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E 000	Initial Comments	E 000		

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MEDICARE COMPLAINT SURVEY

The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation for Hospitals set forth in 42 CFR 482, conducted this health and safety survey.

Onsite dates: 01/08/19 to 01/11/19 and 01/15/19 to 01/17/19

Intake number: 87038

The survey was conducted by:

Surveyor #2
Surveyor #3
Surveyor #5
Surveyor #9
Surveyor #10
Surveyor #11

A state hospital licensing survey (Examination number 2018-978) was also conducted with this Medicare Complaint Survey.

DOH staff found the facility NOT IN COMPLIANCE with the following Conditions of Participation:

42 CFR 482.12 Governing Body

42 CFR 482.21 Quality Assessment and Performance Improvement

42 CFR 482.23 Nursing Services
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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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E 037	EP Training Program CFR(s): 482.15(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037		

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E 037	Continued From page 2 (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.	E 037		

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E 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The	E 037		

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E 037	Continued From page 4 CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that staff received training at orientation or annually regarding the hospital's emergency preparedness program consistent with expected roles of each staff for 9 of 9 staff members reviewed (Staff #205, #206, #207, #208, #209, #213, #214, and #215). Failure to ensure that staff are trained on the hospital's emergency preparedness plan and their expected roles during an emergency risks delayed response, injury or death to staff and patients in the event of an emergency. Findings included: 1. Record review of the hospital policy titled, "Emergency Operation Plan," reviewed 05/08/18, showed that staff identified in critical areas will receive appropriate training on the Incident Command System and the National Incident Management System. The policy does not mention all-staff training or required intervals for that training. Record review of the emergency preparedness	E 037		

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E 037	Continued From page 5 program documents did not show any employee training materials or documentation. 2. Record review of the personnel files for four registered nurses (Staff #205, #206, #207, and #209), two mental health technicians (Staff #213 and #214), two licensed practical nurses (Staff #215 and #216), and one program therapist (Staff #208) showed that there was no documentation of having completed emergency preparedness training in their personnel files. 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who also serves as the hospital clinical educator regarding staff emergency preparedness training. Staff #210 stated that the facilities department should handle emergency preparedness training for all staff. She confirmed that the emergency preparedness trainings were not a part of the normal hospital orientation or annual training process. .	E 037		

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A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: . Based on observation, document review, and interview, the hospital's governing body failed to provide effective oversight of the hospital. Failure to provide effective oversight to prevent substandard practices for quality care, patient safety, pharmacy services, and nursing services resulted in an unsafe environment for patients. Findings included: The hospital failed to develop a hospital-wide quality assessment and performance improvement (QAPI) plan to monitor, evaluate, and improve the quality of patient care services through systematic data collection and analysis, and implementation and monitoring of quality activities. Cross Reference: A0263 The hospital failed to ensure sufficient numbers of nursing staff were available to provide safe and effective care for patient's health care needs Cross Reference: A0385	A 043		

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A 043	Continued From page 1 The hospital failed to maintain ongoing compliance with previously cited deficient practices. Cross Reference: A068, A0144, A0263, A0273, A0286, A0308, A0385, A0392, A0396, A0405, A0749 Due to the cumulative effect of the deficiencies detailed under 42 CFR 482.21 Condition for Participation for Quality Assessment and Performance Improvement Program and 42 CFR 482.23 Condition of Participation for Nursing Services, the Condition of Participation for Governing Body was NOT MET. THIS IS A REPEAT FAILURE TO MEET THE REQUIREMENTS OF THE CONDITION PREVIOUSLY CITED ON 03/15/18, 06/07/18, AND 07/17/18. .	A 043		
A 068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE CFR(s): 482.12(c)(4) [...the governing body must ensure that the following requirements are met:] A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that-- (i) Is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is-- (A) Defined by the medical staff; (B) Permitted by State law; and	A 068		

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A 068	Continued From page 2 (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors. This STANDARD is not met as evidenced by: . Based on interview, record review, and review of hospital policies and procedures the Governing Body failed to develop and maintain effective systems that ensured that patients received quality healthcare that met their needs for 2 of 3 patients with Diabetes Mellitus reviewed (Patient #501 and #503). Failure to provide patients with medical services that meet the patient's healthcare needs risks deterioration of the patient's condition and poor healthcare outcomes. Findings included: 1. Document review of the hospital's document titled, "Medical Staff Rules and Regulations," dated 04/17, state that the attending physician shall assume and accept full responsibility for the quality of the clinical care for his/her patients ....the admitting physician must give complete orders including but not limited to precautions to be followed and labs to be drawn. Document review of the hospital's document titled, "Smokey Point Behavioral Hospital Governing Board Bylaws and Constitution," dated 06/17, states that the Governing Board is ultimately accountable for the quality of patient care, treatment, and services. 2. On 01/08/19 at 2:00 PM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was	A 068		

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A 068	Continued From page 3	A 068		

admitted on 01/05/19 for the treatment of psychosis. The review showed:

-The Psychiatric Evaluation completed on 01/06/19 showed a medical history of Diabetes Mellitus Type 2.

-The Initial Medical Consultation completed on 01/06/19 showed a medical history of Diabetes Mellitus Type 2 and a blood sugar of 387 in the Emergency Room prior to admission to the psychiatric hospital.

-On 01/06/19 at 4:40 PM, a provider order directed nursing staff to check the patient's blood sugar level twice daily. The provider's order did not provide direction for staff response to the patient's blood sugar level.

-Review of blood sugar documentation on the medication administration record from 01/06/19 until 01/08/19 showed the patient's blood sugar level ranged from 157 mg/dl to 240 mg/dl. Surveyor #5 found no provider orders to direct staff when to notify the provider and no orders to treat high or low blood sugar levels.

3. At the time of the observation, Surveyor #5 asked the Registered Nurse (RN) (Staff #505) at what blood sugar levels did he need to notify the provider. Staff #505 stated that he did not know what the blood sugar parameters were and he would need to look at the policy. A search for a policy revealed there was no policy or protocol that addressed blood sugar management or parameter to notify the provider.

Staff #505 verified there were no provider orders to direct staff when to notify the provider and no

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orders to treat high or low blood glucose levels.

4. On 01/09/19 at 9:25 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #511), and a Licensed Practical Nurse (Staff # 512) reviewed the medical record of Patients #503. Patient #503 was admitted for suicidal ideation with intent to harm oneself, major depression, and visual hallucinations. The review showed:

-The Psychiatric Evaluation completed on 01/04/19 showed a medical history of Diabetes Mellitus Type 2

-The Initial Medical Consultation completed on 01/04/19 showed a medical history of Diabetes Mellitus Type 2.

-On 01/04/19, a provider ordered blood sugar checks in the morning and before the patient's evening meal.

-Review of blood sugar documentation from 01/04/19 until 01/09/19 showed the patient's blood sugar level ranged from 122 mg/dl to 299 mg/dl. Surveyor #5 found no provider orders to direct staff when to notify the provider and no orders to treat high or low blood sugar levels.

4. At the time of the observation, Surveyor #5 asked the LPN (Staff #509) at what blood sugar levels did she need to notify the provider. Staff #509 stated that there was an, "element of judgement." Staff #509 verified there were no provider orders to direct staff when to notify the provider and no orders to treat high or low blood sugar levels.

5. On 01/16/19 at 4:45 PM, a Physician (Staff

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A 068	Continued From page 5 #513) provided Surveyor #5 with a copy of a document titled, "Data Entry for Blood Glucose Quality Control," dated 06/17. Staff #513 stated this was a form adopted to guide staff about when to call the provider for low and high blood sugars. Surveyor #5 reviewed the form and noted it was a quality control form for checking controls on the blood sugar machines. It included a column for the control chem-strip lot number, expiration date and code number. It contained a column for acceptable control ranges for low and high that were define above the column as "low range would be 29-59 mg/dl and the high range should be 222-371 mg/dl." It also contained a column to document cleaning and maintenance of the machine. Surveyor #5 found no evidence that this form was an order or protocol to direct staff when to notify a provider of low or high patient blood sugar levels. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18, 06/07/18, 07/17/18, 08/22/18, AND 09/12/18. .	A 068		
A 119	PATIENT RIGHTS: REVIEW OF GRIEVANCES CFR(s): 482.13(a)(2) [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by:	A 119		

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Based on document review and interview, the hospital failed to ensure review and resolution of a patient grievance went through the grievance committee for 1 of 2 grievances reviewed.

Failure to review and approve resolution of grievances by a committee instead of an individual risks incomplete or inadequate evaluation of all aspects of the grievance issue.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Grievances and the Patient Advocate," no policy number, effective 05/17, showed that the patient advocate will investigate all complaints received from patients and others. Each patient making a complaint and others making a complaint will receive a response from the facility staff that addresses the complaint in a timely manner (within one week). A written response is to be provided within 30 days of the filed grievance. The Chief Executive Officer shall have final authority and responsibility in resolving grievances.

2. On 01/16/19 at 1:50 PM, Surveyor #3 interviewed the Director of Quality and Risk Management (Staff #308) about the grievance investigation and resolution process. Staff #307 stated grievances are investigated and reported through the performance improvement and grievance committees. The grievance committee consists of the Chief Executive Officer, the Chief Financial Officer, the Chief Nursing Officer, the Program Directors, and the Chief of Clinical Services. The grievance committee meets monthly.

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A 119	Continued From page 7 3. On 01/16/19 at 2:00 PM, Surveyor #3 reviewed the 2018 grievance log. The surveyor observed that two grievances had been filed in December with one remaining open. The surveyor asked Staff #308 if the one closed grievance filed in December had gone through the grievance committee process. Staff #308 stated the grievance had not gone through the grievance committee. Staff #308 reviewed, investigated, and closed the grievance himself rather than referring it to the grievance committee.	A 119		
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 interview, record review, and review of hospital policy and procedures, the hospital staff failed to implement its policies and procedures when contraband was discovered in a patient's room for 1 or 1 records reviewed (Patient #903). Failure to report, investigate, and prevent contraband and other hazardous items from entering the hospital risks patient, visitor, and staff safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Room Searches," no policy number, revised date 06/18, showed that hospital staff members would search patient rooms for contraband at least twice daily. Contraband	A 144		

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included prohibited items such as illegal drugs and paraphernalia. The policy showed that when staff discover contraband, hospital staff would confiscate the items; immediately notify the patient, the patient's healthcare provider, and the Chief Nursing Officer; and complete an incident report.

