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{A 000}	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Recertification Survey conducted in your facility from 11/05/13 through 11/08/13, in accordance with 42 Code of Federal Regulations (CFR) 482, Conditions of Participation for Hospitals. The census on the first day of the survey was 184 Patients. The sample size was 50 Patients. The facility failed to maintain condition level compliance with the following Conditions of Participation: 42 CFR 482.12 Governing Body 42 CFR 482.23 Nursing Services 42 CFR 482.21 Quality Assurance and Performance Improvements The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	{A 000}	This hospital's goal is to meet or exceed all regulatory expectations and best standards of care in treatment and service delivery and also recognizing it is our responsibility to continuously assess and be accountable when we find areas where we can and need to improve. Tag A043: The hospital has an effective governing body legally responsible for the conduct of the hospital as an institution. The governing body is represented by the Hospital Administrator, the entire Leadership team at the hospital, the Division Administration and the Local Governing Board. Contract oversight was incorporated into operations and was in compliance with State operations that required regular reporting and oversight. Contracted personnel are held to the same performance standards as State employees. At the time of the survey contract Services reporting was not organized to report to or be a component of the Quality Assurance / Performance Improvement (QAPI) program. The Agency Contract Manager and contract oversight was added to the QAPI program. The Agency Contract Manager is responsible for oversight of this corrective compliance activity.	01/17/14 and Ongoing
{A 043}	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital	{A 043}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chelsea Szklany	Hospital Administrator	1-21-14

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 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, interview and document review, the facility failed to manage contracts for temporary staffing (A0084); failed to manage contracts for kitchen and dietary services (A0084 and A0748); failed to manage an organized and effective nursing services (A0385); and Failed to maintain a Quality Assurance Performance Improvement program with an emphasis on continuous improvement (A0308). The cumulative effect of these systemic practices resulted in the failure of the facility to deliver statutorily mandated care to the patients.	{A 043}		
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nursing contract service was educated in the prevention of medication error and the dietary contract service maintained kitchen equipment and followed facility infection control policies. 1. Contracted Nursing Services. On 11/7/13 in the morning, the Director of Pharmacy provided the Pharmacy and Therapeutics Committee Meeting Minutes for the past nine months. The Director of Pharmacy also provided a copy of the aggregate medication	A 084	Tag A 084: Effective 01/17/14 the Agency policy - OF-LDR-03 Contract Services (Attachment A) was revised to include the requirement that contract monitors develop Quality Assurance Performance Improvement processes for additional monitoring of contracts and contract staff, to include data collection, analysis, and monthly reporting. The list of all contracts and contract monitors is attached (Attachment B). Each contract has a Contract Monitor who submits monthly reports to the Agency Contract Manager who intervenes when indicated and submits reports to the Agency QAPI program on a scheduled basis.	01/17/14 and Ongoing

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{A 043}	Continued From page 1 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, interview and document review, the facility failed to manage contracts for temporary staffing (A0084); failed to manage contracts for kitchen and dietary services (A0084 and A0748); failed to manage an organized and effective nursing services (A0385); and Failed to maintain a Quality Assurance Performance Improvement program with an emphasis on continuous improvement (A0308). The cumulative effect of these systemic practices resulted in the failure of the facility to deliver statutorily mandated care to the patients.	{A 043}	The Agency Contract Manager maintains a spreadsheet with all contracts and the identified Contract Monitor for the Agency. The spread sheet (Attachment B) referenced above is organized into: A. Medical Staff and Services; B. Nursing Staff and Services; C. Other Clinical Staff and Services; D. Ancillary Staff and Services; E. Contracted Services; and F. Nutrition and Dietary Services The contract management PI plan is attached. (Attachment C) The first presentation by the Agency Contract Manager is scheduled for the 01/29/14 meeting of the Performance Improvement Committee.	
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nursing contract service was educated in the prevention of medication error and the dietary contract service maintained kitchen equipment and followed facility infection control policies. 1. Contracted Nursing Services. On 11/7/13 in the morning, the Director of Pharmacy provided the Pharmacy and Therapeutics Committee Meeting Minutes for the past nine months. The Director of Pharmacy also provided a copy of the aggregate medication	A 084	All corrective action data, compliance rates, and activities completed are reported monthly to the Executive Leadership, the Division and quarterly to the Local Governing Board. The Hospital Administrator is responsible for submitting these reports. The Director of Nursing acted immediately to intervene with specific individuals and organized further training for all nursing staff employees. State employees and contracted employees are held to the same level of performance.	Ongoing

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A 084	Continued From page 2 variances for July 2013 through October 2013. The tally of medication variances for the month of October 2013 was reported to be partially completed and completion was not required until the second week in November. The Director of Pharmacy reported there was an increase in transcription errors and it was believed the increase was caused by contract registry nurses. The Director of Pharmacy reported the Nursing Department was going to provide the names of contracted registered nurse staff to determine the number and type of errors caused by contracted nurses. Review of the medication variances revealed the following transcription errors over the past four months: July 2013 - 5 errors August - 4 errors September - 3 errors October - 12 errors Review of the Pharmacy and Therapeutics Committee Minutes for 10/8/13 revealed the medication variances report was presented to the committee and the nursing department was to provide a list of contract registry nurses to the Director of Pharmacy. The list of contracted nurses involved in medication errors was to facilitate a focused in-servicing on preventing medication variances. On 11/7/13 in the morning, the Director of Nursing (DON) was aware of the increase in transcription errors and believed they were caused by the contracted registry nursing staff. The DON confirmed nurses were counseled and actions	A 084	All of these individuals receive the same orientation, performance expectations, mentoring and supervision. The Director of Nursing did not have an analysis of the data at the time of survey. The Pharmacy and Therapeutics Team only reported raw data. The Director of Nursing conducted further intensified auditing of the medical record and medication administration record to identify the root cause of the variance reports so as to develop a comprehensive training for all nursing staff employees. It was discovered that contract nurses were more attentive with documenting and reporting variances. Medication variance reporting is strongly encouraged as it provides more opportunity for individuals to learn from others. The Pharmacy and Therapeutics team updated their performance improvement plan to include monthly reporting of data and findings to the Executive Leadership which will add a second level of oversight to ensure timely response.	

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A 084	Continued From page 3 were taken to correct the nurse at the time of the medication error or as soon as possible after occurrence. The DON confirmed counseling and correction were documented and nurses were not allowed to return to work at the facility if they did not improve. The DON reported the contracted agencies were sending new nursing graduates to the facility and the nurses did not have much experience in the transcription of physician orders. The DON reported the facility planned to provide training for the contract nurses in an effort to reduce errors. The DON reported the training was to begin on 11/12/13, thirty-three days after the problem was identified in the Pharmacy and Therapeutics Committee Minutes of 10/8/13. The DON denied she had an analysis of the errors made by the contracted registry nursing staff and denied the problem and the correction were part of the Quality Assurance Performance Improvement Program (QAPI). The DON reported there was not enough time since the discovery of the problem to include it in the QAPI program. Review of the policy entitled "Medication Variances" effective date 10/12 revealed "The variance data shall be compiled and aggregated quarterly. The Pharmacy and Therapeutics (P&T) Team shall review all the Medication Variance reports and provide comments and recommendations to the Medical Staff and Leadership Teams regarding: 1. The medication variance surveillance process 2. Evaluation of (name of facility)'s medication management system to identify risk points and areas to improve safety."	A 084		

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A 084	Continued From page 4 2. Contracted Food Services. On 11/5/13 in the morning, a tour of the facility's kitchen was conducted with Employee #30, the contracted Director of Food and Nutritional Services. During the course of the tour, the following was observed: 1. A ceiling tile between the manual and automatic wash areas dripped water on the floor. The contractor's Executive Chef indicated the dripping was due to condensation, which occurred when operating the automatic washer. An evaporator fan was possibly inoperable. On 11/05/13, the facility's "Master Contract Log Summary Sheet" was reviewed. The document indicated the designated contract monitor for the contracted food service, an Administrative Services Officer III (Employee #8). Employee #8 was interviewed on 11/05/13 at 1:30 PM. The Administrative Services Officer III indicated the contractor failed to notify the facility about the exhaust fan and ceiling tiles. On 9/25/13 at 1:00 PM, a facility work order showed a request for replacement of two ceiling tiles in the same area. On 11/5/13 in the afternoon, the facility's Maintenance Director acknowledged the facility was responsible for replacing the ceiling tiles and the evaporator fan and failed to show documented evidence the ceiling tiles were addressed. 2. The kitchen's ice machine was dispensing a glacier-like blob of ice into the pocket of loose ice	A 084	Contracted Food Services 1. The ceiling tile was ordered and replaced by the close of business 1/14/14 as evidenced by attached receipt. (Attachment D) 2. The evaporator fan was inspected and found to have a broken belt. The belt was replaced on 11/6/13 utilizing work order form. (Attachment E) 3. The kitchen ice machine was serviced on 11/5/13 to correct the malfunction as evidenced by an attached receipt. (Attachment F) 4. Scrap collectors were serviced and made operational on 11/26/13 as evidenced by an attached receipt. (Attachment G) 5. An Agency wide equipment checklist was developed and implemented to verify all equipment is in proper working condition. All equipment was inventoried and checked by 12/31/13. Regular inspection of all equipment is scheduled on a regular basis to ensure proper operation and repair. This has been added to the Maintenance Prevention activities. 6. All Agency buildings including the kitchen areas have been added to monthly environmental rounds.	1/14/14 11/16/13 11/5/13 11/26/13 12/31/13 and Ongoing

