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A 000	INITIAL COMMENTS The State Agency (SA), as directed by the Centers for Medicare & Medicaid Services (CMS) Kansas City Location, performed complaint surveys for complaints #116626-C, 116699-C and 117794-C that ended on 1/16/24. The survey team investigated the Condition of Participation (CoP) for Patient's Rights (42 CFR 482.13) and the CoP for Nursing Services (42 CFR 482.23) for each of the 3 complaints. Complaint #116626-C was not substantiated for Patient Rights and Nursing Services. Complaint #116699-C was substantiated for Patient Rights and was not substantiated for Nursing Services. Complaint #117794-C was substantiated for Patient Rights and Nursing Services. The survey team identified that the psychiatric hospital was not in compliance with the CoP for Patient's Rights, and also identified standard level deficiencies related to the CoP for Nursing Services.	A 000	CMS KCRO sent out the 2567 on 4.9.24-RA	
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on medical record review, review of hospital policy and staff interview, the psychiatric hospital's administrative staff failed to follow their policies for care of patients in the Intake Department. Failure to follow their policies for care of patients in the Intake Department resulted in the following: 1) a patient being admitted to the inpatient unit without an appropriate safety check for contraband (see A0142);	A 115		

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

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A 115	Continued From page 1 2) hospital staff failing to protect a patient's privacy by videotaping a patient without permission (see A0143); and, 3) hospital staff failed to ensure all patients received adequate comfort measures for sleep by having patient's sleep on yoga mats on the floor (see A0144). The cumulative effect of these systemic failures and deficient practices resulted in the CAH administrative staff's inability to ensure the patient rights were maintained and were adequate to meet patient care needs.	A 115		
A 142	PATIENT RIGHTS: PRIVACY AND SAFETY CFR(s): 482.13(c) Patient Rights: Privacy and Safety This STANDARD is not met as evidenced by: Based on hospital policy review, medical record review and staff interviews the psychiatric hospital's administrative staff failed to follow their policy and ensure a complete skin and contraband safety check was completed for 1 of 5 records reviewed (Patient #1) who was transferred to the psychiatric hospital for inpatient admission. Failure to follow their policy and ensure a complete safety check for contraband was completed resulted in Patient #1 being admitted to an inpatient unit without a thorough check for contraband which could have resulted in Patient #1 being able to bring contraband into the psychiatric hospital which could put all patients at risk. The psychiatric hospital identified an average of 10 patients a day who were seen in the Intake Department.	A 142		

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Findings include:

1. Review of policy, "Contraband and Patient Search", last revised 11/2023, revealed in part:

a. The Intake staff will perform an electronic search in the Intake Assessment Room on each patient to assure that there are no metal weapons or any metal objects that could be used for harm. This search will be completed with the use of a metal detector wand.

b. All patients will have a personal search conducted by nursing staff...The personal search will be completed in a respectful manner that includes searching and body mapping sections of the body. Two staff are present during the personal search; at least one staff is the same gender as the patient whenever possible...Ask the patient to remove the clothing from sections of their upper body and then lower body. This will include but is not limited to, torso, arms, hands, neck, face, ears, head, legs, feet, (top and bottom), back etc. A visual inspection of the mouth will be completed by having the patient open their mouth, remove any dentures, move tongue up and down and from side to side.

c. Return from outside appointment accompanied or not accompanied by staff: All patients will have a personal search conducted by nursing staff upon the patient's return, that is, a strip search and a skin search where the person's clothing is removed and the person is subject to an inspection of all or part of his or her body, whether visual or manual.

2. Review of Patient #1's medical record

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revealed:

a. On 11/4/23 at 12:00 PM, Patient #1 arrived per secure car from an outside hospital. Patient #1 had a plan to commit suicide by taking Tylenol and some sleeping pills. Patient #1 had a history of schizoaffective disorder (a mental health disorder that is marked by hallucinations or delusions, and mood disorder symptoms, such as depression or mania) but would not take any medication. Patient #1 also had a history of methamphetamine abuse and stated they had used within the last 24 hours, hadn't slept in days and stated there had better be a bed. Patient #1 was highly agitated.

b. On 11/4/23 at 2:12 PM, psychiatric hospital obtained a legal order for a hold requiring Patient #1 to stay at the hospital for 48 hours.