2. On 01/10/19 at 2:30 PM, Surveyor #9 interviewed a Registered Nurse (RN) (Staff #905) regarding an allegation that Patient #903 had brought contraband into the hospital. He stated that on 12/24/18 he received a note from a patient stating that there were "drugs on the unit." The nurse conducted a room search and found some small blue rubber pieces with a white residue. The nurse contacted the Chief Nursing Officer (CNO) (Staff #906) at the time of the discovery. Staff #905 also shared this information with the healthcare providers in their treatment meeting that day. As a result, the involved patient's provider wrote an order for the patient to be on unit restriction and placed on 5-minute observational monitoring.

3. Staff #905 stated that around 10 AM on 12/24/18, he observed Patient #903 to be pale, sweating, and complaining of right lower quadrant abdominal pain. The nurse contacted the provider who directed the patient to be sent to a local emergency room for diagnosis and treatment. The patient's subsequent diagnosis was determined to be constipation. In addition, it was determined the patient tested positive for amphetamines.

On 12/26/18, Staff #905 conducted another room search. During the search, a white powder in a plastic bag was found in Patient #903's pant

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A 144	Continued From page 9 pocket. The patient was confronted and stated that the powder was Suboxone (a medication used for opioid dependence). The patient stated he had received it during an emergency room visit prior to being admitted at the psychiatric hospital. The staff had not found or detected the medication during the initial admission process. The RN placed the plastic bag in a specimen container and marked it with the patient's name, date and time found. The RN gave the item to the CNO and wrote a progress note on 12/26/18 detailing what he found in the patient's room. 4. The RN stated that he also filled out an incident report regarding the search findings. The surveyor was unable to find a incident report regarding this incident nor the incident on 12/24/18 despite a review of the hospital's incident report logs. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18, 06/07/18, 07/17/18, AND 09/12/18. .	A 144		
A 171	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(8) Unless superseded by State law that is more restrictive-- (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or	A 171		

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A 171	Continued From page 10 (C) 1-hour for children under 9 years of age; This STANDARD is not met as evidenced by: . Based on record review and review of hospital policies and procedures, the hospital failed to ensure staff appropriately ordered the correct time limits for restraint use or seclusion based upon the patient's age for 1 of 6 records reviewed (Patient #1001). Failure to order the correct time of restraint or seclusion duration places patients at risk for physical and psychological harm, loss of dignity, and violation of patient rights. Findings included: 1. Review of the hospital's policy titled, "Use of Seclusion," no policy number, effective 05/17 showed that the use of seclusion requires a time-limited Physician order. For ages 9-17 years old, the time duration is two hours. For those 18 and older, the time duration is four hours. The policy showed that in the event of an emergency, a trained nurse may make the decision to initiate seclusion. 2. A review of Patient #1001's medical record showed a 13-year old patient admitted to the adolescent unit for management of a mental health disorder. On 12/01/18 at 2:45 PM, the patient was observed punching the wall, resulting in harm to himself as staff attempted to de-escalate the situation. The review showed that the patient initially was held manually from 2:45 PM - 2:50 PM and then placed in seclusion from 2:45 PM - 3:00 PM. The nurse obtained a verbal order from a licensed provider at 3:30 PM, but the	A 171		

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A 171	Continued From page 11 time limit ordered for this event was noted to be for an adult with a maximum of 4 hours of seclusion. Since the patient was a 13 year old, the order should have been limited to two hours of seclusion, plus continuous assessment, by staff, to ensure release from seclusion was done at the earliest possible time, as required. .	A 171		
A 196	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(f)(1) Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion- (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. This STANDARD is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that contracted nursing staff received restraint and seclusion training as part of their orientation and at regular intervals for 1 of 3 agency records reviewed (Staff #205). Failure to ensure staff receive orientation in restraint and seclusion training places patients at risk for violations of their rights, unsafe care, and potential injury from improper restraint and seclusion application. Findings included:	A 196		

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A 196	Continued From page 12 1. Record review of the hospital policy titled, "Staff Training," no policy number, revised 09/18, showed that staff are to receive initial and ongoing training on restraints and seclusion. Human resources is responsible for maintaining documentation of all training completed by staff. 2. Record review of employee personnel and training files for one agency registered nurse (Staff #205) who started 10/23/17, showed that the staff member did not have any documentation of in-service training for restraint or seclusion including least restrictive alternatives to their use. 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the hospital clinical educator, regarding the training files for Staff #205. Staff #210 stated that staff have 90 days to complete orientation and that restraint and seclusion in-service training occurred in October of 2018. Staff #210 confirmed that no training files for restraints and seclusion orientation or in-service training were in the employee personnel file. The hospital was unable to provide any training checklist or other documentation to confirm that Staff #205 had completed restraint and seclusion training. .	A 196		
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.	A 263		

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The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

This CONDITION is not met as evidenced by:
.
Based on observation, interview, and review of quality documents, the hospital failed to develop a hospital-wide quality assessment and performance improvement (QAPI) plan to monitor, evaluate, and improve the quality of patient care services through systematic data collection and analysis, and implementation and monitoring of quality activities.

Failure to systematically collect and analyze hospital-wide performance data limited the hospital's ability to identify problems and formulate action plans. This reduced the likelihood of sustained improvements in clinical care and patient outcomes.

Findings included:

The hospital failed to ensure review and resolution of a patient grievance went through the grievance committee.

Cross Reference A0119

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A 263	Continued From page 14 The hospital failed to ensure that data regarding medication errors, assaults, and patient falls, were analyzed for patterns, trends, and common factors through the hospital's quality program. Cross Reference A0273 The hospital failed to develop and implement performance improvement activities and action plans that supported hospital quality indicators related to patient safety and quality of care. Cross Reference A0283 The hospital failed to ensure corrective actions for identified adverse events were implemented and monitored for effectiveness. The hospital failed to ensure corrective actions for identified adverse events were implemented and monitored for effectiveness. Cross Reference A0286 The hospital failed to develop and implement a coordinated, integrated hospital-wide quality assessment and performance improvement plan. Cross Reference A0308 The hospital failed to ensure sufficient numbers of nursing staff were available to provide safe and effective care for patient's health care needs. Cross Reference A0385 The hospital failed to ensure that contracted nurses received documented hospital orientation and the hospital failed to ensure that annual	A 263		

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A 263	Continued From page 15 agency staff performance evaluations were conducted. Cross Reference A0398 The hospital failed to ensure that patients with medical conditions or histories that necessitate dietary consults received consults or that consults ordered by dieticians were conducted. Cross Reference A0629 The hospital failed to ensure that contracted staff were oriented on infection control. The hospital failed to ensure that staff members placed patients with infectious disease diagnosis in appropriate precautions to prevent transmission of infections. Cross Reference A0749 Due to the scope and severity of these deficiencies, the Condition of Participation at 42 CFR 482.21, Quality Assurance, and Performance Improvement was NOT MET. THIS IS A REPEAT FAILURE TO MEET THE REQUIREMENTS OF THE CONDITION PREVIOUSLY CITED ON 03/15/18. .	A 263		
A 273	DATA COLLECTION & ANALYSIS CFR(s): 482.21(a), (b)(1),(b)(2)(i), (b)(3) (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is	A 273		

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A 273	Continued From page 16 evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: . Based on interview, review of the hospital's quality program and review of quality documentation, the hospital failed to ensure that data regarding medication errors, assaults, and patient falls, were analyzed for patterns, trends, and common factors through the hospital's quality program. Failure to collect, aggregate and analyze data to improve patient outcomes puts patients at risk of substandard care. Findings included:	A 273		

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1. Document review of the hospital's document titled: "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no policy number, no approval date, showed that the hospital collects, aggregates, and uses statistical analyses of performance measurement data to:

-determine if there are opportunities for improvement,
-to identify suspected or potential problems,
-to prevent or resolve problems,
-to set process improvement priorities,
-and to monitor effectiveness of actions taken.

The hospital will utilize comparison of outcome and process data to ensure that the same level of care is provided regardless of geographic location in the hospital where care is provided.

2. On 01/10/19 at 5:00 PM, Surveyor #5 reviewed the hospital's document titled, "Quality Dashboard 2018." Surveyor #5 noted that the hospital's quality indicator data including falls, assaults, contraband, employee injuries, medication errors, self-harm, and infections were presented in a line-listed format without aggregation or analysis. The hospital did not stratify data by geographic location for comparison as directed by the hospital's Quality Plan.

3. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and Senior Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality program and PI committee meeting minutes. Review of the PI committee minutes showed the hospital did not aggregate performance improvement indicator data, stratify data by geographic location, set

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A 273	Continued From page 18 benchmarks, set targets for improvement, or perform statistical analysis as directed by the hospital's Process Improvement Plan. 4. At the time of the review, Staff #513 and Staff #514 confirmed the finding and stated that the plan and the format of the minutes needed to be re-evaluated. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18. .	A 273		
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to -.....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.	A 283		

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A 283	Continued From page 19 This STANDARD is not met as evidenced by: . Based on interview, document review, and review of quality data, the hospital failed to develop and implement performance improvement activities and action plans that supported hospital quality indicators related to patient safety and quality of care. Failure to develop projects and action plans based on results of data collection aimed at improving patient outcomes puts patients at risk from harm due to substandard care. Findings included: 1. Document review of the hospital's document titled: "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no policy number, no approval date, showed that the hospital collects, aggregates, and uses statistical analyses of performance measurement data to: -determine if there are opportunities for improvement, -to identify suspected or potential problems, -to prevent or resolve problems, -to set process improvement priorities, -and to monitor effectiveness of actions taken. The document further states that assessment activities carried out by the program included data assessment to identify opportunities for improvement and facilitate setting of priorities and comparison of outcome and process data to ensure that the same level of care is provided regardless of geographic location in the hospital where care is provided.	A 283		

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2. On 01/10/19 at 5:00 PM, Surveyor #5 reviewed the hospital's document titled, "Quality Dashboard 2018." Surveyor #5 noted that the hospital's quality indicator data including falls, assaults, contraband, employee injuries, medication errors, self-harm, and infections were presented in a line-listed format without aggregation or analysis.

The document showed 31 falls, 88 assaults, 33 instances of contraband, and 26 employee injuries.

The hospital did not stratify data by geographic location for comparison as directed by the hospital's Quality Plan.

3. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and Senior Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality program and PI committee meeting minutes. Review of the PI committee minutes showed the hospital did not aggregate performance improvement indicator data, stratify data by geographic location, set benchmarks, set targets for improvement, or perform statistical analysis as directed by the hospital's Process Improvement Plan.

Because the hospital failed to aggregate and analyze its quality indicator data, it was unable to identify problems or potential problems, set process improvement priorities, and develop corresponding process improvement action plans and monitoring plans.

4. At the time of the review, Staff #513 and Staff #514 confirmed the finding. Staff #514 stated that

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A 283	Continued From page 21 the hospitals PI plan would need to be re-evaluated to include the required elements. .	A 283		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: . Based on interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to identify, track, and investigate patient safety events as directed by its process improvement plan for 9 of 13 patient safety events (Item #1) and failed to	A 286		

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implement and evaluate effectiveness of corrective actions for previously identified adverse events (Item #2).

Failure to identify and analyze data to determine factors that contribute to patient injury can result in an unsafe healthcare environment.

Item #1 - Patient Safety Event Reporting and Investigation

Findings included:

1. Document review of the hospital's document titled, "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan) no policy number, no approval date, identified performance improvement indicators including "incidents, adverse events, sentinel events, and critical incidents."

The document stated that the PI committee is responsible for providing oversight of the hospital's systems for process improvement, including clinical outcomes, evidence based practice, resource utilization and patient safety. The committee will receive reports from Risk and Safety, and use data sources in evaluation of the need for quality improvement teams. The Manager of PI and Risk is authorized to conduct any necessary investigation in cases of significant incidents or sentinel events. Any events requiring root cause analysis and process improvement are reported to the PI committee for monitoring and follow-up.

2. During medical record review from 01/08/19 through 01/11/19, Surveyor #3, Surveyor #5, Surveyor #9, and Surveyor #10 identified 13

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patient safety incidences. Review of the hospitals incident report log showed that 9 of the 13 safety incidents were not identified, logged into the incident reporting system, or investigated. The events identified included:

a. Patient #505: Suicide Attempt on 10/04/18

b. Patient #506: Suicide Attempt on 11/22/18

c. Patient #507: Suicide Attempt on 12/02/18

d. Patient #508: Sexual Victimization (female adolescent patient touched inappropriately and without permission by a male peer) on 12/09/18 and 12/10/18

e. Patient #509: Medication Error on 12/13/18

f. Patient #510: Assaulted Staff, threw furniture, and required a police response on 12/16/18

g. Patient #511: Assaulted a peer on 12/21/18

h. Patient #512: Ingested Contraband resulting in patient transfer to hospital on 12/24/18

i. Patient #513: Medication Error (six missed doses) started on 01/03/19

3. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and the Senior Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality and safety program. Surveyor #5 compared the incident report log provided by the hospital with these incidences and noted the incidences had not been identified, logged, or investigated. Staff

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#513 and #514 confirmed the finding and stated that the process they have in place at this time for identifying and managing incidents is not effective.

Item #2 - Adverse Events Corrective Action Monitoring

Findings included:

1. Document review of the hospitals policy and procedure titled, "Root Cause Analysis," no policy number, effective date 05/17, showed that the Root Cause Analysis (RCA) must identify who is responsible for monitoring whether the change has been implemented, at what frequency the monitoring will occur, and how the effectiveness of the change will be evaluated, including who will be responsible and what indicators will be used.

Document review of the hospital's document titled, "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no policy number, no approval date, showed that sentinel events and significant incidences requiring root cause analysis and performance improvement activities are reported to the Process Improvement Committee for monitoring and follow-up.

2. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and the Senior Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality and safety program including the hospital's adverse event log for year 2018. The log showed two events reported for 2018. Surveyor #5 reviewed the two RCA's and noted that the hospital initiated

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A 286	Continued From page 25 corrective action plans for 1 of 2 of the reported adverse events. Surveyor #5 found no evidence the hospital monitored or reevaluated the corrective action plans to determine effectiveness of the interventions or measurable progress toward the established goals. 3. At the time of the review, an interview with Surveyor #5, Staff #513 and #514 confirmed the finding. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18 AND 06/07/18. .	A 286		
A 308	QAPI GOVERNING BODY, STANDARD TAG CFR(s): 482.21 ... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This STANDARD is not met as evidenced by: . Based on interview, document review, and review of the hospital's quality and performance improvement program, the hospital failed to develop and implement a coordinated, integrated hospital-wide quality assessment and performance improvement plan. Failure to develop a coordinated process to oversee the performance of all patient care services and departments risks provision of	A 308		

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improper or inadequate care and adverse patient outcomes.

Findings included:

1. Document review of the hospital's document titled: "Smokey Point Behavioral Hospital 2019 Performance Improvement Plan (PI Plan)," no policy number, no approval date, showed that the hospital collects, aggregates, and uses statistical analyses of performance measurement data to determine if there are opportunities for improvement, to identify suspected or potential problems, to prevent or resolve problems, and to monitor effectiveness of actions taken. The objective of the plan is to ensure coordination and integration of all quality improvement activities by maintaining a PI Committee that all quality improvement information will be exchanged and monitored.

2. On 01/15/19 from 3:00 PM until 5:00 PM, Surveyor #5, Surveyor #10, the hospital's Manager of PI and Risk (Staff #513) and Senior Vice President of Clinical Compliance (Staff #514), reviewed the hospital's quality program. The review showed:

-The program did not include or evaluate performance metrics for the hospital's clinical contracted services. There was no mechanism for reporting process improvement recommendations through the hospital's Quality Committee.

-The program did not include or evaluate performance metrics for the hospital's Pharmacy Services. The quality review process for Pharmacy Services was not part of the hospital's

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quality and performance improvement program. Surveyor #5 found no evidence medication error data was aggregated, analyzed, or monitored for effectiveness of actions taken to reduce medication errors through the hospital's quality program.

3. At the time of the review, Staff #513 and Staff #514 confirmed the findings.

4. On 01/16/19, Surveyor #9 reviewed the Pharmacy and Therapeutics Committee (P & T) meeting minutes for September 2018, October 2018, and November 2018. Surveyor #9 found no evidence that medication errors or near misses had been aggregated, trended, or reported through the Quality Committee. Surveyor #9 observed that the P & T minutes dated 11/29/18 stated "Future medication errors will need to be trended and analyzed for opportunities for improvement."

5. On 01/16/19 at 10:30 AM, during an interview with Surveyor #9, the Pharmacy Director (Staff #908), stated that he was recently hired by the hospital on 11/29/18. He acknowledged that prior to his arrival, medication errors had not been aggregated or trended nor had medication errors been reported to or monitored by the hospital Quality Committee.

6. On 01/16/19 at 1:00 PM, Surveyors #2, #3, and #5 interviewed 3 of 7 voting members of the governing body which included the Chief Executive Officer (CEO) (Staff #309), the Chief Financial Officer (Staff #310), and the Senior Vice President for Clinical Compliance (Staff #311). Other hospital staff in attendance included the Chief Nursing Officer (Staff #306) and the Chief

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of Quality & Risk (Staff #308). Surveyor #3 asked how the Governing Body ensured the hospital remained in compliance with the conditions of participation following the September 2018 revisit. In addition, the surveyor asked what actions have the hospital taken to sustain its compliance efforts given the current on-site survey team is finding similar findings to previous visits? Staff #311 stated a member of the governing body has been on-site at this hospital almost continuously since the March 2018 survey. Staff #311 also stated the corporate leadership recognizes there are problems and is trying to address them. She stated that after the hospital came into compliance, the hospital replaced the CEO in late September. It has replaced the Chief Medical Officer after the former resigned in October. Finally, the CEO brought in a new CNO in late November to make additional changes.

The CEO (Staff #309) stated that she initially noticed many broken processes and looked at each area. She stated there was a need to reorganize the hospital structure. She acknowledged there were daily discussions with the corporate headquarter's leadership regarding the hospital operations. Staff #309 stated there has been tremendous transitions with staffing as result of turnover and on-boarding. She participates in weekly corporate operation meetings, which includes review of several reports both weekly and monthly.

Surveyor #5 stated that she found no evidence in the Governing Board Minutes to reflect these daily or weekly discussions. Staff #311 confirmed that the documentation "could be better."

THIS CITATION WAS PREVIOUSLY CITED ON

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A 308	Continued From page 29 03/15/18. .	A 308		
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: . Based on observation, interviews, and document reviews, the hospital failed to ensure sufficient numbers of nursing staff were available to provide safe and effective care for patient's health care needs. Failure to provide enough staff to meet patient needs risks deterioration of the patient's health status and delayed treatment. Findings included: Failure to ensure that the number of assigned personnel allowed for treatment planning and delivery of care as ordered by the treatment team. Cross Reference: A0392, A0396, Failure to ensure that non-employee licensed nurses were properly orientated to the hospital's policies and procedures. Cross Reference: A0398 Failure to ensure that staff members followed	A 385		

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A 385	Continued From page 30 hospital policy and procedure for transcription and verification of physician orders. Cross Reference: A0405 Due to the scope and severity of deficiencies cited under 42 CFR 482.23, the Condition of Participation for Nursing Services was NOT MET. THIS IS A REPEAT FAILURE TO MEET THE REQUIREMENTS OF THE CONDITION PREVIOUSLY CITED ON 03/15/18 AND 06/07/18. .	A 385		
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 bedside care of any patient. This STANDARD is not met as evidenced by: . Based on document review and interviews, the hospital failed to ensure the facility had sufficient nursing personnel to provide safe and effective care to patients. Failure to provide an adequate number of trained registered nurses (RN), licensed practical nurses (LPN), and mental health technicians (MHT) risks patient safety and delays in care and treatment.	A 392		

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Findings included:

1. Document review of the hospital document titled, "Nurse Staffing Plan," dated 05/17, showed that nursing care is to be provided by sufficient numbers of nursing staff members including registered nurses and licensed practical nurses to meet the identified nursing care needs of patients and family members twenty-four hours a day.

Core staffing is projected based on the following critical factors:

- Patient characteristics
- The number of patients receiving care, including admissions, discharges and transfers
- Intensity of patient care being provided
-The variability of patient care across the unit
-The scope of services provided, accounting for architecture and geography of the unit
- Staff characteristics, including staff consistency, tenure, preparation and experience
- The number and competencies of both clinical and non-clinical support staff the nurse must collaborate or supervise.

