in a confidential and non-punitive manner. All nurses received a skills evaluation by the Riggin Group and from that evaluation a training plan will be developed for each individual nurse. The Nursing Education Department will be responsible for oversight of progress made by each nurse towards their individual plan. This process will be completed by March 31, 2015. - In addition, the Riggin Group will partner with OSH to provide peer review on an ongoing basis. This will assist in the prevention of negative outcomes. - The Director of Nursing will oversee this education, and the Riggin Group will provide professionals to assist in the training process. **Coordinated-Care Clinic** - On February 2, 2015 a Registered Nurse Patient Care Coordinator assumed duties to review all new admissions to ensure each patient's medical conditions are identified, medication reconciliation has been completed correctly, diagnoses for all identified medical conditions are entered correctly, and appropriate physician notification and follow up are completed. - Additionally, a LPN works full-time in the Coordinated-Care Clinic to assist the physicians and the Registered Nurse Patient Care Coordinator, who supervises this LPN position. - The Registered Nurse Patient Care Coordinator is supervised by the Director of Nursing.	

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A 392	Continued From page 75 the unit contributed to failing to communicate the patient's medical concern related to the constipation and the lack of time to document nursing assessments in patient #1's medical record. Administrative staff B interviewed by phone on 1/27/15 verified the nursing department follows the "Core Staffing" grid to staff the units shifts. Staff B revealed the PLS-C1 unit opened 4/14 with a 30 bed capacity. Staff B shared the nursing staffing documents from 12/4/14 to 1/19/15 lists each nursing unit census as of midnight on the date documented and shared the MHT assigned to complete "ligature rounds" are not counted as a nursing care staff member for the shift. Review of " Core Staffing " listed the PLS/C1and Hope/C2 unit nurse staffing requirements as the following: * Day, (AM) shift= 5 staff that includes one registered Nurse (RN), one Licensed Practical Nurse/Licensed Mental Health Technician (LPN/LMHT), and three (Mental Health Technicians/ Mental Health Technician Trainee)MHT/MHTT: * Afternoon/evening (PM) shift=5 staff (one RN, one LPN, and three MHT/MHTT): * and night shift=4 staff (one RN and three MHT/MHTT). The one MHT assigned to ligature rounds is not to be included in their count for meeting their "core" staffing requirement. - Observation on 1/21/15 at 8:45 am revealed unit HPE C-2 lacked hospital staff in the dayroom between 8:55 am and 9:05 am and again from 9:06 am to 9:14 am.	A 392	- On February 4, 2015 a Coordinated-Care Clinic was established in the Biddle Annex Treatment Room for patients to see their medical physician in a medical office setting. - This treatment room has been used by the medical specialists at the hospital for seeing patients who have more complicated medical needs. Its use has been expanded to the Coordinated Care Clinic. Each patient will be accompanied by a nursing staff member who will remain with the patient while waiting to see a physician. The supervision of the patient may be handed off to different nursing staff (e.g. from Mental Health Technician to the clinic LPN) while the patient is in the clinic. At no time will the patient be left unattended. - When a patient on the unit presents with clinical symptoms of a physical nature or expresses a concern, the unit Registered Nurse will assess the patient including obtaining a full set of vital signs. The nurse will inform the physician of any abnormal findings and follow instructions of the physician which may include referral to the Coordinated-Care Clinic. Additionally, any time a patient reports the same medical concern three (3) times, the patient will be referred to the Coordinated-Care Clinic by the nurse. The patient will be seen that day in the clinic. If this occurs after Clinic hours, the nurse will request the on-call physician see the patient and will make a referral to the Clinic to be seen on the next clinic day. - On the unit, patients will be asked daily by Mental Health Technicians (MHTs)	

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A 392	Continued From page 76 MHT staff GG interviewed on 1/21/14 at 9:15 am acknowledged they do not have enough staff on the unit right now. Staff GG revealed one MHT with a patient in the seclusion room, one MHT currently assigned to ligature risk rounds, and one MHT with a patient in physical therapy. Staff GG reported being the only MHT available on the unit at this time.	A 392	when collecting vital signs if they have any medical or physical concerns. These concerns will be documented on the vital signs worksheets. Unit RNs will review these vital signs worksheets for abnormal vitals and any expressed concerns by patients, or observations by the MHTs, for those who have difficulties expressing their concerns. - Training of all MHTs and licensed nursing staff by the Program Nurse Managers on this new process of identifying patient medical and physical concerns will be completed by 02/13/15. - The Registered Nurse Care Coordinator, in addition to monitoring patients with constipation issues, will monitor the care of patients who are considered at high medical risk. Those high risk medical conditions identified include, but are not limited to, o uncontrolled hypertension; o hypotension; o diabetes; o acute congestive heart failure; o acute chronic obstruction pulmonary disease; pneumonia; o history of self-inflicted behavior requiring medical intervention; o uncontrolled / unstable / non-therapeutic INR values; o seizures within the preceding six months; o loss of consciousness; o healing fractures; o pregnancy; o cancer not in remission; and o decubitus ulcer(s)	
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 record review, document review and staff interview, the hospital failed to: ensure nursing staff supervised and evaluated the care provided for each patient; provide ongoing nursing assessments when patients experience a change in condition; complete ongoing assessments of patient responses to interventions; notify the physician of changes in the patient ' s condition for one of 32 sampled patients (Patient #1) who reported physical complaints. The failure to ensure nursing services supervised and completed an evaluation and assessment, re-assessed and notified the physician of the results of the ordered interventions, and to notify the physician of changes in the patient ' s condition places all patients admitted to the hospital with medical issues or who develop a medical issues/physical changes during their admission at risk for harm or death.	A 395		

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A 395	Continued From page 77 Findings included: - Policy titled " Nursing Services (LD-3.21), Organization Procedures Manual, effective date August 13, 2012 " reviewed on 1/15/15 stated the " Nursing Services mission is through utilization of best practices in the delivery of standards of nursing care and collaboration with individuals, families and the community. " The nursing policy directed nursing staff to care for the patient from admission through discharge with the nursing process of data collection, assessment, planning, interventions and ongoing evaluation. The policy directed nursing to complete an initial assessment and nursing care plan at the time of admission and continue to develop and modify the care plan as needed throughout the patient ' s admission. The policy listed the Program Nurse Manager as the responsible member for the supervision of direct and indirect patient care of the nursing units/shifts. The nurse manager ' s responsibility includes safe, adequate, 24 hour nursing coverage of nursing units and the implementation of standards of nursing practice. The Nurse Senior (R.N. senior) is responsible for providing direction and monitoring of assessment skills of unit nursing staff so all aspects of patient care based on sound nursing practice and treatment. - Policy titled, " Assessment (PC-2.0), Effective Date: November 24, 2014, " reviewed on 1/15/15 stated that initial and ongoing assessments are crucial to determine the appropriate care, treatment and services needed to meet the patients individualized needs that may change during the course of hospitalization. Under, " G, 4. RN/LPN will conduct a. A weekly reassessment of the patients physical ...condition	A 395	- Additionally, those patients on high risk medications are monitored to ensure interventions are identified, follow up care is provided, and orders are carried out. The high risk medications include: o clozapine, o digoxin, o enoxaparin, o fentanyl patches, o insulin; , o lithium, o methadone, o oxycodone CR, and o Warfarin. **Management of Constipation** - Using information and assistance from the Riggin Group, new policies, "Constipation Evaluation and Treatment," and "Physician Plans Order Sheet for Constipation Management" (See Attachment 14), were developed. On February 2, 2015, the Director of Nursing trained the Program Nurse Managers and Nursing Supervisors on the new constipation policy and physician order sheet for constipation. Nursing staff received training on the new policy and physician order sheet on 02/03/15 and 02/04/15. (See Attachment 14.) **Education of Nurses** - During the nurse's staff meetings of February 3 and 4, 2015, the Director of Nursing reviewed the following: o Assessment Policy (PC-2.0); and documentation of patient's response to medical interventions. (See Attachment 15.)	

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A 395	Continued From page 78 and will document on the Nurses Assessment/Progress Note and Nursing Physical Reassessment. b. A Nursing Physical Reassessment any time there is a Change in Condition. " ... A Change in Condition is a clinical important deviation from a patient ' s baseline in physical, cognitive, behavioral, or functional domains. " Clinically important " means a deviation that, without intervention, may result in complications or death. " - The " Davis Drug Guide for Nurses, 2014 " reviewed on 1/27/15 listed " Magnesium Laxatives magnesium citrate " as a laxative, with a time/action of within three to six hours. The drug guide directed nursing staff for the following; " Nursing Implication- Assessment; Assess patient for abdominal distention, presence of bowel sounds and usual pattern of bowel function. Assess color, consistency, and amount of stool produced ... Follow all oral laxative doses with a full glass of liquid to prevent dehydration and for faster effect. Do not administer at bedtime or late in the day. " - Patient #1 ' s medical record review on 1/13/15 revealed an admission date of 11/9/14 with an Axis I diagnosis of major depressive disorder (MDD), moderate, recurrent, and an Axis III diagnosis of hypertension (HTN). Patient #1 reason for admission listed; suicidal ideation, hitting their head, and wanting to jump out of a moving vehicle. The plan included a medication treatment of Trazodone (used for the treatment of anxiety and insomnia) 150mg every evening at bedtime and Zyprexa (used for treatment of psychosis (loss of contact with reality that usually includes: false beliefs about what is taking place or who one is (delusions) ; seeing or hearing	A 395	o Treatment Plan Policy (PC-4.0) (see Attachment 16.); o Revised Nursing Process Policy (NUR-1.0) (see attachment 17) that included an additional section to address Temporary Issues with short-term goals and interventions for new medical issues and/or a change in patient condition; o Change in Patient's Condition, Recognition and Response (PC-9.0) (see attachment 18); - Any nurse unable to attend the training will be trained 1:1 by the Program Nurse Manager or Nursing Supervisor upon arrival on the next shift when the nurse returns to work. **How are we monitoring to ensure effectivenes:** - The Program Nurse Managers and Nursing Supervisors review the patient charts weekly to check that nursing assessments are completed upon admission on 100% of newly admitted patients. - The Program Nurse Managers and Nurse Supervisors will audit weekly 50% of "Nurses Assessment / Progress Note" to ensure that they are completed on time and address all components and physical aspects of the nursing assessment. - The Program Nurse Managers and Nurse Supervisors will audit weekly 100% of "Evaluation of Constipation" progress notes and "Change in Condition" progress notes to ensure that they are completed on time, thoroughly, and for appropriateness of intervention.	

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A 395	Continued From page 79 things that aren't there (hallucinations)) and bi-polar (condition in which a person has periods of depression and periods of being extremely happy or being cross or irritable) 10mg two times a day. The physician ' s admission physical examination recorded the vital signs blood pressure of 125/86, pulse 93, documented the abdomen as non-distended and the patient denied problems with appetite or elimination. Nursing assessment on 11/9/14 indicated patient ' s appetite and diet adequate and no complaints of problems noted regarding elimination status. Weekly nursing assessment dated 11/16/14 documented patient #1 ' s " Elimination " assessment as " no known issues. " The medical record lacked evidence of a weekly nursing assessment for patient #1 on 11/23/14. A nursing assessment completed on 11/27/14 (four days late) documented an assessment of the gastrointestinal system and listed date of last bowel movement as 11/25/14. Weekly nursing assessment dated 12/4/14 documented patient #1 ' s " Elimination " assessment as, " no reported problems " . The assessment lacked yes; no; or descriptive responses to the following items on the physical assessment: Bowels sounds present X 4 quadrants; Abdomen-hard, distended, pain; Nausea/vomiting/heartburn; Constipation/diarrhea; difficulty chewing or swallowing; and date of last bowel movement. Supervisor registered nursing staff H on 12/6/16 at 8:00am documented they received a physician telephone order from medical staff I for "Mag Citrate (a laxative), 296 milliliter (ml) by mouth (PO) a one-time order (stat) immediately for constipation," and "docusate sodium (a laxative), 100 milligram (mg), by mouth (PO) two times a day (BID) for constipation. RN staff H signed the	A 395	- During the review of patient charts, if performance issues are identified, the Program Nurse Managers and / or Nursing Supervisors will provide feedback to the involved nursing staff related to appropriate nursing interventions. The Managers and Supervisors will provide additional coaching and counseling as indicated. - The Registered Nurse Patient Care Coordinator reviews 100% of patients with high risk medical conditions and /or high risk medications to ensure physician orders are carried out, laboratory and other test results are ordered, obtained and reviewed by the physician, and timely follow-up for each patient occurs. - The Registered Nurse Patient Care Coordinator reviews 100% of all new admissions to ensure that each patient's medical conditions are identified, medication reconciliation has been completed, diagnoses are entered correctly, and appropriate physician notification and follow up are done. - In order to remain proactive, re-inservicing will be provided to all licensed nursing staff regarding the admission process, completing the nursing admission assessments, writing the initial Nursing Care Plan, nursing monitoring and documentation of patients' response to treatment and interventions, weekly nursing reassessment or more often if a change in condition occurs, and evaluating and reviewing all goals and Temp Issues in collaboration with the IDT Team at each IDT meeting	