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A 084	Continued From page 5 cubes in the machine, requiring an employee to break up the ice with an elongated, shovel-like tool. On 11/5/13 at 11:45 AM, the Maintenance Director indicated the aforementioned description of the glacier-like blob of ice did not sound normal, and the kitchen contractor was responsible for the ice machine maintenance. Invoices dated 3/22/13 and 8/12/13 indicated the kitchen contractor paid for servicing the kitchen's ice machine. On 11/5/13 at 3:15 PM, a refrigeration contractor indicated the ice bin deflector was backwards in the machine, causing ice formation on the insulation side of the deflector. The resulting new ice cubes formed after the repair appeared more clear. The contractor mentioned a more sturdy flap with new screws should be installed, since the old flap was slightly bowed with a screw missing in the center. 3. The kitchen had two Salvajor scrap collectors: one on the manual wash counter and another adjacent to the automatic wash. The electrical spinning components were inoperable in each scrap collector. On 11/5/13 in the morning, the kitchen contractor's Director of Food and Nutritional Services, Executive Chef, and a food service worker indicated the scrap collectors did not spin electrically and had not for years. They indicated the facility was aware of the inoperable scrap collectors. On 11/5/13 at 11:45 AM, the Maintenance	A 084	Data from these reports are routed monthly to the Executive Leadership Team, the Division and quarterly to the Performance Improvement Committee to provide tier level oversight. A quarterly checklist (Attachment H) of all kitchen equipment was developed and is by monitored by the Facility Supervisor so that no equipment falls into disrepair. The Facility Supervisor monitors monthly/quarterly reports and reports compliance rate to the Executive Leadership monthly. Building and Grounds are now incorporated into the QAPI program. The Facility Supervisor is scheduled to present the performance improvement plan to the 01/29/14 scheduled meeting of the Performance Improvement Committee. The Facility Supervisor is responsible for oversight of these corrective compliance activities. Each employee failing to fulfill his/her duty obligations receives coaching and when indicated progressive disciplinary action.	

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A 084	Continued From page 6 Director indicated the facility was never informed about the scrap collectors, and the staff did not repair anything without work orders. The Maintenance Director acknowledged a need to inspect the kitchen periodically to ensure equipment was maintained whether the facility or the kitchen contractor was responsible for a specific issue. The Maintenance Director indicated rounding probably should be done, but nobody told him. According to the facility's policy Contract Services (OF-LDR-03) dated 3/2012, "...Definition: ...D. Contract Monitor: A [facility] employee, usually a program or department head, responsible for contractor compliance during the term of the contract..." On 11/5/13 at 1:30 PM, the Administrative Services Officer III indicated there was no discussion about the scrap collectors not working. There was no documented evidence anyone reported the inoperable scrap collectors or that they were ever serviced. According to the facility's contract with the kitchen contractor #11277 dated 7/1/2010, the facility failed to appoint a field contract monitor in writing, as the entry was left blank. Page 7 of the contract indicated the vendor performed the following tasks... under section 3.4.10 "...Maintenance and repair of all kitchen areas used by the vendor..., and Maintenance, repair and replacement of all equipment and fixtures used by the vendor..."	A 084		
A 122	482.13(a)(2)(ii) PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES	A 122	Tag A122: In all cases the grievances were investigated.	12/17/13

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A 122	Continued From page 7 At a minimum: The grievance process must specify time frames for review of the grievance and the provision of a response. This STANDARD is not met as evidenced by: Based on interview with staff members, clinical record review, and document review, the facility did not thoroughly and appropriately investigate grievances according to established facility policy for 3 of 50 sampled Patients (Patient #47, Patient #48, & Patient #49). Findings include: The facility's policy, titled, "Consumer/Family Complaints and Grievances" Number PF-RRE-03, and dated 06/2013, stated in part, "...Consumers filing grievances shall be informed of the steps taken on behalf of the grievant to investigate the complaint during the process and for level 1 grievances shall be notified in writing the results of the grievance process within 10 business days of submitting the grievance, this written notice will conclude the grievance process". Patient #47: Patient #47 was admitted to the facility on 05/27/2013, on a "Legal 2000" (involuntary hold), after attempting to shock self with a defibrillator at the airport. The patient was diagnosed with bipolar I with psychosis. On 07/16/2013, Patient #47 filed a "Complaint-Concerns Form" with the facility which alleged on 07/02/2013, "...I (Patient #47) went to the counter to ask for my scheduled medication	A 122	The Agency policy PF-RRE-03: Consumer and Family Complaints was revised on 12/17/13 and revised again on 01/15/14 to more specifically define the time frames for patient grievances. The policy is more definitively defined to document the receipt of the grievance as the date the grievance is received. The time frames themselves did not change, the policy was revised to bullet the time frames. (Attachment I) The Recovery Services Coordinator is responsible for oversight of this corrective compliance activity. The Nurse Managers were counseled to document the dates that each task was completed rather than to summarize all the activities and then date the document the summary was written. The summary was documented after all activities were completed, the date that was documented was the date the summary was written rather than the date(s) of the communications and activities with the patient. This has been corrected. The DON is responsible for this corrective compliance activity.	01/15/14

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A 122	Continued From page 8 for anxiety and breathing relief. I was told that the nurse was busy and to wait. At 7:30 after experiencing a panic attack and symptoms of stressors or stress related tension. I went back to the counter and told the staff that was there that I had been awake since 5:30 A.M. and waiting for two hours for relief for my anxiety and now my stress level was at a ten. I went to sit down at the brown table to wait for staff or nurse. The tech came over to the table and grabbed me, knocking me and the journal to the floor and grab (sic) my leg pulling me across the carpet that burned off my skin". The nursing documentation indicated the incident occurred on 07/03/2013. The time stamp on the grievance indicated the facility received the document on 07/16/2013. Patient #47's assessment, dated 05/27/2013, indicated that her skin was intact and she did not have any injuries. On 07/03/2013 at 3:08 PM, Patient #47's physician wrote "(Patient) evaluated post seclusion injury (illegible) stable (with) (right) posterior abrasion". The physician ordered Ultram 50 milligrams to be given by mouth every eight hours if needed for pain. On 07/03/2013 at 3:14 PM, Patient #47's nurse documented, "(Patient) complained of right side back sharp pain rated 6/10 and reported that she obtained an abrasion on her back when she was carried to seclusion room yesterday at (7:00 AM)... MD assess (patient) and ordered pain (medication as needed)". On 07/03/2013, Patient #47's nurse documented	A 122	Effective 01/17/14 additional processes have been put into place to: A. Assist patients to submit grievances. B. Monitor and reconcile time frames per policy. C. Monitor and document communications with the individual submitting the grievance. D. Organize the grievances. E. Monitor employee performance and policy compliance. To enable patients to submit grievances, a Certified Mental Health Technician (CMHT) explains how to submit a compliment or grievance, asks for any forms at every community meeting on the day and evening shifts. The patient may place any form into a large envelope which is then hand delivered to the Recovery Services Coordinator daily and date stamped as received. The CMHT also inquires if there are any patient complaints that have not been responded to and follows up with the appropriate manager so that all grievances are addressed timely. The Nurse Managers document the date each task is completed.	

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A 122	Continued From page 9 in the clinical record, "0720 (7:20 AM) Patient yelling loudly, cursing, demanding to get her scheduled medication early. Patient verbally threatening bodily harm to staff and physically gesturing with clenched fist and exaggerated (sic) hand and arm movements, as well as noted escalation of pressured speech. Patient refused redirection to quiet room, tried 1:1 with patient. Patient presented as a danger to others and to self as peers/patients were disturbed by her assaultive behavior. Patient given one minute manual hold to quiet room, 0732 (7:32 AM) ... " On 07/29/2013, the Nurse Manager for Patient #47's unit documented on the grievance investigation, "On 7/4/13 (Patient #47) filed a complaint alleging she was 'grabbed, knocked down, and then dragged across the carpet by her leg burning off her skin'. (Patient #47) further alleges the assault occurred in the dayroom area of Inpatient Unit D1B @ 0730 (7:30 AM) and a (Mental Health Technician) was the assailant. Unfortunately, I was unable to interview (Patient #47) prior to her discharge from (name of) Hospital on 07/24/2013 regarding her allegations. However, I did review the patient's chart, nursing notes and documentation for several days prior to and after her alleged attack. I was unable to find any type of documentation substantiating (Patient #47's) allegation. Additionally, I interviewed the Day shift staff on Inpatient Unit D1B and no one was able to provide any information regarding (Patient #47's) allegations. The most common refrain from staff was, 'That did not happen'. However, I did note an MD order written by (name of the physician deleted) (medical MD) on 7/4/13 for Triple Antibiotic Ointment to be applied to (Patient #47's) back (three times a day for 3 days and then twice a day for 3 days) related to an	A 122	To monitor employee performance, the Recovery Services Coordinator provides a weekly report to the CMHT and Hospital Administrator of all grievances and dates of completed response. The Recovery Services Coordinator is responsible for this corrective compliance activity. Employees failing to adhere to this policy are coached and if indicated progressive disciplinary action occurs. The Hospital Administrator is responsible for oversight of this corrective compliance activities.	01/17/14 and Ongoing

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A 122	Continued From page 10	A 122		

abrasion. During most of her treatment at (name of) Hospital, (Patient #47) suffered from delusional thoughts and was not clear in her thinking. (Patient #47) primary psychiatrist, Day shift D1B staff, and myself (Employee #28, a licensed nurse), that this alleged attack did not take place as (Patient #47) has described. In retrospect, (Patient #47) did not mention the alleged attack again prior to her discharge. (Patient #47) was discharged from (name of) Hospital on 07/24/13 to (name of group home) with medications. All documentation related to this incident has been completed and closure is recommended."

