

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

Credible Allegation 4/20/21 cmd
Date of Correction 4/30/21

PRINTED: 04/01/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 164006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/17/2021
NAME OF PROVIDER OR SUPPLIER EAGLE VIEW BEHAVIORAL HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 770 TANGLEFOOT LANE BETTENDORF, IA 52722		
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A 000	<p>INITIAL COMMENTS</p> <p>The State Survey Agency (SA), at the direction of the Centers for Medicare and Medicaid (CMS) Kansas City Regional Office (KCRO) staff, performed an on-site investigation of complaint 96192-C from 3/03/21 through 3/17/21. The survey team investigated the Conditions of Participation for: Nursing Services (42 CFR 482.23) and Patient Rights (42 CFR 482.13).</p> <p>The survey team identified an Immediate Jeopardy (IJ) situation. The IJ situation was a crisis situation that placed the health and safety of all patients who failed to receive regular safety checks at risk for harm or death.</p> <p>The IJ situation involved the hospital staff's failure to ensure the nursing staff followed their safety check policies and perform safety rounds on patients every 15 minutes, as required. The lack of regular safety checks provides the patients an opportunity to engage in inappropriate behavior, such as potential sexual contact with another patient or attempting suicide, without staff detection. The Director of Quality & Risk Management reported the hospital was aware of the lack of regular safety rounds and was working to correct the lack of regularity but that the lack of regular safety rounds continued.</p> <p>In response to the IJ situation, the hospital's administrative staff successfully removed the immediacy of the situation by submitting an acceptable plan involving staff training prior to the complaint investigation exit date of 3/17/21. The Conditions of Participation for Patient Rights (42 CFR 482.13) and Nursing Services (42 CFR 482.23) remained out of compliance.</p>	A 000	<p>Eagle View Behavioral Health takes these findings seriously and we understand the urgency of a comprehensive plan to address these deficiencies. At Eagle View, we have implemented an effective plan of action to address the identified deficiencies and monitor for compliance with actions taken. Pursuant to your request, the response is structured as follows:</p> <ul style="list-style-type: none"> • The specific nature of the corrective actions for each deficiency • Reasonable completion dates for all deficiencies prior to the termination date listed in the enforcement letter • How our corrective action plan prevents recurrence for the deficiency cited • The title of the person responsible for implementing and monitoring the plan of correction for future compliance with the regulations 		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Jean A. Whitney

TITLE

Director of Quality/Compliance/Risk

(X6) DATE

4/15/2021

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 115	<p>PATIENT RIGHTS CFR(s): 482.13</p> <p>A hospital must protect and promote each patient's rights.</p> <p>This CONDITION is not met as evidenced by:</p> <p>I. Based on document review and staff interview, the Behavioral Health Hospital's (BHH) administrative staff failed to:</p> <ol style="list-style-type: none"> 1. Ensure the nursing staff followed the hospital's safety check policies to ensure the safety of all behavioral health patients. Please refer to A-0144. 2. Ensure the nursing staff closed and secured patient bedroom doors when unoccupied, as directed by corporate guidelines, to ensure the safety of behavioral health patients. Please Refer to A-0144. <p>The cumulative effect of these failures and deficient practices resulted in the hospital's inability to ensure the nursing staff protected each patient's rights to care in a safe environment. The lack of regular safety checks (approximately every 15 minutes per policy) created a situation which could result in patients attempting to engage in suicide or sexual contact with another patient, without the staff's knowledge. The behavioral health hospital's administrative staff identified a patient census of 25 on entrance.</p> <p>II. During the investigation of incident 96192-C, the on-site survey team identified an Immediate Jeopardy (IJ) situation (a crisis situation that placed the health and safety of patients at risk) related to the Condition of Participation for</p>	A 115	<p>TAG A115 BEGINS HERE</p> <p>In addition to the Plan of Correction for TAGS A144 & A395 provided on 3/15/2021 prior to survey exit, and after reviewing the deficiencies cited in this report, the following action items were implemented:</p> <ul style="list-style-type: none"> - We met with our IT department and discovered that there were technical glitches in use of the I-Pads when documenting 15 minute checks. IT immediately started working on correcting the issues, but in order to prevent further opportunities for appearance of missed 15-minute checks due to IT issues, it was determined that the hospital would start using paper documentation (which was the current Downtime Form) of the 15-minute checks and patient observations. - Reporting of Compliance of Monitoring by Leadership has been added as an agenda item in the Morning Leadership Meetings, QAPI/MEC committees and Governing Board Meetings. - Auditing of the paper Q15s is being conducted on 100% of the patients, daily. When noncompliance is found, a 2nd verification via cameras may be conducted. Audits will be completed until 95% compliance is achieved for 3 consecutive months. <p>A schedule of video monitoring and auditing of Q15 safety checks and unit milieu has been established and implemented.</p> <p>TAG A115 CONTINUED BELOW</p>	<p>3/22/2021</p> <p>3/26/2021</p> <p>4/1/2021</p> <p>4/5/2021</p>
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A 115	<p>Continued From page 2</p> <p>Patient's Rights (42 CFR 482.13). The hospital staff failed to ensure the nursing staff followed their safety check policies and perform safety rounds on patients every 15 minutes, as required.</p> <p>1. The administrative staff failed to initially develop and implement a corrective action plan to ensure the nursing staff performed regular safety checks.</p> <p>2. While on-site, the survey team identified an Immediate Jeopardy (IJ) situation and notified the administrative staff on 3/15/21 at 3:44 PM. The administrative staff promptly took action to remove the immediacy of the situation. The hospital staff removed the immediacy prior to the survey team exiting the complaint investigation when the hospital administrative staff developed education and re-educated all nursing staff, including Mental Health Technicians, prior to their next scheduled shift. The education provided to include the following:</p> <p>a. Reeducation for the staff on the Levels of Observation policy</p> <p>b. Reeducation on the Safety Slides from new hire orientation focusing on eminency of risk if the staff do not complete the safety checks every 15 minutes.</p> <p>c. Traning Attestation signed by each applicable staff.</p> <p>d. Random shift video observations with validation tool to be completed by assigned staff daily.</p> <p>e. Every 15-minute safety check compliance to be</p>	A 115	<p>- Documentation of Follow Up/Corrective Actions, if any, using Eagle View's disciplinary policy are conducted. Disciplinary actions up to and including termination occurs, if warranted.</p> <p>- When the facility returns to electronic documentation of Q15 Safety Checks, a comparison of the electronic documentation with HCS Analytics Reports will also occur.</p> <p>- The new revision of Policy 1000.17 Levels of Observation (revised 1/18/21) was reviewed and approved through our Quality Assurance/Performance Improvement (QAPI) and Medical Executive (MEC) committees by the QCR.</p> <p>- Level of Observation policy 1000.17 (revised 4/14/21)) to include an updated Patient Observation Form (1000.17a), Environmental Unit Rounds policy 1000.5 (revised 4/14/21), 15-minute Check Observation Level Flowsheet Education, and Q15 Commitment Attestation has been created in our organizational compliance program, Healthstream, as the first module of an ongoing training protocol called "Change Week". This first module related to Q15s must be completed by 4/30/21 by all direct care staff. This new ongoing training protocol will ensure up-to-date/current information and education are being communicated to and completed by all Nursing/MHT staff. - All education provided during the previously mentioned in-service trainings and throughout this plan of correction has also been added to the new hire orientation, with the current new hire orientation class.</p>	<p>3/26/2021</p> <p>4/14/2021</p> <p>4/14/2021</p>	

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A 115	Continued From page 3 reported in daily morning meeting to Leadership team. f. Continued monitoring of every 15-minute safety checks as Process Improvement Indicator at monthly QAPI committee meetings. g. Reeducation of all staff to be completed prior to next scheduled shift effective immediately. The following Condition level deficiency remained for the Condition of Participation for Patient Rights (42 CFR 482.13) (A-0115).	A 115	The latest revision of our Levels of Observation policy 1000.17 (4/14/21) will be reviewed and approved ad hoc by our QAPI and MEC committee meetings. The CEO, QCR, EA, IC/Nurse Educator and HRD are responsible for implementing and monitoring the plan of correction for future compliance with the regulations. TAG A115 ENDS HERE	4/16/2021	
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: I. Based on observation, document review, and staff interviews the Behavioral Health Hospital (BHH) staff failed to perform the 15 Minute Safety Checks for 3 of 3 open patient records reviewed (Patient # 1, Patient #5, and Patient #7) and 7 of 7 closed patient records reviewed (Patient #2, Patient #3, Patient #4, Patient #6, Patient #8, Patient #9, and Patient #10). Failure to perform regular safety checks provided the patients an opportunity to engage in inappropriate behavior, such as potential sexual contact with another patient, attempting suicide, self-harm, or assault without staff detection. The BHH administrative staff identified a census of 25 patients upon entrance. Findings include: 1. Review of the BHH policy "Patient Rights"	A 144	TAG A144 BEGINS HERE Education of all Nursing staff including Mental Health Technicians included the following: - Reeducation on Levels of Observation policy 1000.17, effective date 6/12/20 - Safety Slides from new hire orientation focusing on eminency of risk if Q15s are not complete - Reeducation for MHTs on handoff when leaving the unit or responding to a disturbance - Reeducation for MHTs on walking rounds at shift handoff - Training Attestation signed by each applicable staff TAG A144 CONTINUED BELOW	3/15/2021	