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A 395	Continued From page 80 physician order. The medical record lacked evidence of a nursing gastrointestinal assessment or progress note that included listening to the patient ' s bowel sounds, observation/feeling the abdomen, date of last bowel movement, patient complaint of constipation, vital signs including a temperature; and the reason for the physician ordering constipation medications. The medical record lacked documentation of a follow up nursing evaluation/assessment of the patient ' s abdomen, the results of the patient ' s response to the laxative (bowel movement or lack of) and any notification to the physician concerning the lack of results for the prescribed medication. Patient #1 ' s medical record indicated they received the laxative Mag Citrate on 12/6/2014 at 10:16 am and the stool softener Colace twice a day on 12/7/14, 12/8/14, and 12/9/14. The medical record lacked documentation of any follow up nursing assessment of the patient ' s gastrointestinal system including bowel sounds, patient complaints of constipation, pain or distention, or bowel movements on 12/7/14, 12/8/14, and 12/9/14. On 12/10/14 at 11:10 am the IDT (interdisciplinary team) including the psychiatrist, registered nurse and social worker met. Patient #1 reported they had a bowel movement after given some medication but felt they were blocking up again and the bowels were not working well. The nursing staff failed to create a care plan regarding the patient ' s constipation after the IDT meeting. Nursing staff J, on 12/10/14 at 7:58 pm (about 9 hours after the IDT meeting), documented they received a physician telephone order from	A 395	**Documentation:** - Attachment 13: Nursing Clinical Pathways - Attachment 14: Constipation Evaluation and Treatment Policy (PC-2.13) • Physician's Plans Constipation Management form • Training Roster for Constipation Protocol - Attachment 15: Assessment Policy (PC-2.0) - Attachment 16: Treatment Plan Policy (PC-4.0) - Attachment 17: Nursing Process Procedure (Nur-1.0) - Attachment 18: Change in a Patient's Condition Recognition and Response Policy (PC-9.0) **Individual Responsible for Compliance:** Director of Nursing **Date for completion:** 3/12/15 **A 392** **POC:** - OSH Human Resources Department continues to recruit for a permanent, full-time Director of Nursing. - OSH Human Resources Department is actively recruiting for all vacant Registered Nurse, Licensed Practical Nurse, and Mental Health Technicians positions. - Two newly hired Registered Nurses completed orientation during the month of	

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A 395	Continued From page 81 medical staff L for Mag Citrate 296ml solution, PO (oral), Stat(immediately) for constipation. Licensed Practical Nurse staff K, on 12/10/14 at 9:30 pm, documented the patient received " MAG citrate for constipation at 8:26 pm with the patient still voicing complaints, no results yet. " Nursing staff J, on 12/10/14 at 10:22 pm, documented the patient reported that he could not pass his stool. The patient had not had a bowel movement at 9:30 pm, the nurse notified the physician and no new orders were received. The medical record lacked evidence of a complete gastrointestinal assessments that included listening to the bowel sounds of the abdomen, observation/feeling the abdomen, documenting bowel movements and vital signs including the patient ' s temperature prior to calling medical staff L for the patient ' s continued complaint of constipation. The medical record lacked evidence of nursing ' s gastrointestinal assessment after the administration of the mag citrate medication that included bowel sounds, observation/feeling the abdomen, a bowel movement, and vital signs. Nursing staff J obtained a physician ' s order for Milk of Magnesia (a laxative) 30 ml po (oral) for constipation on 12/10/14 at 11:20 pm. The medical record lacked documentation that nursing performed any additional gastrointestinal assessments or notified the physician regarding the patient ' s response to the intervention. The medical record lacked evidence of any nursing progress notes regarding constipation between 12/10/14 10:22 pm and 12/11/14 12:06 pm. Supervisory nursing staff H documented in a	A 395	February and are on staff. Two additional Registered Nurse hires are in progress. A Registered Nurse from a local nursing staffing agency will start orientation on 03/04/15. Additionally, an agreement was executed on 02/27/15 with World Wide agency that supplies nurses that specialize in psychiatric nursing for 13-week assignments, which are renewable every 13 (thirteen) weeks. This travel agency is sending on 03/09/15 four nurses (three Registered Nurses and one Licensed Practical Nurse) to start OSH facility orientation; all four nurses will work on the patient care units to supplement staffing as soon as the facility orientation is completed. An additional four nurses (two Registered Nurses and two Licensed Practical Nurses) will be sent to OSH from the travel agency to begin assignments on 03/23/15. - This augmentation of 14 (fourteen) Registered Nurses and Licensed Practical Nurses will provide more nursing staff working on the patient care units and will decrease the amount of over-time of that current OSH nursing staff, thereby decreasing fatigue. It will also allow more time for the nursing staff to perform assessments and complete documentation. - Additionally, 5 (five) Mental Health Technicians (MHT) will start orientation at OSH on 03/02/15 and 5 (five) more MHT applicants are in progress for hire. This increase of 10 (ten) additional MHTs working on the patient care units provides for additional observation and provision of non-nursing related care of patients. - To augment increased supervision of Nursing Services and to provide	

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A 395	Continued From page 82 progress note dated/timed 12/11/14 at 12:06 pm patient #1 was " unable to respond to her, eyes rolling back into head, abdomen was extremely distended and hard. Mouth had dried brown mucous around edges and their breath smelled of feces. Bowel sounds were hypoactive (decreased or absent bowel sounds often indicating constipation). Vital signs were B/P - 95/58 (normal blood pressure is 120/80), pulse 72, respirations 16, and they were unable to obtain a temperature. " Nursing staff documented in the medical record that they notified the medical staff and the physician ordered patient #1 transferred by ambulance to hospital B emergency department (ED) for possible bowel impaction. The ambulance arrived to transfer the patient at 11:45 am and left at 11:50 am. The patient expired at hospital B at 2:40 pm, two hours and fifty minutes later and the patient ' s cause of death was ileus (the absence of movement in the intestine) with sepsis (infection). Nursing supervisor staff H interviewed on 1/13/15 at 1:30 pm reported they were on duty 12/6/14 when patient #1 complained of constipation and they called the physician to receive an order for the Mag citrate and docusate sodium. Staff H verified they failed to document a complete nursing gastrointestinal assessment that included the bowel sounds, observation/feeling the abdomen, patient bowel movements, vital signs, failed to complete written progress notes for the newly ordered mag citrate and docusate sodium laxative and a nursing assessment with results of the laxative medication. Staff H confirmed the medical record lacked evidence of a nursing assessment of the patient ' s abdomen and elimination status including bowel sounds, observation/feeling the abdomen, bowel	A 395	additional guidance, resources, and assistance to staff, two additional Program Nurse Managers have been assigned to the patient care units (one to MPA and MPB and one to CCP and SSP). The Program Nurse Managers are "hands on" Registered Nurses who are out on the units, assisting the unit nurses with patient care, evaluating the nursing care provided by unit nurses, providing 1:1 training and feedback as performance needs are identified when delivery of care and documentation deficits are found. All Program Nurse Managers are actively engaged in monitoring patient care, assisting the unit nurses with patient care needs, and provide training to reinforce the need for ongoing assessments, including gastrointestinal assessment, of patients when there is a change in condition, evaluating the patient's response to interventions, and ensuring that the physician is notified when a patient's condition changes. - One additional Nursing Supervisor has been added to oversee all patient care units on the evening shift to supplement existing supervision of the over-night and weekend shifts. **How are we monitoring:** - On a weekly basis the Director of Nursing will communicate with the Human Resources Department regarding status of the job posting and whether applications have been received. **Ensure Compliance:** - Once filled, an incumbents will remain in their positions and should a position be	

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A 395	Continued From page 83 movements, or vital signs between the dates of 12/6/14 to 12/10/14 when nursing staff obtained another order for Mag citrate due to patient #1 ' s continued complaint of constipation. Nursing staff J interviewed on 1/13/15 at 3:30 pm shared they worked a double shift the evening of 12/10/14 and the night shift into the morning of 12/11/14. Staff J acknowledged at shift report (day to evening shift) nursing had failed to communicate to them patient #1 ' s complaints of constipation. Staff J verified the medical record lacked evidence of a complete gastrointestinal assessment with bowel sounds, observing/feeling of the abdomen, bowel movements, and vital signs. Administrative nursing director staff UU interview on 1/23/15 revealed the expectation for nursing regarding a patient with constipation would include an assessment of the gastrointestinal system including observation, listening, feeling, vital signs, documentation of bowel habits, response to a laxative medication and notification to the physician of continued patient complaints. Medical staff M interviewed on 1/13/15 at 2:35pm acknowledged the expectation of nursing staff would be to report their observations, the lack of bowel movements, an abdominal assessment and vital signs to the IDT team or the on call medical staff.	A 395	vacated in the future, active recruitment will begin again. **Individual Responsible for Compliance:** Director of Nursing **Documentation:** - Attachment 19: Provider Contract **Individual Responsible for Compliance:** Director of Nursing **Date of Completion:** 03/23/15 **A 395** See response to A385.	
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan	A 396		

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A 396	Continued From page 84 for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on record review, document review and staff interview, the hospital failed to ensure nursing staff updated the patient ' s care plan as part of the interdisciplinary care plan for one of 32 patients (Patient #1). The failure to ensure nursing services updated the care plan, including the update as part of the interdisciplinary (IDT) care plan, resulted in nursing staff failing to perform ongoing assessments of the patient ' s medical issues. This failure placed all patients admitted to the hospital who experienced a change in physical condition during their admission at risk for harm. Findings include: - The policy titled " Nur-1.0 Nursing Process Procedure, Effective date: November 24, 2014, " under, " II. " directed nursing staff under " 8. The Treatment Plan which incorporates the Initial Nursing Care Plan (electronic) ...VIII. Initial Nursing Care Plan (electronic) ... B. The Initial Nursing Care Plan will be evaluated at least weekly and involves: 1. Resolving the goal if met or transferring it to the Treatment Plan if expected to continue beyond 30 days. 2. Documents reason for the change. IX. Treatment Plan (electronic) The Treatment Plan shall be reviewed and revised as needed in accordance with the patient ' s condition. The RN is responsible to write the Treatment Plan regarding medical issues. " - Patient #1 ' s medical record review on 1/13/15 revealed an admission date of 11/9/14 with an	A 396	**A 396** **POC:** **Nursing Care Plan** - Mandatory Training of Nursing Staff regarding the new Policy and Procedure for Constipation, with accompanying Physicians' Orders Template and Flowchart was presented by the Director of Nursing and Assistant Director of Nursing on 02/03/15 and 02/04/15. Other topics discussed and reinforced at the mandatory meetings included reviewing the Nursing Assessment Policy (PC-2.0) to ensure that the patient's medical condition is updated; the Treatment Plan Policy (PC-4.) with emphasis on initiating and revising the Nursing Care Plan and incorporating the findings and recommendations of the Interdisciplinary Treatment Team; the revised Nursing Process Policy (NUR-1.0)(see Attachment 17) with the additional section added to address creating Temporary Issues with short term goals and interventions for new medical issues and/or a change in patient condition; completing and documenting patients' response to interventions in a progress note with follow up assessment and revision of interventions as indicated; and prompt notification of the physician of changes in a patient's condition. The definition of "Clinically Important" (a deviation that, without intervention, may result in complications or death) was reviewed with staff. - Any nursing staff unable to attend the training will be trained 1:1 by the Program Nurse Manager or Nursing	

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A 396	Continued From page 85 Axis I diagnosis of major depressive disorder (MDD), moderate, recurrent, and an Axis III diagnosis of hypertension (HTN). The physician ' s recorded admission physical examination failed to identify concerns with appetite or elimination. The physician ordered Lisinopril to treat the patient ' s hypertension and ordered the DASH diet (The DASH diet eating plan has been proven to lower blood pressure in studies sponsored by the National Institutes of Health (Dietary Approaches to Stop Hypertension). The IDT (Interdisciplinary Team) including the physician, psychiatrist, registered nurse and social worker met on 11/13/2014, 11/20/14 (psychiatrist failed to attend), and 11/25/14. The medical record review revealed the IDT did not meet again to discuss patient #1 complaints of constipation on 12/6/14 and their lack of bowel movements until 12/10/14 (two weeks later) to prevent a bowel impaction. RN staff H on 12/6/16 at 8:00 am documented they received a physician telephone order from medical staff I for " magnesium citrate (a laxative), 296 milliliter (ml) orally, to be administered one time for constipation," and "docusate sodium (a laxative), 100 milligram (mg), orally, two times a day for constipation. " The medical record lacked evidence nursing staff updated the nursing care plan or the treatment plan when the patient began receiving medications for constipation. On 12/10/14 at 11:10 am (two weeks after the last IDT meeting), the IDT including the psychiatrist, registered nurse and social worker met. Patient #1 reported they had a bowel movement after given some medication but felt they were blocking up again and the bowels were not working well. The IDT documented under " Summary of any	A 396	Supervision upon arrival on the next shift when the nurse returns to work. - Registered Nurses for each program will complete a nursing care plan or create treatment plan goals and interventions for medical and psychiatric conditions by the date of the initial treatment plan meeting. Goals and interventions for psychiatric conditions will be individualized and specific with frequency of said interventions, according to the patient's symptoms utilizing the Manual of Psychiatric Nursing Care Planning – 5th Edition. This book includes updates for DSM-V and includes assessment guides and outcomes for the most frequently encountered mental disorders. (See Attachments 20 --- and ---- for two samples from this manual). The nurse will develop and utilize nursing care plans/treatment plan goals/interventions that are evidence based and reflect long and short term goals in attainable and measureable terms. Nursing staff will document patient's progress towards meeting the goals of their specific treatment plan according to stated frequency of interventions. Medical goals and interventions will be developed based on the patient's diagnosis and presenting signs and symptoms. Short term medical goals that are expected to resolve within 30 days will be entered as a temporary issue. Medical conditions that are expected to be ongoing will be incorporated as short term goals in the master treatment plan. - The Registered Nurse completes a nursing care plan or medical goals and interventions for all medical issues by the	

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A 396	Continued From page 86 Assessments Since Last Note; No new Medication " and under " Changes in observational status/Treatment Plan with Rationale; No change. " Nursing staff failed to update the Treatment Plan/care plan to include the change in the patient ' s physical status regarding continued constipation and the physician ordered medications including magnesium and docusate sodium laxative. The patient expired at hospital B on 12/11/14 at 2:40 pm with a diagnosis of ileus (the absence of movement in the intestine) with sepsis (potentially life-threatening bacterial infection in the bloodstream or body). Nursing supervisor H interviewed on 1/13/15 at 1:30 pm reported they were on duty 12/6/14 when patient #1 complained of constipation and they called the physician to receive an order for the magnesium citrate and docusate sodium. Staff H verified they failed to create a care plan and document a complete nursing assessment related to constipation. Nursing supervisor H also verified they failed to update the patient ' s care plan/treatment plan and IDT ' s meeting notes on 12/10/14 regarding patient #1 ' s continued complaints of constipation and the medication interventions implemented for constipation a few days prior. Staff H confirmed the nursing expectation is to document all assessments and medical interventions and update the nursing/IDT care plan when the change in the patient ' s physical condition occurs.	A 396	date of the initial treatment plan meetings. At all subsequent IDT meetings all temporary medical issues and goals are reviewed. As needed the Registered Nurse updates, revises, or resolves these in collaboration with the findings and recommendations of the IDT Team. **How are we monitoring and ensuring compliance?** - The Program Nurse Managers and Nursing Supervisors audit initial nursing care plans weekly to ensure that all identified issues are incorporated into a nursing care plan or the treatment plan. All plans of care are reviewed weekly during the IDT meeting. **Documentation:** - Attachment 17: Nursing Process Procedure (Nur-1.0) - Attachment 20: Samples of Goals and Interventions for Nursing Care Plans **Individual Responsible for Compliance:** Director of Nursing **Date for Completion:** 02/04/15	
A 432	482.24(a) ORGANIZATION AND STAFFING The organization of the medical record service must be appropriate to the scope and complexity	A 432		