A letter dated 07/30/2013 to Patient #47 was addressed to unit D1B at (name of) Hospital, was signed by the Recovery Services Coordinator (a licensed social worker). The letter stated "I am writing to inform you that I have received your Complaint, dated 07/04/13, and the investigation did not substantiate your complaints. F (sic) you wish to appeal this, please feel free to contact me."

The investigation was not completed within the time frame specified for a grievance Level 1 (10 days), per facility policy.

Patient #49:

Patient #49 was admitted to the facility on 06/15/2013, with depression.

Patient #49 completed a "Compliment - Concerns Form" on 06/18/2013, alleging Patient #49 had been sexually harassed by a Mental Health Technician because the patient was inappropriately questioned about her bra. The

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A 122	Continued From page 11 Patient also alleged "My friend on the unit has a second degree burn that has gone untreated for two days." On 07/19/2013, the Nurse Manager of the unit (Employee #31, a licensed nurse), documented, "Upon admission to the unit, she was extremely angry, defiant, uncooperative, arguementive (sic), demanding, and entitled. She would not listen to explainantions (sic) or abide by the unit rules. She was questioned about her bra since underwire bras are not allowed in the patients (sic) possession by a female (Mental Health Technician). She became agitated and (the Mental Health Technician) attempted to de-escalate the situation. Patient had no insight to her illness and refused all medications and remained uncooperative. She denied having suicide ideations or audio/visual hallucinations. Patient was discharged on 06/19/13 to the (name of shelter) and refused all discharge medications and after care plan instructions. All activities related to this incident have been completed. Closure recommended". On 11/08/2013 at 4:00 PM, the facility's Patient Safety Officer (Employee #4) acknowledged the allegation Patient #49's "friend" had an untreated burn was not addressed in the investigation. Patient #48 On 7/8/13, Patient #48 completed a grievance requesting a discharge from services. On 7/18/13, Patient #48 completed a second grievance requesting a discharge from services. On 7/26/13, Patient #48 was discharged to a	A 122	The "friend" was treated for the burn as evidenced in the physician orders. Effective 12/31/13, the Nurse Managers were coached to address all components of the grievance.	12/31/13

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A 122	Continued From page 12 group home. On 8/2/13, a date stamp indicated recovery services received the first and second grievances. On 8/7/13, the complaint-concerns forms for each grievance showed the Recovery Services Coordinator received and reviewed the grievances. According to the facility's policy "Consumer/Family Complaints and Grievances" (PF-RRE-03) dated 6/2013, "...H....2. All grievances shall be reviewed by the Recovery Services Coordinator within two business days of receipt..." An undated memo attached to one of the grievances indicated the grievances were sent from medical records to the Recovery Services Coordinator after culling from the chart after discharge. The Recovery Services Coordinator indicated to "please remind all units that these [grievances] do not belong in charts. Must be sent to me..." On 11/8/13 at 3:40 PM, the Administrator indicated it appeared an employee(s) did not turn in the grievances. According to the facility's policy "Consumer/Family Complaints and Grievances" (PF-RRE-03) dated 6/2013, "...IV. Procedure...B.2...b. All employees shall attempt to connect the grievant with the employee responsible for resolving the concern..."	A 122		
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF	A 123	Tag A123: The Agency policy - PF-RRE-03: Consumer and Family Complaints and	

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A 123	Continued From page 13 GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on policy review, record review and interview, the facility failed to provide a patient with written notice of the grievance decision, including the name of a contact person, the steps taken to investigate, the results of the grievance, and the completion date for 1 unsampled patient. Findings include: According to the facility's policy under part I Responsibility, pages 4-5, Consumer/Family Complaints and Grievances (PF-RRE-03) dated 6/2013, "...1. Any employee receiving a complaint from the Recovery Services Coordinator shall review, resolve, make necessary program/process/procedure changes, document such changes, provide a copy of the resolution to the grievant, and return to the Recovery Services Coordinator within five business days...J. Review and Analysis: 1. The Recovery Services Coordinator shall review all complaints and ensure follow up is documented..." A review of grievance forms documented on 8/8/13, a Nurse Manager (Employee #18) closed two grievances without demonstrating the chart was reviewed for pertinent information related to	A 123	Grievances was revised on 12/17/13 and revised again on 01/15/14. The policy did not require change relating to written response for the grievances. Employees were re-educated to provide the response page to the consumer for all complaints to provide the individuals written communication of all actions taken and the complaint resolution. When the individual has been discharged this shall page shall be mailed to the individual or summarized in a letter. So as to monitor employee performance, the Recovery Services Coordinator provides a weekly report to the CMHT and Hospital Administrator weekly of all grievances and dates of completed response. The Recovery Services Coordinator is responsible for this corrective compliance activity. Employees failing to adhere to policy are coached and if indicated progressive disciplinary action occurs. The Hospital Administrator is responsible for oversight of this corrective compliance activities.	01/15/14 and Ongoing

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A 123	Continued From page 14 the complainant's concern about an earlier discharge. On 11/8/13 in the afternoon, a review of a grievance, date stamped 8/2/13, lacked a written response to the complainant with the steps taken to investigate, the results of the grievance, the name of a contact person, and the completion date. On 11/8/13 at 4:15 PM, the Administrator indicated there was no follow up letter sent to the complainant regarding the steps taken to investigate, the results of two grievances, the name of a contact person, and the completion date.	A 123		
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 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 observation, interview and document	A 263	Tag A263: The hospital has developed an ongoing, hospital-wide data-driven quality assurance and performance improvement (QAPI) program. The hospital's leadership required all programs, departments, sub-committees of the medical staff and teams dictated by the State law to participate in the QAPI program. The leadership identified all entities that were not included. In some cases the performance plans were submitted to the team or Executive Medical Staff. In these cases the performance plans are now submitted to the Performance Improvement Committee. The following performance improvement plans are to be presented and included	12/17/13

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A 263	Continued From page 15 review, the facility failed to ensure repeat issues and knowledge of medication errors without immediate corrective actions were addressed (A0084); failed to manage contracted temporary nursing staff (A0084, A0308 and A3095); failed to ensure on-going continuous performance improvement projects regarding infection control (A0308); failed to ensure on-going continuous performance improvement projects regarding pharmacy services (A0308); and failed to ensure compliance with monitoring of contracted kitchen and dietary services (A0084 and A0308). The cumulative effect of these systemic practices resulted in the failure of the facility to deliver statutorily mandated care to the patients.	A 263	in the 01/29/14 Performance Improvement Committee. A. Infection Control B. Nutrition and Food Services C. Pharmacy D. Pharmacy and Therapeutics E. Contract Management F. Laboratory G. Human Resources H. Buildings and Grounds This corrective compliance activity is the responsibility of the Performance Committee Chairperson.	01/13/14
A 308	482.21 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT ... 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 observation, interview, and document review, the facility did not ensure the Quality Assessment and Performance Improvement Program addressed services provided by contracted resources.	A 308	The Infection Control (IC) Plan was submitted to the Executive Medical Staff in March 2013 and includes several improvement activities. The annual assessment and quality improvement plan for 2014 is currently being generated, once all data from December of 2013 is aggregated. The IC Plan was submitted to the Performance Improvement Committee and is attached. (Attachment J) Performance improvement plans are approved by the Local Governing Board. Performance Improvement data for all corrective activities is submitted monthly to the Executive Leadership, the Division and quarterly to the Local Governing Board. This is the responsibility of the Hospital Administrator.	