2. A review of the daily nurse-staffing sheet for a fourteen-day period (12/23/18 - 01/05/19) showed the following:

a. The adolescent inpatient unit, which cares for children ages 12 to 17, did not have a registered nurse assigned to the night shift for 2 of 14 days reviewed. In addition, one other night shift did not have a registered nurse assigned for a 4-hour period.

b. The adult intensive care unit, which cares for adults with acute and significant behavioral

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disturbances did not have a registered nurse assigned to the night shift for 2 of 14 days reviewed.

c. The open adult unit that cares for adults with first time symptomology for behavioral health illness did not have a registered nurse assigned to the night shift for 2 of 14 days reviewed.

d. The military unit which cares for adults with service connected behavioral health illness did not have a registered nurse assigned to the night shift for 1 of 14 days reviewed. In addition, one other night shift did not have a registered nurse assigned for a 2.5-hour period.

3. On 01/08/19 at 9:10 AM, Surveyor #3 inspected the adolescent inpatient unit. At the time of arrival, the surveyor observed there were three patients on the unit with no licensed nursing personnel present. Two mental health technicians (MHT) (Staff #301 and #302) were the only staff members present. Staff #301 stated the registered nurse (Staff #303) and another MHT had gone to the cafeteria for breakfast with the patients a few minutes ago.

A subsequent interview with the registered nurse upon return to the unit revealed that she usually does not leave the unit for meal times. She stated it is permissible to leave the unit as long as the unit is attended by another nursing staff member.

4. On 01/08/19 at 1:35 PM, Surveyor #5 observed Patient #501 approach the nurse's station and tell the Mental Health Technicians (MHT's) (Staff #501 and #502) at the nurses station that she was feeling shaky and weak and wanted her blood sugar tested. Surveyor #5 observed the

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patient ask to have her blood sugar tested two more times and then a Program Therapist (Staff #504) responded to the patient and asked for the nurse. The MHT's stated that the charge nurse (Staff #505) was at lunch and the other nurse (Staff #506) had left the unit. At that time, the Program Therapist left the unit to go get a nurse.

At 1:42 PM, a nurse (Staff #506), returned to the unit and took the patient's blood sugar. At the same time, Surveyor #5 interviewed Staff #501 and #502 who verified that there is not always a nurse on the unit at all times.

5. On 01/10/19 at 7:00 PM, Surveyor #3 interviewed a registered nurse (Staff #304) about adequacy of nurse staffing for the clinical units. The surveyor asked if there ever was a time when there was no registered nurse on the unit. Staff #304 stated it has happened several times. A licensed practical nurse is in charge of the unit when no registered nurse is available. Staff #304 recalled at least one incident in which there was only one registered nurse providing care and supervision for two clinical units but could not recall the date.

6. On 01/10/19 at 7:30 PM, Surveyor #3 interviewed a mental health technician (Staff #305) about staffing. Staff #305 stated that he has been left alone on the unit at times when the assigned registered nurse was providing care and nursing coverage on another unit. He indicated that the assigned registered nurse would leave the unit to pass medications on another unit and then return to pass medications on their assigned unit.

7. On 01/11/19 at 10:00 AM, Surveyor #3

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reviewed the medical record of Patient #301 who was admitted to the adolescent unit on 12/29/18 for treatment of a mood adjustment disorder. The review of the medical record showed the following:

-On 01/06/19 at 11:30 AM, a nurse wrote a nursing order for sexually acting out precautions and established a five-foot boundary rule from other patients after attempting sexual behavior in the patient's bathroom.

-On 01/09/19 at 9:45 PM, a nursing progress note showed the patient required frequent reminders about his five-foot rule with female peers.

-On 01/10/19 at 6:30 PM, a note written by a MHT (Staff # 301) showed that Patient #301 had sexual contact with Patient #302 on 01/09/19. Patient #301 informed Staff #301 that the consensual sexual contact occurred in the female patient's room while the MHT was passing out snacks to other patients.

A review of the nurse staffing for the adolescent unit on 01/09/19 showed that the hospital had only the minimum required staffing (1 RN and 1 MHT) at the time of incident.

7. On 01/16/19 at 9:25 AM, Surveyor #3 interviewed the Chief Nursing Officer (CNO) (Staff #306) about nurse staffing for the hospital. The CNO stated that the hospital uses a nurse-staffing grid that establishes minimum staffing levels for each of the clinical units. She stated she checks the nurse-staffing schedule several times a day to ensure the units are appropriately staffed. Shortfalls in staffing are covered by calling in staff for voluntary overtime

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A 392	Continued From page 35 or offering shift bonuses for extra hours worked. When asked what happens if this is not effective in resolving the shortage, the CNO stated, "We do what we can". She acknowledged there are occasions when the only licensed nurse staff member on a clinical unit is a licensed practical nurse (LPN). During those occasions, a registered nurse will supervise or cover more than one nursing unit at a time. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18 AND 06/07/18. .	A 392		
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. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: . Based on interview, record review, and review of policies and procedures, the hospital failed to develop an individualized plan for patient care for 5 of 15 patients reviewed (Patient #501, #502, #503, #504, and #902). Failure to develop an individualized plan of care can result in the inappropriate, inconsistent, or delayed treatment of patient's needs and may lead to patient harm and lack of appropriate treatment for a medical condition. Findings included: 1. Document review of the hospital's policy and	A 396		

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procedure titled, "Treatment Planning," no policy number, effective date 05/17, showed that following the nursing assessment, the Registered Nurse will add medical problems to be addressed to the treatment plan. The treatment plan will be reviewed and updated weekly at Treatment Team meetings and will reflect changes in the patient's course of treatment.

Document review of the "2018 {Infection Control} Risk Assessment and Plan & Evaluation," showed that one of the planned opportunities to decrease the risk of infectious disease included addressing infectious diseases on the medical care plan.

Patient #501

2. On 01/08/19 at 2:00 PM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was admitted on 01/05/19 for the treatment of psychosis. The patient's medical history showed the patient underwent a gastric bypass surgery one and a half years ago. Surveyor #5 found no evidence that nutritional support was addressed in the patient's treatment plan.

3. At the time of the observation, Staff #505 confirmed the finding and stated that he would expect to see this added to the treatment plan.

Patient #902

4. On 01/08/19 at 2:30 PM, Surveyor #9 reviewed the medical record of Patient #902 who was admitted to the hospital on 01/05/19 with a diagnosis of acute psychosis and suicidal ideation. An initial medical consultation on 01/06/19 by a physician (Staff #903) showed a

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medical diagnosis of Hepatitis C was added to the patient's problem list. The physician ordered an outpatient consult with a gastroenterologist. Review of the treatment plan for Patient #902 did not include the diagnosis of Hepatitis C.

5. At the time of the record review, Surveyor #9 asked the Director of the Transitional Care Unit (Staff #902) if she would expect to see the diagnosis of Hepatitis C on the patient's treatment plan. She stated that the diagnosis should be there. On 01/16/19 at 1:00 PM during a meeting with the Infection Control Nurse (Staff #904), Surveyor #9 asked if she would expect to see the Hepatitis C diagnosis added to the treatment plan and she confirmed that infectious diseases should be added to the treatment plan.

Patient #502

6. On 01/08/19 at 3:00 PM, Surveyor #5 and the Infection Preventionist (Staff #507), reviewed the medical record for Patient #502, who was admitted for the treatment of schizo-affective disorder with methamphetamine abuse and attempted suicide. On 12/26/18, the patient was tested for Hepatitis A, B, and C related to abnormal liver function tests. On 12/31/18, the patient was diagnosed with Hepatitis C and was referred for consultation with gastroenterology or infectious disease upon discharge for possible treatment with interferon. Surveyor #5 found no evidence that staff added the new medical diagnosis to the patient's treatment plan.

7. At the time of the finding, Staff #507 stated that she was aware of the patient, and confirmed that staff should have added the new medical diagnosis to the medical section of the treatment

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plan.

Patient #503

8. On 01/09/19 at 9:25 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #511) and a Licensed Practical Nurse (Staff # 512) reviewed the medical record of Patient #503, who was admitted for major depression, visual hallucinations, and suicidal ideation with intent to harm oneself. An initial medical consultation completed on 01/04/19 showed a medical diagnosis of Diabetes Mellitus Type 2. On 01/04/19, a provider ordered blood glucose checks twice daily. Surveyor #5 found no evidence that the medical problem of diabetes was included in the patient's treatment plan.

9. At the time of the observation, Staff #511 confirmed the finding.

Patient #504

10. On 01/11/19 at 9:30 AM, Surveyor #5 reviewed the medical record for Patient #504 who was admitted for the treatment of suicide attempt, depression, bipolar, schizoaffective disorder, and auditory hallucinations to harm self. A medical consultation completed on 09/26/18 at 12:24 PM, showed the patient had a rash on the right anterior chest suspicious for Shingles. The provider's examination showed the patient had greater than 12 painful vesicles on the right chest. The patient was started on Acyclovir 800 mg 5 times daily for 7 days. Surveyor #5 found no evidence that staff added the new medical diagnosis to the patient's treatment plan.

On 10/06/18 at 4:00 PM, a medical consultation

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A 396	Continued From page 39 showed the patient had a red rash to the inguinal and groin regions. The patient was treated with fluconazole 100 mg daily for 7 days and antifungal powder for the treatment of intertigo (a rash caused by fungus or bacteria that usually affects the folds of the skin, where the skin rubs together, or where it is often moist) and candidiasis (a fungal infection). On 10/15/18 at 11:40 AM, a medical consult was ordered for increased redness and itching around the groin area. A provider ordered Doxycycline 100 mg daily for 7 days for intertigo. Surveyor #5 found no evidence that the medical diagnosis was included in the patient's treatment plan. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18 AND 06/07/18. .	A 396		
A 398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that contracted nurses received documented hospital orientation for 1 of 3 files reviewed (Staff #205) (Item #1), and failed to complete annual agency staff performance evaluations for 1 of 3 staff members reviewed (Staff #205) (Item #2) .	A 398		

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Failure to ensure contracted nursing staff receive orientation to the hospital policies and procedures and receive annual performance evaluations places patients at risk for inconsistent or inadequate care.