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A 432	Continued From page 87 of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records. This STANDARD is not met as evidenced by: Based on interview the hospital failed to provide a medical record service with a designated professional responsible for maintaining the medical records. This deficient practice has the potential to affect the completion, filing, and retrieval of records. Findings include: - The Kansas State regulation KAR 28-34-9a (b)(1)reviewed on 1/27/15 at 10:00 am revealed " The medical records service shall be under the direction of a person who is a registered record health information administrator or a registered health information technicianas certified by the American Health Information Management Association, or who meets the educational or training requirements for such certification. " - The Kansas State regulations KAR 28-34-9(b)(2) If the employment of a full-time registered health information administrator or registered health information technician is impossible, the hospital shall employ a registered records administrator or an accredited records technician on a part-time consultant basis. The consultant shall organize the department, train full-time personnel, and make periodic visits to evaluate the records. There shall be a written contract between the hospital and the consultant that specifies the consultant's duties and responsibilities. - The hospital failed to have a policy requiring a	A 432	**A 432** **POC:** - The Superintendent has contacted a Registered Health Information Technician on February 25, 2015. She has agreed to enter into a contract with OSH to provide consultation services for medical records. The consultant will visit at least once a quarter or as needed to ensure compliance with State and Federal regulations. - The RHIT consultant will provide the first consultation by March 6, 2015. - The RHIT will ensure the quality of the medical record by verifying the completeness, accuracy, timeliness, proper entry, and retrieval process. The RHIT will review active and closed medical records for the above elements. The random sample of records will be of active and closed records and will be at least 10 percent of the average daily census or no less than 30 records. The consultant will be provided remote access to the electronic medical record for ongoing review of the records off site. - The RHIT will ensure the organizational structure and policies are appropriate to meet the needs of the hospital and the patients. The RHIT will provide training to the Health Information Management staff when deficiencies are identified. - The RHIT will ensure that the Conditions of Participation 482.24 Medical Records Services and the subsequent standards are met. **How are we monitoring:**	

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A 432	Continued From page 88 Registered Health Information Technician (RHIT) to be the Medical Records Director.	A 432	The Director of Quality Management will monitor to ensure there is continuous RHIT services.	
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observation, document review, and staff interview the hospital failed to develop and maintain an environment to ensure the safety and well-being for special needs of patients admitted to the psychiatric hospital (refer to A-0701) and failed to maintain facility supplies and equipment to ensure safety and quality (refer to A-0724). The cumulative effect of the systematic failure to develop and maintain an environment to ensure the safety and well-being for special needs of patients admitted to the psychiatric hospital and maintain facility supplies and equipment resulted in the hospital's inability to provide care in a safe and effective manner.	A 700	**Ensure Compliance:** The Director of Quality Management will maintain contact with the RHIT and the RHIT's intention to fulfill the contract. If the RHIT cannot, the Director of Accreditation will obtain the services of another RHIT. **Individual Responsible for Compliance:** Director of Quality Management **A700** **See A 115 482.13 Patient Rights** **A701** **See A 115 482.13 Patient Rights**	
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to develop and maintain an environment to ensure the safety and	A 701		

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A 701	Continued From page 89 well-being for special needs of patients admitted to the psychiatric hospital by failing to: - Identify potential risks and conduct surveillance in the physical environment according to the "Safety Management Plan" Policy; - Provide non-suicide resistive shower and tub water control knobs, non-exposed plumbing on sinks and commodes, and non-hinged commode seats. The configuration of the water control knobs, exposed plumbing pipes, and hinged commode seats created a looping hazard (material or a device could be looped around the knobs or plumbing to be used for choking or strangulation) in all 30 bathrooms/shower rooms in seven of seven nursing units throughout the facility; - Secure heavy furniture which could provide dangerous projectiles or could easily be maneuvered and positioned under a protruding device as potential for hanging in all 138 patient rooms; - Remove metal closet doors with either a handle, latch hook, or a one-inch opening. The closet handles, latch hooks, or openings potentially provide a hanging, choking, or strangulation hazard in all 138 patient rooms; - Provide door handles that prevent an anchor point. The door handles created a potential ligature attachment point affecting all patients admitted to the hospital at risk for suicide; - Secure pictures to the wall using tamper resistant screws or anchors. The picture frames have the potential to be used as a weapon on others affecting all patients admitted to the hospital at risk for harming themselves or others; - Secure heating/cooling vents to the ceiling and air exchange vents to the wall with tamper resistant screws or anchors creating an anchor for hanging or used as a weapon affecting 16	A 701		

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A 701	Continued From page 90 hallways, 138 patient rooms, seven day halls, 30 bathrooms/shower rooms throughout the facility; - Provide a non-tamper proof ceiling. The suspended ceiling with removable tiles expose pipes and wiring above the tiles that have the potential to provide a hanging, choking, or strangulation hazard in 132 patient rooms, 16 hallways, 4 comfort rooms, and seven day halls throughout the facility; - Remove, replace, or cover electrical outlets. The electrical outlets could be accessed with the potential to create a fire or electrical shock in 138 patient rooms, 30 bathrooms/shower rooms, 16 hallways, 4 comfort rooms, and 7 day halls throughout the facility; - Secure ceiling mounted florescent light fixtures. The light fixtures have the potential to provide an anchor for hanging in 138 patient rooms, 30 bathrooms/shower rooms, 16 hallways, 4 comfort rooms, and 7 day halls throughout the facility; - Remove hospital gowns with string closers and fitted sheets with elastic from patient use. The strings and elastic have the potential to provide a hanging, choking, or strangulation risk for all patients at risk for suicide in seven of seven nursing units throughout the facility; - Provide a barrier between the Mental Health Technician (MHT) station and patients in the day hall. Patients could reach the telephone and computer keyboard and cord to use for hanging, choking, or strangulation or as a weapon on three of seven patient units; - Secure laundry soap in patient's laundry room in two of seven laundry rooms. Laundry soap, when ingested, could be harmful; - Provide a patient lift for patients exceeding four hundred pounds. The lift had the potential for a fall hazard for one patient over four hundred pounds.	A 701		

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A 701	Continued From page 91 Findings Include: - The hospital's policy "Safety Management Plan" dated 7/23/12 reviewed on 1/22/15 at 3:00 pm directed, "...The Environment of Care Committee (EOCC) conducts quarterly rounds of buildings, grounds, equipment, and occupants to: c. Identify safety risks d. Conduct hazard surveillance. C. Safety Planning 1. The EOCC participates in performance improvement activities...monitoring performance regarding actual or potential risks ...Safety and Hazard Assessment, Identification of Processes, identify opportunities for improvement in order to ...establish and maintain a physical environment free of hazards ..." H. Environment 5. Facilities and grounds are maintained through collaborative efforts of Facility Services and program staff in order to create an environment that is comfortable, safe, clean and attractive. 6. Furnishings and equipment provided are safe and in good repair ...8. The EOCC reviews safety concerns submitted by employees, patient, visitors or other hospital committees/teams. The Director of Operations or designee, with the assistance of members of the EOCC, a. Directs ongoing performance improvement activities related to the environment of care; b. Directs the integration of environment of care monitoring and response activities into the hospital wide patient safety program; c. Reviews summaries of deficiencies, problems, failures and/or user errors related to managing, i. Safety; ii. Security; v. Fire Safety. Staff BB, Assistant Superintendent, interviewed on 1/22/14 at 2:00 pm was unable to provide documentation of any findings from the EOCC addressing safety issues or any potential or	A 701		

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A 701	Continued From page 92 actual risks or hazards identified in the physical environment of the hospital. Managing and Preventing Symptoms (MAPS) unit (Individuals who are unable to manage behaviors and care for their wellbeing due to an acute impairment in the ability to perceive reality) A1 building observed on 1/12/15 between 2:00 pm and 4:30 pm and 1/20/15 between 3:15 pm to 4:20 pm showed the following: - The MAPS unit A1 had a total of 30 beds with 29 current patients (2 patients at risk for suicide (2 intermediate risk suicidal) and 29 Assaultive/violent patients (27 potentially assaultive/violent and 2 actively assaultive/violent). Therapeutic Observational Status for the 29 patients revealed: Red (15 minute) - 2 patients; Orange - 11 patients; Yellow - 16 patients. - Hallway A and hallway B revealed a total of 19 patient rooms including eight private and 11 semi-private rooms. All 19 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slats formed into a grid pattern to hold the mattress. The unsecured lightweight furniture in patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 2 of 2 patients on the unit assessed as a suicide risk. All rooms have a 6 inch door handle that protrudes 3 ½ inch out from the door. The door handles potentially provide a hanging, choking, or strangulation for 2 of 2 patients on the unit assessed as a suicide risk. All 19 patient rooms have a metal closet with either a handle, latch hook, or a one-inch opening. The closet	A 701		

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A 701	Continued From page 93 handles, latch hooks, or openings potentially provide a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. All 19 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. All 19 patient rooms had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 19 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 19 patient rooms had one metal ceiling heating/cooling vent easily removed and one metal air exchange vent secured to the wall with non-tamper proof screws potentially creating an anchor for hanging or use as a weapon. All 19 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic has the potential to provide a hanging, choking, or strangulation risk for 2 of 2 patients on the unit assessed as a suicide risk. - Observation of room 143 revealed a displaced ceiling tile and room 144 revealed a missing ceiling tile. Above the ceiling tiles are plumbing and electrical wiring. Access to the plumbing pipes and electrical wiring has the potential to provide a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The shower room on hallway B revealed a metal vent with missing screws and room 143 revealed a displaced vent. The metal vent could easily be removed and create an anchor for hanging or be used as a weapon.	A 701		

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A 701	Continued From page 94 - The Day Hall (the units living and dining area) revealed a suspended ceiling with approximately 20-inch by 20-inch ceiling tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The Day Hall contained two water fountains attached to the wall that could be pulled off of the wall and used for a weapon. Two telephones for patient use located beside the nurses station had a 29 inch cord providing a potential hazard for hanging, choking, or strangulation affecting 2 of 2 patients on the unit assessed as a suicide risk. The Day Hall had eight electrical outlets easily accessible with the potential to create a fire or electrical shock. The Day Hall had ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The day hall had eight metal ceiling vents easily removed creating an anchor for hanging or use as a weapon. One wall had four cabinets with C handles with the potential hazard for hanging, choking, or strangulation for 2 of 2 patients on the unit assessed as a suicide risk. The Mental Health Technician (MHT) station (desk area) in the day hall failed to have an adequate barrier enclosing the area from patients. The MHT station measured 42 ½ inches tall and had a 12 ¾ inch wide counter. Patients could easily reach the telephone and the telephone cord could be used as a strangulation device as well as the computer keyboard and cord to be used as a weapon. - MHT staff O interviewed on 1/13/15 at 2:00 pm indicated patients can and have reached over the	A 701		

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A 701	Continued From page 95 MHT station to obtain the phone and keyboard. - The patient bathroom on hallway A had two commodes with a hinged seat and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. The bathroom had one urinal with exposed plumbing. Two sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The bathroom had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal vent in the ceiling tiles and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or use as a weapon. The bathroom had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. - The shower room on hallway A had a bathtub with a water temperature dial with a 3 inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The plumbing is 28 inches from the floor and 5 inches from the wall. One sink has a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The shower room had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The shower room had one metal vent in the ceiling tiles easily removed and one vent secured to the wall with non-tamper	A 701		

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A 701	Continued From page 96 proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - Hallway A revealed seven ceiling mounted florescent light fixtures with a plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. Hallway A had four electrical outlets easily accessible with the potential to create a fire or electrical shock. - The comfort room revealed a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The comfort room had four electrical outlets easily accessible with the potential to create a fire or electrical shock or electrical shock. The comfort room had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The comfort room had one eraser board and five picture frames secured with non-tamper proof screws with the potential for removal and use as a weapon. - The patient bathroom on hallway B had two commodes with hinged seats and exposed	A 701		

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A 701	Continued From page 97 plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The bathroom had one metal vent with non-tamper proof screws and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. The bathroom had two ceiling mounted florescent light fixtures with a plastic inserts covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - The shower room on hallway B had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as a suicide risk. The bathroom had one metal vent in the ceiling tiles easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets with the potential to create a fire or electrical shock. The shower room had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging.	A 701		

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A 701	Continued From page 98 - Hallway B revealed six ceiling mounted florescent light fixtures with a plastic covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway B has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 2 of 2 patients on the unit assessed as suicidal risk. Hallway B had four electrical outlets easily accessible with the potential to create a fire or electrical shock. - Managing and Preventing Symptoms (MAPS) unit A1 building observed on 1/13/15 at 2:00 pm revealed a patient in the day hall wearing a hospital gown with strings for securing the gown. Mental Health Technician (MHT) staff D interviewed on 1/13/15 at 2:00 pm revealed patients wear hospital gowns when doing laundry and some wear them at night. Staff D acknowledged the use of hospital gowns with strings and the fitted bed sheets with elastic edging had the potential to be used by patients as a means of hanging or strangulation. Staff D acknowledged that all patients on the unit can request gowns or sheets from staff members regardless of whether they are a suicidal risk or at risk to harm others. Managing and Preventing Symptoms (MAPS) unit (Individuals who are unable to manage behaviors and care for their well-being due to an acute impairment in the ability to perceived reality) A2 building observed on 1/13/15 between 11:20 am to 12:30 pm and 1/20/15 between 4:20 pm and 5:15 pm showed the following:	A 701		

