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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	160067	A. BUILDING ______ B. WING ______	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCYONE WATERLOO MEDICAL CENTER	3421 WEST NINTH STREET WATERLOO, IA 50702

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A 000	INITIAL COMMENTS The State Survey Agency (SA), at the direction of the Centers for Medicare and Medicaid (CMS) Kansas City Location staff, performed an investigation into complaint 102823-C related to Patient Rights (42 CFR 482.13) and complaint 103931-C related to Nursing Services (42 CFR 482.23), from 4/11/22 to 4/14/22. The on-site survey team determined the hospital was complaint with the COVID-19 vaccine mandate requirements. However, the survey team determined the hospital was not operating in compliance with the Condition of Participation related to Patient's Rights.	A 000	Creditable allegation 5/16/22 CMD Date of Correction 5/13/22 Please see additional document	
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 document review and staff interview, the hospital's administrative staff failed to ensure 3 of 3 reviewed patients (Patient #1, Patient #2, and Patient #3) received care in a safe setting when the nursing staff failed followed the hospital's policies for performing visual safety checks on the patients in the Emergency Room and prevented patients from attempting to cause harm to self, others, or attempt to commit suicide. Please refer to A-0144 for additional information. The cumulative effect of these failures and deficient practices resulted in the hospital's inability to ensure staff provided patient care occurred in a safe setting.	A 115		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2)	A 144		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly Richards DNP, RN — TITLE — (X6) DATE

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 144	Continued From page 1	A 144		

The patient has the right to receive care in a safe setting.
This STANDARD is not met as evidenced by:
Based on document review, staff interviews, and review of video footage, the hospital's administrative staff failed to ensure the hospital staff provided adequate supervision to 3 of 3 patients in the Emergency Department (ED) that were deemed as low risk on the Initial Suicide Assessment, unstable behavioral health patients (Patient #1, Patient #2, and Patient #3). Failure to provide adequate supervision for the patients could potentially result in patient attempting to harm themselves or others, while in the ER. The hospital's administrative staff identified a census of 1,787 ED patients in the fiscal year 2021 and 189 ED behavioral health patient in the fiscal year of 2021.

Findings include:

1. Review of the policy "Suicide screening, risk assessment, and interventions," revised 06/2020, revealed in part, "Upon arrival to the ED or admission ...if the patient makes suicidal comments after being screened on admission ...If the patient (ages 10 and up) answers "yes" to any of the screening questions ...have someone remain with the patient until Risk Level and appropriate interventions are determined." "Document the interventions that are implemented. Document 15-minute visual checks on the appropriate Rounding Flowsheet for patient who score low, moderate, or high risk."

"Once the patients are identified as an 'at risk' patient for suicide the ED staff will: ... Establish therapeutic relationships, ... Inventory patient

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belongings, ... Remove any prohibited items from room, ... Place patient in burgundy scrubs/gown, ... Door to room should be open, ... Obtain psychiatric consult ..."

Appendix A of the "Suicide screening, risk assessment, and interventions," policy revealed in part, "High Suicide Risk Required Interventions ... 1 on 1 observation. Video monitoring may be used as a secondary safety measure but CANNOT be used as the only means to observe the patient." "Moderate Suicide Risk Required Interventions ...Direct or video observation ... initiate every 15-minute visual checks." "Low Suicide Risk Required Interventions ... every 15-minute visual checks."

2. Review of the policy "Care of Patients Presenting with Psychiatric Complaints in the Emergency Department" revealed in part, " ... If Security or safety tech needs to leave the Emergency Department to respond to an urgent situation, the Emergency Department Charge Nurse will assign an Emergency Department associate to perform the Direction Observation of the patient until the Security personnel returns. Direct observation may occur via video at the Nursing Station or with personnel positioned immediately outside the patient room. Staff performing direct observation will keep the patient within his or her view at all times."