Item #1 - Non-Employee Nurse Orientation

Findings included:

1. Record review of the personnel and training files for a contracted registered nurse (Staff #205) with a start date of 10/23/17, showed that no documentation of an orientation or training regarding nursing policies and procedures, emergency procedures, or safety policies were in the file.

2. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the clinical educator (Staff #210) regarding the training files for Staff #205. Staff #210 stated that staff have 90 days to complete orientation and confirmed that Staff #205 did not have any orientation or training documents in their personnel file.

Item #2 - Non-Employee Nursing Evaluation

Findings included:

1. Record review of the hospital policy titled "Evaluations," reviewed 04/18, showed that staff receive an evaluation 90 days post-hire and annually. The policy does not mention evaluations of contracted or agency staff.

2. Record review of the personnel file for a contracted registered nurse (Staff #205) with a

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A 398	Continued From page 41 start date of 10/23/17, did not show evidence that the hospital conducted a performance evaluation of the staff member one year after initial employment. 3. On 01/16/19 at 9:45 AM, Surveyor #2 interviewed the Human Resources Director (Staff #211) and the Vice President of Human Resources (Staff #212) regarding employee evaluations. The Human Resources Director stated that the hospital should evaluate agency staff at the end of their contract under the same process as hospital employees and the performance improvement department should be performing an overall evaluation of all contracted staff. Staff #211 confirmed the finding of the missing employee evaluation. .	A 398		
A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing	A 405		

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A 405	Continued From page 42 or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: . Based on record review and review of hospital policy and procedures, the hospital staff failed to follow its procedure for transcribing physician orders to the medication administration record for 4 of 7 patient records reviewed (Patient #301, #302, #303 and #904). Failure to transcribe and process physician orders promptly places patients at risk for delayed treatment and medication errors. Findings included: 1. Document review of the hospital's policy and procedure titled, "Physician Orders," no policy number, effective 05/17, showed that the nurse will transcribe medication and treatment orders. Any medication order transcribed to the medication administration record (MAR) is to be checked for accuracy by a second nurse during the chart check (at shift change and 24-hour chart check). Staff will ensure a copy of all medication orders, including as needed orders, are delivered without delay to the Pharmacy mailbox. Document review of the hospital's policy and procedure titled, "Written Medication Orders," no policy number, effective 05/17, showed that nursing staff will forward the written copy of the order to pharmacy in a timely manner.	A 405		

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2. On 01/09/19 at 9:00 AM, Surveyor #3 reviewed the medical record of Patient #301. The review showed that on 01/02/19 at 11:59 AM, a provider wrote a medication order for Depakote (medication used for mood disorders). The medication order was transcribed to the medication administration record (MAR) and sent to the pharmacy at 8:30 PM, over eight and one-half hours after being initially ordered. As a result, Patient #301 did not receive the medication in the evening as ordered due to the pharmacy being closed.

3. On 01/09/19 at 11:15 AM, Surveyor #3 reviewed the provider medication orders for five patients. The review showed:

a. Patient #302 had seven new medication orders written by a provider between 11/26/18 and 12/31/18 in which they were not transcribed by the nurse to the medication record for greater than 3 hours. The delay in transcribing ranged from 3 hours and 10 minutes to 8 hours and 45 minutes.

b. Patient #303 had one new medication order written by a provider on 12/13/18 at 7:00 PM but was not transcribed by the nurse until 12/16/18 at 1:00 AM, which is 2 days and 6 hours after being originally ordered.

4. On 01/10/19 at 10:40 AM, Surveyor #9 and Surveyor #11 interviewed a provider (Staff #907) regarding an allegation that Patient #904 had not received a medication as ordered and subsequently was not discharged as planned due to psychiatric decompensation. The provider stated that he ordered lorazepam 1 mg (a medication used to treat anxiety) to be

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administered to the patient three times a day. The original order written on 12/26/18 had an expiration date of 01/02/19. The provider stated that he reordered the medication on 01/02/19. On 01/04/19, the provider noted that the patient seemed more anxious. He reviewed her medications, looked at the patient's medication administration record (MAR), and discovered that 5 doses of lorazepam (2 days) had not been given. Further, the MAR did not reflect the renewal order for continuing the lorazepam as ordered on 01/02/19.

Document review for Patient #904 showed the following:

a. The MAR reflected that Lorazepam was ordered on 12/26/18 by the provider and was to be given three times a day.

-On 01/01/19 to 01/02/19 the medication lorazepam was only given twice a day (due to the MAR not being transcribed correctly).

-On 01/02/19 to 01/03/19 the medication lorazepam was not transcribed on the MAR and therefore was not given to the patient.

-On 01/03/19 to 01/04/19 the medication lorazepam was not transcribed on the MAR initially but added later after discovering the error. As a result, the patient only received the medication twice that day.

- A total of 5 doses of the medication lorazepam were missed from 01/01/19 to 01/04/19.

b. On 12/31/18, a reorder form for drugs expiring between 12/31/18-01/02/19 showed that the

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A 405	Continued From page 45 provider reordered the medication lorazepam. There were two stamped "Faxed" dates on the medication reorder form. One had no date noted and the second medication reorder form showed the order was refaxed on 01/04/19. 5. The provider stated that when he discovered this, he contacted the Chief Nursing Officer (Staff #906) and submitted an incident report to the pharmacy. Surveyor #9 was unable to find an incident report regarding this error despite a review of the hospital's Medication Error Incident Reports. 6. On 01/16/19 at 10:30 AM, Surveyor #9 discussed this finding with the Pharmacy Director (Staff #908). Staff #908 stated that he had not received an incident report on this error; however, around 01/02/19 he found that faxes were not being received in the pharmacy leading to duplications on orders. Additionally, he stated the process to verify the MAR was not clearly defined which led to errors. The Pharmacy Director (Staff #908) changed the reorder process so that medication orders are now scanned to pharmacy. The scanned orders are in a database that is accessible to pharmacy, physicians, and nursing to enable clarification and avoid duplications and missed orders. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18, 06/07/18, AND 07/17/18. .	A 405		
A 454	CONTENT OF RECORD: ORDERS DATED & SIGNED CFR(s): 482.24(c)(2) All orders, including verbal orders, must be dated,	A 454		

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A 454	Continued From page 46 timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by: . Based on record review and review of hospital policies and procedures, the hospital failed to ensure medical staff promptly signed and authenticated verbal or telephone orders taken by a nurse for initiation of seclusion or restraint as observed in 2 of 4 records reviewed (Patient # 303, #1001). Failure to authenticate verbal or telephone orders for initiation of seclusion risks treatment errors and violation of patient rights. Findings included: 1. Document review of the hospital's policy and procedure titled, "Use of Seclusion," no policy number, effective 05/17, showed that the physician's order governs the use of seclusion and the order will include the behavior that led to the intervention. The policy showed that the orders for seclusion must be authenticated within 24 hours. Document review of the medical staff rules and regulations, approved 05/31/17, showed that seclusion and/or restraint procedures require an order from the physician. In the event of an emergency, the registered nurse can initiate the procedure but must obtain an order. Seclusion and/or restraint orders must be authenticated by	A 454		

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A 454	Continued From page 47 the physician within 24 hours. 2. On 01/09/19 at 9:00 AM, Surveyor #3 reviewed the medical record of Patient #303. Patient #303 was a 14-year old admitted on 12/01/18 for major depressive disorder. The surveyor reviewed five episodes of manual physical holds and seclusion events from 12/15/18 to 12/23/18. No physician signature could be found authenticating the telephone order received by the registered nurse for seclusion episodes that occurred on 12/20/18 and 12/21/18 in the medical record. 3. On 01/11/19 at 10:45 AM, Surveyor #10 reviewed Patient #1001's medical record that showed a 13-year old patient admitted to the adolescent unit for management of a mental health disorder. On 12/01/18 at 2:45 PM, the record showed that the patient was observed punching a wall resulting in harm to himself as staff attempted to de-escalate the situation. The record showed that the patient initially was placed in a manual hold from 2:45 PM to 2:50 PM, followed by being placed in seclusion from 2:45 PM to 3:00 PM. The nurse obtained a verbal order from a licensed provider at 3:30 PM and included the behavior that led to the intervention. At the time of the review, the verbal order had not been authenticated by a licensed provider's signature as required by policy. .	A 454		
A 505	UNUSABLE DRUGS NOT USED CFR(s): 482.25(b)(3) §482.25(b)(3) - Outdated, mislabeled, or otherwise unusable drugs and biologicals must not be available for patient use This STANDARD is not met as evidenced by:	A 505		

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Based on observation, interview, and review of hospital policy and procedures, the hospital failed to ensure appropriate disposal of unusable medications.

Failure to ensure medication storage areas are devoid of outdated or otherwise unusable medications puts patients at risk for receiving medications with compromised sterility, integrity, or stability.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Multi-Dose Vials," no policy number, effective date 05/17, showed that all multi-dose vials must be dated with a 28 day expiration date and initialed with the time of the original opening by the person initially accessing the multi-dose vial.

2. On 01/09/19 at 8:53 AM, Surveyor #5 and a Program Director (Staff #508) inspected the medication room on the Adult Unit. Surveyor #5 observed two opened partially used multi-dose vials of diphenhydramine 500 mg per ml (an antihistamine) sitting on top of the medication-dispensing machine. The bottles did not contain a label with an expiration date or the initials of the staff initialing accessing the bottle.

3. At the time of the observation, Staff #508 confirmed the finding and removed the vials.

4. On 01/09/19 at 10:15 AM, Surveyor #9 and the Program Director (Staff #902) of the Transitional Care Unit (TCU) inspected the TCU medication room. Surveyor #9 found three opened partially

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A 505	Continued From page 49 used vials of injectable bacteriostatic water in a cabinet. The bottles did not have a label with an expiration date or the initials of the staff who accessed the vial. 5. At the time of the observation, Staff #902 confirmed the finding and removed the vials. .	A 505		
A 629	THERAPEUTIC DIETS CFR(s): 482.28(b), (b)(1) §482.28(b) Menus must meet the needs of patients. (1) Individual patient nutritional needs must be met in accordance with recognized dietary practices. This STANDARD is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that patients with medical conditions or histories that necessitate dietary consults received consults or that consults ordered by dieticians were conducted for 2 of 10 records reviewed. (Patient #501, #901) Failure to ensure that patients needing dietary consults receive nutritional assessments risks improper nutrition that could lead to unanticipated patient outcomes. Findings included: 1. Document review of the hospital's policy and procedure titled, "Nutritional Service for Patients," no policy number, effective 05/17, showed that a nurse will perform a nutritional screen and initiate	A 629		

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a dietary consult when a potential for malnutrition has been identified or the patient has a medical disorder such as diabetes.