c. On 11/4/23, RN House Supervisor F documented the following summary for the timeframe 2:30 PM to 7:30 PM: Patient #1 was paranoid and agitated immediately upon assessment, and they were accusing RN House Supervisor F of stealing/removing cards from their wallet during an inventory of Patient #1's belongings. Patient #1 refused skin checks and checks for contraband so they were unable to take Patient #1 to an inpatient unit. RN House Supervisor F discussed the situation with the Chief Nursing Officer (CNO) who gave approval for Patient #1 to stay in the Intake Area.

d. On 11/4/23 at approximately 8:45 PM, Patient #1 was transferred to an outside hospital ED after complaining of chest pain.

e. On 11/5/23 at 8:45 AM, RN House Supervisor F documented Patient #1 had returned to the

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psychiatric hospital. RN Supervisor F was unable to use the metal detector due to Patient #1's verbally aggressive language and rising up from their chair and flailing their arms.

f. On 11/5/23, RN House Supervisor F documented the following summary for the timeframe 8:30 AM to 10:00 AM: Patient #1 returned from the ED, agitated and uncooperative. Refusing skin check and check for contraband, additional staff came to talk to Patient #1 to try and de-escalate. Staff were able to able to convince Patient #1 to change into hospital green scrubs in one of the Intake rooms. Staff could see Patient #1 on the video camera so were able to zoom in and see skin/arms/legs. CNO contacted who said this was adequate for a "pseudo skin check" and that it was best for the safety of Patient #1 and hospital staff to get Patient #1 to an inpatient unit.

3. During an interview on 1/16/24 at 9:30 AM, RN House Supervisor F could not recall the exact timeline but confirmed Patient #1 had endorsed suicidal thoughts and was aggressive and paranoid, had banged on the Intake door hard enough to crack it. Patient #1 was refusing to allow staff to do the required skin checks and the check for contraband.

RN House Supervisor F did not feel safe, explained that per their training they could do a physical hold on the patient but House Supervisor F described themselves as a small person and stated they were taught that they were not supposed to do a physical hold unless a patient was an active danger to self or others. RN House Supervisor F obtained a physician order for some medication to help him calm Patient #1 but they

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refused to take them. RN House Supervisor F did notify leadership that Patient #1 was refusing a skin check and check for contraband, and they agreed to have Patient #1 remain in the Intake Department that first day. Patient #1 finally did de-escalate a bit and then stayed in the Intake Department until later that day when they were transferred to an ED because Patient #1 complained of chest pain.

RN House Supervisor F confirmed that Patient #1 returned from the ED to the Intake Department the following morning. Patient #1 still refused to have a skin check and check for contraband completed. Recalled MHT G and RN H were also there, and they were all trying to figure out what to do. RN House Supervisor F had MHT G sit with Patient #1, and they again contacted the CEO and the CNO. The CEO suggested they do a "pseudo skin check" by having Patient #1 lift up their pant legs, the CNO told RN House Supervisor F that Patient #1 could not be taken to an inpatient unit without a skin/contraband check. RN House Supervisor F got scrubs for Patient #1 and while Patient #1 was changing clothes in an assessment room RN House Supervisor F "kind of looked" at Patient #1's skin and to see if they had any contraband. RN House Supervisor F thought RN H had looked at the camera too, explained they did use the camera to zoom in on Patient #1's skin, there was no contraband that they could see. RN House Supervisor F could not recall if Patient #1 removed their underwear. RN House Supervisor F also did not ask Patient #1 to open their mouth to check for contraband as required by policy.

When asked what their policy directed in these situations, RN House Supervisor F responded

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that that was their concern as they did not know what to do. RN House Supervisor F understood that they were to hold Patient #1 in the Intake Department but felt that could be also be a concern for other patients. RN House Supervisor F acknowledged they did not do a thorough skin/contraband check, felt it was not appropriate to do the pseudo skin check via the video monitor so that is why they talked to the CEO and CNO.