3. Review of the policy "Safety Companions" revealed in part, "To provide constant observation, visualization, and companionship to assigned high risk patients ... RNs, LPNs, Paramedics, PCAs/Techs, Security Officers or

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A 144	Continued From page 3 any other trained colleague may serve as safety companions." 4. Review of Patient #1's medical record revealed the following: a. Patient #1 presented to the hospital's emergency department on 4/9/22 at 11:51 PM, complaining of trying to kill themselves. Patient #1 indicated they wanted to kill themselves by overdosing on an excess of pills and attempting to cut wrists with a knife. b. at 12:00 AM, ED RN F requested Security Guard I perform every 15 minute observations on Patient #1. c. at 12:05 AM on 4/10/22, ED RN F performed the C-SSRS (Columbia-Suicide Severity Rating Scale is a questionnaire used for suicide assessment) on Patient #1, which revealed Patient #1 was at low risk for committing suicide. d. at 2:00 AM on 4/10/22, Security Guard I asked Security Guard H assume the responsibility to perform every 15 minute observations on Patient #1. e. the flow sheet, titled Security Department Patient Watch Log, lacked evidence the hospital staff performed 15 minute/continuous checks between 2:00 AM and 5:00 AM on 4/10/22 on Patient #1. f. the hospital staff resumed performing 15 minute checks at 5:09 AM on 4/10/22 (resulting in Patient #1 going 3 hours and 9 minutes without	A 144		

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A 144	Continued From page 4 the hospital staff providing Patient #1 the required 15 minute observations, potentially allowing Patient #1 to harm themselves without the ED staff's knowledge). 5. Review of Patient #2's medical record revealed the following: a. Patient #2 presented to the hospital's emergency department on 4/9/22 at 11:30 PM, complaining of trying to kill themselves. Patient #2 indicated they wanted to kill themselves by using a toothbrush to cut their wrist and attempting to cut their throat. b. on 4/9/22 at 11:00 PM, ED RN F performed the C-SSRS (Columbia-Suicide Severity Rating Scale is a questionnaire used for suicide assessment) on Patient #2, which revealed Patient #2 was at low risk for committing suicide. c. at 11:40 PM, ED RN F requested Security Guard I to perform every 15 minute observations on Patient #2. d. at 2:00 AM on 4/10/22, Security Guard I asked Security Guard H assume the responsibility to perform every 15 minute observations on Patient #2. e. the flow sheet, titled Security Department Patient Watch Log, lacked evidence the hospital staff performed 15 minute/continuous checks between 2:00 AM and 5:00 AM on 4/10/22 on Patient #2. f. the hospital staff resumed performing 15	A 144		

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A 144	Continued From page 5 minute checks at 5:09 AM on 4/10/22 (resulting in Patient #2 going 3 hours and 9 minutes without the hospital staff providing Patient #2 the required 15 minute observations, potentially allowing Patient #2 to harm themselves without the ED staff's knowledge). 6. Review of Patient #3's medical record revealed the following: a. Patient #3 presented to the hospital's emergency department on 2/23/22 at 3:22 PM, complaining of trying to hurt themselves. Patient #3 indicated they wanted to hurt themselves by cutting their right forearm 7 times with a pocket knife. b. at 6:00 PM, ED RN K performed the C-SSRS (Columbia-Suicide Severity Rating Scale is a questionnaire used for suicide assessment) on Patient #3, which revealed Patient #3 was at low risk for committing suicide. c. at 3:52 PM, ED RN K requested Security Guard A to perform every 15 minute observations on Patient #3. d. at 4:47 PM, Security Guard A asked Security Guard D assume the responsibility to perform every 15 minute observations on Patient #3. e. the flow sheet, titled Security Department Patient Watch Log, lacked evidence the hospital staff performed 15 minute checks between 6:37 PM and 6:55 PM on 2/23/22 on Patient #3. f. the hospital staff resumed performing 15	A 144		

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A 144	Continued From page 6 minute checks at 6:55 PM on 2/23/22 (resulting in Patient #3 going 18 minutes without the hospital staff providing Patient #3 the required 15 minute observations, potentially allowing Patient #3 to harm themselves without the ED staff's knowledge). 7. During an interview on 4/13/22 at 7:54 AM, RN G revealed the security guards sat with behavioral health patients at risk for self-harm and provided monitoring to the behavioral health patients. The ED staff had placed a table outside the rooms used for behavioral health patients, so the security guards could monitor the patients. If a Security Guard had to stop monitoring a behavioral health patient and leave the ED, the nursing staff are responsible for finding someone to continue monitoring the behavioral health patient. 8. During an interview on 4/12/22 at 2:49 PM, RN C revealed the ED staff normally placed behavioral health patients in rooms designed specifically to help keep behavioral health patients safe. If the behavioral health dedicated rooms were not available, the ED staff would place a behavioral health patient in a regular ED room and attempt to remove items from the regular ED room that a behavioral health patient could use to harm themselves. However, RN C acknowledged that the ED staff could not provide the required monitoring to behavioral health patients, especially patients in non-dedicated behavioral health rooms, due to a lack of staff available to monitor the patients.	A 144		

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Continued From page 7

9. During an interview on 4/12/22 at 12:51 PM, the Security Manager revealed that the security staff perform the monitoring of behavioral health patients requiring monitoring (video monitoring, 1 to 1 continuous observation, or every 15 minute visual checks) in the Emergency Department. In the prior 3 weeks, due to staffing issues, the security staff only had 1 Security Guard on-duty from midnight to noon. The Security Manager had notified the hospital's Safety Officer and the Director of Facilities they only had 1 Security Guard on-duty from midnight to noon.