2. On 01/08/19 at 2:00 PM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was admitted on 01/05/19 for the treatment of psychosis. The patient had a medical history of Diabetes Mellitus Type II and a blood sugar of 387 documented in the Emergency Room prior to admission to the psychiatric hospital. The patient's history showed the patient had underwent gastric bypass surgery one and a half years ago. On 01/06/19 at 12:30 AM, a provider ordered a regular diet and an ADA diet (American Diabetic Association diet). Surveyor #5 and Staff #505 found no evidence that staff obtained a clarification order for which diet was correct. Surveyor #5 and Staff #505 reviewed the patient's dietary card and found the patient was receiving a diabetic diet. Surveyor #5 and Staff #505 reviewed the dietician consult form and found the patient received a nutritional screen but did not need a dietician's consultation.

3. At the time of the observation, during an interview with Surveyor #5, the Registered Nurse (RN) (Staff #505) stated that patients with diabetes should receive a dietary consult. The nurse was unaware that the patient had a gastric bypass surgery.

4. On 01/16/19 at 2:23 PM, Surveyor #5 and Surveyor #2 interviewed a dietician (Staff #510) about the dietary consultation process. Staff #510 stated that nursing staff complete a nutritional screening upon admission. She would only become aware of a patient's diagnosis requiring a

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A 629	Continued From page 51 dietary consult if she received a dietary consultation request. She stated that she did not receive a dietary consultation request for this patient. She stated that nursing staff completes the dietary order card and sends it to the dietary staff. The dietician does not reconcile the cards sent from the nursing staff against the physician diet order. 5. On 01/09/19 at 11:45 AM, Surveyor #9 reviewed the medical record of Patient #901 who was admitted on 10/15/18 with a diagnosis of depression and psychosis. The record review showed that the patient had an initial medical consult on 10/16/18 that identified his concurrent diagnosis of diabetes type 2, hypertension (high blood pressure), and hyper cholesteremia (high cholesterol). The physician (Staff #901) conducting the medical consultation ordered a dietary consult. As of 01/09/19, a dietary consult had not been completed. 6. At the time of the medical record review, Surveyor #9 interviewed the Director of Transitional Care Unit (Staff #902) about the lack of a dietary consult. She acknowledged that the dietary consult was not in the record and it appeared it was not completed. She took action at this time to contact the dietician for a consult. .	A 629		
A 631	THERAPEUTIC DIET MANUAL CFR(s): 482.28(b)(3) A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel.	A 631		

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A 631	Continued From page 52 This STANDARD is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that the medical staff and dietician approved a diet manual per hospital policy. Failure to approve a diet manual risks patients receiving inadequate nutrition. Findings included: 1. Record review of the hospital policy titled, "Diet Manual," effective 05/17, showed that the medical director and the dietician are required to review the diet manual annually. Record review of the diet policies showed that the hospital last reviewed them on 05/17. 2. On 01/16/19, Surveyors #2 and #5 interviewed the dietician (Staff #204) regarding dietetic services. The dietician stated that she had not reviewed the diet manual annually and had not reviewed it with the medical staff.	A 631		
A 710	. LIFE SAFETY FROM FIRE CFR(s): 482.41(b)(1)(2)(3) (b) Standard: Life safety from fire. (1) Except as otherwise provided in this section— (i) The hospital must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4.) Outpatient surgical departments must meet the provisions applicable	A 710		

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A 710	Continued From page 53 to Ambulatory Health Care Occupancies, regardless of the number of patients served. (ii) Notwithstanding paragraph (b)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors. (2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospital, but only if the waiver will not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This STANDARD is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to meet the requirements of the 2012 edition of the Life Safety Code. Findings included: Refer to the deficiencies written on the Medicare Life Safety inspection report dated 01/08/19 . .	A 710		
A 724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(d)(2)	A 724		

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A 724	Continued From page 54	A 724		

Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This STANDARD is not met as evidenced by:
.
Based on observation and interview, and review of hospital policies and procedures, the hospital staff failed to ensure patient care supplies were not stored or available for patient use beyond the manufacturer's expiration date (Item #1), failed to verify that emergency supplies and equipment were available and ready for use (Item #2), and failed to ensure staff performed quality control checks for blood sugar point of care testing as required (Item #3).

Failure to ensure that patient care supplies are ready for use and not expired, risks ineffective patient care and treatment, as well as potential patient harm.

Item #1 - Expired Supplies

Findings included:

1. On 01/08/19 at 9:35 AM during an inspection of the adolescent unit, Surveyor #3 found the following items in the medication room:

a. One bottle of urine drug screening dipstick tests with an expiration date of 08/18.

b. One package of Streptococcal A dipstick rapid test with an expiration date of 09/30/18

c. One bottle of Streptococcal A regent 1 control agent with an expiration date of 12/28/18.

d. One bottle of Streptococcal A regent 2 control

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agent with an expiration date of 01/04/19.

e. One package of Streptococcal A controls with an expiration date of 01/04/19.

f. One bottle of Chemstrip urine test strips with an expiration date of 09/30/18.

2. On 01/08/19 at 10:15 AM, Surveyor #2 inspected the laboratory area of the hospital. During the inspection, the surveyor observed the following expired supplies:

a. 9 BD Vacutainer UA Transfer Straw Kits with an expiration date of 05/18

b. 16 BD Vacutainer C&S Transfer Kits with an expiration date of 05/18

c. 59 UTM-RT Specimen Collection Kits with an expiration date of 11/18

d. 27 OC-Auto Personal Use Kits with an expiration date of 09/20/18

e. 1 container of Chemstrip 10 MD - Cobas UA Strips with an expiration date of 09/30/18.

3. During the observation, Surveyor #2 interviewed a facilities engineer (Staff #201) who confirmed the observations.

4. On 01/08/19 at 2:00 PM, Surveyor #5, a Registered Nurse (Staff #507), and a Program Manager (Staff #503) inspected an emergency cart located in the Intensive Care Unit. Surveyor #5 observed one container of Cavi wipes with a manufacturer's expiration date of 09/01/18.

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5. At the time of the observation, Surveyor #5 asked Staff #507 and Staff #503 about how the hospital checked for outdated supplies on the locked cart. Staff #507 stated that the hospital did not have a system in place.

6. On 01/09/19 at 9:00 AM, Surveyor #5, a Program Director (Staff #508), and a Licensed Practical Nurse (LPN) (Staff #509) inspected the medication room on the hospital's Adult Unit. Surveyor #5 observed four intravenous start kits with a manufacturer's expiration date of 03/18 and one urinalysis vacutainer transfer kit with a manufacturer's expiration date of 09/18.

7. At the time of the observation, Staff #508 and #509 confirmed the finding and removed the supplies.

Item #2 - Emergency Cart Checks

Findings included:

1. Document review of the hospital's policy and procedure titled, "Emergency Drugs and Supplies - Crash Cart," no policy number, effective 12/17, showed that the crash cart will be inspected after each use and each month to ensure completeness of contents.

Document review of the instructions for the crash cart checklist showed that night shift would check the cart daily, initial each box, and sign at the bottom of the sheet. On the first of the month, the crash cart is opened and checked for expired items.

2. On 01/08/19 at 9:35 AM during a tour of 2-North, Surveyor #3 inspected the emergency

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cart. A review of the emergency cart checklist logs showed that cart checks were missing for 12 of 30 days in November 2018, for 14 of 31 days in December 2018, and were missing the first 7 days of January 2019.

3. On 01/08/19 at 9:35 AM, Surveyor #3 interviewed the Program Manager (Staff #307) about the missing emergency cart checks. She stated the night shift nursing staff were responsible for performing the checks.

4. On 01/08/19 at 2:00 PM, Surveyor #5 and a Program Manager (Staff #503) inspected an emergency cart located in the Intensive Care Unit. The observation showed missing or partial completion of cart checks for 2 of 8 days in January 2019 and 14 of 31 days in December 2018.

At the time of the observation, Staff #503 confirmed the finding.

Item #3 - Point of Care Testing Quality Control Checks

Findings included:

1. Document review of the hospital's policy and procedure titled, "Glucose Monitoring," no policy number, effective 05/17, showed that on a daily basis, the glucometer will be checked by the night shift staff using the normal control solution obtained from the manufacturer.

2. On 01/08/19 at 10:35 AM, Surveyor #3 inspected the adolescent unit's medication room. During the inspection, the surveyor reviewed the point of care testing blood sugar quality control

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A 724	Continued From page 58 record sheets. The review showed that quality control checks for the glucometer were missing for 7 of 30 days in November 2018, 11 of 31 days in December 2018, and 7 of 8 days in January 2019. 3. An interview with the Program Manager (Staff #307) at the time of the observation confirmed these observations. She stated the hospital policy is that glucometer quality control checks are done daily.	A 724		
A 726	VENTILATION, LIGHT, TEMPERATURE CONTROLS CFR(s): 482.41(d)(4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: . Based on observation and record review, the hospital failed to ensure that staff were monitoring refrigeration temperatures to ensure proper cold holding of patient food items. Failure to ensure that refrigerators maintain patient food items at proper cold holding temperatures risks food-borne illness. Findings included: 1. Record review of the hospital policy titled, "Food Storage," no policy number, effective date 05/17, showed that staff are to check and record temperatures twice a day. 2. On 01/10/19 at 7:00 PM, Surveyors #2	A 726		

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A 726	Continued From page 59 reviewed a refrigeration log from the first floor patient refrigerator. Hospital staff had not checked or recorded the temperature since 01/01/19. Reference: 2009 FDA Food Code 3-501.16 .	A 726		
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: . Based on interview, review of hospital policies and procedures, and personnel file review, the hospital failed to ensure that staff members put specific precautions in place for patients diagnosed with infectious disease to prevent transmission of infections (Item #1, #2); and failed to ensure that contracted staff members received infection control training specific to their jobs (Item #3). Failure to ensure that staff members implement appropriate isolation procedures for patients with infections and failure to provide appropriate infection control education to contracted employees puts patients and staff members at risk of infection from communicable diseases. Item #1- Herpes Zoster	A 749		

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Reference: Centers for Disease Control and Prevention, "Preventing Varicella-Zoster Virus (VZV) Transmission from Zoster in Healthcare Settings," reviewed 10/17/17, states that if a patient is immunocompetent with localized herpes zoster, then standard precautions should be followed and lesions should be completely covered. If the patient is immunocompetent with disseminated herpes zoster, then standard precautions plus airborne and contact precautions should be followed until lesions are dry and crusted.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Infection Control Policies Subject: Isolation procedures," no policy number, date issued 05/17, states that standard precautions plus contact precautions should be used for patients known or suspected to have serious illnesses easily transmitted by direct patient contact or items in the patient's environment.