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A 701	Continued From page 99 - The MAPS unit A2 had a total of 30 beds with 24 current patients (14 patients at risk for suicide (9 low risk suicidal; 4 intermediate risk suicidal; 1 acute risk suicidal risk) and 12 Assaultive/violent patients (11 potentially assaultive/violent; 1 actively assaultive/violent). Therapeutic Observational Status for the 24 patients revealed: Red (1:1) - 1 patient; Red (15 minute) - 4 patients; Orange - 9 patients; and Yellow-10 patients. - Hallway A and hallway B revealed a total of 18 patient rooms including six private and 12 semi-private rooms. All 18 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slats formed into a grid pattern to hold the mattress. The unsecured lightweight furniture in patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 14 of 14 patients assessed at risk for suicide on the unit. All rooms have a 6 inch door handle that protrudes 3 ½ inch out from the door. The door handles potentially provides a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. All 18 patient rooms have a metal closet with either a handle, latch hook, or a one-inch opening. The closet handles, latch hooks, or openings potentially provide a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. All 18 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 14	A 701		

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A 701	Continued From page 100 of 14 patients assessed at risk for suicide on the unit. All 18 patient rooms had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 18 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 18 patient rooms had one metal ceiling vent easily removed and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. All 18 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic on the fitted sheets provide a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. - The Day Hall (the units living and dining area) revealed a suspended ceiling with approximately 20-inch by 20-inch ceiling tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. The Day Hall contained two water fountains attached to the wall that could be pulled off of the wall and used for a weapon. Two telephones for patient use located beside the nurses station had a 29 inch cord providing a potential hazard for hanging, choking, or strangulation affecting 14 of 14 patients assessed at risk for suicide on the unit. The Day Hall had eight electrical outlets easily accessible with the potential to create a fire or electrical shock. The Day Hall had 17 ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for	A 701		

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A 701	Continued From page 101 hanging. The day hall had six cabinet doors with C handles with the potential hazard for hanging, choking, or strangulation. The Mental Health Technician (MHT) station (desk area) in the day hall failed to have an adequate barrier enclosing the area from patients. The MHT station measured 42 ½ inches tall and had a 12 ¾ inch wide counter. Patients could easily reach the telephone and the telephone cord which could be used as a strangulation device as well as the computer keyboard and cord for use as a weapon. - The patient bathroom on hallway A had two commodes with a hinged seat and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. The bathroom had one urinal with exposed plumbing. Two sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. The bathroom had one metal vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathroom had two electrical outlets easily accessible with the potential to create a fire or electrical shock. The bathroom had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - The shower room on hallway A had a bathtub and shower stall with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with hinged seat and exposed plumbing pipes on the toilet. The piping is 28	A 701		

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A 701	Continued From page 102 inches from the floor and 5 inches from the wall. One sink has a 10-inch protruding water faucet. The toilet seat and exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. The shower room had two ceiling mounted florescent light fixtures with a plastic insert easily removed. The light fixtures have the potential to provide an anchor for hanging. - Hallway A revealed seven ceiling mounted florescent light fixtures with a plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. Hallway A had five electrical outlets easily accessible with the potential to create a fire or electrical shock. - The comfort room revealed a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. The comfort room had four electrical outlets easily accessible with the potential to create a fire or electrical shock. The comfort room had five picture frames secured with non-tamper proof screws with the potential for removal and use as	A 701		

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A 701	Continued From page 103 a weapon. - The patient bathroom on hallway B had two commodes with hinged seats and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 14 of 14 patients on the unit assessed as a suicide risk. The bathroom had one metal ceiling vent easily removed from the tiles and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. The bathroom had two ceiling mounted florescent light fixtures with a plastic inserts covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - The shower room on hallway B had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with a hinged seat and exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 7 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The toilet seat and exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 14 of 14 patients assessed at risk for suicide on the unit. The bathroom had one metal vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets with the potential to create a fire or electrical shock. The shower room had three	A 701		

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A 701	Continued From page 104 ceiling mounted florescent light fixtures with a plastic covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - Hallway B revealed six ceiling mounted florescent light fixtures with a plastic covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 14 of 14 patients on the unit assessed as a suicide risk. Hallway B had four electrical outlets easily accessible with the potential to create a fire or electrical shock. Hallway B had three pictures attached to the wall with non-tamper proof screw. Continuing Care (CCP) unit (Individuals whose psychiatric symptoms have contributed to their involvement with the courts; and individuals who are referred by law enforcement for Detox, care and treatment (DCT)) B1 building observed on 1/12/15 between 2:00 pm and 4:30 pm showed the following: - The CCP unit B1 had a total of 30 beds with 28 current patients - (1 patient assessed as risk for suicide (1 low risk suicidal) and 20 patients assessed as risk for assaultive/violent (16 potentially assaultive/violent and 4 actively assaultive/violent). Therapeutic Observational Status for the 28 patients revealed: Red (15 minute) - 3 patients; Orange - 12 patients; Yellow - 8 patients and Green - 5 patients.	A 701		

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A 701	Continued From page 105 - Hallway A and hallway B revealed a total of 18 patient rooms including seven private and 11 semi-private rooms. All 18 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slats formed into a grid pattern to hold the mattress. The unsecured lightweight furniture in patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 1 of 1 patient on the unit. All rooms have a 6 inch door handle that protrudes 3 ½ inch out from the door. The door handles potentially provides a hanging, choking, or strangulation hazard for 1 of 1 patient on the unit. All 18 patient rooms have a metal closet with either a handle, latch hook, or a one-inch opening. The closet handles, latch hooks, or openings potentially provide a hanging, choking, or strangulation hazard for 1 of 1 patient on the unit. All 18 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 1 of 1 patient on the unit. All 18 patient rooms had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 18 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 18 patient rooms had one metal ceiling vent easily removed and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. All 18 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic on the fitted sheets provide a hanging, choking, or	A 701		

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A 701	Continued From page 106 strangulation hazard for 1 of 1 patient assessed at risk for suicide on the unit. - The bathroom on hallway A had two commodes with a hinged seat and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. The bathroom had one urinal with exposed plumbing. Two sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 1 of 1 suicidal patients on the unit. The bathroom had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathroom had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. - The shower room on hallway A had a bathtub with a water temperature dial with a 3 inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. One sink has a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. The shower room two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for	A 701		

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(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 701	Continued From page 107 hanging or used as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - Hallway A revealed seven ceiling mounted florescent light fixtures with a plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. Hallway A had four electrical outlets easily accessible with the potential to create a fire or electrical shock. - The comfort room revealed a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. The comfort room had four electrical outlets easily accessible with the potential to create a fire or electrical shock. The comfort room had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The comfort room had one eraser board and five picture frames secured with non-tamper proof screws with the potential for removal and use as a weapon. - The patient bathroom on hallway B had two commodes with hinged seats and exposed plumbing pipes on the toilets. The piping is 28 inches from thefloor and 7 inches from the wall.	A 701		

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	174004	A. BUILDING _____ B. WING _____	01/23/2015

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A 701	Continued From page 108 Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 1 of 1 patient on the unit. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. The bathroom had two ceiling mounted florescent light fixtures with a plastic inserts covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - The shower room on hallway B had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets with the potential to create a fire or electrical shock. The shower room had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - Hallway B revealed six ceiling mounted florescent light fixtures with a plastic covering easily removed. The light fixtures have the potential to provide an anchor for hanging.	A 701		

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A 701	Continued From page 109 Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. Hallway B had four electrical outlets easily accessible with the potential to create a fire or electrical shock. - The Day Hall (the units living and dining area) revealed a suspended ceiling with approximately 20-inch by 20-inch ceiling tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 1 of 1 suicidal patient on the unit. The Day Hall contained two water fountains attached to the wall that could be pulled off of the wall and used for a weapon. Two telephones for patient use located directly across from the nurse ' s station had a 29 inch cord providing a potential hazard for hanging, choking, or strangulation affecting 1 of 1 suicidal patient. The Day Hall had six electrical outlets easily accessible with the potential to create a fire or electrical shock. The Day Hall had ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The day hall had eight metal ceiling vents easily removed creating an anchor for hanging or used as a weapon. One wall had five cabinets with C handles with the potential hazard for hanging, choking, or strangulation. Stepping Stones Program, (SSP) (Individuals who have met their discharge criteria but have barriers to placement in the community) unit B2	A 701		

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A 701	Continued From page 110 building toured on 1/12/15 between 1:55 pm to 4:47 pm and on 1/13/15 between 2:10 pm and 3:00 pm showed the following: - The SSP unit B2 had a total of 26 beds with 25 current patients (3 patients assessed as risk for suicide (1 low risk suicidal and 2 intermediate risk suicidal) and 25 patients assessed as risk for assaultive/violent (24 potentially assaultive/violent and 1 actively assaultive/violent). Therapeutic Observational Status for the 25 patients revealed: Red (15 minute) - 2 patients; Orange - 8 patients; Yellow - 13 patients; and Green - 2 patients. - Hallways A and B revealed a total of 15 patient rooms including four private and 11 semi-private rooms. All 15 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slates formed into a grid pattern to hold mattress. The unsecured lightweight furniture in the patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 3 of 3 patients assessed at risk for suicide on the unit. All rooms have a six-inch door handle that protrudes three and one-half inches out from the door. The door handles potentially provides a hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. All 15 patient rooms have a metal closet with a latch hook. The closet latch hooks potentially provide a hanging, chocking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. All 15 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging,	A 701		

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A 701	Continued From page 111 choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide. All 15 rooms had one to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 15 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 15 patient rooms had one metal ceiling vent easily removed and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. All 15 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic has the potential to provide a hanging, choking, or strangulation risk for 3 of 3 patients at risk for suicide. - Observation of room 154 revealed a displaced ceiling tile. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide. - The men ' s bathroom on hallway A had one porcelain commode with a hinged seat and exposed plumbing pipes on the toilet and one metal commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and approximately seven inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing pipes and hinged toilet seat potentially provide a hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. The bathroom had two ceiling mounted florescent light fixtures and a florescent light fixture mounted above each sink on the wall with a plastic insert	A 701		

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A 701	Continued From page 112 covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. - Observation in the men ' s bathroom on hallway A on 1/14/15 at 9:20 am revealed three florescent light fixtures mounted on the wall above the sinks. A screw was missing from each of the light fixtures, indicating tampering of the light fixtures. The screws could be used as weapons or to inflict self-harm or the easy access to the electrical wiring creates a potential for fire or electrical shock. Staff N, Physical Plant Supervisor Specialist, interviewed on 1/14/15 at 9:20 am verified the missing screws for each of the light fixtures above the sinks. Staff N explained the light fixtures were secured with screws that were supposed to be tamper proof. " I guess we ' ll need to get some screws back in there " . - The shower room on hallway A had a bathtub with a water temperature dial with a three inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and five inches from the wall. One sink had a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. The shower room had two ceiling mounted florescent light fixtures with plastic inserts covering easily removed and above the sink there was a wall mounted florescent light fixture. The light fixtures have the	A 701		

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A 701	Continued From page 113 potential to provide an anchor for hanging. The shower room had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or use as a weapon. - Observation in the men ' s shower room on hallway A on 1/14/15 at 9:20 am revealed the one florescent light fixture mounted on the wall above the sink. A screw was missing from the light fixture, indicating tampering of the light fixture. The screws could be used as weapons or to inflict self-harm or the accessibility to the electrical wiring creates a potential for fire or electrical shock. - The Arjo tub room (a special kind of bathtub) had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and five inches from the wall. One sink had a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, chocking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. The shower room had four ceiling mounted florescent light fixtures with plastic inserts covering easily removed and above the sink they had a wall mounted florescent light fixture. The light fixtures have the potential to provide an anchor for hanging. - Hallway A revealed seven ceiling mounted florescent light fixtures with plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has a suspended ceiling with approximately 20 inch by 20-inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the	A 701		

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A 701	Continued From page 114 potential for hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit Hallway A had seven electrical outlets easily accessible with the potential to create a fire or electrical shock. - Observation of hallway A on 1/14/15 at 9:20 am revealed that one side of the hallway is not visible to the staff at the " aide " station on the Day Hall between hallway A and B potentially leaving patients unobserved and 3 of 3 suicidal patients at risk for harming themselves or 25 of 25 assaultive/violent patients at risk for harming others. - The women ' s bathroom on hallway B had two porcelain commodes with hinged seats and exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and approximately seven inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit The bathroom had two ceiling mounted florescent light fixtures and a florescent light fixture mounted above each sink on the wall with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. - Observation in the women ' s bathroom on 1/14/15 at 9:20 am revealed the three florescent light fixtures mounted on the wall above the sinks. A screw was missing from each of the light fixtures, indicating tampering of the light fixtures.	A 701		

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A 701	Continued From page 115 The screws could be used as weapons or to inflict self-harm or the easy access to the electrical wiring creates a potential for fire or electrical shock. Staff N, Physical Plant Supervisor Specialist, interviewed on 1/14/15 at 9:20 am verified the missing screws for each of the light fixtures above the sinks. Staff N explained the light fixtures were secured with screws that were supposed to be tamper proof. " I guess we ' all need to get some screws back in there " . - Hallway B revealed seven ceiling mounted florescent light fixtures with plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway B has a suspended ceiling with approximately 20 inch by 20-inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit Hallway B had three electrical outlets easily accessible with the potential to create a fire or electrical shock. - The Day Hall (the units living and dining area) revealed a suspended ceiling with approximately 20 inch by 20-inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. The Day Hall contained one drinking fountain attached to the wall that could be pulled off of the wall and used as a weapon. One telephone for patient use located against the wall in a corner of the Day	A 701		