5. During an interview on 1/16/24 at 10:48 AM, MHT G recalled responding to a request for assistance and when they arrived to the Intake Department they were able to get Patient #1 to calm down a bit. MHT G tried to explain to Patient #1 that they had to check them for contraband to keep them and others safe, and that they would be more comfortable in a bed upstairs than in one of the Intake rooms. MHT G also went to talk to Patient #1 in the Intake Department on the second day after they had returned from the outside ED. Patient #1 still refused the skin and contraband safety check. MHT G did not have any further interactions with Patient #1, nor were they there during the video skin and contraband safety check.

6. During an interview on 1/16/24 at 11:04 AM, RN H recalled Patient #1 but stated they did not recall and were not involved in any skin and contraband safety check via videocamera.

7. During an interview on 1/16/24 at 2:15 PM, CEO recalled Patient #1, knew they were refusing skin and contraband safety checks, stated there had been multiple conversations to try and figure out the best way to approach the problem and get Patient #1 to an inpatient unit. Recalled discussing it with RN House Supervisor F, had

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A 142	Continued From page 7 understood that Patient #1 had been really paranoid, and had coached them on a couple different ways to best approach someone in this situation with these symptoms. CEO acknowledged that using the video camera to monitor Patient #1 while they changed their clothes was not an appropriate or complete skin or safety check. 8. During an interview on 1/16/24 at 10:00 AM, CNO explained that this was a very challenging situation, and they had been focused on finding the best solution from a safety perspective. CNO recalled a previous, recent incident where a patient had been able to smuggle in a razor in their bra so they were concerned that Patient #1 could be hiding something and that would be a bigger risk on an inpatient unit than in the Intake Department. CNO was not okay with foregoing a full skin and contraband safety check but did not believe they had a better option. In hindsight thought maybe they could have put Patient #1 in a physical hold and given them medication so they could proceed but did not think that was the right thing either.	A 142		
A 143	PATIENT RIGHTS: PERSONAL PRIVACY CFR(s): 482.13(c)(1) The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on hospital policy review, medical record review and staff interviews, the psychiatric hospital's administrative staff failed to follow their policy and ensure that 1 of 5 patients reviewed (Patient #1) was aware of, and consented to, video monitoring while Patient #1 changed their	A 143		

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clothes in an assessment room in the Intake Department. Failure of the hospital to ensure Patient #1 was aware of, and consented to this monitoring resulted in Intake staff performing a skin assessment and a check for contraband while they changed their clothes without their consent. The psychiatric hospital identified an average of 10 patients a day who were seen in the Intake Department.

Findings include:

1. Review of policy, "Care of Patients in the Intake Department", last revised 10/2023, revealed in part: "Patients will be maintained in camera-monitored rooms at all times, unless in the restroom".

2. Review of policy, "Contraband and Patient Search", last revised 11/2023, revealed in part: "...All patients will have a personal search conducted by nursing staff...The personal search will be completed in a respectful manner that includes searching and body mapping sections of the body. Two staff are present during the personal search; at least one staff is the same gender as the patient whenever possible. Explain the process and the purpose of the personal search for safety and to identify any injuries to the person. Ask the patient to remove the clothing from sections of their upper body and then lower body. This will include but is not limited to, torso, arms, hands, neck, face, ears, head, legs, feet, (top and bottom), back etc. A visual inspection of the mouth will be completed by having the patient open their mouth, remove any dentures, move tongue up and down and from side to side... "

"The inspection is conducted in private only by a

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provider or Registered Nurse. Another staff person shall be in attendance. If the provider or Registered Nurse and the patient are of different sexes, then the other staff member must be of the same sex as the person being examined. No other persons should be present... The reasons for the search are made known to the individual. Advise the patient of the search policy and the purpose of the search. Inform the patient ahead of time what the search entails and reassure the patient that his/her privacy will be maintained during the search."

3. Review of Patient #1's medical record revealed:

a. On 11/4/23 at unknown time, Patient #1 signed the "Review of Conditions of Admission and Application for Admission", which revealed in part: "...the Facility uses real-time video surveillance and recording equipment on its program units solely for monitoring the patient areas for safety. . Video surveillance and recording equipment is used in common areas and is never used in a patient's bedroom or bathroom..."

b. On 11/5/23, House Supervisor F documented the following summary for the timeframe 8:30 AM to 10:00 AM: Patient #1 returned from the ED, agitated and uncooperative. Calling government agencies and saying they will "sue this place", screaming at staff and accusing them of taking away their rights, and threatening to take down the whole place and harm staff. Patient #1 was banging on the door and screaming.