2. On 01/11/19 at 9:30 AM, Surveyor #5 reviewed the medical record for Patient #504 who was admitted for the treatment of suicide attempt, depression, bipolar, schizoaffective disorder, and auditory hallucinations to harm self. A medical consultation completed on 09/26/18 at 12:24 PM, showed the patient had a rash on the right anterior chest suspicious for Shingles. The provider's examination showed greater than 12 painful vesicles on the right chest. The patient was started on Acyclovir 800mg 5 times daily for 7 days. Surveyor #5 found no evidence the lesions were covered or the patient was placed on contact precautions.

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3. On 01/16/19 at 2:00 PM, Surveyor #9 and the Infection Control Nurse (ICN) (Staff #904) reviewed the medical record of Patient #504. The ICN noted that staff did not report this condition to her. She agreed that the patient should have been placed in contact isolation.

Item #2- Hepatitis C

Reference: Centers for Disease Control and Prevention, Division of STD Prevention, National Center for HIV/AIDS,STD, and TB Prevention (last reviewed 06/06/15) stated that Hepatitis C can be transmitted through exposures in health care settings as a consequence of inadequate infection control practices.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Isolation Procedures," issued 05/17 showed that standard precautions will apply to blood; all bodily fluids and secretions, except sweat; non-intact skin; and mucous membranes. The document showed that standard precautions are combined with disease-specific precautions when a disease is identified.

Document review of the "2018 {Infection Control} Risk Assessment and Plan & Evaluation," showed that one of the planned opportunities to decrease risk of infectious disease included addressing infectious diseases on the medical care plan.

2. On 01/08/19 at 2:30 PM, Surveyor #9 reviewed the medical record of Patient #902, admitted to the hospital on 01/05/19 with a diagnosis of acute psychosis and suicidal ideation. The record

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review showed that a physician (Staff #903) conducted an initial medical consultation on 01/06/19 with a medical diagnosis of Hepatitis C added to the patient's problem list. The physician ordered an outpatient consult with a gastroenterologist. Review of the treatment plan for Patient #902 did not include the diagnosis of Hepatitis C.

3. At the time of the record review, Surveyor #9 asked the Director of the Transitional Care Unit (Staff #902) if she would expect to see the diagnosis of Hepatitis C on the patient's treatment plan. She stated that the diagnosis should be there. On 01/16/19 at 1:00 PM during a meeting with the Infection Control Nurse (Staff #904), Surveyor #9 asked if she would expect to see the Hepatitis C diagnosis added to the treatment plan and she confirmed that infectious diseases should be added to the treatment plan.

4. On 01/08/19 at 3:00 PM, during record review, Surveyor #5 reviewed the medical record of Patient #503, admitted on 12/15/18 for suicide attempt, schizoaffective disorder, and methamphetamine abuse. On 12/31/18, the patient was diagnosed with Hepatitis C and was referred for consultation with gastroenterology or infectious disease upon discharge for possible treatment with interferon. On 12/31/18, the record showed that a medical provider (Staff #909) wrote an order for the patient to be in "Enteric Precautions" for Hepatitis C. The patient's Kardex dated 12/27/18 showed that "Enteric Precautions" had been noted, but was crossed out and replaced with "Standard Precautions." Further review of the patient's record of every 15 minute rounding for 01/02/19, 01/03/19, 01/04/19, 01/05/19, and 01/06/19, showed the patient is

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A 749	Continued From page 63 noted to be in "Contact Precautions". 5. On 01/16/19 at 2:00 PM, Surveyor #9 and the Infection Control Nurse (ICN) (Staff #904) reviewed the medical record of Patient #905. The ICN stated that staff did not appear to have an understanding of what type of precautions measures should be in place for this patient who should have been in "Standard Precautions". Item #3 - Infection Control Training Findings included: 1. Record review of the hospital policy titled, "Staff Training," revised 09/18, showed that staff are to receive initial training on infection control and human resources is to maintain documentation of all training completed by staff. 2. Record review of employee personnel and training files for a registered nurse (Staff #205) showed that the staff member did not have any documentation of orientation regarding infection control. 3. On 01/16/19 at 10:00 AM, Surveyor #2 interviewed the Infection Preventionist (Staff #210), who is also the clinical educator, regarding the training file for Staff #205. Staff #210 confirmed that the training files for Staff #205 were not in the employee personnel file. THIS CITATION WAS PREVIOUSLY CITED ON 03/15/18.	A 749		
A 811	. DISCUSSION OF EVALUATION RESULTS CFR(s): 482.43(b)(6)	A 811		

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A 811	Continued From page 64 The hospital ... must discuss the results of the evaluation with the patient or individual acting on his or her behalf. This STANDARD is not met as evidenced by: . Based on interview and document review, the hospital failed to include the family of a patient in the discharge planning process for 1 of 1 patients reviewed (Patient #515). Failure to include the family in the discharge planning process places patients at risk for readmission to the hospital. Findings included: 1. Document review of the hospital's policy and procedure titled, "Discharge Planning," no policy number, effective date, 05/17 showed the discharge planning process will include timely and direct communication with and transfer of information to other programs, agencies, or individuals that will be providing continuing care. When developing aftercare plans, the hospital must consider: -Family relationships; -Physical and psychiatric needs; -Financial needs; -Housing needs and/or placement issues; -Employment needs; -Educational/vocational needs; -Social and recreational needs; -Accessibility to community resources; -Personal support systems; -Spiritual needs; -Transportation problems related to aftercare treatment;	A 811		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 811	Continued From page 65 - Potential for recidivism 2. On 01/10/19, Surveyor #5 reviewed the medical record for Patient #515, who was admitted on 10/28/18 for the treatment of personality disorder, depression, anxiety, and rule out psychosis. The review showed: a. The intake assessment completed on 10/28/18 showed the patient had been living with his father, but could not return after discharge. b. Psychosocial assessment completed on 10/30/18 showed the patient is homeless. c. On 11/24/18, nursing staff documented in the nursing notes that the patient's mother requested a family session to discuss the patient's "care, housing, and other things." d. On 11/25/18, a provider documented in the psychiatric progress notes that the mother requested a family session to discuss the patient's care. e. On 11/26/18, a provider documented in the psychiatric progress notes his discussion with the patient regarding discharge that included a potential option to live with his mother. The psychiatric progress note stated that the mother "needed" a family session. 3. Surveyor #5 found no evidence in the medical record that a family session or meeting with the patient's mother occurred related to the care and discharge plan for the patient as requested. 4. On 01/10/19 at 12:00 PM, during interview with Surveyor #5, a Program Therapist (Staff #515)	A 811		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	C 01/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

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A 811	Continued From page 66 stated that the request for a family session was not communicated and did not occur. She stated that it was the responsibility of the program therapist to set up a meeting if the family requests one and requests for these meetings should have been discussed in the treatment team meeting. Staff #515 stated that the hospital recently changed the discharge planning process and the program therapists are now responsible for doing discharge planning.	A 811		

Received 03/07/19 (3RD SUBMISSION)

Smokey Point Behavioral Hospital survey ending 1/17/19 revised 3/1/2019

Team Recommended Approval 03/08/19

E037 Plan of Correction for Each specific deficiency Cited:

The Hospital failed to ensure that staff are trained on the hospital's emergency preparedness plan and their expected roles during an emergency risks delayed response, injury or death to staff and patients in the event of an emergency.

Procedure/process for implementing the plan of correction:

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- The facilities manager has added new employee orientation slides with the assistance of HR to identify what the roles are during an emergency.
- The Clinical Nurse Educator has educated and re-trained current staff to those roles on the week of February 11th. 2019
- Nursing staff were educated on their role in case of emergency on February 11 & 12, 2019 via an educational tool provided by the CNO. Any person that has not completed by 3/1/2019 will be required to complete prior to working a shift.
- This education will be part of the annual training process for hospital employees

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- The Safety committee will review the slides and education materials on an annual basis to ensure the most up-to-date practices.

- The Safety Committee will review the HR Documentation to insure 100% of employees are either oriented or re-educated on the EOP and their role by 3/1/19.

Individual Responsible:

Director of Facilities

Date Completed:

3/1/2019

A 043 Plan of Correction for Each specific deficiency Cited:

The hospital failed to provide effective oversight to prevent substandard practices for patient safety, and patient rights, resulted in an unsafe environment for patients.

Procedure/process for implementing the plan of correction: The Governing Board will review the PI Process in every other week calls.

- The Governing Board will review the PI process, with focus on monitoring, evaluating and improving patient care including but not limited to patient safety, pharmacy services, and nursing services on a weekly basis through direct supervision by the Sr VP Clinical and every other week Governing Board calls. This be continued until the Governing Body is ensured the process's will remain compliant.

- SPBH Governing Board will conduct a meeting a weekly basis to provide oversight to this Plan of Correction. The Governing Board communication will assure appropriate and adequate oversight and guidance. The Governing Board oversight and guidance will include review of the findings and plan of correction for the follow-up survey by:

- Reviewing the plan of Correction to assure the corrective action for deficiencies are clinically indicated and responsive to the Conditions of Participation cited; are sufficient to prevent recurrence of the deficiencies; to make certain patients' rights are protected and patients are receiving appropriate care with positive outcomes

- The Administrative assistant has been re-educated and offered assistance in taking meeting minutes. A template was provided to the administrative assistant on how to use the template appropriately on 3/1/2019.
  - The minutes will be reviewed by a GB member and a director attending the meeting for appropriateness and ensure that communication is documented thoroughly.
- Assistance from an employee in the Risk department will additionally take PI minutes to ensure completeness and accurateness.
  - Both minutes from individuals will be compared when formally typing the minutes.

Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.