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A 701	Continued From page 116 Hall had a 29 inch cord providing a potential hazard for hanging, choking, or strangulation affecting 3 of 3 patients assessed at risk for suicide on the unit. The Day Hall had 11 electrical outlets easily accessible with the potential to create a fire or electrical shock. The Day Hall had 12 ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The linen room contained shelves of clean linen accessed only by staff. The linen closet revealed patient gowns with cloth ties attached for patients to secure the gown closed and fitted sheets with elastic around the sheet to hold the sheet on the beds. The patient gowns and elastic sheets are made available to all patients on the unit upon request. The patient gowns with ties and the elastic on the fitted sheets provide a hanging, choking, or strangulation hazard for 3 of 3 patients assessed at risk for suicide on the unit. The Mental Health Technician (MHT) station (desk area) in the Day Hall failed to have an adequate barrier enclosing the area from the patients. The MHT station measured 42 ½ inches tall and had a 12 ¾ inch wide counter. Patients could easily reach the telephone and the telephone cord could be used as a strangulation device as well as the computer keyboard and cord be used as a weapon. Staff R Mental Health Technician interviewed on 1/12/15 at 3:30 pm explained they try to have a staff member in the Day Hall at all times, but there are times they need to attend to several patients at the same time, which makes the Day Hall unattended. Staff R, Mental Health Technician interviewed on 1/12/15 at 3:30 pm explained the patients can	A 701		

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A 701	Continued From page 117 reach over the counter and have reached over the counter before to grab things off of the desk area. Staff C, Mental Health Technician interviewed on 1/21/15 at 8:00 am verified the patients do reach over the counter to grab stuff and also jump over it, into the station (desk area). Staff C explained they have asked to have a barrier put up so the patients could not reach or jump over the counter. - Observation of the laundry room used by the patients to wash their personal laundry on 1/12/15 at 3:45 pm revealed an unlocked cabinet containing a pan of laundry soap packets. Patient T, demonstrated how they do their laundry and explained the staff open the cabinet that contains the soap because they are to keep it locked, however on this day the cabinet was open. Patient T explained the staff let the patients in the laundry room but do not stay with them at all times when they are in the room. All patients on the unit had the potential to access the unattended laundry room and the unlocked cabinet containing a potentially harmful substance. - The Material Safety Data Sheet (MSDS) for the laundry soap packets reviewed on 1/22/15 at 3:00 pm directed, " Ingestion: May be harmful if swallowed. Drink large amounts of water or milk. DO NOT induce vomiting. Get medical attention immediately. " Staff U, Mental Health Technician (MHT) interviewed on 1/12/15 at 3:45 pm acknowledged the unlocked cabinet containing the soap packets and stated staff are to keep the soap packets locked at all times.	A 701		

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A 701	Continued From page 118 Positive Living Skills (PLS) unit C1 observed on 1/13/15 between 12:30 pm and 2:45 pm, 1/14/15 between 9:00 am and 4:30 pm, and 1/21/15 between 7:40 am and 9:00 am showed the following: - The PLS unit C1 had a total of 30 beds with 24 current patients (24 patients assessed as risk for suicide (22 low risk suicidal and 2 acute risk suicidal) and 19 patients assessed as risk for assaultive/violent (16 potentially assaultive/violent and 3 actively assaultive/violent). Therapeutic Observational Status for the 24 patients revealed: Red (15 minute) - 1 patient; Orange - 10 patients; and Yellow - 13 patients. - Hallway A and hallway B revealed a total of 19 patient rooms including eight private and 11 semi-private rooms. All 19 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slats formed into a grid pattern to hold the mattress. The unsecured lightweight furniture in patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 24 of 24 patients assessed at risk for suicide on the unit. All rooms have a 6 inch door handle that protrudes 3 ½ inch out from the door. The door handles potentially provide a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. All 19 patient rooms have a metal closet with either a handle, latch hook, or a one-inch opening. The closet handles, latch hooks, or openings potentially provide a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. All 19	A 701		

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A 701	Continued From page 119 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. All 19 patient rooms had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 19 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 19 patient rooms had one metal ceiling vent easily removed and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. All 19 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic on the fitted sheets provide a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. - The Day Hall (the units living and dining area) revealed two telephones for patient use located near the entry door. Each phone had a 24 inch cord providing a potential hazard for hanging, choking, or strangulation affecting 24 of 24 patients assessed at risk for suicide on the unit. The Day Hall had seven electrical outlets easily accessible with the potential to create a fire or electrical shock. One wall had cabinet doors with six C handles with the potential hazard for hanging, choking, or strangulation for 24 of 24 patients assessed at risk for suicide on the unit. The Day Hall had one Mental Health Tech (MHT) station with a barrier and locking doors. Observation on 1/14/15 at 10:20 am revealed	A 701		

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(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 701	Continued From page 120 MHT station door unlocked and open. The unlocked door allows patients access to telephone and cord, computer keyboard, pen and pencils to use as potential strangulation hazard or weapons affecting all 24 of 24 patients on the unit. Mental Health Technician Staff P interviewed on 1/15/15 at 11:00 am revealed the MHT station doors should remain closed and locked at all times. - Observation on 1/14/15 at 10:25 am revealed two patients wearing hospital gowns with strings attached at the neck and lower back for securing the gown. The hospital gown strings provide a risk for hanging, choking, or strangulation affecting all 24 of 24 patients on the unit. Registered Nurse Staff H interviewed on 1/14/15 at 10:25 am indicated the two patients wearing hospital gowns with strings are currently washing their dirty laundry. - Hallway A revealed seven ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. Hallway A had three electrical outlets easily accessible with the potential to create a fire or electrical shock.	A 701		

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	174004	A. BUILDING _____ B. WING _____	01/23/2015

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A 701	Continued From page 121 - Observation of rooms 123 and 161 revealed each room had a hospital bed with an unsecured coil style cord measuring greater than 12 inches in length. Room 123 also contained a Manual hydraulic patient lift (a patient lifting device) and sit- to- stand style lift with an unsecured power cord plugged into the electrical outlet. The unsecured cord measures greater than 12 inches in length. Unsecured cords measuring greater than 12 inches in length have the potential to provide a looping and hanging hazard for 24 of 24 patients assessed at risk for suicide on the unit. - Observation of hallway A on 1/13/15 at 12:30 pm and 1/14/15 at 9:20 am revealed an unlocked and unattended bathroom door. Unlocked bathrooms provide 24 of 24 patients assessed at risk for suicide on the unit access to potential anchor points for hanging, choking, or strangulation hazards. Sign placed on outside of door stated, " Restrooms will remain locked when not in use. Staff will unlock the door and monitor every 4-5 minutes for safety while in use " . Registered Nurse Staff H interviewed on 1/14/15 at 9:25 am indicated that the bathroom was unlocked in preparation for bringing a patient from his/her room. RN Staff H indicated multiple staff members were assisting with using a hydraulic patient lift to transfer the patient to the bathroom and revealed the Manual hydraulic patient lift used for patient #24 has a maximum weight lifting capacity of 400 pounds evidenced by the manufacturer ' s warning sticker placed on the lift. Patient #24 ' s weight recorded on 12/4/14 was 440 pounds. Staff H revealed that staff must stand on the legs of the Manual hydraulic patient lift to keep it from tipping over. The use of the	A 701		

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A 701	Continued From page 122 Manual hydraulic patient lift beyond its stated maximum weight lifting capacity placed patient #24 at risk for injury from a fall. Administrative Staff BB on 1/14/15 when told about the use of the lift on a patient exceeding the weight limit said: " Well, they are not supposed to do that. " - The patient bathroom on hallway A had two commodes with a hinged seat and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. The bathroom had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - The shower room on hallway A had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit.	A 701		

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A 701	Continued From page 123 The shower room had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The shower room had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or use as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - Observation of room 157 and 159 revealed multiple displaced ceiling tiles. The exposed pipes and wiring above the displaced tiles have the potential for hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. Mental Health Technician staff P interviewed 1/15/15 at 11:15 am revealed that patients do remove the ceiling tiles and ceiling mounted florescent light fixtures with a plastic insert covering. Review of the facility ' s work order logs for the Carpenter Shop from 6/29/14-1/29/15 revealed at least 20 requests to replace ceiling tiles that were damaged by patients, pulled down by patients, missing, pushed in, and some ceiling vents knocked out of position. - Observation of room 162 revealed one displaced ceiling mounted florescent light fixture with plastic insert easily removed. The light fixtures have the potential to provide an anchor for hanging. - Hallway B revealed seven ceiling mounted	A 701		

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A 701	Continued From page 124 florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. Hallway B had four electrical outlets. The electrical outlets easily accessed with the potential to create a fire or electrical shock. - Observation of hallway B on 1/21/15 at 8:20 am revealed an unlocked and unattended patient bathroom door. Unlocked bathrooms provide 24 of 24 patients assessed as risk for suicide on the unit access to potential anchor points for hanging, choking, or strangulation hazards. Sign placed on outside of bathroom door stated " Restrooms will remain locked when not in use. Staff will unlock the door and monitor every 4-5 minutes for safety while in use " . - The patient bathroom on hallway B had one commode with a hinged seat and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. The bathroom had one urinal with exposed plumbing. The bathroom had two commodes with exposed pipes on the toilets. The piping is 28 inches from the floor and 5 inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with	A 701		

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A 701	Continued From page 125 non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathroom had two covered electrical outlets with non-tamper proof screws. The electrical outlet covers easily accessible with the potential to create a fire or electrical shock. - The shower room on hallway B had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with a hinged seat and exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. One sink has a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 24 of 24 patients assessed at risk for suicide on the unit. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or use as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. Healthy Options, Plans, and Experiences (HOPE) unit C2 building observed on 1/12/15 between 2:00 pm and 4:30 pm, 1/13/15 between 8:00 am and 12:00 pm, and 1/21/15 between 8:30 am and 9:30 pm of the HOPE C2 showed the following: - The HOPE unit C2 had a total of 30 beds with 26 current patients - (6 patients assessed as risk for suicide (3 low risk suicidal; 1 intermediate risk suicidal; and 2 acute risk suicidal) and 15 patients assessed as risk for assaultive/violent (11 potentially assaultive/violent and 4 actively assaultive/violent). Therapeutic Observational	A 701		

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A 701	Continued From page 126 Status for the 26 patients revealed: Red (15 minute) -2 patient; Orange - 14 patients; Yellow - 8 patients and Green - 2 patients. - Hallway A and hallway B revealed a total of 19 patient rooms including eight private and 11 semi-private rooms. All 19 patient rooms have furniture including dressers with removable drawers and wooden beds with legs and flat metal springs with metal slats formed into a grid pattern to hold the mattress. The unsecured lightweight furniture in patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 6 of 6 patients assessed at risk for suicide on the unit. All rooms have a 6 inch door handle that protrudes 3 ½ inch out from the door. The door handles potentially provide a hanging, choking, or strangulation hazard. All 19 patient rooms have a metal closet with either a handle, latch hook, or a one-inch opening. The closet handles, latch hooks, or openings potentially provide a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. All 19 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. All 19 patient rooms had two to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 19 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 19 patient rooms had one metal ceiling vent easily removed	A 701		

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A 701	Continued From page 127 and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. All 19 patient rooms had a bed made with a fitted sheet with elastic edging. The elastic on the fitted sheets provide a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. - The Day Hall (the units living and dining area) revealed two telephones for patient use located near the entry door. Each phone had a 24 inch cord providing a potential hazard for hanging, choking, or strangulation for 6 of 6 patients assessed at risk for suicide on the unit. The Day Hall had six electrical outlets easily accessible with the potential to create a fire or electrical shock. The Day Hall had one Mental Health Tech (MHT) station with a barrier and locking doors. Observation on 1/13/15 at 9:05 am revealed MHT station door unlocked and open. The unlocked door allows patients access to the telephone and telephone cord which can be used as a strangulation hazard, computer keyboard, pens and pencils to use as weapons affecting 6 of 6 patients assessed at risk for suicide and 15 of 15 patients assessed as at risk of harming others. Registered Nurse staff Q interviewed on 1/13/15 at 9:35 am revealed the MHT station doors should remain closed and locked at all times. - Observation on 1/12/15 at 10:15 am revealed two patients wearing hospital gowns with strings attached at the neck and lower back for securing the gown. One of the patients (patient #20) observed wearing the hospital gown with ties was assessed as a patient at risk for suicide. The hospital gown strings provide a risk for hanging, choking, or strangulation for patient # 20.	A 701		

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A 701	Continued From page 128 - Hallway A revealed seven ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. Hallway A had three electrical outlets easily accessible with the potential to create a fire or electrical shock. - The patient bathroom on hallway A had one commode with a hinged seat and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. Three sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. The bathroom had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - Observation of hallway A on 1/12/15 at 9:00 am revealed an unlocked and unattended bathroom door. Unlocked bathrooms provide 6 of 6 patients assessed as risk for suicide on the unit access to	A 701		

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A 701	Continued From page 129 potential anchor points for hanging, choking, or strangulation hazards. Sign placed on outside of door stated, " Restrooms will remain locked when not in use. Staff will unlock the door and monitor every 4-5 minutes for safety while in use " . Registered Nurse staff Q interviewed on 1/13/15 at 9:35 am verified the bathroom doors should remain locked when not in use. - The shower room on hallway A had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with a hinged seat with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. The shower room had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The shower room had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - Observation of rooms 127 and 140 revealed a solid ceiling with ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Room 140 revealed two electric radios with unsecured cords	A 701		

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A 701	Continued From page 130 greater than 12 inches in length. Unsecured cords measuring greater than 12 inches in length have the potential to provide a looping and hanging hazard for 6 of 6 patients assessed at risk for suicide on the unit. - Hallway B revealed seven ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallway A has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. Hallway B had one electrical outlet easily accessible with the potential to create a fire or electrical shock. Hallway B had three picture frames secured with non-tamper proof screws. Picture frames secured with non-tamper proof screws have the potential for removal and use as a weapon for 15 of 15 patients assessed as risk to harm others. - Hallway B revealed an " L " shape with a section unobservable from the main hallway with two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The blind hallway leaves patients unobserved creating the potential for 6 of 6 patients at risk for suicide and 15 patients assessed as assaultive/violent at risk for harming others. The light fixtures have the potential to provide an anchor for hanging. Hallway B has drop style ceiling with approximately 20 inch X 20 inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the	A 701		

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A 701	Continued From page 131 ceiling tiles have the potential for hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. - The patient bathroom on hallway B had two commodes with hinged seats and exposed plumbing pipes on the toilets. The piping is 28 inches from the floor and 7 inches from the wall. The bathroom had one urinal with exposed plumbing. Two sinks have a 10-inch protruding water faucet. The exposed plumbing and hinged toilet seat potentially provides a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. The bathroom had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The bathroom had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The bathrooms had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - The shower room on hallway B had a bathtub with a water temperature dial with a 3-inch protruding handle. The shower room had one commode with a hinged seat with exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and 5 inches from the wall. The shower room had one sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. The shower room had three ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an	A 701		