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A 144	Continued From page 4 revealed in part "Patient have the right to ... Receive care in a safe environment." 2. Review of the policy "Locator Rounds Procedure," effective 7/12/20, revealed in part, "... all patients are supervised, at a minimum, every 15 minutes through ... rounds/milieu Locator process." "purpose ... To identify high risk or high alert behaviors ... and implement other precautions as required ... perform rounds at staggered intervals and in a varying pattern to minimize planned acting out opportunities ... document patient location and behavior" "be aware of times your focus can be diverted: changes in shift, codes, crisis de-escalation, visiting hours, unit staffing ..." "Charge Nurse ... Ensures ... Patient Locator Rounds are occurring as ordered, 24 hours per day, seven days a week ... while monitoring hallways ... patient care areas ensure patients are: ... not entering rooms not assigned to them, not in rooms or areas ... 'off limits' ... not left in treatment areas without direct staff supervision ... participating in their treatment by being where they are directed to be ... not sleeping or otherwise avoiding participation in treatment activities ..." "Hand off assigned patient - Locator rounds to another staff member before leaving the patient treatment area (meals, breaks, emergencies) ... Hand Off from shift to shift ... Off-going and oncoming staff will walk/monitor the unit jointly ... to ensure continuity of care ..."	A 144	TAG A144 CONTINUED - Scheduled shift video observations with validation tool is completed by Leadership team - Nursing/Unit supervisors sign-off of Q15 safety checks is evident on Patient Observation forms at minimum of twice per shift - Q15s compliance is reported in daily morning meeting to Leadership team - Continued monitoring of Q15s as a PI Indicator at monthly QAPI committee meetings. - Reeducation of all staff was completed prior to their next scheduled shift. - The new Q15 Attestation and revised 1000.17 Levels of Observation policy (revised 4/14/21), reinforces Eagle View's commitment to keeping our patients safe above all else. - New red-light flashlights and clipboards with digital clocks built in were purchased (4/2/21) and rolled out to staff to facilitate qualitative as well as quantitative Q15s. TAG A144 CONTINUED BELOW	4/7/2021	

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A 144	<p>Continued From page 5</p> <p>3. Review of the policy "Level of Observation," effective 7/12/20, revealed in part, "The patient is observed with visual checks every 15 minutes" "15-minute observations will occur at random intervals no longer than 15 minutes ... Assigned staff will document the patient's behavior, location, activity, special precautions (if indicated) and level of observation while conforming they are in no danger or distress ... If and/or when a mental health tech [MHT] has to leave the floor, the MHT will notify nursing staff and another MHT or the nurse will replace them on the floor for patient observation until the staff member returns."</p> <p>4. Review of the policy "Nursing Rounds," effective 7/12/20, revealed in part, "Objectives for rounds for Registered Nurses (minimum 3 times per shift) ... Observe nursing staff performance including mental health workers compliance with patient observation levels."</p> <p>5. Review of the document, "ALL STAFF ORIENTATION Week 1 TESTS, Patient Observation Competency" checklist form, revised 5/29/20, revealed in part, "While completing the observation, staff will not allow distractions to interfere with patient rounding: Peer to peer conversations, Patient requests, Crisis situations ... **While assigned the patient observations the number one priority will be completing the observation and documentation of the patients ..."</p> <p>6. Review of 3 of 3 open medical records (patients currently admitted on survey entrance) revealed the following:</p> <p>a. The hospital staff admitted Patient #1 to the</p>	A 144	<p>TAG A144 CONTINUED</p> <ul style="list-style-type: none"> - Guidance points for Q15s were attached to Safety Check clipboards. Those guidance points include but are not limited to: <ol style="list-style-type: none"> 1. Emphasizing the importance that shift hand-off be peer to peer. 2. Lack of staffing, unit disruption, EHR malfunctions are not considered valid reasons for non-compliance of Safety Checks. 3. Prefilling in the times of the observations is not allowed (on paper forms) 4. Observe sleeping patients with flashlight and be sure to see chest rise and fall at least 3 times. 5. Q15 safety checks are the #1 tool we use to keep patient's safe. It is the most important thing we do. 6. Falsification or failing to complete rounds appropriately will result in immediate termination. <p>TAG A144 CONTINUED BELOW</p>	

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A 144	<p>Continued From page 6</p> <p>BHH on 3/16/21 at 9:21 PM. Review of Patient #1's chart from admission through 3/10/21 at 11:57 AM revealed that Patient #1's mental health provider ordered the "Level of Observation: Every 15 Minutes and Precautions: No Precautions" (a measure taken in advance to prevent something dangerous, unpleasant, or inconvenient from happening). During Patient #1's admission, the BHH staff had 344 opportunities to perform 15-minute checks (where the staff observe the patient's location to ensure the patient is safe). Of the 344 opportunities to perform 15-minute safety checks, on 51 occasions, the hospital staff performed the safety checks longer than 15 minutes after the prior safety check (giving patients an opportunity to engage in inappropriate sexual behavior, fight, or attempt to kill themselves or another patient). On 14 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 16 minutes to 107 minutes (over an hour and a half) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"Unit disruption" "just came on floor" "wifi" Numerous entries failed to include a reason for the late safety check and the staff only documented "."</p>	A 144	<p>TAG A144 CONTINUED</p> <p>Level of Observation policy 1000.17, revised 4/14/21, sections N-Q were updated and revised to include the expectation that patient doors are to be closed and locked when the patient is not in his/her room. Additionally, patients should be encouraged to attend groups or participate in other relevant activities during the day per their treatment plan. If a patient refuses to attend group or other activity and requests to stay in their room, the staff member will provide for the comfort and safety of the patient, monitor the patient per the provider's order for level of observation, document the reason for refusal and notify the provider/ members of the treatment team.</p> <p>The CEO, IC/Nurse Educator and RN House Supervisors are responsible for implementing and monitoring the plan of correction for future compliance with the regulations.</p> <p>TAG A144 ENDS HERE</p>	4/14/2021	

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A 144	<p>Continued From page 7</p> <p>b. The hospital staff admitted Patient #5 on 2/21/21 at 3:02 AM and discharged Patient #5 on 3/8/21 at 11:41 AM. Patient #5's mental health provider ordered the "Level of Observation: Every 15 Minutes" and "Precautions: Suicide precautions." During Patient #5's admission to the BHH, the hospital staff had 2,342 opportunities to perform 15-minute safety checks. Of the 2,342 opportunities to perform 15-minute safety checks, on 85 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 69 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 16 minutes to 108 minutes (over an hour and a half) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"Unit disruption" "discharging patient" "helping other patients" "computers were down for update" "staff" "MHT off unit" "RN busy"</p> <p>c. The hospital staff admitted Patient #7 on 2/27/21 at 10:20 AM and discharged Patient #7 on 3/8/21 at 4:05 PM. Patient #7's mental health provider ordered the "Level of Observation: Every</p>	A 144		

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A 144	<p>Continued From page 8</p> <p>15 Minutes" and "Precautions: Suicide precautions." During Patient #7's admission to the BHH, the hospital staff had 856 opportunities to perform 15-minute safety checks. Of the 856 opportunities to perform 15-minute safety checks, on 76 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 22 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 16 minutes to 108 minutes (over an hour and a half) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"Unit disruption" "checks done" "N/A" "RN busy" "RN distracted" "MHT off unit" "working on discharge" "making me put in reason interval not missed" "off unit" "shift change"</p> <p>7. Review of 7 of 7 closed medical records (patients discharged before survey entrance) revealed the following:</p> <p>a. The hospital staff admitted Patient #2 on 11/17/20 at 10:57 PM and discharged Patient #2 on 12/8/20 at 8:40 AM. Patient #5's mental health</p>	A 144			

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A 144	<p>Continued From page 9</p> <p>provider ordered the "Level of Observation: Every 15 Minutes" and "Precautions: Homicidal, Self-Harm, and Suicide precautions." During Patient #2's admission to the BHH, the hospital staff had 1,986 opportunities to perform 15-minute safety checks. Of the 1,986 opportunities to perform 15-minute safety checks, on 144 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 34 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 16 minutes to 137 minutes (over 2 hours) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"Unit disruption" "staffing" "taking out trash and doing vitals" "calming [patient's name] down" "training" "had to get snacks" "short staffed, MHT obtaining supplies" "no MHT on unit" "sharpening colored pencils" "IT"</p> <p>b) The hospital staff admitted Patient #3 on 2/1/21 at 10:30 AM and discharged Patient #3 on 2/24/21 at 7:45 PM. Patient #3's mental health provider ordered the "Level of Observation: Every</p>	A 144			

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A 144	<p>Continued From page 10</p> <p>15 Minutes" and "Precautions: Assault precautions and Suicide precautions." During Patient #3's admission to the BHH, the hospital staff had 887 opportunities to perform 15 minute safety checks. Of the 887 opportunities to perform 15 minute safety checks, on 86 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 36 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 16 minutes to 84 minutes (almost an hour and a half) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"Unit disruption" "RN distracted" "MHT on break" "MHT off unit" "shift change" "computers were down for update" "I was off unit" "RN busy" "staff" "checks were made but not documented" "tablets not working"</p> <p>c. The hospital staff admitted Patient #4 on 2/1/21 at 7:24 PM and discharged Patient #4 on 2/1/21 at 2:33 PM. Patient #4's mental health provider ordered the "Level of Observation: One to One"</p>	A 144			

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A 144	<p>Continued From page 11</p> <p>on admission (requiring a staff member to stay within 6 feet of Patient #3 at all times). Patient #4's mental health provider later ordered the "Level of Observation: Every 15 minutes," on 1/23/21 at 6:09 PM and "Precautions: Assault." During Patient #4's admission to the BHH, the hospital staff had 1,017 opportunities to perform 15 minute safety checks. Of the 1,017 opportunities to perform 15 minute safety checks, on 76 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 26 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 17 minutes to 162 minutes (over 2.5 hours) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"unit disruption" "off unit" "doing environmental's [rounds]" "looking for belongings" "just got on floor" "staff" "no staff" "tablet froze"</p> <p>d. The hospital staff admitted Patient #6 on 11/18/20 at 5:57 PM and discharged Patient #6 on 12/1/20 at 12:45 PM. Patient #6's mental health provider ordered the "Level of Observation:</p>	A 144			

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A 144	<p>Continued From page 12</p> <p>Every 15 Minutes" and "Precautions: Suicide precautions." During Patient #6's admission to the BHH, the hospital staff had 1,221 opportunities to perform 15 minute safety checks. Of the 1,221 opportunities to perform 15 minute safety checks, on 84 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 27 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 17 minutes to 78 minutes (over an hour and 15 minutes) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"unit disruption" "obtaining supplies" "not with MHT" "staff" "only one MHT log in" "vitals/short staffed" "moving rooms" "short staffed?MHT obtaining supplies" "not with MHT/nurse to chart" "shift change" "Tablet issues"</p> <p>e. The hospital staff admitted Patient #8 on 12/3/20 at 9:53 PM and discharged Patient #8 on 12/11/20 at 4:11 PM. Patient #8's mental health provider ordered the "Level of Observation: Every 15 Minutes" and no precautions. During Patient</p>	A 144			