Patient #1 was refusing a skin check and check for contraband, stated, "I don't need you to see my [private area]". Administrator on call

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contacted, as well as the CNO. Additional staff came to talk to Patient #1 to try and de-escalate, were able to able to convince Patient #1 to change into hospital scrubs in one of the Intake rooms. Staff could see Patient #1 on the camera so were able to zoom in and see skin/arms/legs. CNO contacted again and said this was adequate for a "pseudo skin check" and that it was best for the safety of Patient #1 and hospital staff to get Patient #1 to the inpatient unit.

4. During an interview on 1/16/24 at 9:30 AM, RN House Supervisor F could not recall the exact timeline but confirmed Patient #1 had endorsed suicidal thoughts and was aggressive and paranoid, had banged on the Intake door hard enough to crack it. Patient #1 was refusing to do the check of their skin and the check for contraband that staff was supposed to do.

RN House Supervisor F confirmed that Patient #1 had been sent to a local ED after complaints of chest pain and had returned to the Intake Department the following morning. Patient #1 still refused to allow staff to complete a skin check and check for contraband. Recalled MHT G and RN H were involved, they were trying to figure out what to do. RN House Supervisor F had MHT G sit with Patient #1 and then they contacted the CEO and the CNO. Recalled CNO told RN House Supervisor F that Patient #1 could not be taken to an Inpatient unit without a skin/contraband check. The CEO suggested they have Patient #1 do a "pseudo skin check" by having Patient #1 lift up their pant legs, etc. RN House Supervisor F got scrubs for Patient #1 and then RN House Supervisor F "kind of looked" at Patient #1's skin via video monitoring while they were changing their clothes in an assessment room. RN House

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Supervisor F used the camera to zoom in on Patient #1's skin and they did not see any contraband, thought RN H also looked at the video feed while Patient #1 was changing their clothes.

RN House Supervisor F stated they got Patient #1 to change into scrubs voluntarily. RN House Supervisor F was not aware of the language in the consent regarding video monitoring will not be done in a patient's "bedroom". RN Supervisor F did not know if Patient #1 would have understood that language and did actually consent to someone watching them while they changed their clothes. RN House Supervisor F stated Patient #1 was kind of screaming at the camera, but RN House Supervisor F did not know if Patient #1 knew they were watching them as they changed their clothes. RN House Supervisor F fully acknowledged the issue, understood it was not appropriate and that was why they had asked the CEO and CNO what to do in this instance.

5. During an interview on 1/16/24 at 10:48 AM, MHT G recalled responding to a request for assistance and had talked to Patient #1 on both days they were in the Intake Department, but they not there during the video skin and contraband safety check.

6. During an interview on 1/16/24 at 11:04 AM, RN H recalled Patient #1 but stated they did not recall and were not involved in any skin and contraband safety check via videocamera.

7. During an interview on 1/16/24 at 2:15 PM, CEO recalled Patient #1, knew they were refusing skin and contraband safety checks, stated there had been multiple conversations to try and figure

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A 143	Continued From page 12 out the best way to approach the problem and get Patient #1 to an inpatient unit. CEO acknowledged that using the video camera to monitor Patient #1 while they changed their clothes was not appropriate, and it appeared Patient #1 did not have full understanding or give consent. 8. During an interview on 1/16/24 at 10:00 AM, CNO stated they were not okay with what had happened but had understood that Patient #1 had consented to the video monitoring by staff while they were changing their clothes. CNO was not physically present at the psychiatric hospital and understood from phone conversations that Patient #1 had consented.	A 143		
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: Based on observation, hospital policy and document review, and staff interviews, the psychiatric hospital failed to provide basic comfort measures for all patients who stayed overnight in the Intake Department. Failure to provide basic comfort measures resulted in patients sleeping on yoga mats in the Intake Department. The psychiatric hospital identified an average of 10 patients a day who were seen in the Intake Department. Findings include: 1. On 12/19/23 at approximately 2:30 PM, during a tour of the Intake Unit, noted four carpeted exam rooms, each of which had a table with four	A 144		

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chairs around the table. There were also two uncarpeted waiting rooms, both of which had several stuffed chairs, a TV, and an attached bathroom.