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A 701	Continued From page 132 anchor for hanging. The shower room had one metal ceiling vent easily removed and one vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon. The shower room had two electrical outlets easily accessible with the potential to create a fire or electrical shock. - The comfort room revealed a suspended ceiling with 12-inch tiles easily removed. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 6 of 6 patients assessed at risk for suicide on the unit. The comfort room had three electrical outlets easily accessible with the potential to create a fire or electrical shock. The comfort room had two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. The comfort room had one picture frame secured with non-tamper proof screws. The picture frame could be easily removed and used as a weapon. Crisis Stabilization Program (CSP) (Individuals in crisis who are experiencing a critical disruption in their ability to function in the community and will likely be stabilized within two weeks) East Biddle (EB) building toured on 1/15/15 between 8:10 am to 12:00 am showed the following: - The CSP unit EB had a total of 30 beds with 25 current patients - (17 patients assessed as risk for suicide (12 low risk suicidal; 4 intermediate risk suicidal; and 1 acute risk suicidal) and 5 patients assessed as risk for assaultive/violent (5 potentially assaultive/violent). Therapeutic Observational Status for the 26 patients revealed:	A 701		

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A 701	Continued From page 133 Red (15 minute) - 3 patients; Orange - 6 patients; Yellow - 16 patients. - Hallways A, B, and C revealed a total of 30 patient rooms including all private rooms. All 30 patient rooms have furniture including dressers with removable drawers, wooden beds with legs and flat metal springs with metal slates formed into a grid pattern to hold mattress. The unsecured lightweight furniture in the patient rooms moved easily with the potential for placement under a protruding device or propped up as a potential for hanging for 17 of 17 patients assessed as risk for suicide on the unit. All rooms have a six-inch door handle that protrudes three and one-half inches out from the door. The door handles potentially provides a hanging, choking, or strangulation hazard for 17 of 17 patients assessed as risk for suicide on the unit. All 26 rooms have a suspended ceiling with removable 12-inch tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 17 of 17 patients assessed as risk for suicide on the unit. Four of the patient rooms have a solid ceiling above the tiles, and affects two patients in these rooms. All 30 rooms had one to four electrical outlets easily accessible with the potential to create a fire or electrical shock. All 30 patient rooms had one or two ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. All 30 patient rooms had one metal ceiling vent easily removed and one metal vent secured to the wall with non-tamper proof screws creating an anchor for hanging or used as a weapon.	A 701		

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A 701	Continued From page 134 - Observation of rooms 227, 220, 203, 209, 213, and 215, showed blackened areas around the electrical outlets indicating they had been tampered with. Staff AA, Registered Nurse (RN) interviewed on 1/15/15 at 8:10 am explained patients pick up cigarette butts outside and bring them in. They get paper clips and put in the outlet to light their cigarettes. Now we are doing checks on patients when they come in to make sure they don ' t have any cigarettes. Review of the facility ' s maintenance log for the electric shop from 6/29/14 to 1/29/15 revealed the following: 1. At least 6 requests to fix electrical outlets which had been pulled away from the wall exposing wires. 2. At least 2 requests for outlets to be replaced due to foreign objects (pencils/graphite) stuck in them. 3. At least two requests for broken light fixtures and covers to be reattached/replaced. 4. Request to replace missing screws on electrical outlets. - Hallway B and A had seven bathroom/showers and one tub room. The bathroom/shower rooms each had one commode with a hinged seat and exposed plumbing pipes on the toilet. The piping is 28 inches from the floor and five inches from the wall. One bathroom/shower room had a sink with a 10-inch protruding water faucet. The exposed plumbing potentially provides a hanging, choking, or strangulation hazard for 17 of 17 patients on the unit. The bathroom/shower rooms each had one ceiling mounted florescent light fixture in the shower and one in the rooms with plastic inserts with coverings easily removed. The light fixtures have the potential to provide an anchor for hanging. - Hallways A, B, and C revealed ceiling mounted	A 701		

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A 701	Continued From page 135 florescent light fixtures with plastic inserts easily removed. The light fixtures have the potential to provide an anchor for hanging. Hallways A, B, and C have a suspended ceiling with approximately 20 inch by 20-inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 17 of 17 patients assessed as risk for suicide on the unit. - The Day Hall (the units living and dining area) revealed a suspended ceiling with approximately 20 inch by 20-inch removable tiles. Above the ceiling tiles are plumbing and electrical wiring. The exposed pipes and wiring above the ceiling tiles have the potential for hanging, choking, or strangulation hazard for 17 of 17 patients assessed as risk for suicide on the unit. The Day Hall contained two drinking fountains attached to the wall that could be pulled off the wall and used as a weapon. Two telephones for patient use located in the area of the TV room had a 29 inch cord providing a potential hazard for hanging, choking, or strangulation for 17 of 17 patients assessed as risk for suicide on the unit. The Day Hall had ceiling mounted florescent light fixtures with a plastic insert covering easily removed. The light fixtures have the potential to provide an anchor for hanging. - The linen room contained shelves of clean linen accessed only by staff. The patient gowns and fitted sheets are made available for all patients upon request and revealed cloth ties attached to the gowns for patients to secure the gown closed, and fitted sheets with elastic around the sheet to hold the sheet on the beds. The patient gowns with ties and the elastic on the fitted sheets	A 701		

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A 701	Continued From page 136 provide a hanging, choking, or strangulation hazard for 17 of 17 patients on the units assessed as risk for suicide. - Observation of the laundry room used by the patients to wash their personal laundry on 1/14/15 at 5:10 pm revealed a pan of laundry soap packets placed on the counter. Staff AA, RN explained they are to be kept at the nurses ' station. The laundry room was unattended providing the potential for 17 of 17 suicidal patients to have access to a harmful substance. - The Material Safety Data Sheet (MSDS) for the laundry soap packets reviewed on 1/22/15 at 3:00 pm directed, " ...Ingestion: May be harmful if swallowed. Drink large amounts of water or milk. DO NOT induce vomiting. Get medical attention immediately ... " Review of the facility ' s maintenance log for the paint shop from 6/29/14 to 1/29/15 revealed: at least 6 requests to repair holes due to patients punching holes in the wall and at least two requests to repair wall where patient had carved or etched writing into the wall. Review of the facility ' s maintenance log for the plumbing shop from 6/29/14 to 1/29/15 revealed at least 10 requests to repair water fountains due to patients pulling them off the wall, kicking them, shaking them or vandalizing them. The log indicates the facility repaired or replaced them. Staff N, Physical Plant Supervisor Specialist, interviewed on 1/14/15 at 9:20 am during tour of B2 unit explained all of the nursing units throughout the facility have the following: · The electrical outlets are " hot " - the patients	A 701		

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A 701	Continued From page 137 can receive a jolt or start a potential fire if they are tampered with. · The vent covers are possible to remove and patients often remove the ones in their room. · The tiles in the suspended ceilings are movable and above the ceiling there is plumbing, electrical wiring, and pipes for the sprinkler system. · The drinking fountains are pulled off the walls by the patients; the facility keeps a supply of them in stock to replace them. · The plastic covering over the fluorescent lights in the patient rooms, bathrooms, and hallways are removable. · The furniture in the patient rooms is movable and patients often move the furniture in their room. Recognized standards of practice for a psychiatric facility include: The Veteran's Health Administration (VHA) National Center for Patient Safety formed a national committee that developed The Environment of Care Checklist for the purpose of reducing environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors. This initiative is consistent with current literature on prevention of suicidal behaviors (Suicide Prevention Strategies: A systematic review. The Journal of the American Medical Association, (JAMA), 2005, v 294, 2064-2074). JAMA, published continuously since 1883, is an international peer-reviewed general medical journal published 48 times per year. JAMA is the most widely circulated medical journal in the	A 701		

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A 701	Continued From page 138 world. The VHA and JAMA have all established accepted standards of practice for psychiatric inpatient facilities in the United States. The VHA committee developed the Mental Health Environment of Care Checklist (MHEOCC) with the goal to prospectively identify and eliminate environmental risks for inpatient suicide and suicide attempts. The following are some of the items included on the MHEOCC to reduce environmental risks for inpatient suicide: - Faucets and water faucets in sinks and showers should be an institutional type. There should be no handheld shower devices and no temperature adjusting devices within the showers (unless recessed). Institutional faucets will not provide an anchor point for hanging exposed plumbing pipes created a looping hazard. -Furniture should be free of anchor points. -Closet doors should be free of anchor points. -Door handles should be free of anchor points. -Pictures and wall hanging should be tamper resistant screws or anchors. -Vents should be secured to the wall or ceiling with tamper resistant screws or anchors. -Ceilings should be constructed of solid materials. -Electrical outlets should be protected and tamper resistant. -Light fixtures should be flush mounted and tamper resistant. -Hospital gowns should have no strings and fitted sheets should not have elastic	A 701		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE	A 724		

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A 724	Continued From page 139 Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observations, policy review, and interview the hospital failed to maintain facility supplies and equipment to ensure safety and quality in one of two walk-in refrigerators, one of two walk-in freezers, one of eight treatment rooms, and one of one supply rooms. Findings include: -The hospital's policy "Establish Effective Recordkeeping Procedures" reviewed on 1/22/15 at 5:40pm directed, "...Effective food safety procedures can be critical in the event of an outbreak of foodborne illness ...Refrigerator and Freezer Temperature Log-Twice daily. -Observation on 1/13/15 at 8:45am in the hospital ' s warehouse revealed a walk-in refrigerator with 60 cases of ½-pint containers of milk. The walk-in freezer had approximately nine pallets of frozen foods. The facility lacked documentation for monitoring the refrigerator and freezer to ensure food safety. -Materials Management employee staff X interviewed on 1/13/15 at 8:45am indicated they did not document refrigerator or freezer temperatures daily. Staff X stated they were in and out of the refrigerator and freezer many times a day and would know if they were not working right. - The Hospital's policies and procedure titled, "Sterile and Non-Sterile Items" reviewed on 1/22/15 at 10:00am directed, "...The date on a	A 724	**A724** **POC:** **Freezer and Refrigerator Temperatures** - A tool was developed for monitoring the refrigerator and freezer temperatures in Supply in January. - The Directors of Nutrition Services and Facility Services collaborated on implementation of the tool. - On January 21, 2015, the Director of Nutrition communicated the process to the Procurement Officer and Storekeeper Specialist. o The form is set up so a temperature is taken- twice daily- in the morning and the afternoon. On weekends and holidays, the Power Plant Operator will monitor the temperatures twice daily. o Temperature forms are posted by the refrigerator/freezer and replaced at the beginning of each month. o When temperatures are above the acceptable temperature, a corrective action is written in the space provided and monitored. - The Director of Nutrition Services provided training to the staff responsible for taking temperatures. This was completed by January 21, 2015. - Electronic thermometers are being obtained that will allow staff to remotely check refrigerator temperatures. Delivery is expected by March 6, 2015. **Outdated Supplies** - All outdated supplies identified during survey were immediately removed from service.	

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A 724	Continued From page 140 STERILE item that has the date and the words "exp" or "best if used by "...would be an expiration date ...ALL STERILE Supplies EXPIRE THREE YEARS AFTER THE RECEIVED DATE ...The only exception is if the manufacturer's expiration date comes prior to our date..." - Treatment room in the East Biddle Annex observed on 1/13/15 at 10:00am revealed a room with one exam table, one cabinet with drawers beside the exam table, and one large built-in cabinet with multiple shelves. The hospital ' s physicians and a podiatrist who comes to the hospital once a month to see patients use the treatment room. Observation of the cabinets revealed the following: One-250milliliter (ml) of Hydrogen Peroxide with an expiration date of 2/13. One-box of 100 count plus one full glass container of sterile tongue depressors with an expiration date of 4/14/14. One -box of 100 count sterile tongue depressors with an expiration date of 4/9/12. One-box of 1000 count of sterile single tipped applicators with an expiration date of 6/2000. Two-boxes plus ½ of a glass container of individual packets of sterile surgical lubricant with an expiration date of 4/12. One-24 count package of "Ready Cleanse" cleansing wipes with an expiration date of 10/2011. Eighteen-packages of sterile Kelly Forceps with an expiration date of 11/14/11. One-package of a sterile dental instruments with an expiration date of 12/14/12. - Satellite supply room observed on 1/13/15 at 11:05am revealed a room with multiple shelving units that store patient supply items including the following:	A 724	- The LPN responsible for oversight of the supplies was educated at the time of survey. **How are we monitoring:** - The Director of Nutrition Services is verifying that temperatures are monitored and corrective action is taken when temperatures are identified outside of range on a weekly basis. - The LPN assigned to the coordinated care clinic will provide oversight to ensure that supplies are not expired. **Ensure Compliance:** - During Environment of Care Rounds, the assigned staff will verify compliance with o Freezer and refrigerator temperatures and o No expired supplies. **Individual Responsible for Compliance:** Chair of Environment of Care Committee	

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A 724	Continued From page 141 Thirteen-4ounce tubes of Nutrashield Skin Protection Cream with an expiration date of 8/20/14. Licensed Practical Nurse (LPN), staff MM interviewed on 1/13/15 acknowledged the expired supplies. Staff MM was unaware that some of the supplies had expiration dates. Staff MM explained the Hospital's policy states that all sterile supplies contain a sticker with a date on it when they receive the supply and three years from that date the item expires. Staff MM indicated they were in charge of supplies and failed to remove outdated items.	A 724		
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, policy review, and staff interview the hospital's infection control officer failed to develop and maintain an active infection control system ensuring hospital personnel followed basic infection control practices for five of six observed glucometer (blood sugar analyzer) tests, three of three observed handling of dirty laundry, one of two observed dressing changes (patient #31), two of two observed cleanings of a discharged patient's room, and cracked vinyl on wheelchairs, torn mattresses, rusted bed springs, and trash cans in five of seven units. This deficient practice places	A 749	**A 749** **POC:** - The unloading of soiled linens has been relocated to the West dock of the laundry building. Soiled linens are now brought into the laundry building at that area. The cleaning process for soiled linens begins on West side of building. Soiled linens do not pass through the clean linen area as of 02/25/15. - Policy Nur-4.1 revised and renamed "Cleaning of Patient Rooms and Handling of Soiled Linen." (See Attachment 21) Wording was added to Section V: "Cleaning is completed in a manner that does not contaminate clean surfaces. A new section was added to the policy, Section VII: Procedure for Handling Soiled Linen:	