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A 144	<p>Continued From page 13</p> <p>#8's admission to the BHH, the hospital staff had 713 opportunities to perform 15 minute safety checks. Of the 713 opportunities to perform 15 minute safety checks, on 43 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 15 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 17 minutes to 68 minutes (over an hour) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"unit disruption" "none" "sharpening supplies for patient" "staffing" "talking with patient" "iPads locking up"</p> <p>f. The hospital staff admitted Patient #9 on 11/15/20 at 6:16 AM and discharged Patient #9 on 11/25/20 at 3:25 PM. Patient #9's mental health provider ordered the "Level of Observation: Every 15 Minutes" and "Precautions: Suicide precautions." During Patient #9's admission to the BHH, the hospital staff had 970 opportunities to perform 15 minute safety checks. Of the 970 opportunities to perform 15 minute safety checks, on 43 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 12 occasions, the hospital</p>	A 144			

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A 144	<p>Continued From page 14</p> <p>staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 17 minutes to 91 minutes (an hour and a half) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"unit disruption" "not with tech" "checking another's vitals" "helping sanitize [room] 500" "staff" "training MHT charting" "Not with patient" "discharging a patient" "was in the bathroom" "nurse got busy" "no tablet" "training" "couldn't log into tablet"</p> <p>g. The hospital staff admitted Patient #10 on 10/21/20 at 5:01 PM and discharged Patient #10 on 11/10/20 at 4:55 PM. Patient #10's mental health provider ordered the "Level of Observation: Every 15 Minutes" and "Precautions: No precautions." During Patient #10's admission to the BHH, the hospital staff had 1,920 opportunities to perform 15 minute safety checks. Of the 1,920 opportunities to perform 15 minute safety checks, on 75 occasions the hospital staff performed the safety checks longer than 15</p>	A 144		

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A 144	<p>Continued From page 15</p> <p>minutes after the prior safety check. On 26 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 16 minutes to 369 minutes (over 6 hours) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"unit disruption" "went to make coffee for multiple MHT's" "shift change" "tablet was not working properly" "short staffed" "nurse was suppose to chart while I found belongings" "not enough staff" "discharging a patient" "off unit" "unknown, left on unit/I was not on the unit"</p> <p>8. Observations on 3/8/21 at 4:25 PM revealed the hospital staff paged a "Code White" (indicating a patient had a medical emergency) in the adult 300 wing. All of the staff assigned to the adult 400 wing left the adult 400 wing and responded to the emergency on the adult 300 wing (leaving the patients on the adult 400 wing unsupervised). The hospital staff assigned to the adult 400 wing did not return to the adult 400 wing until 4:45 PM (20 minutes later).</p>	A 144			

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A 144	<p>Continued From page 16</p> <p>9. Observations on 3/9/21 at 1:45 PM, on the adult 400 unit, revealed MHT D escorted several patients outside to the courtyard, so the patients could smoke. The hospital staff left 2 patients unattended while MHT D took the patients to the courtyard. At 2:12 PM, while MHT D took the patients outside, Patient #1 left their room and wandered the adult 400 unit. At 3:10 PM, Patient #1 approached the nurses' station. Patient #1 was crying and requested medication from the nursing staff. The observations revealed that the hospital staff failed to perform observations approximately every 15 minutes on Patient #1 from 1:45 PM to 3:10 PM.</p> <p>Review of Patient #1's medical record revealed that the hospital staff documented performing a safety check on Patient #1 on 3/9/21 at 1:42 PM, indicating they saw Patient #1 in Patient #1's bedroom. The hospital staff documented they next performed a safety check on Patient #1 at 2:16 PM (34 minutes later and during the observations the staff failed to perform a safety check on Patient #1). The hospital staff documented Patient #1 was in the Day Room on the phone. The hospital staff documented the reason they failed to perform the safety checks was "unit disruption."</p> <p>10. Review of a memo, "To: All Staff," dated 2/17/21, from the Director of Nursing (DON) revealed in part, "Not following the standard or rule set forth ... undermines your fellow coworkers ... leaves our milieu (environment that creates a safe, secure place for people who are in therapy, supports the individual in their process toward recovery and wellness) to chance ... a milieu left</p>	A 144			

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A 144	<p>Continued From page 17</p> <p>to chance will fail ... 15 minute checks are not an option, they are mandatory ... They are not to be done from the nurse's station. You must be physically out and about with the patient in order to do these checks ..."</p> <p>11. During an interview on 3/9/2021 at 3:12 PM, the Director of Quality and Risk Management acknowledged the hospital's administrative staff knew the hospital staff did not complete the required safety checks approximately every 15 minutes, as required by the hospital's policy. The hospital's administrative staff had identified the issue during the February quality committee meeting. The hospital's administrative staff had developed an audit system and plan to correct the situation, but they did not implement the auditing and corrective plan, as the hospital's DON left and the hospital staff had to hire a new DON.</p> <p>12. During an interview on 3/11/21 and 8:10 AM, the CEO acknowledged the hospital's administrative staff knew the nursing staff failed to perform patient safety checks approximately every 15 minutes. The CEO had developed a plan to address the problem and reviewed it with the hospital's DON in early February. The hospital staff did not implement the CEO's corrective plan and the nursing staff continued to fail to perform safety checks approximately every 15 minutes.</p>	A 144			

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A 144	Continued From page 18 II. Based on observation, document review, and staff interviews, the behavioral health hospital administrative staff failed to ensure the nursing staff closed and secured patient bedroom doors when the patient was not in the room for 3 of 3 inpatient units (300 hall, 400 hall, and 500 hall). The failure to close the patient's bedroom door and secure an unoccupied patient bedroom could potentially result in the patients having unauthorized access to the rooms, potentially allowing the patients to hide from the hospital staff, and engage in inappropriate sexual behavior or attempt to kill themselves. The hospital's administrative staff identified a census of 25 inpatient behavioral health patients upon entrance. Findings include: 1. Review of a memo dated 11/25/20 from the prior interim DON revealed in part, "Patient rooms can and should be locked during active programming hours and certainly during group times. This is per ... Corporate Policy. If a patient goes to room during these times; it must be authorized and approved by [a Registered Nurse, RN]." 2. Review of the document "ALL STAFF ORIENTATION Week 1 TESTS, Patient Observation Competency" checklist form, revised 5/29/20, revealed in part, "Staff will articulate that the patient bedroom doors [should be] ... closed	A 144			

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A 144	<p>Continued From page 19 and secured when unoccupied."</p> <p>3. Review of a memo from the DON, dated 2/17/21, revealed in part, "Doors are shut and locked unless it is bedtime and patients are sleeping"</p> <p>4. Review of an email sent by the Directory of Quality, Compliance & Risk Management to the House Supervisors, dated 2/17/21 at 12:05 PM, revealed in part, "... [as] I've stated, [not securing and locking the door to a patient's unoccupied room is] a safety issue, so unless the patient is sick or needs to go to the bathroom, the doors should be locked (technically, it's also a security issue)."</p> <p>5. Observations on 3/4/21 at 10:25 AM revealed the hospital staff failed to close and lock the doors to the patients' rooms in the 500 inpatient hall.</p> <p>6. Observations on 3/8/21 at 4:25 PM revealed the staff on the 300 hall paged a "Code White" (a patient experiencing a medical emergency). All of the staff from the 400 hall left the 400 hall and went to the 300 hall, leaving the patients on the 400 hallway unsupervised. The hospital staff also failed to secure and lock the doors to patient room 401, 402, 404, and 405.</p> <p>7. Observations on 3/8/21 at 1:45 PM in the 400 hall revealed the hospital staff took 7 of the 9 patients off the unit, leaving 2 patient unattended on the unit. However, the hospital staff failed to secure and lock the doors to rooms 401, 403, and 405 (potentially allowing the remaining patients to access the rooms and engage in inappropriate behavior or attempt to kill themselves).</p>	A 144			

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A 144	Continued From page 20 8. Observations on 3/11/21 at 11:40 AM, on the 300 hall, revealed the hospital staff failed to secure and lock 1 of 9 patient bedroom doors. Observations on the 400 hall revealed the hospital staff failed to secure and lock 5 of 5 doors to the patients' bedrooms. 9. During an interview on 3/17/21 at 12:05 PM, the Director of Quality, Compliance, and Risk Management, and the CEO, verified they expected the nursing staff to secure and lock the doors to the patients' bedrooms when the bedroom was unoccupied. The Director of Quality, Compliance, and Risk Management indicated they watched the video footage of the events described and verified the hospital staff failed to secure and lock the doors to the patients' rooms when the patients' bedroom was unoccupied.	A 144			
A 385	NURSING SERVICES CFR(s): 482.23 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: I. Based on document review and staff interview, the Behavioral Health Hospital's (BHH) administrative staff failed to: 1. Ensure the nursing staff followed the hospital's safety check policies to ensure the safety of behavioral health patients. Please refer to A-0395.	A 385	TAG A385 BEGINS HERE Re-education on treatment planning and medical treatment planning is occurring with staff with treatment planning responsibilities. Clinical Services staff will be required to complete this training by 4/30/21. The content of the training, to include current policy review, is outlined below: TAG A385 CONTINUED BELOW	4/30/2021	