2. Review of policy, "Care of Patients in the Intake Department", last revised 10/2023, revealed in part: "...It is the policy of [psychiatric hospital] to ensure the safety and well-being of any patient who may need to remain in the Intake Department for an extended period of time pending the availability of a bed assignment on an inpatient unit or transfer to an accepting facility...If hold period includes sleep hours, the patient will be made comfortable."

3. Review of report provided by psychiatric hospital revealed from 10/1/23 - 12/31/23, there were 37 instances of patients sleeping over night in the Intake Department.

4. During an interview on 12/18/24 at 12:30 PM, RN A explained that they would go to the gym and get a yoga mat and a blanket and the patient would sleep on the floor in one of the waiting rooms if the patient needed to stay overnight.

5. During an interview on 1/9/24 at 12:25 PM, RN B stated that there used to be cots for overnight use if a patient needed to stay the night in the Intake Department, but the psychiatric hospital no longer allowed them for reasons unknown to RN B. RN B explained that the waiting areas have chairs that are similar to a very small loveseat, and RN B would put a yoga mat on top of that and provide a blanket and a pillow to the patient. RN B acknowledged that sometimes patients did sleep on the floor with the yoga mat because it was hard for even smaller people to get

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A 144	Continued From page 14 comfortable in the chair(s). RN B had also tried putting two chairs together but felt that too was limited in terms of providing comfort for sleep. 6. During an interview on 1/9/24 at 12:45 PM, RN C explained that they would get yoga mats and lay those out next to each other on the floor, and then get a blanket and pillow for the patient to use for sleep. If the patient was not "super" tall, they would take two of the larger chairs and push them together so the patient could kind of curl up on the chairs. RN C explained that wasn't ideal for comfort as an adult patient couldn't ever lay flat if they were too tall. RN C stated the last patient they had wanted to sleep in one of the assessment rooms because it was carpeted, and they thought a yoga mat on carpet would be more comfortable than a yoga mat on a hard floor. RN C stated they had asked about having cots or a mattress for patients but were told it was a safety issue. 7. During an interview on 1/11/24 at 1:15 PM, Director of Intake indicated that the psychiatric hospital had recently purchased two loungers, one for each waiting room, that will be more comfortable and allow patients to lay flat when they need to stay in the Intake Department overnight.	A 144		
A 386	ORGANIZATION OF NURSING SERVICES CFR(s): 482.23(a) The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service,	A 386		

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including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.

This STANDARD is not met as evidenced by:
Based on document review and staff interviews, the psychiatric hospital failed to have one hospital-wide and single nursing service all under the direction of the Chief Nursing Officer (CNO). Failure to have one hospital-wide and single nursing service under the direction of the CNO may result in psychiatric hospital's inability to ensure adequate oversight of all nursing services which may result in patient harm. The psychiatric hospital reported a census of 52 on entrance, and an average of 10 patient visits per day in the Intake Department. .

1. Review of CNO Position Description, revised 7/2023, revealed in part: "The [CNO] is responsible for organizational, administrative and nurse leadership duties including but not limited to the development, organization, provision, and evaluation of all nursing functions with the facility with 24/7 responsibility for those functions...". The CNO supervises all nursing personnel and all Mental Health Technicians (MHT).

2. Review of psychiatric hospital's Organizational Chart, dated 12/2023, revealed Director of Intake and CNO both reported directly to the CEO. Director of Intake was responsible for the Intake Department staff and the DON was responsible for the nursing staff on the inpatient units.

3. Review of Intake Staff roster provided by the psychiatric hospital on 12/19/23 revealed there were 7 RNs and 1 MHT.

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A 386	Continued From page 16 4. During an interview on 1/10/23 at 12:45 PM, Director of Intake confirmed that they reported directly to the CEO, and all Intake Department staff reported directly to them including RNs and MHTs. Intake Director was solely responsible for all performance evaluations. Director of Intake stated that their interaction with the CNO was limited to coordination of RN staffing. 5. During an interview on 1/10/23 at 2:15 PM, CNO explained that the Intake Department is kind of it's own entity, but they have become more collaborative since CNO assumed this position in November of 2023. CNO works with the Intake Director on staffing issues and will help find inpatient staff to help as needed. CNO confirmed that the Intake RNs and MHT do not report to them and they do not participate in their evaluations. CNO stated they are starting monthly nursing staff meetings next week and will highly encourage Intake staff to attend. CNO does include Intake staff in their email communications if CNO thinks the topic would be applicable to Intake staff. CNO had reviewed Intake policies in their prior role as Director of Intake but has not done that as a CNO.	A 386		
A 392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for care of any patient.	A 392		