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A 308	482.21 QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT ... 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 observation, interview, and document review, the facility did not ensure the Quality Assessment and Performance Improvement Program addressed services provided by contracted resources.	A 308	Tag A308: The hospital ensures that the QAPI program reflects the complexity of the hospital's organization and services. It involves all hospital departments and services. The Leadership identified all departments and services that were reporting performance improvement activities to other bodies and incorporated these into the hospital QAPI program. The Leadership also identified all departments and services that were not participating in performance improvement activities and requested such to develop performance improvement plans and submit them to the performance improvement committee. Presentations will occur at the 01/29/14 Performance Improvement Committee meeting. This corrective compliance	12/17/13 and Ongoing

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A 308	Continued From page 16 Findings include: On 11/06/2013, the facility's policy, titled "Performance Improvement Plan", dated 06/26/2013, was reviewed. The policy stated in part, "It is the policy of (name of facility) to implement and evaluate:...The processes to design, measure, assess, improve, and maintain the performance of (name of facility)'s management, clinical and support services...The purpose of the Performance Improvement Program at (name of facility) is to monitor and assist (name of facility)'s Governing Body, Leaders and the (name of facility)'s organization to meet its client quality of care, safety, treatment and service responsibilities..." On 11/06/2013 at 3:00 PM, the facility's Administrator stated the facility had not brought forward the oversight of contracted services to the Performance Improvement Committee. The Administrator indicated that within the State system the designated compliance monitor was responsible to monitor the scope of work for specific contracts. The Administrator further acknowledged the facility was ultimately responsible for oversight of the contracted work. Contracted Nursing Services. On 11/7/13 in the morning, the Director of Pharmacy provided the Pharmacy and Therapeutics Committee Meeting Minutes for the past nine months. The Director of Pharmacy also provided a copy of the aggregate medication variances for July 2013 through October 2013. The Director of Pharmacy reported there was an	A 308	activity is the responsibility of the Hospital Administrator. The following performance improvement plans are to be presented at and included in the 01/29/14 Performance Improvement Committee. A. Infection Control B. Nutrition and Food Services C. Pharmacy D. Pharmacy and Therapeutics E. Contract Management F. Laboratory G. Human Resources H. Nutrition and Food Services I. Buildings and Grounds This corrective compliance activity is the responsibility of the Performance Improvement Committee Chairperson. 1. The Agency's Infection Control (IC) program participates in the Agency's Quality Assessment and Performance Improvement (QAPI) program, by generating its own Quality Assessment and Performance Improvement Plan annually; which is then approved by the Infection Control Committee (ICC) and Executive Medical Staff Committee (EMSC). It is now included in the QAPI of the Performance Improvement Committee. The plan is attached. (Attachment J)	

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A 308	Continued From page 17 increase in transcription errors and it was believed the increase was caused by contract registry nurses. The Director of Pharmacy reported the Nursing Department was going to provide the names of contracted registered nurse staff to determine the number and type of errors caused by contracted nurses. Review of the medication variances revealed the following transcription errors over the past four months: July 2013 - 5 errors August - 4 errors September - 3 errors October - 12 errors Review of the Pharmacy and Therapeutics Committee Minutes for 10/8/13 revealed the medication variances report was presented to the committee and the nursing department was to provide a list of contract registry nurses to the Director of Pharmacy. The list of contracted nurses involved in medication errors was to facilitate a focused in-servicing on preventing medication variances. On 11/7/13 in the morning, the Director of Nursing (DON) was aware of the increase in transcription errors and believed they were caused by the contracted registry nursing staff. The DON confirmed nurses were counseled and actions were taken to correct the nurse at the time of the medication error or as soon as possible after occurrence. The DON confirmed counseling and correction were documented and nurses were not allowed to return to work at the facility if they did not improve. The DON reported the contracted agencies were sending new nursing graduates to	A 308	2. The Pharmacy and Therapeutics team participated in the QAPI program by reporting performance improvement plans and data to the EMSC. The team now submits to the Performance Improvement Committee. The plan is attached. (Attachment K) 3. Nutrition and Food Services participated in the QAPI program by submitting to the Business Manager. It is now submitted to the Performance Improvement Committee. 4. Nursing Services effective 01/17/14 submits data relating to contracted employees to the Contract Manager who submits data and summaries to the Performance Improvement Committee. 5, The Pharmacy developed a performance improvement plan which is presented to the Performance Improvement Committee. 6. Buildings and Grounds developed a performance improvement plan which is presented to the Performance Improvement Committee. 7. Contract Oversight developed a performance improvement plan which is presented to the Performance Improvement Committee.	01/17/14

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A 308	Continued From page 18 the facility and the nurses did not have much experience in the transcription of physician orders. The DON reported the facility planned to provide training for the contract nurses in an effort to reduce errors. The DON reported the training was to begin on 11/12/13, thirty-three days after the problem was identified in the Pharmacy and Therapeutics Committee Minutes of 10/8/13. The DON denied she had an analysis of the errors made by the contracted registry nursing staff and denied the problem and the correction were part of the Quality Assurance Performance Improvement Program (QAPI). The DON reported there was not enough time since the discovery of the problem to include it in the QAPI program. Review of the policy entitled "Medication Variances" effective date 10/12 revealed "The variance data shall be compiled and aggregated quarterly. The Pharmacy and Therapeutics (P&T) Team shall review all the Medication Variance reports and provide comments and recommendations to the Medical Staff and Leadership Teams regarding: 1. The medication variance surveillance process 2. Evaluation of (name of facility)'s medication management system to identify risk points and areas to improve safety." Infection Control On 11/6/13, the Infection Control Coordinator, Employee #5, was interviewed. The Director reported the Infection Control Program was integrated into the hospital QAPI program but did	A 308	The performance improvement committee annually identifies all department and services. Each department and service is required to complete an annual risk analysis that identifies all activities completed or conducted and the vulnerability of each activity. Each department or service then identifies performance improvement plans to monitor, mitigate and improve services. These activities are the responsibility of the manager and the corrective compliance oversight is the responsibility of the Performance Improvement Committee Chairperson. Employees failing to adhere to policy are coached and if indicated progressive disciplinary action occurs. The Hospital Administrator is responsible for oversight of this corrective compliance activities.	

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A 308	Continued From page 19 not have a current QAPI project. Pharmacy On 11/6/13, the Director of Pharmacy, Employee #35, was interviewed. The Director of Pharmacy reported the Pharmacy Department was integrated into the QAPI program but did not have a current QAPI project. The Director did report the pharmacy the facility was monitoring medication variances and planned to initiate an electronic record to reduce transcription errors. Contracted Food Services. On 11/5/13 in the morning, a tour of the facility's kitchen was conducted with Employee #30, the contracted Director of Food and Nutritional Services. During the course of the tour, the following was observed: 1. A ceiling tile between the manual and automatic wash areas dripped water on the floor. The contractor's Executive Chef indicated the dripping was due to condensation, which occurred when operating the automatic washer. An evaporator fan was possibly inoperable. On 11/05/13, the facility's "Master Contract Log Summary Sheet" was reviewed. The document indicated the designated contract monitor for the contracted food service, an Administrative Services Officer III (Employee #8). Employee #8 was interviewed on 11/05/13 at 1:30 PM. The Administrative Services Officer III indicated the contractor failed to notify the facility about the exhaust fan and ceiling tiles. On 9/25/13 at 1:00 PM, a facility work order	A 308		

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A 308	Continued From page 20 showed a request for replacement of two ceiling tiles in the same area. On 11/5/13 in the afternoon, the facility's Maintenance Director acknowledged the facility was responsible for replacing the ceiling tiles and the evaporator fan and failed to show documented evidence the ceiling tiles were addressed. 2. The kitchen's ice machine was dispensing a glacier-like blob of ice into the pocket of loose ice cubes in the machine, requiring an employee to break up the ice with an elongated, shovel-like tool. On 11/5/13 at 11:45 AM, the Maintenance Director indicated the aforementioned description of the glacier-like blob of ice did not sound normal, and the kitchen contractor was responsible for the ice machine maintenance. Invoices dated 3/22/13 and 8/12/13 indicated the kitchen contractor paid for servicing the kitchen's ice machine. On 11/5/13 at 3:15 PM, a refrigeration contractor indicated the ice bin deflector was backwards in the machine, causing ice formation on the insulation side of the deflector. The resulting new ice cubes formed after the repair appeared more clear. The contractor mentioned a more sturdy flap with new screws should be installed, since the old flap was slightly bowed with a screw missing in the center. 3. The kitchen had two Salvajor scrap collectors: one on the manual wash counter and another adjacent to the automatic wash. The electrical	A 308		

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A 308	Continued From page 21 spinning components were inoperable in each scrap collector. On 11/5/13 in the morning, the kitchen contractor's Director of Food and Nutritional Services, Executive Chef, and a food service worker indicated the scrap collectors did not spin electrically and had not for years. They indicated the facility was aware of the inoperable scrap collectors. On 11/5/13 at 11:45 AM, the Maintenance Director indicated the facility was never informed about the scrap collectors, and the staff did not repair anything without work orders. The Maintenance Director acknowledged a need to inspect the kitchen periodically to ensure equipment was maintained whether the facility or the kitchen contractor was responsible for a specific issue. The Maintenance Director indicated rounding probably should be done, but nobody told him. According to the facility's policy Contract Services (OF-LDR-03) dated 3/2012, "...Definition: ...D. Contract Monitor: A [facility] employee, usually a program or department head, responsible for contractor compliance during the term of the contract..." On 11/5/13 at 1:30 PM, the Administrative Services Officer III indicated there was no discussion about the scrap collectors not working. There was no documented evidence anyone reported the inoperable scrap collectors or that they were ever serviced. According to the facility's contract with the kitchen	A 308		