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A 385	<p>Continued From page 21</p> <p>2. Ensure a registered nurse (RN) adequately assessed all patients. Please refer to A-0395.</p> <p>3. Ensure the nursing staff kept a current nursing care plan that reflected the nursing care and interventions required to meet the patient's needs. Please refer to A-0396.</p> <p>The cumulative effect of these failures and deficient practices resulted in the hospital's inability to ensure the nursing staff provided care individualized to each patients needs in a safe environment. The lack of regular safety checks (approximately every 15 minutes per policy) created a situation which could result in patients attempting to engage in suicide or sexual contact with another patient, without the staff's knowledge. The behavioral health hospital's administrative staff identified a patient census of 25 on entrance.</p> <p>II. During the investigation of incident 96192-C, the on-site survey team identified an Immediate Jeopardy (IJ) situation (a crisis situation that placed the health and safety of patients at risk) related to the Condition of Participation for Nursing Services (42 CFR 482.23). The hospital staff failed to ensure the nursing staff followed their safety check policies and perform safety rounds on patients every 15 minutes, as required.</p> <p>1. The administrative staff failed to initially develop and implement a corrective action plan to ensure the nursing staff performed regular safety checks.</p> <p>2. While on-site, the survey team identified an</p>	A 385	<p>TAG A385 CONTINUED</p> <ul style="list-style-type: none"> - Each patient admitted to the psychiatric unit shall have an individualized treatment plan which is based on interdisciplinary clinical assessments. - The multidisciplinary team is headed by the provider and consists of nursing, therapists, recreational therapists and other health professions as indicated. - Patients are involved in the treatment planning process and sign their treatment plans. - The treatment planning process is continuous, beginning at the time of admission and continuing through discharge with ongoing updates throughout the inpatient timeframe to include interventions, goals and/or safety concerns identified in assessments/ reassessments. - Re-education and review of applicable policies including: <ol style="list-style-type: none"> 1. 1000.0 Plan for Provision of Care 2. 1300.10 Staffing Plan for Provision of Care 3. 1300.31 Assessment/ Reassessment of the Patient 4. 1200.9 Treatment Plan Acute Inpatient <p>TAG A385 CONTINUED BELOW</p>		

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A 385	<p>Continued From page 22</p> <p>Immediate Jeopardy (IJ) situation and notified the administrative staff on 3/15/21 at 3:44 PM. The administrative staff promptly took action to remove the immediacy of the situation. The hospital staff removed the immediacy prior to the survey team exiting the complaint investigation when the hospital administrative staff developed education and re-educated all nursing staff, including Mental Health Technicians, prior to their next scheduled shift. The education provided to include the following:</p> <p>a. Reeducation for the staff on the Levels of Observation policy</p> <p>b. Reeducation on the Safety Slides from new hire orientation focusing on eminency of risk if the staff do not complete the safety checks every 15 minutes.</p> <p>c. Traning Attestation signed by each applicable staff.</p> <p>d. Random shift video observations with validation tool to be completed by assigned staff daily.</p> <p>e. Every 15 minute safety check compliance to be reported in daily morning meeting to Leadership team.</p> <p>f. Continued monitoring of every 15 minute safety checks as Process Improvement Indicator at monthly QAPI committeee meetings.</p> <p>g. Reeducation of all staff to be completed prior to next scheduled shift effective immediately.</p>	A 385	<p>TAG A385 CONTINUED</p> <ul style="list-style-type: none"> - Shift to shift hand-off forms will be revised to include treatment plan updates. The shift to shift hand off forms are reviewed daily. - Treatment Planning and Medical Treatment Planning slides are a point of focus at New Hire Orientation and will be added to the curriculum. - Treatment Plan elements are a PI Indicator and are reviewed/audited for completion weekly with findings reported monthly at QAPI committee meetings. - Treatment Planning Competencies are being signed signifying completion and understanding of Treatment Plan documentation. <p>The CEO, HRD, DCS, IC/Nurse Educator and RN House Supervisors are responsible for implementing and monitoring the plan of correction for future compliance with the regulations.</p> <p>TAG A385 ENDS HERE</p>	

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A 385	Continued From page 23 The following Condition level deficiency remained for the Condition of Participation for Nursing Services (42 CFR 482.23) (A-0385).	A 385		
A 395	<p>RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3)</p> <p>A registered nurse must supervise and evaluate the nursing care for each patient.</p> <p>This STANDARD is not met as evidenced by: I. Based on observation, document review, and staff interviews the Behavioral Health Hospital (BHH) staff failed to supervise patients by performing the 15 Minute Safety Checks for 3 of 3 open patient records reviewed (Patient # 1, Patient #5, and Patient #7) and 7 of 7 closed patient records reviewed (Patient #2, Patient #3, Patient #4, Patient #6, Patient #8, Patient #9, and Patient #10). Failure to perform regular safety checks provided the patients an opportunity to engage in inappropriate behavior, such as potential sexual contact with another patient, attempting suicide, self harm, or assault without staff detection. The BHH administrative staff identified a census of 25 patients upon entrance.</p> <p>Findings include:</p> <p>1. Review of the policy "Locator Rounds Procedure," effective 7/12/20, revealed in part, "... all patients are supervised, at a minimum, every 15 minutes through ... rounds/milieu Locator process."</p> <p>"purpose ... To identify high risk or high alert behaviors ... and implement other precautions as required ... perform rounds at staggered intervals</p>	A 395	<p>TAG A395 BEGINS HERE</p> <p>Education of all Nursing staff including Mental Health Technicians included the following:</p> <ul style="list-style-type: none"> - Reeducation on Levels of Observation policy 1000.17, effective 6/12/20 - Safety Slides from new hire orientation focusing on eminency of risk if Q15s are not complete - Reeducation for MHTs on handoff when leaving the unit or responding to a disturbance - Reeducation for MHTs on walking rounds at shift handoff - Training Attestation signed by each applicable staff - Scheduled shift video observations with validation tool is completed by Leadership team - Nursing/Unit supervisors sign-off of Q15 safety checks is evident on Patient Observation forms at minimum of twice per shift - Q15s compliance is reported in daily morning meeting to Leadership team - Continued monitoring of Q15s as a PI Indicator at monthly QAPI committee meetings <p>TAG A395 CONTINUED</p>	3/15/2021

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A 395	<p>Continued From page 24</p> <p>and in a varying pattern to minimize planned acting out opportunities ... document patient location and behavior" "be aware of times your focus can be diverted: changes in shift, codes, crisis de-escalation, visiting hours, unit staffing ..."</p> <p>"Charge Nurse ... Ensures ... Patient Locator Rounds are occurring as ordered, 24 hours per day, seven days a week ... while monitoring hallways ... patient care areas ensure patients are: ... not entering rooms not assigned to them, not in rooms or areas ... 'off limits' ... not left in treatment areas without direct staff supervision ... participating in their treatment by being where they are directed to be ... not sleeping or otherwise avoiding participation in treatment activities ..."</p> <p>"Hand off assigned patient - Locator rounds to another staff member before leaving the patient treatment area (meals, breaks, emergencies) ... Hand Off from shift to shift ... Off-going and oncoming staff will walk/monitor the unit jointly ... to ensure continuity of care ..."</p> <p>2. Review of the policy "Level of Observation," effective 7/12/20, revealed in part, "The patient is observed with visual checks every 15 minutes" "15 minute observations will occur at random intervals no longer than 15 minutes ... Assigned staff will document the patient's behavior, location, activity, special precautions (if indicated) and level of observation while conforming they are in no danger or distress ... If and/or when a mental health tech [MHT] has to leave the floor, the MHT will notify nursing staff and another MHT or the nurse will replace them on the floor for patient observation until the staff member</p>	A 395	<p>TAG A395 CONTINUED</p> <ul style="list-style-type: none"> - Reeducation of all staff was completed prior to their next scheduled shift. - The new Q15 Attestation and revised 1000.17 Levels of Observation policy (revised 4/14/21), reinforces Eagle View's commitment to keeping our patients safe above all else. - New red-light flashlights and clipboards with digital clocks built in were purchased (4/2/21) and rolled out to staff to facilitate qualitative as well as quantitative Q15s. - Guidance points for Q15s were attached to Safety Check clipboards. Those guidance points include but are not limited to: <ol style="list-style-type: none"> 1. Emphasizing the importance that shift hand-off be peer to peer. 2. Lack of staffing, unit disruption, EHR malfunctions are not considered valid reasons for non-compliance of Safety Checks. 3. Prefilling in the times of the observations is not allowed (on paper forms) 4. Observe sleeping patients with flashlight and be sure to see chest rise and fall at least 3 times. 5. Q15 safety checks are the #1 tool we use to keep patient's safe. It is the most important thing we do. 6. Falsification or failing to complete rounds appropriately will result in immediate termination. 	4/7/2021	

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A 395	Continued From page 25 returns." 3. Review of the policy "Nursing Rounds," effective 7/12/20, revealed in part, "Objectives for rounds for Registered Nurses (minimum 3 times per shift) ... Observe nursing staff performance including mental health workers compliance with patient observation levels." 4. Review of the document, "ALL STAFF ORIENTATION Week 1 TESTS, Patient Observation Competency" checklist form, revised 5/29/20, revealed in part, "While completing the observation, staff will not allow distractions to interfere with patient rounding: Peer to peer conversations, Patient requests, Crisis situations ... **While assigned the patient observations the number one priority will be completing the observation and documentation of the patients ..." 5. Review of 3 of 3 open medical records (patients currently admitted on survey entrance) revealed the following: a. The hospital staff admitted Patient #1 to the BHH on 3/16/21 at 9:21 PM. Review of Patient #1's chart from admission through 3/10/21 at 11:57 AM revealed that Patient #1's mental health provider ordered the "Level of Observation: Every 15 Minutes and Precautions: No Precautions" (a measure taken in advance to prevent something dangerous, unpleasant, or inconvenient from happening). During Patient #1's admission, the BHH staff had 344 opportunities to perform 15 minute checks (where the staff observe the patient's location to ensure the patient is safe). Of the 344 opportunities to perform 15 minute safety checks, on 51 occasions, the hospital staff	A 395	TAG A395 CONTINUED Policy 1000.17 Level of Observation, revised 4/14/21, sections N-Q were updated and revised to include the expectation that patient doors are to be closed and locked when the patient is not in his/her room. Additionally, patients should be encouraged to attend groups or participate in other relevant activities during the day per their treatment plan. If a patient refuses to attend group or other activity and requests to stay in their room, the staff member will provide for the comfort and safety of the patient, monitor the patient per the provider's order for level of observation, document the reason for refusal and notify the provider/ members of the treatment team. TAG A395 CONTINUED ON PAGE 38	4/14/2021	

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A 395	<p>Continued From page 26</p> <p>performed the safety checks longer than 15 minutes after the prior safety check (giving patients an opportunity to engage in inappropriate sexual behavior, fight, or attempt to kill themselves or another patient). On 14 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 16 minutes to 107 minutes (over an hour and a half) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"Unit disruption" "just came on floor" "wifi"</p> <p>Numerous entries failed to include a reason for the late safety check and the staff only documented "."</p> <p>b. The hospital staff admitted Patient #5 on 2/21/21 at 3:02 AM and discharged Patient #5 on 3/8/21 at 11:41 AM. Patient #5's mental health provider ordered the "Level of Observation: Every 15 Minutes" and "Precautions: Suicide precautions." During Patient #5's admission to the BHH, the hospital staff had 2,342 opportunities to perform 15 minute safety checks. Of the 2,342 opportunities to perform 15 minute safety checks, on 85 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 69 occasions, the hospital</p>	A 395			