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This STANDARD is not met as evidenced by:
Based on hospital policy review, review of hospital Intake Department schedules, medical record review and staff interviews, the psychiatric hospital administrative staff failed to follow their policies and ensure the Intake Department was staffed with at least one RN, or at least two staff members, to provide nursing assessment and nursing care and other needs for each of the Intake Department's patients. Failure to ensure that Intake Department was staffed with at least one RN, or at least two staff members, may result in an unrecognized urgent or emergent patient condition potentially resulting in patient harm and/or death, or unmet patient needs. The psychiatric hospitals's administrative staff reported an average of 10 patients/day were seen in the Intake Department.

Findings include:

1. Review of policy, "Appropriate Staffing Levels", last revised 3/2023, revealed in part:
a. Each patient care unit will have a minimum of one RN at all times.
b. A minimum of two staff will be assigned to all units, one of which will be an RN on each shift.

2. Review of policy, "Plan for the Provision of Nursing Care", last revised 12/2021, revealed in part:
a. Nursing care shall be administered in a large variety of treatment situations, including but not limited to the Intake Department.
b. Nursing care needs of patients shall be identified using the nursing process. Specifically, registered nurses shall use assessment skills initially and on an on-going basis to determine the level of care and necessary interventions to

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ensure the identified needs are addressed.
c. As part of the intake process, the nurse will complete the physical portion of the Medical Screening Examination (MSE). The nurse will complete a re-assessment every two hours (documenting via re-assessment form and progress note) for any patient in the Intake Department who is awaiting admission or transfer to another facility.

3. Review of Intake Department staffing schedule from 10/1/23 - 12/31/23 revealed:
a. There was no RN scheduled to care for patients in the Intake Department on 10/3/23 from 7 AM - 3 PM (8 hours).
b. There was no RN scheduled to care for patients in the Intake Department on 12/17/23 from 7:45 PM to 12/18/23 at 6:45 AM (11 hours).
c. There was no RN scheduled to care for patients in the Intake Department on 12/18/23 from 7:30 PM to 12/19/23 at 7:30 AM (12 hours).
d. There was no RN scheduled to care for patients in the Intake Department on 12/19/23 from 7:00 PM to 12/20/23 at 7:00 AM (12 hours).
e. There was no RN scheduled to care for patient in the Intake Department on 12/21/23 from 7:30 PM to 12/22/23 at 12/22/23 at 8:45 AM (13 hours and 15 minutes).
f. There was no RN scheduled to care for patients in the Intake Department on 12/22/23 from 8:15 PM - 11:00 PM.
g. There was no RN scheduled to care for patients in the Intake Department on 12/23/23 from 7:30 PM - 11:00 PM.

4. Review of data provided by psychiatric hospital on 1/9/24 revealed there were 13 patients seen in the Intake Department during the above timeframe's when an RN was not present to do

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the MSE or provide ongoing nursing care as required by policy.

5. Review of Patient #2's medical record revealed:
a. On 12/16/23 at 11:35 PM, Patient #2 arrived at the psychiatric hospital Intake Department with concerns of self-harm. Patient #2 had recently used a plastic knife to cut their arm.
b. On 12/17/23 at 12:30 AM (when there was no RN scheduled in the Intake Department), Masters in Social Work (MSW) D completed the MSE.

6. Review of Patient #3's medical record revealed:
a. On 12/18/23 at 1:00 AM, Patient #3 arrived at the psychiatric hospital Intake Department following a methamphetamine relapse during the past 48 hours.
b. On 12/18/23 at 1:04 AM (when there was no RN scheduled in the Intake Department), Director of Intake, Licensed Mental Health Counselor, completed the MSE.
c. Patient #3 was discharged to Intensive Outpatient Services, medical record lacked any assessment by an RN prior to discharge.