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A 308	Continued From page 22 contractor #11277 dated 7/1/2010, the facility failed to appoint a field contract monitor in writing, as the entry was left blank. Page 7 of the contract indicated the vendor performed the following tasks... under section 3.4.10 "...Maintenance and repair of all kitchen areas used by the vendor..., and Maintenance, repair and replacement of all equipment and fixtures used by the vendor..."	A 308		
{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 staff interview and document review, the facility failed effectively monitor temporary nursing staff (A0398); failed to ensure patient receives medications as ordered by a physician (A0405); and failed to prevent medication errors according to a plan of correction (A0398). The cumulative effect of these systemic practices resulted in the failure of the facility to deliver statutorily mandated care to the patients.	{A 385}	Tag A385: The Nursing Services provides 24 hour nursing services furnished or supervised by a Registered Nurse who effectively monitors temporary nursing staff as evidenced by: 1. The Agency's Nursing Department evaluates and monitors contracted nursing staff on all shifts by performing a Performance Evaluation of Contract Nursing Staff on all contract nursing staff utilized by the agency. (Attachment L) 2. The contracted nurses are given their assignments and supervised by the Psychiatric Nurse (PN) III or the Charge Nurse on each unit utilizing the nurse assignment sheet and the Performance Evaluation of Contract Nursing Staff form. (Attachment L) 3. The PN III or Charge Nurse monitors duties performed, mentors and evaluates each contracted staff, every shift, that is under his/her supervision on the Performance Evaluation of Contract Nursing Staff form.	Complete & Ongoing
{A 398}	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by:	{A 398}		

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A 308	Continued From page 22 contractor #11277 dated 7/1/2010, the facility failed to appoint a field contract monitor in writing, as the entry was left blank. Page 7 of the contract indicated the vendor performed the following tasks... under section 3.4.10 "...Maintenance and repair of all kitchen areas used by the vendor..., and Maintenance, repair and replacement of all equipment and fixtures used by the vendor..."	A 308	4. These completed contracted nursing staff evaluations are submitted, reviewed, and signed by the PN IV and compares the Performance Evaluation of Contract Nursing form for any deviations from policies and procedures related to patient care/safety. These deviations are then identified for action and training.	
{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 staff interview and document review, the facility failed effectively monitor temporary nursing staff (A0398); failed to ensure patient receives medications as ordered by a physician (A0405); and failed to prevent medication errors according to a plan of correction (A0398). The cumulative effect of these systemic practices resulted in the failure of the facility to deliver statutorily mandated care to the patients.	{A 385}	5. All contracted nursing staff evaluations are sent to the respective contracted nursing agencies twice a week or more often if necessary. The DON then works with the contract agencies to identify training and performance requirements. 6. The medication administration training was implemented utilizing a Power Point presentation. (Attachment M) The attendance is also tracked. (Attachment N) The implementation date began 11/12/13 with the monitoring of the compliance rates. 7. Testing for medication procedures, knowledge and skills began December 2013 utilizing a medication testing	
{A 398}	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by:	{A 398}	competency tool. (Attachment O) The competencies are reviewed and immediate one to one education is provided by the nursing education personnel if needed. The medication administration competencies are completed by all hospital nursing staff and contracted nursing staff. 8. The procedure "Nursing Medication Administration Process" (Attachment P) was revised on 01/16/14.	

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A 308	Continued From page 22 contractor #11277 dated 7/1/2010, the facility failed to appoint a field contract monitor in writing, as the entry was left blank. Page 7 of the contract indicated the vendor performed the following tasks... under section 3.4.10 "...Maintenance and repair of all kitchen areas used by the vendor..., and Maintenance, repair and replacement of all equipment and fixtures used by the vendor..."	A 308	All nursing staff will be required to review the procedure to obtain a 100% compliance rate. Any deviation from the policies and procedures identified will be addressed immediately with education and training documented on the Education Acknowledgment Form.	
{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 staff interview and document review, the facility failed effectively monitor temporary nursing staff (A0398); failed to ensure patient receives medications as ordered by a physician (A0405); and failed to prevent medication errors according to a plan of correction (A0398). The cumulative effect of these systemic practices resulted in the failure of the facility to deliver statutorily mandated care to the patients.	{A 385}	To ensure all contract staff is monitored and evaluated the PN IV will compare the daily shift assignment sheets to the contract nursing evaluations. The Contract Evaluation Audit is reviewed and initialed by the DON I and DONII. The evaluation is then used by the PN IV for training, coaching and progressive disciplinary action as needed. The DON II is responsible for oversight.	
{A 398}	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by:	{A 398}	Tag A 398: The DON implemented a nightly audit that compares the physician orders to the medication administration record. The performance improvement personnel then conducts a random validation audit. (Attachment Q) A tier audit commenced on 01/06/14 to incorporate all nurses to be involved in the auditing and education process.	11/12/13 and Ongoing 01/06/14

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A 308	Continued From page 22 contractor #11277 dated 7/1/2010, the facility failed to appoint a field contract monitor in writing, as the entry was left blank. Page 7 of the contract indicated the vendor performed the following tasks... under section 3.4.10 "...Maintenance and repair of all kitchen areas used by the vendor..., and Maintenance, repair and replacement of all equipment and fixtures used by the vendor..."	A 308	This process involves more personnel and provides a greater sample size. This process includes auditing of the auditor. The medical record audit sheet is attached. (Attachment R) When discrepancies in the findings are discovered, training, coaching and if indicated progressive disciplinary action is provided.	
{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 staff interview and document review, the facility failed effectively monitor temporary nursing staff (A0398); failed to ensure patient receives medications as ordered by a physician (A0405); and failed to prevent medication errors according to a plan of correction (A0398). The cumulative effect of these systemic practices resulted in the failure of the facility to deliver statutorily mandated care to the patients.	{A 385}	The data is aggregated monthly for compliance rates on each element so the DON can identify areas for needed improvement. The DON is responsible for this corrective compliance oversight. All contract nursing staff are trained to the hospital policies and procedures during their orientation period the same as State employees.	
{A 398}	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by:	{A 398}	The Director of Nursing (DON) provides supervision of contract nursing staff using the direct supervision from the charge nurses. The charge nurse is required to monitor, mentor and evaluate all contract staff during their assigned shifts. The Charge Nurse evaluates and monitors contracted nursing staff on all shifts by performing a Performance Evaluation of Contract Nursing Staff on all contract nursing staff utilized by the agency. The information from each form is used for	

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{A 398}	Continued From page 23 Based on staff interview and document review, the facility failed to provide training in the transcription of physician's orders for nursing staff upon discovery of an increasing error rate by contracted nurses. Findings include: On 11/7/13 in the morning, the Director of Pharmacy provided the Pharmacy and Therapeutics Committee Meeting Minutes for the past nine months. The Director also provided a copy of the aggregate medication variances for July 2013 through October 2013. The Director reported there was an increase in transcription errors and it was believed the increase was caused by contract registry nurses. The Director reported the Nursing Department was going to provide the names of contracted registered nurse staff to determine the number and type of errors caused by contracted nurses. Review of the medication variances revealed the following transcription errors over the past four months: July 2013 - 5 errors August - 4 errors September - 3 errors October - 12 errors Review of the Pharmacy and Therapeutics Committee Minutes for 10/8/13 revealed the medication variances report was presented to the committee and it was determined the nursing department was to provide a list of contracted registry nurses to the Director of Pharmacy. The list of contracted registry nurses involved in	{A 398}	individual coaching, training and if indicated disciplinary action. The data from all form is aggregated monthly to identify trends for necessary improvement.	

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{A 398}	Continued From page 24 medication errors was to facilitate a focused in-servicing on preventing medication variances. On 11/7/13 in the morning, the Director of Nursing (DON) was aware of the increase in transcription errors and believed they were caused by the contracted registry nursing staff. The DON confirmed nurses were counseled and actions were taken to correct the nurse at the time of the medication error or as soon as possible after occurrence. The DON confirmed counseling and correction were documented and that nurses were not allowed to return to work at the facility if they did not improve. The DON reported she believed the agencies were sending new nursing graduates to the facility and they did not have much experience in the transcription of physician orders. The DON reported the facility planned to provide training for the contract nurses in an effort to reduce errors. The DON reported the training was to begin on 11\12/13, thirty-three days after the problem was identified in the Pharmacy and Therapeutics Committee Minutes of 10/8/13. The DON was unable to provide a break down of transcription errors that identified errors made by regular staff from contracted staff. The DON reported there was not enough time between the discovery of the problem and the current date to include the problem and corrective action into the Quality Assurance Performance Improvement Program (QAPI). Review of the policy entitled "Medication Variances" effective date 10/12 revealed "The variance data shall be compiled and aggregated quarterly. The Pharmacy and Therapeutics	{A 398}		