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A 749	Continued From page 142 patients at risk for hospital-acquired infections. Findings include: - The Hospital's "Infection Prevention and Control Program" reviewed on 1/22/15 at 2:00 pm, directed, "...The Infection Control Officer is given the authority to institute any surveillance, prevention, and control measures to prevent or control the acquisition and transmission of infectious agents..."Infection Prevention Responsibility of Infection Prevention Committee", ...reviewing conclusions, recommendations and actions taken relating to the evaluation of healthcare associated incidence rates, epidemiological significant outbreaks, unusual pathogens and personnel infections...forwarding minutes to the Medical Staff and Nursing Administrative Committees ..." -The Hospital's policy/procedure, "Hand Hygiene" reviewed on 1/22/15 at 2:00pm directed, "...Hand Antisepsis Using Alcohol-Based Hand Rubs, B. Indication for Use if Hands are Not Visibly Soiled 1. Before and after having direct contact with patients. Before preparing medications...After removing gloves...During medication pass, if the patient is touched or if an object is handled that the patient has touched..." -Infection Control Officer staff CC interviewed on 1/22/15 at approximately 1:00pm verified they were responsible for the management of the infection control program. The infection control committee started reviewing policies and procedures and approves hospital wide cleaning products. Staff CC acknowledged they have a formal surveillance program with criteria for staff and environmental practices observing breaches	A 749	o "Soiled linens are handled in a manner that prevents transfer of microorganisms to others and the environment. Soiled linen is placed in an impervious bag contained in the laundry hamper with lid. Gloves are worn for handling soiled linen. o "Laundry hamper with bag is placed outside the doorway of the room to be cleaned. o "Soiled linens are placed inside the hamper and the lid shut. o "When soiled linen bags become full, and at the end of the shift, the hamper with the lid closed is wheeled to the soiled utility room, bag removed and placed in the designated container. o "Gloves are removed and hand hygiene performed. o "Fresh bag is placed in the hamper prior to replacing in the restroom." - The revised policy, includes the need to prevent soiled or dirty items from coming into contact with clean surfaces, will be distributed for review and education by 03/06/15. - Hand hygiene policy will be reviewed with housekeeping and nursing staff and a computer-based training on hand hygiene, cleaning patient rooms, handling soiled linens, and methods to prevent contamination of clean surfaces will be ready for housekeeping and nursing staff on 03/06/15.	

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A 749	Continued From page 143 in infection control for hand hygiene, handling of soiled linens and use of PPE (personal protective equipment) with between 70% to 80% compliance. Staff E acknowledged they failed to develop and implement a surveillance program for cleaning of patient rooms or the laundry handling. -Observation on 1/13/15 at 7:55am in the laundry building of the hospital revealed a loading and unloading dock on the east side of the building. Laundry staff HH interviewed on 1/13/15 at 8:10am indicated the truck picks up laundry from the units and deliver to the dock on the east side of the building. Staff HH acknowledged the soiled linen from the units has to pass the clean linen ready to be delivered to the unit and passes through the laundry room to the west side of the building. Staff HH acknowledged the potential risk for cross contamination when taking soiled linen by clean linens. -Observations during the survey process revealed the following breaches in infection control practices for hand hygiene, disinfectant wet time per manufacturer's recommendation, and cleaning of a discharged patient room. -The manufacturer's information sheet for "pH7Q Ultra" reviewed on 1/21/15 at 12:50pm directed, "...disinfection...let solution remain on surfaces for a minimum of 10 minutes..." -The hospitals policy for "Patient Unit, Cleaning of" reviewed on 1/21/15 at 12:50pm directed,	A 749	Whole Blood Glucose Monitors: - Policy CL-0.2 "Whole Glucose Blood Testing" (See Attachment 22) was revised on February 25, 2015 to include instructions to disinfect the glucometer with Sani Wipe disinfecting cloth upon completion of patient testing of blood glucose. The equipment maintenance portion of that procedure, Section 8, was revised to require cleaning the exterior of the glucometer after each use and between patients with Sani-Cloth disinfectant wipe. - All newly hired licensed nursing staff are required to read policy CL-0.2. The revised version of the policy will be distributed to licensed nursing staff for review and education by 03/06/15. - The Competency Checklist (See Attachment 22) for training on Whole Blood Glucose procedure was revised on 2/25/15 and includes: Disinfect glucometer with Sani-Cloth disinfectant wipe after removing the test strip." All licensed nursing staff will be educated on this new step by 03/14/15. - Education and testing regarding the proper procedure for testing patient blood glucose and cleaning of the glucometer will be added to the annual EXPO training and a computer-based training will be developed by 03/06/15 and required to be completed by all licensed nursing staff by 03/14/15. - Policy IC-6.0 "Hand Hygiene" (see Attachment 23) revised to include instructions for hand hygiene before donning gloves, upon removal of gloves and between glove changes. Hand hygiene policy will be reviewed with	

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A 749	Continued From page 144 "...Clean and disinfect bed, bed drawers, dresser, and locker..." -Mental Health Technician (MHT) staff D and Housekeeping staff DD observed on 1/14/15 between 10:35am to 11:15am cleaned room 146 on Managing and Preventing Symptoms (MAPS) A1 after a patient's dismissal. Staff D entered room 146 failed to perform hand hygiene, applied gloves, and removes trash and soiled linens from the room. Staff D removed their gloves and reapplied gloves without performing hand hygiene. Staff D sprayed the mattress with "pH7Q Ultra" disinfecting cleaner, wiped the mattress with a cloth. The mattress remained wet for five minutes not the required 10 minutes for disinfection. Staff D placed the "pH7Q Ultra" spray bottle on the floor. Staff D obtained the "pH7Q Ultra" spray bottle from the floor, sprayed the dresser and dresser draws, wiped off the top of the dresser, and placed the contaminated "pH7Q Ultra" spray bottle that sat on the floor on top of the dresser. Housekeeping staff DD, wearing gloves cleaned the closet, bed frame and cross bars, then laid the soiled cloth and "pH7Q Ultra" spray bottle on the dresser. The surfaces of the closet and bed remained wet between one to four minutes. The closet and bed frame failed to remain wet for the required 10 minutes for disinfection. The head board, foot board, bed springs, and bed legs failed to be cleaned at all. When staff D and staff DD removed their gloves they failed to perform hand hygiene. Failure to clean a discharged patient's room effectively and	A 749	nursing staff and a computer-based training on hand hygiene will be ready for nursing staff on 03/06/15. - Policy IC-6.0 "Hand Hygiene" (see Attachment 23) revised to include instructions for hand hygiene before donning gloves, upon removal of gloves and between glove changes. Hand hygiene desk top alerts have been added to the computer screen. Hand hygiene quiz has been completed for completion by all staff. A new infection control computer training module has been created, that is required training and included annually at the EXPO training for all staff. Monitoring tools (see Attachment 24) have been created for hand hygiene compliance, appropriate use of gloves, and appropriate procedures for wound care and treatments. - Hand hygiene policy and proper use of gloves will be reviewed with ancillary staff by lab director and infection control officer by 03/06/15. - Inventory of damaged or compromised equipment on each unit will be completed by 2/26/15. Damaged and/or compromised equipment have been identified and will be removed by March 14, 2015. - Beds with rusted springs will be removed and/or replaced as a priority upon delivery of new beds, starting with delivery of the first 73 beds on 03/06/15, with subsequent delivery of an additional 73 beds every two weeks over the next month. For the bed springs that cannot be replaced prior to March 14, 2015, an encapsulating rubber coat barrier (Locktite) will be applied to the bed springs.	

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A 749	Continued From page 145 perform hand hygiene places all patients at risk for exposure to blood borne pathogens. Staff D interviewed on 1/14/15 at 11:15am acknowledged they were unaware of the disinfection time for "pH7Q Ultra" and verified they placed the contaminated spray bottle on the dresser, they failed to perform hand hygiene between glove changes, and they failed to clean all of the bed parts. - Housekeeping staff II observed on 1/15/15 between 10:10 am to 10:37 am cleaned room 264 on Crisis Stabilization Program (East Biddle) unit after a patient's dismissal. Staff II entered room 264, failed to perform hand hygiene, applied gloves, removed trash, removed soiled linen from the bed and placed it on the floor. Staff II sprayed the mattress, bed frame, foot board, and the head board, with " pH7Q Ultra" disinfecting cleaner, wiped the sprayed items with a dry cloth. The surfaces remained wet seven to eight minutes not the required 10 minutes for disinfection. Housekeeping staff II sprayed the window sill, and vent with "pH7Q Ultra" and immediately wiped them with a dry cloth. The surfaces failed to remain wet for the required 10 minutes for disinfection. Housekeeping staff II picked up the soiled linen and carried the linen against their body down the hall to the soiled utility room unlocked the door and placed the soiled linen in a linen hamper. Staff II went back to the room and sprayed the door and door frame with "pH7Q Ultra" using the same gloves. Staff II then removed the gloves stating, "one had a hole in it", applied clean gloves. Staff II failed to perform hand hygiene after removing the gloves. Failure to clean a discharged patient room effectively, perform hand	A 749	- New wheelchairs will be ordered for each unit with an identified need by 03/06/15. - GMRT (General Maintenance Repair Technician) staff have been assigned to repair and replace worn equipment on an ongoing basis on all patient units. - New vinyl covering for exam table ordered and will be replaced by 03/20/15. **How are we monitoring:** - A monitoring tool (see Attachment 24) for handling of soiled linen has been implemented and was distributed to WIG (Wildly Important Goals) members 2/27/15 for monitoring and reporting to infection control officer. Immediate feedback will be provided at the time of the monitoring. - Monitoring of housekeeping staff for appropriate use of hand hygiene and gloves, handling of soiled linens, and disposal of dirty linens will be supervised by the Housekeeping Supervisor and Infection Control Officer on an ongoing basis. - The Lab Director will monitor PT staff for appropriate use of hand hygiene, gloves and wound care procedures. - Environmental and/or Infection Control rounds will be utilized to o Monitor compliance with cleaning of the environment and overall cleanliness, o Proper use of hand hygiene techniques, o Monitor compliance with cleaning and disinfecting Whole Blood Glucose Meters, and o Identify damaged and/or compromised equipment and furnishings on an ongoing basis.	

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A 749	Continued From page 146 hygiene, and dispose of soiled linen appropriately places all patients at risk for exposure to blood borne pathogens. Staff II interviewed on 1/15/15 at 10:37am acknowledged they were aware of the disinfection time of the " pH7Q Ultra". Staff II acknowledged they were unaware the surfaces did not remain wet for the required 10 minutes, that the soiled loose linens should not be carried to the soiled utility. -The Hospital's policy for glucose monitoring failed to direct staff on cleaning/disinfecting of the monitor. -Licenses Practical Nurse (LPN) staff EE observed on 1/14/15 at 4:45pm, on Managing and Preventing Symptoms (MAPS) A2 unit performed a finger stick glucometer test on patient #33 in the treatment room. Staff EE wearing gloves performed a finger stick glucometer test. Staff EE removed their gloves and failed to performed hand hygiene. Staff EE replaced the glucometer in the case and failed to disinfect the glucometer after use on a patient. Staff E then went to medication room, obtained a medication for patient #33, and failed to perform hand hygiene. Failure to perform hand hygiene and clean the glucometer after each use places all patients at risk for exposure to blood borne pathogens. -Registered Nurse (RN) staff FF observed on 1/14/15 at 5:10pm on Managing and Preventing Symptoms (MAPS) A2 unit performed a finger stick glucometer test on patient #14 in the treatment room. Staff FF wearing gloves	A 749	**Ensure Compliance:** - The Environment of Care Committee will review Environment of Care Rounds and Preventative Maintenance Rounds to ensure the environment is free of equipment and furnishing requiring repair. Appropriate action will be taken when issues are identified. - The Infection Control Committee will review Environmental and/or Infection Control rounds to ensure proper cleaning and disinfection of the unit and proper hand hygiene. Based upon their analysis and review, appropriate action will be taken to correct any deficiencies. **Documentation:** - Attachment 21: Cleaning of Patient Rooms and Handling of Soiled Linen Policy (Nur-4.1) - Attachment 22: Whole Blood Glucose Testing (CL-0.2) ▪ Competency Validation and Assessment - Attachment 23: Hand Hygiene Policy (IC-6.0) - Attachment 24: Monitoring Tools ▪ Soiled Linens, Gloves, Treatment and Finger Sticks, Hand Hygiene **Individual Responsible for Compliance:** Infection Control Officer **Completion Date:** 02/25/15	

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A 749	Continued From page 147 performed a finger stick glucometer test, removed their gloves and performed hand hygiene. Staff FF replaced the glucometer in the case and failed to disinfect the glucometer after use on a patient. Failure to clean the glucometer after each use places all diabetic patients at risk for exposure to blood borne pathogens. RN staff FF interviewed on 1/14/15 at 5:15pm acknowledged nursing staff should perform hand hygiene before and after treating patients and should disinfect equipment after use on patients. -Registered Nurse (RN) staff Y observation on 1/14/15 at 9:55am on Plosive Living Skills (PLS) C2 unit performed a finger stick glucometer test on patient #33 in the treatment room. Staff Y, wearing gloves, performed a finger stick glucometer test, removed their gloves and performed hand hygiene. Staff Y replaced the glucometer in the case and failed to disinfect the glucometer after use on a patient. Failure to clean the glucometer after each use places all diabetic patients at risk for exposure to blood borne pathogens. -RN staff Z interviewed on 1/12/15 at 2:30 pm revealed that glucometers require cleaning after each patient and checked every 24 hours. - Registered Nurse staff KK observed on 1/14/15 at 4:50pm in the medication room passing medications to the patients. Staff KK drew up insulin into a syringe, applied one clean glove to one hand and gave the patient their insulin, and removed the glove and washed their hands. Staff KK failed to perform hand hygiene before applying the glove.	A 749		