10. During an interview on 4/12/22 at 1:17 PM, Security Guard A revealed that if a security guard was assigned to monitor a patient in the ED, and the security guard had to leave the ED to address a security issue in the hospital, the security guard informs the ED nursing staff that the security guard has to leave the ED due to them needing to respond to the security issue in the hospital. The security guards reminded the nursing staff that the ED nursing staff needed to find someone to take over monitoring the behavioral health patient in the ED.

When the security guard returns to the ED, after addressing the hospital's security issue, the security guards normally find that the ED staff did not complete the Rounding Flowsheet to document if the ED staff monitored the behavioral health patients to ensure the behavioral health patient did not attempt to harm themselves while the security guard was not in the ED. Security Guard A had informed the Emergency Department Manager about the issue and the Emergency Department Manager acknowledged

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the ED staff had failed to provide the required monitoring to behavioral health patients.

11. Review of video footage on 4/10/22 at 2:00 AM in the core area of the ED an emergency call was paged overhead in which Security Guard I and Security Guard H attended. Security Guard I was performing video monitoring on behavioral health Patient #1 and Patient #2. Security Guard I informed Security Guard H that Security Guard I was leaving the video monitoring of Patient #1 and Patient #2. RN F was in charge of Patient #1 and Patient #2. From approximately 2:00 AM until 4:47 AM, neither RN F nor RN G physically checked on either Patient #1 or Patient #2, nor looked at the video monitor. The door to both Patient #1's and Patient #2's ED room door was closed the entire time Security Guard I and Security Guard H had left the ED.

Additional observations of the video footage revealed:

a. at 2:05 AM Environmental Service staff walked through the ED.

b. between 2:06 AM until 3:09 AM ED staff randomly walked through the department, entering information into a computer, pulling medication out of Pyxis machine (an automated medication dispensing system), and making phone calls.

c. at approximately 3:25 AM, Security H walks through ED and held a conversation with RN G until 3:32 AM, approximately 12-15 feet from Patient #1 room.

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A 144	Continued From page 9 d. at 3:33 AM, Security H walked through the ED without visually monitoring Patient #1 or Patient #2. d. at 4:51 AM, Security Guard H picked up a patient's belongings that were placed at a desk in the center of the ED. e. at 5:00 AM, Patient #1 and Patient #2 had no observable monitoring or assessment by RN F or RN G. f. at 5:09 AM, Security Guard H resumed monitoring Patient #1 and Patient #2 and performing the required checks every 15 minutes.	A 144		

Credible Allegation 5/11/22
CMD
Date of Correction 5/13/22

MercyOne Waterloo Medical Center ("MercyOne") received a Statement of Deficiencies from CMS on May 3, 2022. Below is MercyOne's response and Plan of Correction, following an internal review of the alleged deficiencies and relevant policies and procedures.

Emergency Department Monitoring Action Plan

The following action steps apply to both findings (A 115 and A 144)

1-A new position, called an Emergency Department Monitor Tech ("ED VMT") will be added to the Emergency Department staff. The ED VMT will be assigned to observe the patient video camera monitors on the Emergency Department Unit on a 24/7 basis. The ED VMT will be positioned directly in front of the monitor station and will observe the monitor screens on a continuous basis, while minimizing any potential distractions. Should the ED VMT need a break of any sort, support will be provided by an Emergency Department Leader, an Emergency Department Team Member, Security Officer, and/or the House Supervisor. Change of shift handoff will occur between the incoming and outgoing ED VMT directly in front of the monitors. If there are any concerning patient safety behaviors noted on the monitor, including pacing, or destructive, or intimidating actions, the ED VMT will be expected to promptly notify an Emergency Department staff member, so that safety interventions can be implemented to minimize the risk of harm to the patient and/or the staff. If there is no Emergency Department Team Member readily available in the immediate area, the ED VMT will request assistance via a voice activated electronic communication system to summon assistance. If indicated, a "Security Assistance" code can be activated. The ED VMT will complete a *"Rounding Flowsheet: Non-behavioral Health Units"* each shift, which will include any reportable observations that are noted and to whom they are reported.