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A 395	<p>Continued From page 27</p> <p>staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 16 minutes to 108 minutes (over an hour and a half) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"Unit disruption" "discharging patient" "helping other patients" "computers were down for update" "staff" "MHT off unit" "RN busy"</p> <p>c. The hospital staff admitted Patient #7 on 2/27/21 at 10:20 AM and discharged Patient #7 on 3/8/21 at 4:05 PM. Patient #7's mental health provider ordered the "Level of Observation: Every 15 Minutes" and "Precautions: Suicide precautions." During Patient #7's admission to the BHH, the hospital staff had 856 opportunities to perform 15 minute safety checks. Of the 856 opportunities to perform 15 minute safety checks, on 76 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 22 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 16 minutes to 108 minutes (over an hour and a half) after the prior</p>	A 395			

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A 395	<p>Continued From page 28 safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"Unit disruption" "checks done" "N/A" "RN busy" "RN distracted" "MHT off unit" "working on discharge" "making me put in reason interval not missed" "off unit" "shift change"</p> <p>6. Review of 7 of 7 closed medical records (patients discharged before survey entrance) revealed the following:</p> <p>a. The hospital staff admitted Patient #2 on 11/17/20 at 10:57 PM and discharged Patient #2 on 12/8/20 at 8:40 AM. Patient #5's mental health provider ordered the "Level of Observation: Every 15 Minutes" and "Precautions: Homicidal, Self-Harm, and Suicide precautions." During Patient #2's admission to the BHH, the hospital staff had 1,986 opportunities to perform 15 minute safety checks. Of the 1,986 opportunities to perform 15 minute safety checks, on 144 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 34 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed</p>	A 395			

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A 395	<p>Continued From page 29</p> <p>the safety checks between 16 minutes to 137 minutes (over 2 hours) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"Unit disruption" "staffing" "taking out trash and doing vitals" "calming [patient's name] down" "training" "had to get snacks" "short staffed, MHT obtaining supplies" "no MHT on unit" "sharpening colored pencils" "IT"</p> <p>b) The hospital staff admitted Patient #3 on 2/1/21 at 10:30 AM and discharged Patient #3 on 2/24/21 at 7:45 PM. Patient #3's mental health provider ordered the "Level of Observation: Every 15 Minutes" and "Precautions: Assault precautions and Suicide precautions." During Patient #3's admission to the BHH, the hospital staff had 887 opportunities to perform 15 minute safety checks. Of the 887 opportunities to perform 15 minute safety checks, on 86 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 36 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 16 minutes to 84</p>	A 395			

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A 395	<p>Continued From page 30</p> <p>minutes (almost an hour and a half) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"Unit disruption" "RN distracted" "MHT on break" "MHT off unit" "shift change" "computers were down for update" "I was off unit" "RN busy" "staff" "checks were made but not documented" "tablets not working"</p> <p>c. The hospital staff admitted Patient #4 on 2/1/21 at 7:24 PM and discharged Patient #4 on 2/1/21 at 2:33 PM. Patient #4's mental health provider ordered the "Level of Observation: One to One" on admission (requiring a staff member to stay within 6 feet of Patient #3 at all times). Patient #4's mental health provider later ordered the "Level of Observation: Every 15 minutes," on 1/23/21 at 6:09 PM and "Precautions: Assault." During Patient #4's admission to the BHH, the hospital staff had 1,017 opportunities to perform 15 minute safety checks. Of the 1,017 opportunities to perform 15 minute safety checks, on 76 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 26 occasions, the hospital staff performed the safety checks longer than 30</p>	A 395			

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A 395	<p>Continued From page 31</p> <p>minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 17 minutes to 162 minutes (over 2.5 hours) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"unit disruption" "off unit" "doing environmental's [rounds]" "looking for belongings" "just got on floor" "staff" "no staff" "tablet froze"</p> <p>d. The hospital staff admitted Patient #6 on 11/18/20 at 5:57 PM and discharged Patient #6 on 12/1/20 at 12:45 PM. Patient #6's mental health provider ordered the "Level of Observation: Every 15 Minutes" and "Precautions: Suicide precautions." During Patient #6's admission to the BHH, the hospital staff had 1,221 opportunities to perform 15 minute safety checks. Of the 1,221 opportunities to perform 15 minute safety checks, on 84 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 27 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 17 minutes to 78 minutes (over an hour and 15 minutes) after the</p>	A 395			

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A 395	<p>Continued From page 32 prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"unit disruption" "obtaining supplies" "not with MHT" "staff" "only one MHT log in" "vitals/short staffed" "moving rooms" "short staffed?MHT obtaining supplies" "not with MHT/nurse to chart" "shift change" "Tablet issues"</p> <p>e. The hospital staff admitted Patient #8 on 12/3/20 at 9:53 PM and discharged Patient #8 on 12/11/20 at 4:11 PM. Patient #8's mental health provider ordered the "Level of Observation: Every 15 Minutes" and no precautions. During Patient #8's admission to the BHH, the hospital staff had 713 opportunities to perform 15 minute safety checks. Of the 713 opportunities to perform 15 minute safety checks, on 43 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 15 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 17 minutes to 68 minutes (over an hour) after the prior safety check.</p>	A 395			

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A 395	<p>Continued From page 33</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p> <p>"unit disruption" "none" "sharpening supplies for patient" "staffing" "talking with patient" "iPads locking up"</p> <p>f. The hospital staff admitted Patient #9 on 11/15/20 at 6:16 AM and discharged Patient #9 on 11/25/20 at 3:25 PM. Patient #9's mental health provider ordered the "Level of Observation: Every 15 Minutes" and "Precautions: Suicide precautions." During Patient #9's admission to the BHH, the hospital staff had 970 opportunities to perform 15 minute safety checks. Of the 970 opportunities to perform 15 minute safety checks, on 43 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 12 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 17 minutes to 91 minutes (an hour and a half) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p>	A 395			

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A 395	<p>Continued From page 34</p> <p>"unit disruption" "not with tech" "checking another's vitals" "helping sanitize [room] 500" "staff" "training MHT charting" "Not with patient" "discharging a patient "was in the bathroom" "nurse got busy" "no tablet" "training" "couldn't log into tablet"</p> <p>g. The hospital staff admitted Patient #10 on 10/21/20 at 5:01 PM and discharged Patient #10 on 11/10/20 at 4:55 PM. Patient #10's mental health provider ordered the "Level of Observation: Every 15 Minutes" and "Precautions: No precautions." During Patient #10's admission to the BHH, the hospital staff had 1,920 opportunities to perform 15 minute safety checks. Of the 1,920 opportunities to perform 15 minute safety checks, on 75 occasions the hospital staff performed the safety checks longer than 15 minutes after the prior safety check. On 26 occasions, the hospital staff performed the safety checks longer than 30 minutes after the prior safety check. Review of the safety checks revealed the staff performed the safety checks between 16 minutes to 369 minutes (over 6 hours) after the prior safety check.</p> <p>For every safety check over 15 minutes, the hospital staff had to document a reason why the staff failed to complete the check within 15 minutes. The reasons the staff documented included:</p>	A 395			

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A 395	<p>Continued From page 35</p> <p>"unit disruption" "went to make coffee for multiple MHT's" "shift change" "tablet was not working properly" "short staffed" "nurse was suppose to chart while I found belongings" "not enough staff" "discharging a patient" "off unit" "unknown, left on unit/I was not on the unit"</p> <p>7. Observations on 3/8/21 at 4:25 PM revealed the hospital staff paged a "Code White" (indicating a patient had a medical emergency) in the adult 300 wing. All of the staff assigned to the adult 400 wing left the adult 400 wing and responded to the emergency on the adult 300 wing (leaving the patients on the adult 400 wing unsupervised). The hospital staff assigned to the adult 400 wing did not return to the adult 400 wing until 4:45 PM (20 minutes later).</p> <p>8. Observations on 3/9/21 at 1:45 PM, on the adult 400 unit, revealed MHT D escorted several patients outside to the courtyard, so the patients could smoke. The hospital staff left 2 patients unattended while MHT D took the patients to the courtyard. At 2:12 PM, while MHT D took the patients outside, Patient #1 left their room and wandered the adult 400 unit. At 3:10 PM, Patient #1 approached the nurses' station. Patient #1 was crying and requested medication from the nursing staff. The observations revealed that the hospital staff failed to perform observations</p>	A 395			

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A 395	<p>Continued From page 36</p> <p>approximately every 15 minutes on Patient #1 from 1:45 PM to 3:10 PM.</p> <p>Review of Patient #1's medical record revealed that the hospital staff documented performing a safety check on Patient #1 on 3/9/21 at 1:42 PM, indicating they saw Patient #1 in Patient #1's bedroom. The hospital staff documented they next performed a safety check on Patient #1 at 2:16 PM (34 minutes later and during the observations the staff failed to perform a safety check on Patient #1). The hospital staff documented Patient #1 was in the Day Room on the phone. The hospital staff documented the reason they failed to perform the safety checks was "unit disruption."</p> <p>9. Review of a memo, "To: All Staff," dated 2/17/21, from the Director of Nursing (DON) revealed in part, "Not following the standard or rule set forth ... undermines your fellow coworkers ... leaves our milieu (environment that creates a safe, secure place for people who are in therapy, supports the individual in their process toward recovery and wellness) to chance ... a milieu left to chance will fail ... 15 minute checks are not an option, they are mandatory ... They are not to be done from the nurse's station. You must be physically out and about with the patient in order to do these checks ..."</p> <p>10. During an interview on 3/9/2021 at 3:12 PM, the Director of Quality and Risk Management acknowledged the hospital's administrative staff knew the hospital staff did not complete the required safety checks approximately every 15 minutes, as required by the hospital's policy. The hospital's administrative staff had identified the</p>	A 395			