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A 749	Continued From page 148 - Physical Therapist, staff KK observed on 1/13/15 at 9:40am in the physical therapy department performed wound care to a patient. Staff KK applied ointment to the patient's foot, removed gloves, applied clean gloves. Staff KK failed to perform hand hygiene before applying clean gloves. Staff KK, wearing gloves, dressed the wound area, removed one glove on right hand to tape the dressing, removed the glove from the left hand, picked up trash, and put slippers/shoes on the patient. Staff KK failed to perform hand hygiene after removing the gloves. -Guidelines for Environmental Infection Control in Health-Care Facilities Recommendations of Center of Disease Control (CDC) and the Healthcare Infection Control Practices Advisory Committee (HICPAC) Cleaning: remove all visible soil. Rust is visible therefore it cannot be cleaned. -Managing and Preventing Symptoms (MAPS) A1 unit observed on 1/20/15 between 3:15pm and 4:20pm revealed rusted bed springs in rooms 143, 145, and 149. Rust is visible therefore it cannot be cleaned. Torn vinyl with foam exposed arm rests on a wheelchair in the day hall, and room 146. Torn mattresses in rooms 143 and 145 leave a pathway to the inside foam rendering the area non-cleanable with the potential for cross contamination. -Registered Nurse staff SS interviewed on 1/20/15 between 3:15 and 4:20 acknowledged the rust on bed springs, torn vinyl on wheelchairs and the torn mattress covers. Staff SS indicated they were unaware if these had been reported to management. -Managing and Preventing Symptoms (MAPS) A2	A 749		

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A 749	Continued From page 149 unit observed on 1/20/15 between 4:20pm and 5:15pm revealed a bed in room 144 with rusted springs. -Observation on Continuing Care (CCP) B1 unit on 1/22/15 at 9:30am revealed a patient treatment room examination table with vinyl upholstery had a torn corner exposing the threaded backing approximately three inches by three inches. A chair in the treatment room had a tear in the vinyl covering on the chairs back support exposing the threaded backing approximately two inches by two inches. The torn vinyl leave a pathway to the inside foam rendering the area non-cleanable with the potential for cross contamination. A metal waste basket in the treatment room had rust on the metal lid and foot pedal mechanism that opened the trash can. Rust is visible therefore it cannot be cleaned. - Stepping Stones Program (SSP) B2 unit observed on 1/12/15 between 1:55pm to 4:47pm and 1/13/15 between 2:10pm to 3:00pm revealed a metal step stool with chipped paint, a metal trash can rusted around the bottom and lid. Torn vinyl with foam exposed on the arm rests of a wheel chair. The torn vinyl rendered the areas non-cleanable with the potential for cross contamination. -Registered Nurse Specialist (Unit Manager) RR interviewed on 1/14/15 between 1:55pm to 4:47pm acknowledged the rusted step stool and trash can and the torn vinyl on wheelchairs. - Crisis Stabilization Program (CSP) East Biddle unit observed on 1/14/15 between 5:10pm and 6:00pm and 1/15/15 between 8:10am to 12:00pm revealed rusted bed springs in rooms, 203, 207,	A 749		

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A 749	Continued From page 150 209, 211, 213, 216, 230, 228, and 262. Torn and cracked vinyl on two wheel chairs with foam exposed on arm rest and seats. One wheel chair had tape covering the entire arm rest. The torn and cracked vinyl rendered the areas non-cleanable with the potential for cross contamination. -Registered Nurse Specialist (Unit Manager) RR interviewed on 1/15/15 between 8:10 to 12:00pm acknowledged the rusted bed springs and torn and cracked wheelchairs. Staff RR indicated they have ordered new beds. -Healthy Options, Plans, and Experiences (HOPE) unit C2 building observed on 1/21/15 at 9:00am revealed three folded linen bags on the floor, MHT staff GG picked the linen bags up off the floor and place them on the clean linen cart located near the nurses' station. Dirty items placed on the clean linen have the potential for cross contamination and the potential spread of infection. -Staff GG interviewed on 1/21/15 at 9:00 am revealed the folded linens located on the floor next to the clean linen cart were the dirty linen bags.	A 749		
A 799	482.43 DISCHARGE PLANNING The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by: Based on staff interview, the hospital failed to develop in writing specific discharge planning policies and procedures (refer to A-0799) and the	A 799	**A 799** **POC:** - Policy PC 12.0, "Discharge Planning" (see Attachment 25) was created and will be implemented March 6, 2015 - The policy provides detailed information on the development of the discharge planning evaluation by a Social Worker and/or Registered Nurse, and the development and initial implementation of the subsequent discharge plan by the Social Work staff.	

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A 799	Continued From page 151 hospital failed to discharge patients when they transferred the patient to another hospital for further care and/or treatment (refer to A-0837). Findings include: - The hospital failed to provide discharge planning policies and procedures as requested on entrance. The hospital lacked a policy/procedure regarding identification of patients in need of discharge planning. The hospital lacked a policy/procedure regarding discharge planning evaluations. The hospital lacked a policy/procedure that specifies who can develop a discharge evaluation.The hospital lacked a policy/procedure that specifies that the discharge evaluation is completed in a timely manner, to avoid unnecessary delays in discharge. The hospital lacked a policy/procedure that specifies the hospital discusses the results of the discharge evaluation with the patient or their representative.The hospital lacked a policy/procedure that specifies the hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan.The hospital lacked a policy/procedure that specifies that a registered nurse, social worker, or other appropriately qualified personnel must develop, or supervise the development of, a discharge plan. The hospital lacked a policy/procedure that specifies in the absence of a finding by the hospital that a patient needs a discharge plan; the patient's physician may request a discharge plan.The hospital lacked a policy/procedure that specifies the hospital must arrange for the initial implementation of the patient's discharge plan.	A 799	- Training on the policy, the Discharge Planning Evaluation (see Attachment 25), and its use in creating the discharge plan will be provided to the nursing and social work staff, with the training to be completed by 03/06/15. **How are we monitoring:** - The IDT Weekly Meeting Progress Note template (see Attachment 26) has been revised to include the requirement that the team review the discharge plan for revision and to ensure that implementation has begun as appropriate - The Director of Social Work will review the Discharge Planning Evaluations of staff prior to, or during, regular supervision meetings - If problems are noted, they will be addressed by the supervisor. If problems persist, they will be addressed as part of the social worker's performance evaluation and/or through disciplinary action. **Ensure Compliance:** - The Director of Social Work will prepare a monthly report on the completion rate of discharge planning evaluations within the specified timeframe, and the subsequent development/implementation of the discharge plan, and this report will be presented to the Executive Clinical Team at least quarterly. - The Clinical Program Director, or designee, will review a random sampling of 10% of all new patient admissions each week, to ensure that the Discharge Planning Evaluation was initiated as required by policy.	

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A 799	Continued From page 152 The hospital as needed will counsel the patient and family members or interested person to prepare them for post-hospital care.The hospital lacked a policy/procedure that specifies the hospital mst reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.The hospital lacked a policy/procedure that specifies the hospital must include in the discharge plan a list of home health agencies or skilled nursing facilities that are participating in the Medicare program. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs. - Licensed Social Worker staff S, interviewed on 1/13/15 explained the hospital does not have "formal" policies and procedures for discharge planning. The cumulative effect of the systematic failure to ensure the facility met the requirements to have written discharge planning policies and procedures and discharge patients when they transferred to another hospital for further care and/or treatment and had the potential to put all patients in need of discharge planning at risk for inadequate services and care after hospitalization.	A 799	**Documentation (See Attachments):** - Attachment 25: Discharge Planning (PC-12.0) • Discharge Evaluation tool - Attachement 26: IDT Weekly Meeting Progress Notes **Individual Responsible for Compliance:** Director of Social Services	
A 837	482.43(d) TRANSFER OR REFERRAL The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.	A 837		

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A 837	Continued From page 153 This STANDARD is not met as evidenced by: Based on document review, staff interview, and medical record review, the hospital failed to discharge patients when they transferred to another hospital for further care and/or treatment for 4 of 4 transferred patient's medical records reviewed (patient #'s 9, 13, 21, and 27). The hospital's failure to discharge patients when they are transferred to another facility for further care or treatment has the potential to affect all patients transferred to other facilities and places these patients at risk for inadequate care, assessment, and evaluation. Findings include: - The Hospital's policies/procedures titled "Discharge to a Hospital (Psychiatric and/or Medical", reviewed on 1/13/15 at 3:15pm directed, "...patients who are transferred form Osawatomie State Hospital (OSH) and admitted to a medical hospital should be reviewed for discharge from OSH...Following the transfer, the attending physician will contact the physician at the medical hospital for an update about the expected treatment and length of stay at the medical hospital...after consulting with the physician at the medical hospital and it is affirmed the patient has been admitted for care and treatment of a physical issue, the OSH physician will initiate the discharge process for the patient...IDT (interdisciplinary team) will summarize the above information to the Medical Director prior to making a decision regarding discharge."	A 837	**A 837** **POC:** - Policy PC 11.6, "Discharge to a Hospital" (see Attachment 27) was revised and implemented on 01/20/15 to indicate that when a patient requires inpatient hospitalization at an outside healthcare provider, the patient will be discharged from Osawatomie State Hospital. - All medical staff will be provided education on the policy revision by 03/06/15. - For those patients who have been committed to OSH by a court and administratively transferred to the Security Behavioral Unit (SBU) of Larned State Hospital (LSH) as required by state law, an OSH physician will review progress toward each patient's return to OSH. The physician will enter a progress note in each transferred patient's medical record, not less than monthly, documenting each patient's treatment while receiving services at LSH. When the patient is ready to be returned to OSH, an OSH physician will discuss the patient's course of treatment at SBU with an LSH physician and enter appropriate medical orders to be followed prior to each patient's return to OSH. - For those patients who have been committed to OSH by courts of criminal jurisdiction for evaluation or treatment pursuant to trial competency, criminal responsibility, pre-sentence evaluation, or treatment in lieu of sentencing and need to be transferred to an acute care hospital for medical reasons, an OSH physician	

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A 837	Continued From page 154 - The Hospital's policies/procedures titled "Emergency Medical Transfer to Outside Healthcare Facility" reviewed on 1/13/15 at 10:00am directed, "...Patient Admitted to Inpatient Bed at Outside Healthcare Facility...The following business day after the initial transfer and daily thereafter...Physician and RNs contact the healthcare facility to inquire about the patient's status...Social workers contact the healthcare facility, when applicable, Phone conversations may be completed with the entire IDT...Document all information in the Patient Care System (electronic medical record)...request the healthcare facility to provide hospital records when the patient is returned..." -Patient # 9's medical record reviewed on 1/12/15 and 1/13/15 revealed an admitting date of 4/16/14 with psychiatric diagnoses of Schizophrenia and Psychotic Disorder and a medical diagnosis of hypothermia. Patient #9's medical record revealed a transfer to an acute care hospital (hospital A) on 12/11/15 for an exacerbation of hypothermia. Patient #9's medical record remained open and patient #9 returned from hospital A on 12/19/14 (eight days later). Patient #9's medical record lacked evidence of discharge after the patient transferred to another facility. -Patient #13's medical record reviewed on 1/14/15 revealed an admitting date of 10/29/14 with a diagnosis of Schizoaffective Disorder, Bipolar type. The medical record revealed Patient #13 transferred to an inpatient psychiatric hospital (hospital C) on 12/3/14 for further care and treatment. Patient #13's medical record remained	A 837	will review progress toward each patient's return to OSH. The physician will enter a progress note in each transferred patient's medical record not less than monthly documenting each patient's treatment while receiving services at the acute care hospital. When the patient is ready to be returned to OSH, an OSH physician will discuss the patient's course of treatment at the acute care hospital with a physician at the acute care hospital and enter appropriate medical orders to be followed prior to each patient's return to OSH. **How are we monitoring:** - When patients are on leave for medical appointments or follow-up outside of the hospital, the Health Information Manager, or designee, will monitor the appointment to determine if the patient is admitted as an inpatient to an outside healthcare provider. If an admission occurs, the Health Information Manager or designee will notify the IDT and physician (or covering physician) who will initiate the discharge process. - If the discharge process has not been initiated the Health Information Manager will contact the IDT and Medical Director and the Medical Director will ensure that the discharge is initiated promptly. **Ensure Compliance:** The Medical Director, or designee, will compile and provide to the Clinical Executive Team a monthly report of the total number of patients transferred to outside healthcare providers, to include the percentage that were discharged as required.	

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 _____	01/23/2015

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A 837	Continued From page 155 open and patient #13 returned to the above-named hospital on 1/6/15 (thirty four days later). The medical record lacked evidence of discharge after the patient transferred to another facility. -Patient # 21's medical record reviewed on 1/12/15 revealed an admitting date of 10/31/14 and a diagnosis of Schizophrenia. The medical record revealed Patient # 21 transferred to a psychiatric facility on 1/9/15 for further care and treatment. Patient # 2's medical record remained open and the patient remained on the unit census as of 1/21/15 (12 days later). The medical record lacked evidence of discharge after the patient transferred to another facility. - Patient #28's closed medical record reviewed on 1/21/15 revealed an admitting date of 12/21/14 with diagnosis of paranoid schizophrenia. The medical record revealed patient #28 transferred to an acute care hospital on 12/28/14 for further care and treatment. Patient #28's medical record remained open and patient #28 returned to the above-named hospital on 12/30/14 (two days later). The medical record lacked evidence of discharge after the patient transferred to another facility. Staff S, LSMSW interviewed on 1/13/15 at 3:05pm explained when the hospital transfers a patient to another hospital the patient's medical record will remain on the unit and the patient remains listed on the patient census but designated as on leave. When the patient is	A 837	**Documentation:** - Attachment 27: Discharge to a Hospital (PC-11.6) **Individual Responsible for Compliance:** Medical Director	

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A 837	Continued From page 156 transferred back to the hospital, the unit uses the same chart, does a medication reconciliation, new preliminary orders, head to toe assessment, reviews the same treatment plan the patient had before being transferred to another hospital, and then revises the treatment plan when the Interdisciplinary Team meets.	A 837		