7. Review of Patient #4's medical record revealed:
a. On 12/22/23 at 6:00 AM, Patient #4 arrived at the psychiatric hospital Intake Department with complaints of wanting to cut or hurt themselves.
b. On 12/22/23 at 6:33 AM (when there was no RN scheduled in the Intake Department), Director of Intake, Licensed Mental Health Counselor, completed the MSE.

8. Review of Intake Department staffing schedule from 10/1/23 - 12/14/23 revealed there was only

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one staff member scheduled in the Intake Department on:
a. 10/4/23 from 12:00 AM to 7:00 AM
b. 10/5/23 from 12:30 AM to 7:00 AM
c. 10/6/23 at 11:30 PM until 10/7/23 at 6:45 AM
d. 10/12/23 from 8:15 PM until 10/13/23 at 1:15 AM
e. 10/13/23 from 8:30 PM to 10/14/23 at 6:45 AM
f. 10/19/23 from 1:30 AM to 10/19/23 at 6:45 AM
g. 10/19/23 from 9:30 PM to 10/20/23 at 7:00 AM
h. 10/20/23 from 11:15 PM to 10/21/23 at 7:00 AM
i. 10/22/23 from 12:00 AM to 6:45 AM
j. 10/22/23 from 12:30 AM to 6:45 AM
k. 10/25/23 from 10:45 PM to 10/16/23 at 7:00 AM
l. 10/26/23 from 11:30 PM to 10/27/23 at 7:00 AM
m. 10/27/23 from 11:30 PM to 10/28/23 at 7:00 AM
n. 10/28/23 from 10:15 PM to 10/29/23 at 6:45 AM
o. 11/1/23 from 11:15 PM to 11/2/23 7:00 AM
p. 11/4/23 from 3:15 AM to 6:45 AM
q. 11/5/23 from 12:15 AM to 6:45 AM
r. 11/6/23 from 4:00 AM to 6:45 AM
s. 11/8/23 from 11:15 PM to 11/9/23 at 6:45 AM
t. 11/10/23 from 11:15 PM to 11/11/23 at 7:00 AM
u. 11/11/23 from 8:15 PM to 11/12/23 at 6:45 AM
v. 11/15/23 from 4:30 AM to 5:00 AM
w. 11/15/23 from 11:15 PM to 11/16/23 at 6:45 AM
x. 11/16/23 from 10:00 PM to 11/17/23 at 7:00 AM
y. 11/17/23 from 9:15 PM to 11/18/23 at 6:45 AM
z. 11/18/23 from 8:00 PM to 11/19/23 at 6:45 AM
aa. 11/22/23 from 8:15 PM to 11/23/23 at 7:45 AM
bb. 11/25/23 from 8:45 PM to 11/26/23 at 6:45 AM
cc. 12/2/23 from 3:00 AM to 7:00 AM
dd. 12/3/23 from 1:45 AM to 7:00 AM
ee. 12/4/23 from 12:45 AM to 12/4/23 at 6:45 AM

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ff. 12/6/23 from 8:15 PM to 12/7/23 at 7:00 AM
gg. 12/9/23 from 8:00 PM to 11:00 PM
hh. 12/12/23 from 5:00 AM to 7:00 AM
ii. 12/13/23 from 4:30 AM to 6:45 AM
jj. 12/13/23 from 8:30 PM to 11:00 PM
kk. 12/14/23 from 8:30 PM to 12/15/23 at 6:45 AM

9. During an interview on 1/4/24 at 9:00 AM, Director of Intake confirmed the times on seven separate days when there was no RN present in the Intake Department to do the MSE, or an assessment and ongoing monitoring of patients. During an additional interview on 1/10/24 at 12:45 PM, Director of Intake also confirmed that there had not always been two staff members scheduled in the Intake Department.

10. On 1/16/24 at 8:42 AM, Director of Intake verified via email the above schedule which demonstrated the multiple occasions the Intake Department failed to staff the department with two staff members..

11. During an interview on 1/10/24 at 2:15 PM, CNO acknowledged that there needs to be at least one RN in the Intake Department 24/7. CNO felt like the policy referencing scheduling a minimum of two staff in each unit was specifically addressing inpatient units, but from a safety standpoint felt it was also important to have a minimum of two staff scheduled in the Intake Department.