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A 395	<p>Continued From page 37</p> <p>issue during the February quality committee meeting. The hospital's administrative staff had developed an audit system and plan to correct the situation, but they did not implement the auditing and corrective plan, as the hospital's DON left and the hospital staff had to hire a new DON.</p> <p>11. During an interview on 3/11/21 and 8:10 AM, the CEO acknowledged the hospital's administrative staff knew the nursing staff failed to perform patient safety checks approximately every 15 minutes. The CEO had developed a plan to address the problem and reviewed it with the hospital's DON in early February. The hospital staff did not implement the CEO's corrective plan and the nursing staff continued to fail to perform safety checks approximately every 15 minutes.</p> <p>II. Based on document review and staff interview, the Behavioral Health Hospital (BHH) administrative staff failed to ensure a registered nurse (RN) fully assessed 1 of 6 patients (Patient #2) to determine if the patient posed a potential risk to other patients. Failure to fully assess the patient on an ongoing basis to determine the patient's condition potentially resulted in the hospital staff failing to identify a patient with a prior sexual history which could place other patients at risk for the patient engaging in sexual behavior with them. The Behavioral Health Administrative staff identified a census of 25 patients upon entrance.</p>	A 395	<p>TAG A395 CONTINUED</p> <p>Re-education on the assessment/ reassessment process of potentially high-risk behaviors and treatment planning, is occurring for staff with treatment/care planning responsibilities. Attending Providers, A&R Assessors, Patient Care Nurses and Clinical Therapists will be required to complete this training by 4/30/21. If not completed by due date, staff will be taken off the schedule until completion. The content of the training, to include current policy review, is outlined below:</p> <p>TAG A395 CONTINUED BELOW</p>	4/30/2021	

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A 395	Continued From page 38 Findings include: 1. Review of the policy "Plan for Provision of Care," effective 6/12/20, revealed in part, "... Assessment ... begins on admission ... is integral to the treatment process ... [the] treatment planning is individualized according to individual needs identified through assessments ..." "[The] primary goal of nursing service ... [is] to provide planned, comprehensive, therapeutic, safe and consistent nursing care 24 hours a day, seven days a week." "Psychiatric nursing is a specialized area of professional nursing practice ... [with the] primary activities [aimed at the] ... establishment of trusting, therapeutic relationship ... through daily, consistent contact ... [with] additional responsibilities [including] ... providing therapeutic contact (milieu)." 2. Review of the policy "Hospital Plan for Provision of Nursing Care," effective 6/12/20, revealed in part, "NURSING RESPONSIBILITIES/SCOPE OF PRACTICE ... Nursing Standards of Practice ... Standard II ... nurse continuously collects data which is comprehensive, accurate, and systematic." "Standard V-E - Intervention: Therapeutic Environment ... nurse provides, structures, and maintains a therapeutic environment in collaboration with ... other health care providers." "Standard VII - Interdisciplinary Collaboration ... nurse collaborates with other health care providers in assessing, planning, implementing, and evaluating ..." 3. Review of the policy "Staffing Plan for Provision of Care," effective 6/12/21, revealed in part, "[the] nurse is expected to ... Formulate a nursing diagnosis through observation of the patient's	A 395	TAG A395 CONTINUED RISK ASSESSMENT/REASSESSMENT: 1. The initial patient assessment tool will be revised to include questions that address trauma history and potentially high risk behaviors which may include but are not limited to, Risk of Harm to Self or Others (physically, sexually, or emotionally). 2. Nursing Admission Assessment will also assess the patient's history of trauma related to sexual abuse and sexual history (Statement of sexual abuse/neglect history, abusing others, general sexual history, patterns of satisfaction/dissatisfaction with sexual behavior pattern, reproductive patterns, orientation.) 3. If sexual issues or other high risk behaviors are identified, the provider will be notified and if indicated, the provider will place the patient on the appropriate precautions. The Treatment Team will be notified and an individualized problem will be added to the treatment plan 4. Revision of high-risk hand off tool designed to communicate identified high-risk behaviors in A&R which is handed off to admitting RN. 5. Education of the revised admission assessment, revised High Risk Hand-Off form, and re-education of Policy 1000.23 Sexually Acting Out Precautions, will be completed with all attending providers, A & R assessors, nursing and clinical therapists (by 4/30/21). Staff not completing the education by 4/30/21 will be removed from the schedule and expected to complete the education before their next scheduled shift.	4/30/2021	

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A 395	<p>Continued From page 39</p> <p>condition and behavior and through interpretation of information obtained from the patient and others including ... other healthcare team members ..." "Formulate a plan of care, in collaboration with ... [the] patient ... other healthcare team members which ... provides for the patient's safety, ... protection ..." "Evaluate effectiveness of the plan and modify plan as needed ..." "Specifically, ... nurses shall use the assessment skills initially and on an ongoing basis to determine ... necessary interventions ... for effectiveness ... modifications shall be made ... based on nurse's evaluation ..."</p> <p>4. Review of Patient #2's medical record revealed the hospital staff admitted Patient #2 (an adolescent male) on 11/17/20 at 10:57 PM. The admitting provider, Psychiatric Mental Health Nurse Practitioner N (PMHNP - an advanced practice registered nurse trained to autonomously diagnose, conduct therapy, prescribe medications for patients with psychiatric disorders, provide emergency psychiatric services, perform psychosocial and physical assessments, develop treatment plans, and manage patient care) ordered the nursing staff to observe Patient #2 every 15 minutes. PMHNP N ordered the nursing staff to place Patient #2 on homicidal and self harm/suicidal precautions (instructions to the nursing staff to watch for Patient #2 to attempt to kill themselves or others).</p> <p>PMHNP N completed the "Initial Psychiatric Evaluation" of Patient #2 on 11/18/20 at 4:57 PM (the day after Patient #2's admission to the hospital). During the assessment, Patient #2 reported, in addition to thoughts of killing themselves and issues with aggression, Patient #2 had a prior criminal charge of attempted</p>	A 395	<p>TAG A395 CONTINUED</p> <p>TREATMENT PLAN:</p> <ul style="list-style-type: none"> Each patient admitted to the psychiatric unit shall have an individualized treatment/care plan which is based on interdisciplinary clinical assessments. (The multidisciplinary team is headed by the provider and consists of nursing, therapists, recreational therapists, and other health professions as indicated). The treatment planning process is continuous, beginning at time of admission and continuing through discharge. The registered nurse prioritizes treatment goals and/or interventions with updates to include changes identified in clinical and nursing assessments/reassessments. The re-education indicates that if staff recognize or observe patient behavior or a change in condition the treatment plan is updated with appropriate goals and interventions by the nurse prior to the end of shift. Re-education and review of applicable policies including: <ol style="list-style-type: none"> 1000.0 Plan for Provision of Care 1300.10 Staffing Plan for Provision of Care 1300.31 Assessment/ Reassessment of the Patient 1200.9 Treatment Plan Acute Inpatient <p>TAG A395 CONTINUED BELOW</p>		

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A 395	<p>Continued From page 40</p> <p>homicide and some "sexual stuff." PMHNP N failed to explain and/or document what Patient #2 meant by "sexual stuff" during the "Initial Psychiatric Evaluation" and during subsequent meetings with Patient #2.</p> <p>Further review of Patient #2's medical record revealed Social Worker O completed the "New Psychosocial" assessment on 11/19/20 at 8:29 AM. During the assessment, Patient #2 answered "yes" to the question "History of Sexual Assault:" and reported "legal history with some 'sexual stuff'". Social Worker O failed to explain and/or document what Patient #2 identified as their history of sexual assault and what Patient #2 meant by "sexual stuff."</p> <p>4. During an interview on 3/9/2020 at 11:00 AM, PMHNP L revealed they spoke with Patient #2 during the initial psychiatric evaluation. Patient #2 revealed they had a legal history that included some "sexual stuff." PMHNP L could not remember if they further assessed Patient #2's statement about "sexual stuff" to determine if Patient #2 presented a sexual risk to other patients in the inpatient adolescent behavioral health unit. PMHNP L acknowledged that, even if they did fully assess Patient #2's statement about "sexual stuff", PMHNP L failed to document their findings so that other hospital staff had access to the information PMHNP L obtained during Patient #2's initial psychiatric evaluation, so that other staff could provide appropriate treatment to Patient # 2 and ensure the safety of the other patients on the inpatient adolescent behavioral health unit.</p>	A 395	<p>TAG A395 CONTINUED</p> <p>Treatment Plan elements are a PI Indicator and are reviewed/audited for completion weekly with findings reported monthly at QAPI committee meetings. Treatment care plans are audited for the following:</p> <ul style="list-style-type: none"> ▪ Completion of Patient goals in their own words ▪ That 2-3 strengths are documented. ▪ Criteria and Process for patients expected successful transfer or discharge. Which is discussed with the patient and documented. ▪ Treatment goals are established and documented upon admission and revised as needed. ▪ Treatment goals are updated and re-evaluated at a minimum of every 7 days or if there is an observation of a change of behavior or patient condition. ▪ Signatures, titles, and goals are all documented with date and time of treatment plan review. <p>TAG A395 CONTINUED BELOW</p>		

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A 395	Continued From page 41 5. During an interview on 3/10/21 at 1:32 PM, Social Worker O revealed they spoke to Patient #2 during the psychosocial assessment interview. Patient #2 revealed they had a history of sexual assault and had a legal history that included "sexual stuff". Social Worker O revealed they asked Patient #2 to explain the history of sexual assault and "sexual stuff." Patient #2 declined to explain and refused to talk about it further. All of Social Worker O's remaining interactions with Patient #2 occurred in a group therapy setting. Social Worker O failed to conduct any further evaluation regarding Patient #2's history of sexual assault of "sexual stuff" to determine if Patient #2 presented a sexual risk to other patients in the inpatient adolescent behavioral health unit. 6. Review of an incident report, dated 11/28/20 at 8:00 PM, revealed the nursing staff found a piece of paper in Patient #2's shoe which contained the social media contact information for Patient #6 on the paper. 7. Review of an incident report, dated 11/30/20 at 8:30 PM - 9:00 PM, revealed the nursing staff discovered Patient #6 (a female adolescent 5 years younger than Patient #2) hidden in Patient #2's bathroom. Mental Health Technician (MHT) H later found Patient #6 in Patient #2's room with the door closed. Patient #6 told MHT H 3 times that Patient #6 and Patient #2 "were just talking." MHT H notified the RN on duty, and the RN on duty notified House Supervisor P. House Supervisor P instructed the nursing staff to relocate Patient #6 from a room across the hall from Patient #2's room to a room close to the	A 395	TAG A395 CONTINUED Nursing assessments/reassessments are a PI Indicator and are reviewed/ audited to ensure critical elements of the treatment plan have been followed up on and added as a treatment goal/ intervention. The findings are reported monthly at QAPI committee meetings. * An Attestation for Re-Training on Treatment Planning & Nursing Assessment/Reassessment Competencies will be signed signifying completion and understanding. The CEO, DCS, IC/Nurse Educator and RN House Supervisors are responsible for implementing and monitoring the plan of correction for future compliance with the regulations. TAG A395 ENDS HERE	