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{A 398}	Continued From page 25 (P&T) Team shall review all the Medication Variance reports and provide comments and recommendations to the Medical Staff and Leadership Teams regarding: 1. The medication variance surveillance process 2. Evaluation of ______ medication management system to identify risk points and areas to improve safety."	{A 398}		
A 405	482.23(c)(1) ADMINISTRATION OF DRUGS Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (1) - All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on record review, policy review and staff interview, the facility failed to obtain a physician ordered medication for 1 of 50 patients (Patient #39). Findings include: Patient #39: Patient #39 was admitted to the psychiatric observation unit on 11/1/13 at 2:35 AM, with	A 405	Tag A405: Administration of drugs is completed by licensed nursing personnel who abides to Federal and State laws and has been prescribed by medical staff in accordance with the hospital policies and procedures. Any staff member deviating from these requirements will be given individual training, competency assessment, and counseling. If needed progressive discipline will occur with notification to the respected licensing board. The Pharmacy and Therapeutics Committee Chairperson reviewed the above-referenced event at the 01/14/14 meeting and revised the process so that all non-psychotropic, non-formulary medications are to be dispensed as ordered and then the medical consultation form will be transmitted. The medication consultation form may be received in the Pharmacy up to 72 hours after the medication was ordered. Policy PF-CC-45: Hospital Formulary and	Complete & Ongoing

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A 405	Continued From page 26 diagnoses including mood disorder, mental retardation, bedwetting, and seizure disorder. Review of the physician orders revealed the patient was ordered DDAVP (Desmopressin) intranasal and by mouth for diabetes insipidus on 11/1/13 and again on 11/2/13. On 11/6/13, medication pass on Unit E was observed. While preparing to administer medications to Patient #39, the nurse discovered DDAVP 20 mcg (micrograms) intranasal was not available for administration. According to the medication administration record, the nursing staff documented the patient was without the intranasal drug on 11/2/13, 11/3/13, 11/4/13, and 11/5/13. The physician had also written an order for DDAVP 0.1 milligrams (mg) po (orally) every 12 hours. The oral dosage was available on the morning of 11/6/13 but had not been available for administration on 11/2/13, 11/3/13, 11/4/13 and 11/5/13 according to nursing documentation. Registered Nurse #24, who was administering medications, was interviewed on the morning of 11/6/13 and did not know why the intranasal DDAVP was not available for administration. The nurse contacted the pharmacy and reported she was told the drug was non-formulary so there was a delay in obtaining the drug. The nurse reported she was told the weekend further delayed the delivery of the medication. Record review revealed the physician completed a Medical Consultation Form on 11/1/13 indicating the non-formulary medication, DDAVP 20 mcg and 0.1 mg, was ordered for enuresis and the form was labeled as scanned. The form	A 405	Non-Formulary (Attachment S) was updated to reflect this change. The responsible person is the State-Wide Pharmacy Director. A 100% sample of all medication consultation requests was monitored for compliance with the amended policy, namely, that all non-psychotropic non-Formulary medications were dispensed and administered as ordered. All findings are evaluated as per the Pharmacy Services Performance Improvement Plan Policy OF-PI-22 (Attachment K) and reported vertically through the hospital governance pathway.	

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A 405	Continued From page 27 indicated three working days should be allowed for inpatient non formulary drugs. On 11/2/13 a second Medical Consultation Form was completed by the physician indicating 0.1 mg dosage of DDAVP was needed, but the frequency of administration was changed to hour of sleep. Nursing progress notes dated 11/2/13, revealed the form was scanned to pharmacy. The pharmacist signed the form on 11/4/13. On 11/5/13 a third Medical Consultation Form requesting the non-formulary DDAVP 20 mcg intranasal was requested by the physician. The form indicated the drug was needed for diabetes insipidus. On 11/6/13 at 10:00 AM, two more Medical Consultation Forms were completed by the medical physician requesting both DDAVP in the intranasal form and oral forms of the drugs and indicated a change in the frequency of dosage. On 11/6/13in the afternoon, the Pharmacy Director and a Pharmacist were interviewed regarding the delay of the medication. The Director of Pharmacy reported non-formulary requests were usually filled in one day. The Director indicated the drug orders for DDAVP remained unclear, six days after the original order was written. The pharmacist, Employee #33, reported she was aware of the non formulary request. The pharmacist reported she attempted to contact the medical physician on 11/5/13 for order clarification but was unsuccessful. The pharmacist reported she left voice mail requesting the physician contact her but he did not call her back. The DDAVP for intranasal administration continued to be unavailable to the nursing staff as	A 405		

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A 405	Continued From page 28 of the morning of 11/7/13. Review of the policy entitled "Hospital Formulary and Non Formulary" effective date 12/11 revealed the results of the pharmacy consultation form would be provided in three business days after it was received.	A 405		
A 505	482.25(b)(3) UNUSABLE DRUGS NOT USED Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use. This STANDARD is not met as evidenced by: Based on observation, interview and policy review, the facility failed to dispose of an opened/dated vial of medication after 28 days. Findings include: On 11/6/13 at 2:15 PM, a 50 milligram/milliliter vial of Haldol was observed in a drawer of a medication cart in the medication room at the Charleston clinic. The vial had lot number 6105179 and was to expire 11/14. The vial's open date was 10/4/13. The Clinical Psychiatric Nurse Supervisor indicated the facility's policy was to discard opened vials after 28 days. According to the facility's policy Multiple Dose Vials Dating (PF-CC-24) dated 10/2013, "...IV. Procedures: A. Upon the initial withdrawal of medication from a multiple dose vial, the vial shall have an auxiliary label affixed thereon indicating the date of expiration [10/4/13], which shall be	A 505	Tag A505: In this case the vial was used for a single patient. All medications/drugs that are mislabeled, outdated and/or expired are disposed of and not available for patient use. Upon opening multiple dose vials the licensed nursing staff is required to label the vial with a discard date of twenty eight days from the date opened and add their initials. The nursing staff is to check every multiple dose vial before withdrawing any medication for the correct label, discard date, expiration date and particulate matter. If the medication is found to be outdated, mislabel, expired or compromised in anyway it will be disposed of immediately. Policy PF-CC-24: Multiple Dose Vials Dating (Attachment T) was redrafted on 10/2013 to minimize any confusion between the opening date and expiration date by limiting the auxiliary label to contain the expiration date and initials of the nurse only.	Complete & ongoing

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A 505	Continued From page 29 twenty-eight (28) days there from, and will be initialed by the person performing this procedure. B. Once entered, the vial shall be used within twenty-eight (28) days or within the manufacturer's expiration date on the vial, whichever is lesser...E. Vials that are outdated as in procedure (B) above shall be returned to the pharmacy for proper disposal, and replacement if necessary..."	A 505	Nursing Services has added this policy to their monthly in-services for all nurses, effective 01/15/14. Pharmacy Services personnel conduct Pharmacy medication inspections on a monthly basis for all medication room storage areas. This provides for an oversight tier process.	
{A 716}	482.41(b)(9) ALCOHOL-BASED HAND RUB DISPENSERS Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a hospital may install alcohol-based hand rub dispensers in its facility if- (i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities; (ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls; (iii) The dispensers are installed in a manner that adequately protects against inappropriate access; and (iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by the NFPA Temporary Interim Amendment 00-1(101). (v) The dispensers are maintained in accordance with dispenser manufacturer guidelines This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure an alcohol-based hand rub (ABHR) dispenser was properly located.	{A 716}	The responsible person is the Statewide Pharmacy Director. Policy PF-CC-25: Medication Station Surveys (Attachment U) monitors adherence to this policy on a monthly basis as evidenced by the survey reports. Data collection to commence by the office of the Statewide Pharmacy Director.	11/16/13

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A 505	Continued From page 29 twenty-eight (28) days there from, and will be initialed by the person performing this procedure. B. Once entered, the vial shall be used within twenty-eight (28) days or within the manufacturer's expiration date on the vial, whichever is lesser...E. Vials that are outdated as in procedure (B) above shall be returned to the pharmacy for proper disposal, and replacement if necessary..."	A 505		
{A 716}	482.41(b)(9) ALCOHOL-BASED HAND RUB DISPENSERS Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a hospital may install alcohol-based hand rub dispensers in its facility if- (i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities; (ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls; (iii) The dispensers are installed in a manner that adequately protects against inappropriate access; and (iv) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by the NFPA Temporary Interim Amendment 00-1(101). (v) The dispensers are maintained in accordance with dispenser manufacturer guidelines This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure an alcohol-based hand rub (ABHR) dispenser was properly located.	{A 716}	Tag A716: The alcohol-based hand rub dispenser that was installed over an ignition source was removed on 11/6/13. Environment inspections are performed monthly by the clinic director in building 1. The report is completed by the 5th of every month and submitted to the facility supervisor. The aggregated report is submitted to the Agency and Division Leadership monthly and to the Environment of Care (EOC) team quarterly. The Facility Supervisor conducts validation audits on each building quarterly and is responsible for corrective compliance.. 1. A visual inspection of all wall-mounted hand sanitizers throughout the agency was conducted specifically noting: a. Location in reference to an ignition source; b. Operational status of dispenser;	11/6/13