A robust recruitment plan including multiple site position postings, communication with higher education organizations, calls to former colleagues, and working with external recruiting companies, has been put into place and will continue until the ED VMT positions are filled. Until all permanent positions are filled, the ED VMT role will be filled with temporary, in-house colleagues. Job descriptions and expectations, and competencies, will be implemented.

Date: Implemented: May 13, 2022, 3-11 shift
Responsible Party: Chief Nursing Officer ("CNO")
Attached: " Rounding Flowsheet: Non-Behavioral Health Units"-used by the Tech. (#1)

3800407 Rounding Flowsheet Nonbehavi

2-The ED VMT will receive education outlining the expectations of the role, prior to assuming the role. The ED VMT will also receive education on the type of behavior to report, including agitation, pacing, intimidating stance, self-harm, and verbal or physical threats. Reports will be made to an Emergency Department Team Member. Education will be provided by the Emergency Department Director and/or their designee. The ED VMT will demonstrate competency before they are permitted to perform the role independently. Competency will be evaluated on an ongoing basis through the audit process and during periodic performance reviews.

Video Monitor Tech 25557 rev 5-22.doc

Video Monitor Tech CBO Updated 5-12-2

Responsible party: Emergency Department Director (or their designee)

3-The performance of the ED VMT will be monitored and evaluated by Emergency Department Director or their designee. Random performance monitoring will occur, ensuring the monitor tech is devoting their undivided time and attention to the role. These performance evaluations will occur by the Emergency Department Director or designee, utilizing two methodologies. Performance observations will be a blend of direct observations on the unit by the Emergency Department Director or their designee and by random observations that will occur from security monitors, located off the unit.
Each shift, 1-2random observations will be conducted. It is expected that the ED VMT will demonstrate 100% compliance with the outlined expectations during the observations.

See attachment: "Audit Tool: Emergency Department Video Monitor Tech" (Leader use, designee use)

House.Supervisor.Video.Monitor.Tech.audit

Leader.Video.Monitor.Tech.audit.xlsx

Video.Monitor.Tech.Compliance.Audit.xlsx

Responsible party: CNO
Date: May 13, 2022

4-Audit results will be reported weekly to the Emergency Department Director and the CNO. The CNO, on a monthly basis, will bring the audit results to the Outcomes Improvement Committee. When 100% compliance of audit criteria is achieved for 3 consecutive months, the CNO will then move reporting to a quarterly basis. The audit results reported to the Outcomes Improvement Committee will also be reported to the Quality and Safety Committee of the Board of Directors.

Responsible party: CNO

5- To ensure that evaluations and assessments of Behavioral Health patients who present to the ED are completed as intended, several policies were reviewed. The "Suicide Screening, Risk Assessment, and Interventions" (PFG438) policy was reviewed, revisions made, so that the self-harm screening process is more clearly defined. The "Elopement Procedure, Inpatient and Emergency Department" (PFG 457) policy was reviewed, with updates to more clearly differentiate what constitutes "direct observation" and "video monitoring" procedures. The form used for documentation of monitor findings was streamlined to encompass the contents of what was previously two separate forms. This will allow for consistency of documentation, in a more concise manner. "The Care of Patients Presenting with Psychiatric Complaints in the Emergency Department" (PFG 456) policy was reviewed, with revisions designed to more clearly clarify expectations. The "Safety Companions" (PFG 476) policy was also reviewed. The "Safety Companion Request Form" will be used for any patient who is determined to be at high risk for self-harm. The form will be forwarded to the Staffing Office for review and evaluation. This process will be utilized only when the need cannot be met by ED Colleagues, within the department.

The ED Director will provide information to the ED Colleagues and Providers on changes to the noted policies and expectations of changes.

Room Safety Checklist.pdf

Form---ED BH Screening.pdf

Safety Companion request form.pdf

PFG456.doc

PFG438.doc

PFG476.docx

PFG457.doc

Date: May 12, 2022---policies completed; Information to Colleagues on updates to policies and forms have been initiated by the ED Clinical Nurse Specialist and will continue with remaining colleagues prior to their next oncoming shift.
Responsible party: CNO