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A 395	Continued From page 42 nurses' station. House Supervisor P documented that "Both patients to remain 10 feet apart at all times. No exceptions." 8. Review of Patient #2's treatment plan revealed the nursing staff failed to identify any potential or actual problems related to Patient #2 having a sexual risk to themselves or other patients. Patient #2's treatment plan lacked interventions such as observation for potential inappropriate sexual behavior such as adolescent grooming (befriending and establishing an emotional connection to lower inhibitions with the objective of sexual abuse). The failure of PMHNP L, Social Worker O, and the nursing staff to fully assess and evaluate Patient #2's history of "sexual stuff" could result in the nursing staff missing an opportunity to add important significant safety interventions to the patient's plan of care to prevent potential inappropriate interactions and/or sexual activity between adolescent patients.	A 395			
A 396	NURSING CARE PLAN CFR(s): 482.23(b)(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient that reflects the patient's goals and the nursing care to be provided to meet the patient's needs. The nursing care plan may be part of an interdisciplinary care plan. This STANDARD is not met as evidenced by: Based on document review and staff interviews, the Behavioral Health Hospital (BHH) administrative staff failed to ensure the nursing staff kept a current nursing care plan that	A 396	TAG A396 BEGINS HERE Re-education on treatment planning and medical treatment planning is occurring with staff with treatment planning responsibilities. Clinical Services staff will be required to complete this training by 4/30/21. The content of the training, to include current policy review, is outlined below:	4/30/2021	

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NAME OF PROVIDER OR SUPPLIER EAGLE VIEW BEHAVIORAL HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 770 TANGLEFOOT LANE BETTENDORF, IA 52722	
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A 396	<p>Continued From page 43</p> <p>reflected the nursing care and interventions required to meet the patient's needs in 1 of 6 patient records reviewed (Patient #2). Failure to reassess a patient's (Patient #2) nursing care needs, add appropriate nursing interventions, and revise the care plan may result in the nursing staff failing to fully meet the patient's care needs, and potentially result in the staff failing to provide necessary supervision to potentially prevent a patient from engaging in inappropriate sexual behavior with another patient. The BHH administrative staff reported a census of 25 patients upon entrance.</p> <p>Findings include:</p> <p>1. Review of the policy "Plan for the Provision of Care," effective 6/12/20, revealed in part, "... multidisciplinary approach to treatment planning ... [includes the] patient's physicians, nursing staff, clinical staff, counselors, mental health technicians, teachers, and recreation therapists ..." "Treatment planning is individualized ... according to individual needs identified through assessments ..." "[The] nurse initiates the preliminary plan based upon findings ..." "[The] nursing staff and Clinical Services staff ... [are] responsible for ... revisions of the treatment plan ... on an ongoing basis ..." "Treatment plans are reassessed ... and revised as needed ..." "[The] primary goal of nursing service ... [is] to provide planned, comprehensive, therapeutic, safe and consistent nursing care 24 hours a day, seven days a week."</p> <p>2. Review of the policy "Pre-Admission Screening and Admission Process," effective 6/12/20, revealed in part, "... treatment plan based on the Progress Notes, interdisciplinary assessments,</p>	A 396	<p>TAG A396 CONTINUED</p> <ul style="list-style-type: none"> - Each patient admitted to the psychiatric unit shall have an individualized treatment plan which is based on interdisciplinary clinical assessments. - The multidisciplinary team is headed by the provider and consists of nursing, therapists, recreational therapists and other health professions as indicated. - Patients are involved in the treatment planning process and sign their treatment plans. - The treatment planning process is continuous, beginning at the time of admission and continuing through discharge with ongoing updates throughout the inpatient timeframe to include interventions, goals and/or safety concerns identified in assessments/ reassessments. - Re-education and review of applicable policies including: <ol style="list-style-type: none"> 1. 1000.0 Plan for Provision of Care 2. 1300.10 Staffing Plan for Provision of Care 3. 1300.31 Assessment/ Reassessment of the Patient 4. 1200.9 Treatment Plan Acute Inpatient <p>TAG A396 CONTINUED BELOW</p>	

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A 396	<p>Continued From page 44 physician notes ..."</p> <p>3. Review of the policy "Staffing Plan for Provision of Care," effective 6/12/20, revealed in part, "... To identify nursing care needs of ... [the] patient ... " [The] registered nurses use ... assessment skills initially and on an ongoing basis to determine ... necessary interventions ... target positive patient outcome ..." "A competent registered nurse is expected to ... formulate a nursing diagnosis through observation of the patient's condition and behavior and through interpretation of information obtained from the patient and others including ... healthcare team members ... "Formulate a plan of care ... [that] provides for ... safety ... protection and ... evaluate the effectiveness of the plan of care and modify the plan as needed ..." "A registered nurse plans, prescribes, delegates, supervises and evaluates the nursing care of each patient on a 24-[hour] basis ..."</p> <p>4. Review of the policy "Assessment & Reassessment of the Patient," effective 6/12/20, revealed in part, "... the Registered Nurse is responsible for assessing the patient and prioritizing the plan of care ..." "Each patient is reassessed every shift and as ... needs are warranted ..." "Reassessment is done to determine ... response to treatment and to update the patient's treatment plan ..."</p> <p>5. Review of Patient #2's medical record revealed the hospital staff admitted Patient #2 (an adolescent male) on 11/17/20 at 10:57 PM. The admitting provider, Psychiatric Mental Health Nurse Practitioner N (PMHNP - an advanced practice registered nurse trained to autonomously diagnose, conduct therapy, prescribe medications for patients with psychiatric disorders, provide</p>	A 396	<p>TAG A396 CONTINUED</p> <ul style="list-style-type: none"> - Shift to shift hand-off forms will be revised to include treatment plan updates. The shift to shift hand off forms are reviewed daily. - Treatment Planning and Medical Treatment Planning slides are a point of focus at New Hire Orientation and will be added to the curriculum. - Treatment Plan elements are a PI Indicator and are reviewed/audited for completion weekly with findings reported monthly at QAPI committee meetings. - Treatment Planning Competencies are being signed signifying completion and understanding of Treatment Plan documentation. <p>The CEO, HRD, DCS, IC/Nurse Educator and RN House Supervisors are responsible for implementing and monitoring the plan of correction for future compliance with the regulations.</p> <p>TAG A396 ENDS HERE</p>		

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A 396	<p>Continued From page 45</p> <p>emergency psychiatric services, perform psychosocial and physical assessments, develop treatment plans, and manage patient care) ordered the nursing staff to observe Patient #2 every 15 minutes. PMHNP N ordered the nursing staff to place Patient #2 on homicidal and self harm/suicidal precautions (instructions to the nursing staff to watch for Patient #2 to attempt to kill themselves or others).</p> <p>PMHNP N completed the "Initial Psychiatric Evaluation" of Patient #2 on 11/18/20 at 4:57 PM (the day after Patient #2's admission to the hospital). During the assessment, Patient #2 reported, in addition to thoughts of killing themselves and issues with aggression, Patient #2 had a prior criminal charge of attempted homicide and some "sexual stuff." PMHNP N failed to explain and/or document what Patient #2 meant by "sexual stuff" during the "Initial Psychiatric Evaluation" and during subsequent meetings with Patient #2.</p> <p>Further review of Patient #2's medical record revealed Social Worker O completed the "New Psychosocial" assessment on 11/19/20 at 8:29 AM. During the assessment, Patient #2 answered "yes" to the question "History of Sexual Assault:" and reported "legal history with some 'sexual stuff'". Social Worker O failed to explain and/or document what Patient #2 identified as their history of sexual assault and what Patient #2 meant by "sexual stuff."</p> <p>6. During an interview on 3/9/2020 at 11:00 AM, PMHNP L revealed they spoke with Patient #2 during the initial psychiatric evaluation. Patient #2 revealed they had a legal history that included</p>	A 396			

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A 396	<p>Continued From page 46</p> <p>some "sexual stuff." PMHNP L could not remember if they further assessed Patient #2's statement about "sexual stuff" to determine if Patient #2 presented a sexual risk to other patients in the inpatient adolescent behavioral health unit. PMHNP L acknowledged that, even if they did fully assess Patient #2's statement about "sexual stuff", PMHNP L failed to document their findings so that other hospital staff had access to the information PMHNP L obtained during Patient #2's initial psychiatric evaluation, so that other staff could provide appropriate treatment to Patient # 2 and ensure the safety of the other patients on the inpatient adolescent behavioral health unit.</p> <p>7. During an interview on 3/10/21 at 1:32 PM, Social Worker O revealed they spoke to Patient #2 during the psychosocial assessment interview. Patient #2 revealed they had a history of sexual assault and had a legal history that included "sexual stuff". Social Worker O revealed they asked Patient #2 to explain the history of sexual assault and "sexual stuff." Patient #2 declined to explain and refused to talk about it further. All of Social Worker O's remaining interactions with Patient #2 occurred in a group therapy setting. Social Worker O failed to conduct any further evaluation regarding Patient #2's history of sexual assault of "sexual stuff" to determine if Patient #2 presented a sexual risk to other patients in the inpatient adolescent behavioral health unit.</p> <p>8. Review of an incident report, dated 11/28/20 at 8:00 PM, revealed the nursing staff found a piece of paper in Patient #2's shoe which contained the</p>	A 396			