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{A 716}	Continued From page 30 Findings include: One alcohol-based hand rub dispenser was observed to be installed over an ignition source in the following location: On 11/6/13 at 2:55 PM, two alcohol-based hand rub dispensers (ABHR) were observed in the "Injection Room" in Building 1 (West Charleston Clinic-Administrative and Outpatient Services). One ABHR was installed above a light switch, and the other ABHR was installed below the same light switch. A staff member indicated that the upper ABHR was not in use. The dispensing button on the upper ABHR was pressed and alcohol gel came out.	{A 716}	c. Presence of wall and floor protector drip-tray; 3. Any wall-mounted hand sanitizer found to be out of compliance with noted indicators above, was immediately relocated, replaced, or repaired. The responsible individuals is the Facility Supervisor.	
{A 724}	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE 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 observation, interview and policy review, the facility failed to address maintenance issues in the kitchen specified by contract and/or policy. Findings include: On 11/5/13 in the morning, a tour of the facility's kitchen was conducted with Employee #30, the contracted Director of Food and Nutritional Services. During the course of the tour, the following was observed:	{A 724}	1. A total count of all wall-mounted hand sanitizers throughout the agency tallied, inspected and the location noted. 2. Wall-mounted hand sanitizers inspection has been added to the Environment of Care environmental rounds checklist with the following inspection indicators: a. Location in reference to an ignition source b. Operational status of dispenser c. Presence of wall and floor protector drip-tray.	01/17/14

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{A 724}	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE 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 observation, interview and policy review, the facility failed to address maintenance issues in the kitchen specified by contract and/or policy. Findings include: On 11/5/13 in the morning, a tour of the facility's kitchen was conducted with Employee #30, the contracted Director of Food and Nutritional Services. During the course of the tour, the following was observed:	{A 724}	Tag A724: Buildings and grounds is now required to submit a performance improvement plan to the QAPI program chairperson. The plan includes the regular inspection of all buildings, the regular inspection of all equipment, the reporting of maintenance requests and repairs. And any other improvement activities identified. The Facility Supervisor is responsible for oversight of this corrective action and is scheduled to present at the 01/29/14 Performance Improvement Committee.	01/13/14

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{A 724}	Continued From page 31 1. A ceiling tile between the manual and automatic wash areas dripped water on the floor. The contractor's Executive Chef indicated the dripping was due to condensation, which occurred when operating the automatic washer. An evaporator fan was possibly inoperable. On 9/25/13 at 1:00 PM, a facility work order showed a request for replacement of two ceiling tiles in the same area. On 11/5/13 in the afternoon, the facility's Maintenance Director acknowledged the facility was responsible for replacing the ceiling tiles and the evaporator fan and failed to show documented evidence the ceiling tiles were addressed. On 11/5/13 at 1:30 PM, an Administrative Services Officer III indicated the contractor failed to notify the facility about the exhaust fan and ceiling tiles.	{A 724}	1. The ceiling tile has been ordered and will be replaced by the close of business 1/14/14. The evaporator fan in question was inspected and found to have a broken belt. The belt was replaced on 11/6/13.	
	2. The kitchen's ice machine was dispensing a glacier-like blob of ice into the pocket of loose ice cubes in the machine, requiring an employee to break up the ice with an elongated, shovel-like tool. On 11/5/13 at 11:45 AM, the Maintenance Director indicated the aforementioned description of the glacier-like blob of ice did not sound normal, and the kitchen contractor was responsible for the ice machine maintenance. Invoices dated 3/22/13 and 8/12/13 indicated the kitchen contractor paid for servicing the kitchen's ice machine.		2. The kitchen ice machine was serviced on 11/5/13 to correct the malfunction.	11/5/13

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{A 724}	Continued From page 32 On 11/5/13 at 3:15 PM, a refrigeration contractor indicated the ice bin deflector was backwards in the machine, causing ice formation on the insulation side of the deflector. The resulting new ice cubes formed after the repair appeared more clear. The contractor mentioned a more sturdy flap with new screws should be installed, since the old flap was slightly bowed with a screw missing in the center.	{A 724}		
	3. The kitchen had two Salvajor scrap collectors: one on the manual wash counter and another adjacent to the automatic wash. The electrical spinning components were inoperable in each scrap collector. On 11/5/13 in the morning, the kitchen contractor's Director of Food and Nutritional Services, Executive Chef, and a food service worker indicated the scrap collectors did not spin electrically and had not for years. They indicated the facility was aware of the inoperable scrap collectors. On 11/5/13 at 11:45 AM, the Maintenance Director indicated the facility was never informed about the scrap collectors, and the staff did not repair anything without work orders. The Maintenance Director acknowledged a need to inspect the kitchen periodically to ensure equipment was maintained whether the facility or the kitchen contractor was responsible for a specific issue. The Maintenance Director indicated rounding probably should be done, but nobody told him. According to the facility's policy Contract Services (OF-LDR-03) dated 3/2012, "...Definition: ...D. Contract Monitor: A [facility] employee, usually a		3. Scrap collectors were serviced and made operational on 11/26/13.	11/26/13

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{A 724}	Continued From page 33 program or department head, responsible for contractor compliance during the term of the contract..." On 11/5/13 at 1:30 PM, the Administrative Services Officer III indicated there was no discussion about the scrap collectors not working. There was no documented evidence anyone reported the inoperable scrap collectors or that they were ever serviced.	{A 724}		
	According to the facility's contract with the kitchen contractor #11277 dated 7/1/2010, the facility failed to appoint a field contract monitor in writing. Page 7 of the contract indicated the vendor performed the following tasks... under section 3.4.10 "...Maintenance and repair of all kitchen areas used by the vendor..., and Maintenance, repair and replacement of all equipment and fixtures used by the vendor..."		4. The original contract effective 7/1/2010 with the food services vendor identifies the Administrative Services Officer III as the contract monitor. This duty was revised to be shared between the agency's Dietitian for Food Services and the Administrative Services Officer III for environmental controls as indicated by the internal contract log.	07/1/10
	5. The floor drain nearest the deep fryer area in the kitchen had standing black water. On 11/5/13 at 11:45 AM, the Maintenance Director indicated the facility was responsible for maintaining kitchen drains, and nobody requested drain maintenance recently. On 11/5/13 at 3:15 PM, the drain in question was augured.		5. The floor drain that had standing black water was augured on 11/5/13.	11/5/13
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.	A 748	Tag A748: 1. The Agency's registered Dietitian is also the contract monitor for the Agency's Food Service Vendor. She therefore serves as member of the Infection Control Committee (ICC), and is the Food Service	01/16/14

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A 748	Continued From page 34 This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control policies were followed related to the ice machines in the main kitchen and cafe kitchen. Findings include: 1. On 11/5/13 in the morning, the kitchen's ice machine was dispensing a glacier-like blob of ice into the pocket of loose ice cubes in the machine, requiring an employee to break up the ice with an elongated, shovel-like tool. The employee opened and closed the lid on the ice machine several times without hand-sanitizing or wearing gloves. On 11/5/13 at 3:15 PM, a refrigeration contractor was observed handling ice machine parts and opening/closing the lid of the ice machine without wearing gloves. According to the facility's policy Infection Control of Ice Machine (#OF-SP-01) dated 4/2013, "...IV. Procedure...B. Employees must wash and glove hands before scooping, bagging, or otherwise touching the ice..." The part handled by the refrigeration contractor came into direct contact with ice. 2. The café kitchen's ice machine was streaked with what appeared to be "calcium deposits" around its perimeter. On 11/5/13 at 11:45 AM, the facility's Maintenance Director indicated the facility was responsible for cleaning the outside perimeter of the ice machines.	A 748	representative between Infection Control and The Food Service Vendor. 2. The ICC representative provides the agency's policies that directly pertain to food service operations and infection control surveillance policies. 3. The Food Service Vendor's director ensures that there is staff education on updates, through staff in service. 4. The ice machine was labeled with the following, "This ice is not used for human consumption". 5. Routine cleaning is performed daily, to include wiping down of the outside of the machine to be free of debris and organic material per Food Service Vendor's policy. 6. Interior sanitation is performed quarterly 7. The ice machine is serviced by a contractor used by the Food Vendor, which includes a routine cleaning (including deep cleaning and descaling) every 6 months. 8. The service technician was advised on January 16, 2014 regarding the proper handling of ice machines in regards to infection control practices utilizing policy OF-SP-01. The responsible individuals for oversight of this corrective compliance are: 1. Agency's Dietitian 2. Director of Infection Control/Employee Health/Laboratory Services 3. Director of Vendor Food Services	

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A 748	Continued From page 35 According to the facility's policy Infection Control of Ice Machine (OF-SP-01) dated 4/2013, "...IV. Procedure...F...2. Housekeeping shall maintain the exterior components of the individual units [ice machines]..." On 11/5/13 at 1:30 PM, an Administrative Services Officer III indicated ice machines were wiped and cleaned daily. On 11/5/13 at 1:30 PM, the Maintenance Director indicated there was no documented evidence of cleaning rounds for the ice machines, and someone was already sent to clean the perimeter of the café kitchen's ice machine. On 11/5/13 at 3:30 PM, the café kitchen's ice machine showed the same streaking it had earlier in the morning.	A 748	1. The Agency's Dietitian continues to be the Food Service Representative between the Contracted Food vendor and Infection Control. She continues to provide bi-directional communications of identified infection control issue(s), by providing the Food Vendor service with any directives, policies and procedures pertaining to infection control and food services through written communication, as needed. 2. The director of Vendor Food Services continues to be responsible for in-servicing food services personnel, under his/her charge, on infection control updates through in-service, as evidenced by Ice Handling in service done on 08/7/2013. (Attachment W) 3. Documentation is generated when this type of maintenance is performed as evidenced by Ice Machine Cleaning Procedure, Sanitation and Infection Control procedures. (Attachment X) 4. Service Technician service calls are documented and invoiced. This documentation is given to the Director of Food Services. 100% completed and in compliance.	
A 886	482.45(a)(1) OPO AGREEMENT Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the hospital for this purpose; This STANDARD is not met as evidenced by: Based on policy review, interview, and donor	A 886		

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A 748	Continued From page 35 According to the facility's policy Infection Control of Ice Machine (OF-SP-01) dated 4/2013, "...IV. Procedure...F...2. Housekeeping shall maintain the exterior components of the individual units [ice machines]..." On 11/5/13 at 1:30 PM, an Administrative Services Officer III indicated ice machines were wiped and cleaned daily. On 11/5/13 at 1:30 PM, the Maintenance Director indicated there was no documented evidence of cleaning rounds for the ice machines, and someone was already sent to clean the perimeter of the café kitchen's ice machine. On 11/5/13 at 3:30 PM, the café kitchen's ice machine showed the same streaking it had earlier in the morning.	A 748		
A 886	482.45(a)(1) OPO AGREEMENT Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the hospital for this purpose; This STANDARD is not met as evidenced by: Based on policy review, interview, and donor	A 886	Tag A886: Effective 01/15/14 the Agency policy OF-MOI-10 (Attachment Y) was revised to ensure all deaths that occur in the hospital are to be referred to the Nevada Donor Network. Medical Staff were informed of the procedure. The Associate Medical Director is responsible for oversight of this corrective compliance activity.	01/17/14

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A 886	Continued From page 36 network agreement, the facility failed to ensure that all deaths were reported to the donor network as required. Findings include: A review of the organ and tissue donations policy #OF-MOI-10 dated 12/12 revealed on page two all deaths would be referred as indicated by the client or next of kin, to donate organs /or tissues to the Nevada Donor Network (NDN) for donor evaluations. A review of the agreement with the Nevada Donor Network (NDN) dated 9/21/12, under the title of Hospital Services Responsibilities, stated in part, "2. Refer all deaths to NDN in a timely manner according to clinical triggers". An interview with the facility administrator revealed there were no reported deaths in the facility in the last year.	A 886		
A1112	482.55(b)(2) QUALIFIED EMERGENCY SERVICES PERSONNEL There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility. This STANDARD is not met as evidenced by: Based on record review, document review, and interview, the facility failed to ensure medical records were accurately created and maintained including failure to ensure Legal 2000 (Nevada Process of Civil Commitment) paperwork was completed correctly; and failure to complete COBRA (Consolidated Ominbus Reconciliation	A1112	Tag A1112: Medical staff were following policy at the time and documenting the release in the electronic medical record. In each case the medical staff employee documented in the progress notes or discharge summary per policy. The Medical Staff were informed and educated how to completely fill out all forms including the Legal 2K also known as the Emergency Admission to a Hospital form. Medical Staff employees have now been educated and instructed to complete the form.	01/15/14

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A1112	Continued From page 37 Act) transfer forms for 3 of xx sampled patients (Patient #16, Patient #24, and Patient #25). Findings include: The facility policy titled Involuntary Admissions effective date 3/12 documented: - "IV. G. Discontinuing Legal 2000R: The discontinuance of a Legal 2000R by any SNAMHS physician requires face to face assessment/evaluation of the individual with alleged mental illness. The written justification for this action shall be fully addressed in the patient's chart, including the determination that the patient is no longer a danger to self and/or others." Patient #16 Patient #16 presented to the Outpatient (OP) Clinic on 10/23/13, with complaints of depression and thoughts of suicide. The patient was placed on a Legal 2000 and admitted to the Psychiatric Observation Unit (POU). The Legal 2000 form was completed by the physician The form specified the reason the patient was being admitted to the facility was for depression and was suicidal. The facility's Medical Doctor medically cleared the patient on 10/23/13 at 3:45 PM. Patient #16's medical record revealed the patient was observed and monitored overnight. The patient was discharged home on 10/24/13 with referrals for outpatient follow up for depressive disorder. The Legal 2000 form contained a section titled "Discharge" which was to be completed by the	A1112	In the hospital, individuals are often petitioned to the court for involuntary commitment and not released. The nursing staff in outpatient services have been instructed to complete the COBRA document completely and leaving no blanks. The nurse involved in the mentioned incident received coaching to comply with Agency policy. The requirements for proper patient assessment and documentation of all hospital discharges was reviewed with the inpatient medical staff during the inpatient medical staff meeting on 01/15/14. The medical staff is oriented to the policy titled "Involuntary admissions" (Attachment Z) at the start of their employment. The requirements for proper patient assessment and documentation of all hospital discharges were reviewed with the inpatient medical staff during the inpatient medical staff meeting on 01/15/14. The updated policy is included in the orientation package for newly hired medical staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294002	A. BUILDING ______ B. WING ______	R 11/08/2013

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A1112	Continued From page 38 physician prior to the patient's discharge. The discharge section indicated - "I have personally observed and examined this allegedly mentally ill person and have concluded that (s)he is not or no longer a danger to self or others as a result of mental illness. My opinions are based on the following facts:_______". The discharge section of the Legal 2000 form was not completed or signed by a physician. Patient #24 Patient #24 presented to the Outpatient Clinic on 11/7/13 with complaints of severe depression and suicidal thoughts. The patient was evaluated by the nurse and psychiatrist. The patient was placed on a Legal 2000 and admitted to the Psychiatric Observation Unit. The Legal 2000 form was completed by the physician. The form specified the reason the patient was being admitted to the facility was for worsening depression and suicudal ideations. The facility's Medical Doctor medically cleared the patient on 11/7/13 at 1:50 PM. Patient #24's medical record revealed the patient was observed and monitored overnight. The patient was discharged home on 11/8/13 with referrals for outpatient follow up for major depression. The Legal 2000 form contained a section titled "Discharge" which was to be completed by the physician prior to the patient's discharge. The discharge section indicated - "I have personally observed and examined this allegedly mentally ill person and have concluded that (s)he is not or no	A1112	Beginning 01/15/14 all charts of individuals discharged from active Legal 2000 hold have been audited for compliance with documentation on "DISCHARGE" portion of Legal 2000R form. A sample of 10% of active charts are audited weekly by the medical staff. The audit provides data to provide evidence that patients are assessed by the medical staff for any patient symptom changes, patient's condition at the time of discharge and risk to self and/or others. The goal is to have 100% compliance. This audit is ongoing and data is forwarded to the Agency Medical Director, the Division and the Local Governing Board. The Agency Medical Director is responsible for corrective compliance oversight. To ensure sustainment the nursing discharge checklist was revised on 01/16/14 to include "discharge portion of the legal 2000R form completed by physician before patient may be discharged". (Attachment AA)	

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A1112	Continued From page 39	A1112		

longer a danger to self or others as a result of mental illness. My opinions are based on the following facts:_______".

The discharge section of the Legal 2000 form was not completed or signed by a physician.

There was no documented evidence of a face-to-face assessment/evaluation by a physician. There was no documented evidence the patient was no longer a danger to himself and/or others.

Patient #25

Patient #25 presented to the Outpatient Clinic on 11/7/13 with complaints of suicidal ideations. The patient was evaluated by the nurse and psychiatrist. The patient was placed on a Legal 2000 and admitted to the Psychiatric Observation Unit.

The Legal 2000 form was completed by the physician and documented the patient attempted to run into traffic. The form specified the reason the patient was being admitted to the facility was for depression and suiciadal ideations. The facility's Medical Doctor medically cleared the patient on 11/7/13 at 2:00 PM.

Patient #25's medical record revealed the patient was discharged home on 11/10/13 with referrals for outpatient follow up for mood disorders

The Legal 2000 form contained a section titled "Discharge" which was to be completed by the physician prior to the patient's discharge. The discharge section indicated - "I have personally observed and examined this allegedly mentally ill

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A1112	Continued From page 40 person and have concluded that (s)he is not or no longer a danger to self or others as a result of mental illness. My opinions are based on the following facts:_______". The discharge section of the Legal 2000 form was not completed or signed by a physician. On 11/12/13 at 3:00 PM, the Hospital Administrator (Adm) verbalized when someone showed up requesting services after the clinic was closed and there was a determination the patient was a Legal 2000, there was no requirement for the nurse to complete a transfer form, as the person was not an admission to the facility. The Adm added, the determination as to which the facility the patient was referred to was totally the decision of the EMS (Emergency Medical Staff). There was no communication between the staff at facility and the receiving facility.	A1112		