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A 396	<p>Continued From page 47</p> <p>social media contact information for Patient #6 on the paper.</p> <p>9. Review of an incident report, dated 11/30/20 at 8:30 PM - 9:00 PM, revealed the nursing staff discovered Patient #6 (a female adolescent 5 years younger than Patient #2) hidden in Patient #2's bathroom. Mental Health Technician (MHT) H later found Patient #6 in Patient #2's room with the door closed. Patient #6 told MHT H 3 times that Patient #6 and Patient #2 "were just talking." MHT H notified the RN on duty, and the RN on duty notified House Supervisor P. House Supervisor P instructed the nursing staff to relocate Patient #6 from a room across the hall from Patient #2's room to a room close to the nurses' station. House Supervisor P documented that "Both patients to remain 10 feet apart at all times. No exceptions."</p> <p>10. During an interview on 3/10/21 at 4:38 PM, RN Q revealed that another unknown nurse, possibly during a shift report, to watch Patient #2 and Patient #6 together, as the nursing staff noticed Patient #2 and Patient #6 becoming "chummy." RN Q and the nursing staff had concerns because Patient #2 and Patient #6 were of opposite sexes and Patient #2 was 5 years older than Patient #6.</p> <p>RN Q informed the other nurses verbally, during shift change report, about the interactions between Patient #2 and Patient #6. However, RN Q could not recall if they documented the interactions in either Patient #2's or Patient #6's medical record.</p>	A 396			

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A 396	<p>Continued From page 48</p> <p>11. During an interview on 3/10/21 at 2:46 PM, MHT H revealed that an unknown staff member instructed MHT H to watch Patient #2 and Patient #6, as "they were getting touchy feely." MHT H discovered Patient #6 hiding in Patient #2's bathroom on 11/30/20. Patient #2 was hiding behind Patient #6's bathroom door, in a closed room, when MHT H discovered Patient #2. MHT H separated the patients and informed RN E and House Supervisor K. MHT H completed the incident report.</p> <p>12. During an interview on 3/9/21 at 7:30 AM, RN E revealed they worked as the nurse on duty in the adolescent unit on 11/30/20 (the night staff discovered Patient #6 in Patient #2's room). After MHT H discovered Patient #2 in Patient #6's room, RN E contacted House Supervisor K for guidance. House Supervisor K instructed RN E to separate Patient #2 and Patient #6, keep them physically separated, and move Patient #6 closer to the nurses' station to allow the nursing staff to keep a closer eye on Patient #2 and Patient #6. RN E did not recall modifying either patient's care plan to reflect the new interventions placed after the staff discovered Patient #2 in Patient #6's bedroom.</p> <p>13. During an interview on 3/16/21 at 3:00 PM, House Supervisor K revealed they were working as the House Supervisor on 11/30/20, the night when MHT H found Patient #6 in Patient #2's bathroom. House Supervisor K directed RN E to keep Patient #2 and Patient #6 10 feet apart at all times and move Patient #6 to a room closer to the nurses' station. House Supervisor K told RN E to inform the oncoming nursing shift about the situation and have the therapist evaluate the situation to determine if the situation required any</p>	A 396			

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A 396	Continued From page 49 other follow-up actions. House Supervisor K intended for the interdisciplinary team to identify the long term plan on the following day (12/1/20). 14. Review of Patient #2's treatment plan (nursing care plan) lacked evidence of the staff identifying potential or actual problems related to Patient #2 being a sexual risk to other patients and the treatment plan lacked evidence of any interventions such as the staff observing for potential inappropriate sexual behavior, such as adolescent grooming (befriending and establishing an emotional connection to lower inhibitions with the objective of sexual abuse). The failure of PMHNP L, Social Worker O, and the nursing staff to fully assess and evaluate Patient #2's history of "sexual stuff" could result in the nursing staff missing an opportunity to add important significant safety interventions to the patient's plan of care to prevent potential inappropriate interactions and/or sexual activity between adolescent patients. The treatment plan/care plan lacked any modifications and/or added interventions to ensure the potential safety of all adolescent patients following the incident on 11/28/20 at 8:00 PM (when staff found Patient #6's social media contact information in Patient #2 shoe) and 11/30/20 at 8:30 PM (when staff found Patient #6 in Patient #2's bathroom, behind closed doors).	A 396			
A 438	FORM AND RETENTION OF RECORDS CFR(s): 482.24(b) The hospital must maintain a medical record for each inpatient and outpatient. Medical records	A 438	TAG A438 BEGINS HERE In addition to the Plan of Correction for TAGS A144 & A395 provided on 3/15/2021 prior to survey exit, and after reviewing the deficiencies cited in this report, the following action items were implemented:		

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A 438	<p>Continued From page 50</p> <p>must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.</p> <p>This STANDARD is not met as evidenced by: Based on observation, document review, and staff interviews, the behavioral health hospital administrative staff failed to ensure the nursing staff accurately documented patient observations for 1 of 9 observed patients (Patient #1) in the 400 hall inpatient unit. Failure to ensure the nursing staff accurately documented patient observations potentially resulted in the nursing staff lacking a complete understanding of a patient's behavior and implement appropriate treatments for the patient. The behavioral health hospital's administrative staff identified a census of 25 patients on admission.</p> <p>Findings include:</p> <p>1. Review of the policy "General Guidelines EMR (electronic medical record) Documentation," revealed in part, "... to ensure complete, accurate and timely electronic medical records medical record is an accurate, prompt recording of their observations including relevant information about the patient, the patient's process, and the results of treatment."</p> <p>2. Review of the policy "Levels of Observation," effective 6/12/20, revealed in part, "Never go back and post-date documentation of patient observation" Document time of patient observation at the time patient activity and behavior is observed."</p>	A 438	<p>TAG A438 CONTINUED</p> <p>- We met with our IT department and discovered that there were technical glitches in use of the I-Pads when documenting 15 minute checks. IT immediately started working on correcting the issues, but in order to prevent further opportunities for appearance of missed 15-minute checks due to IT issues, it was determined that the hospital would start using paper documentation (which was the current Downtime Form) of the 15-minute checks and patient observations. - Reporting of Compliance of Monitoring by Leadership has been added as an agenda item in the Morning Leadership Meetings, QAPI/MEC committees and Governing Board Meetings.</p> <p>- Auditing of the paper Q15s is being conducted on 100% of the patients, daily. When noncompliance is found, a 2nd verification via cameras may be conducted. Audits will be completed until 95% compliance is achieved from 3 consecutive months.</p> <p>A schedule of video monitoring and auditing of Q15 safety checks and unit milieu has been established and implemented.</p> <p>TAG A438 CONTINUED BELOW</p>	<p>3/22/2021</p> <p>3/26/2021</p> <p>4/1/2021</p> <p>4/5/2021</p>	

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A 438	<p>Continued From page 51</p> <p>3. Observation on 3/9/2021 at 1:45 PM in the 300-400 hall revealed:</p> <p>a. Patient #1 returned from the group therapy room at 1:55 PM, and went to their bedroom.</p> <p>b. Patient #1 left their bedroom at 2:12 PM.</p> <p>c. Patient #1 went to the medication window at 3:10 PM. Patient #1 was crying and asked for medication. RN G obtained the medication for Patient #1. Patient #1 became frustrated, shut the medication window, and walked away from the medication window, not wanting the medication. Patient #1 walked to their bedroom and entered their bedroom.</p> <p>d. Patient #1 left their bedroom at 3:27 PM and told the RN F and MHT B that Patient #1 wanted to go outside to smoke. When RN F informed Patient #1 they could not go outside, as the unit only had one MHT working at that time, Patient #1 became upset and verbalized their frustration.</p> <p>Further observations revealed that the nursing staff did not perform safety rounds from 1:42 PM until 3:10 PM.</p> <p>2. Review of Patient #1's medical record for 3/9/21 between 1:30 PM and 3:30 PM revealed the staff documented the following information regarding Patient #1's location during the safety checks:</p> <p>a. at 1:42 PM, the staff documented Patient #1 was in Patient #1's room, laying/sitting (despite</p>	A 438	<p>- Documentation of Follow Up/Corrective Actions, if any, using Eagle View's disciplinary policy are conducted. Disciplinary actions up to and including termination occurs, if warranted.</p> <p>- When the facility returns to electronic documentation of Q15 Safety Checks, a comparison of the electronic documentation with HCS Analytics Reports will also occur.</p> <p>- The new revision of Policy 1000.17 Levels of Observation, revised 1/28/21, was reviewed and approved through our Quality Assurance/Performance Improvement (QAPI) and Medical Executive (MEC) committees by the QCR.</p> <p>- Level of Observation policy 1000.17 (revised 4/14/21) to include an updated Patient Observation Form (1000.17a), Environmental Unit Rounds policy 1000.5 (revised 4/14/21), 15-minute Check Observation Level Flowsheet Education, and Q15 Commitment Attestation has been created in our organizational compliance program, Healthstream, as the first module of an ongoing training protocol called "Change Week". This first module related to Q15s must be completed by 4/30/21 by all direct care staff. This new ongoing training protocol will ensure up-to-date/ current information and education are being communicated to and completed by all Nursing/MHT staff. - All education provided during the previously mentioned in-service trainings and throughout this plan of correction has also been added to the new hire orientation, with the current new hire orientation class.</p>	<p>3/26/2021</p> <p>4/14/2021</p> <p>4/14/2021</p>	

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A 438	Continued From page 52 observations showing Patient #1 in the group therapy room) b. at 2:16 PM, the staff documented Patient #1 was in the dayroom using the phone (despite all staff members being off the unit to handle an emergency on another unit) c. at 3:04 PM, the staff documented Patient #1 was in the dayroom crying (despite observations showing Patient #1 was at the medication window, crying and yelling). d. at 3:20 PM, the staff documented Patient #1 as in Patient #1's room, sleeping (despite observations showing Patient #1 interacting with staff, demanding to smoke, and yelling at the nurses' station). 3. During an interview on 3/17/21 at 12:05 PM with the Director of Quality, Compliance, and Risk Management revealed they reviewed the hospital's video footage of Patient #1's behavior and verified the staff's documentation did not match the observations of Patient #1's behavior.	A 438	TAG A438 CONTINUED The latest revision (4/14/21) of our Levels of Observation policy 1000.17 will be reviewed and approved ad hoc by our QAPI and MEC committee meetings. The CEO, QCR, EA, IC/Nurse Educator and HRD are responsible for implementing and monitoring the plan of correction for future compliance with the regulations. TAG A438 ENDS HERE	4/16/2021	