- An assigned governing board member will communicate with the CEO, CNO, and Director of Risk on a weekly basis instead of quarterly to provide oversight to this Plan of Correction as to monitoring and evaluation of actions taken and review the statistical results of the ongoing QAPI reporting and make recommendations as needed.
- Governing Board will convene on a monthly basis with SPBH in order to ensure that the Plan of Correction is effective.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.

- A member representative of the Governing Board will visit the hospital monthly at a minimum. During the visit a meeting will be held with leadership and staff delegated to carry out activities of the Plan of Correction; to identify progress or lack of progress, and any other needs or considerations.

Individual Responsible:
CEO

Date Completed:

3/9/2019

A068 Plan of Correction for Each specific deficiency Cited:

The Hospital failed to develop and maintain effective systems that ensured that patients received quality healthcare that met their needs for 2 of 3 patients with Diabetes Mellitus

Procedure/process for implementing the plan of correction:

- CNO, Medical Director, and Excellence Educator met with the medical director of company that provides medical care for patients at Smokey Point Behavioral Health. Developed protocol for these instances.
- Will continue to work on other common issues and developing protocol with Medical Directors.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- CNO, Medical Director, and Excellence educator have created a glycemia protocol written and checked by Medical Director of SPBH and Medical Company to ensure appropriate on February 13, 2019. This includes a flow sheet used by nurses in order to ensure that medical staff are notified of any hypoglycemic events.
- Nursing staff educated on February 11 & 12, 2019 on hypoglycemia protocol.
- Medical Staff (Pontum) Director approved glycemia protocol on February 13, 2019 .

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- This protocol will be reviewed on an annual basis. The protocol will be evaluated on effectiveness of protocol with patients at the facility.
- 20% medical records from 2/28/2019 forward will be audited weekly. This will review diabetics by reviewing blood sugar levels and whether the flowsheet was used for an event. This audit will continue until 90% compliance for 3 months is achieved. If compliance drops below 90% organizationally for two consecutive months than a new corrective action plan will be created and continued monitoring until 90% at 3 months compliance achieved.

Individual Responsible:

CNO

Date Completed:

3/9/2019

(A 119) Plan of Correction for Each specific deficiency Cited:

- The hospital failed to follow procedure by having either the CEO or the grievance committee approving the letter of acknowledgment and resolution prior to being sent.

Procedure/process for implementing the plan of correction:

- PI director has re-educated attendees of the grievance committee of the procedure and will ensure the proper procedure is conducted.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Tracking by the PI committee will be by the change in language stating of compliance of letter sent "after approval of grievance committee or CEO" in the PI Dashboard discussed at the PI committee.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Tracking by the PI committee will be by the change in language stating of compliance of letter sent "after approval of grievance committee or CEO" in the PI Dashboard discussed at the PI committee.
-

Individual Responsible:
Director of Risk and PI

Date Completed:

2/19/2019

A 144 Plan of Correction for Each specific deficiency Cited:
-The hospital failed to place the incident report in the variance log , thus showing that an investigation had not been conducted.

Procedure/process for implementing the plan of correction:

- CNO Communication provided on January 25, 2019 described the process for incident reporting. Nursing staff are required to read CNO Communication at least one time per week.
    - A sample incident report was placed in a red folder for staff to access with questions on how to complete an incident report.
- On February 11 & 12, 2019 100% of nursing staff were re-educated on the proper procedures of reporting incident reports. Educations included but was not limited to, how to fill out an incident report, Non-Punitive approach of reporting, use of the locked box.
- A new secure drop box was created for all variance reports to be placed upon completion in order to centrally locate a collection place for both floors.
- Patients are searched upon admission, and skin checks and room checks are conducted in order to mitigate possible events of contraband on units. The mitigation plan of room checks is what identified the patient.
- A new process initiated to ensure 100% compliance and follow up of all reported incidents. Incident reports will be placed in a secure, locked container on the floors, accessible by pharmacy, nursing director, and risk management. The CNO and Risk director will review each submitted report to assign severity, risk, and follow up necessary for each patient.
- Medication Variance reports follow the same process and are reviewed weekly by the Director of Pharmacy and CNO.
- Reminder cards (primer cards) were created and given to departments and units on the process.
- Two types of investigational templates have been created in order to follow up with incident reports that will be attached to the incident report once completed.
- Incidents are placed in the variance log by the PI director prior to even completing an investigation.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Program Directors will review incident reports and communicate with programs from the previous day to ensure all reports of incidents were reported.
- Program Directors and nursing supervisors will check in with shifts and ensure all incidents have been

reported and written correctly via a daily checklist being completed.

- CNO, Program Directors, and any other Department Heads pertaining to the incident reports will review the variance log on a weekly basis. The variance log includes the daily count of incidents ensuring that it matches the variances reported to the Risk Director.
- If variances are found not reported the staff and supervisor will be re-educated. If non-compliance is continued than a new corrective action plan will be created.
- 20% medical records from 2/28/2019 forward will be audited weekly. This audit will continue until 90% compliance for 3 months is achieved. If compliance drops below 90% organizationally for two consecutive months than a new corrective action plan will be created and continued monitoring until 90% at 3 months compliance achieved.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Program directors will aggregate and analyze via the created checklist for their reports on the weekly basis and will be turned into the CNO.
- Non-compliance will be addressed via re-education.
- Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard.

Individual Responsible:
Director of PI and Risk

Date Completed:

3/9/2019

(A 171) Plan of Correction for Each specific deficiency Cited:

The hospital failed to order the correct time of restraint or seclusion duration places patients at risk for physical and psychological harm, loss of dignity, and violation of patient rights

Procedure/process for implementing the plan of correction:

- 100% of Psychiatric Medical staff re-educated on restraint timing in medical Staff meeting on 2/28/19.
- Re-educated nursing staff of restraint policy and documentation completion (which says every 2 hours for adolescents) Education completed on February 11 & 12, 2019 via an educational tool provided by the CNO. Any person that has not completed by 3/1/2019 will be required to complete prior to working a shift.
- Restraint/Seclusion Order Sheet updated to include the correct time for adolescents and adults with a checkbox for MD/ARNP to complete this was included in the above training.
- RN Department Staff were re-educated on required documentation for interventions of less than 15 minutes, all interventions regardless of duration require the completion of the form "Restraint and Seclusion Flow Sheet".
- Restraint and Seclusion Flow sheet will be updated by Program Director and approved by corporate vice president by February 12, 2019.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- When reviewing Restraint/Seclusion paperwork, will check time frame to ensure correct
- The Program Directors will audit all medical records containing the utilization of a manual hold, seclusion, or mechanical restraint to ensure that the flow sheets documenting the monitoring of patients are present, and appropriately completed. The Restraint/Seclusion audit tool will be utilized to audit each situation.
    - Program Directors will submit the audits weekly to the Chief Nursing Officer. Chief Nursing Officer will analyze and aggregate the date and describe trends and patterns to the Performance Improvement Committee on at least a quarterly basis.
- Any nurse with errors in documentation of restraint/seclusion will be re-educated in the correct documentation.
    - If the same nurse has another error, he/she will be asked to audit at least 5 actual or sample restraint/seclusion documentation and process and return to the Chief Nursing Officer the findings.
    - If the same nurse has another error, the disciplinary process will be followed.
- The audits evaluates compliance with appropriate completion of flowsheets documenting the monitoring of patients who require restraint, seclusion, and mechanical restraint interventions
    - 100% of Restraint/Seclusion paperwork from 2/28/2019 forward will be audited. If compliance drops below 90% organizationally for two consecutive months than a new corrective action plan will be created and continued monitoring until 90% at 3 months compliance achieved.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- 100% of the time, the restraint policy will be followed for provider follow-up
- The Chief Nursing Officer will communicate the findings of this audit during the Performance Improvement Committee meeting held monthly for at minimum six months and then quarterly.

Individual Responsible:

CNO/Program Directors

Date Completed:

3/1/2019

A 196 Plan of Correction for Each specific deficiency Cited:

The hospital failed to train 2 contracted employees on Seclusion and Restraint.

Procedure/process for implementing the plan of correction:

- 100% of nursing employees will be trained Seclusion & Restraint training on February 11 & 12, 2019.
- The Excellence educator and HR have met and will continue to meet on a monthly basis to review all staff requiring Seclusion/Restraint education and report any non-compliance for the month to PI committee.
- The excellence educator has audited 100% of files of required employees needing Seclusion and restraint training in order to ensure Seclusion and Restraint has been trained to all required employees.
    - Seclusion and Restraint training will be offered with every New Employee Orientation and on an as needed basis in order to ensure all staff have current Seclusion and restraint training.
- A database will be created showing compliance with all trainings by HR and will be kept up to date.
- All contract employees will be trained to Seclusion and Restraint policies.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- HR and the Excellence Educator will review files on a monthly basis to ensure all training for required staff have been completed and are in 100% compliance,
- This will be reported to the PI Committee monthly for a minimum of 6 months with a compliance rate of 100%.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

HR will report on the monthly basis to the PI committee on any non-compliant staff per HR and Clinical excellence review.

Individual Responsible:
HR Director

Date Completed:

2/13/2019

A263 Plan of Correction for Each specific deficiency Cited:
The Hospital failed to systematically collect and analyze hospital-wide performance data limited the hospital's ability to identify problems and formulate action plans. This reduced the likelihood of sustained improvements in clinical care and patient outcomes.

Procedure/process for implementing the plan of correction:

- The PI director have re-educated the minutes writer and re-educated departments on the requirement of providing detailed aggregated data for discussion of analyzation by the committee during the meeting.
- An update has been created for the annual performance improvement plan dashboard to show new metrics that include, benchmarks, patterns, and trends.
- PI meeting minutes template has been revised to include supplemental reports in the actual minutes given by departments.
- Action plans will also be included in the PI minutes for identified corrective actions required.
- The annual PI plan had been delayed in order to complete the findings requirements. This was completed 2/13/2019
- A quarterly score card has been created to notify staff of data collected at the hospital and will be updated on the quarterly basis.
-

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Any reportable events requiring RCA will have a monthly report out for 3 months to the PI committee to ensure that all POC's are within compliance.
- All departments are required on a monthly basis to report aggregated data for analyzation by the committee for report out to Medical executive committee and the Governing board.
- Each department and committee are required to provide aggregated data and committees are to provide all meeting minutes as well.
-

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Program directors will complete the created checklist for their reports on the weekly basis and will be turned into the CNO. CNO will aggregate and analyze checklist completion.
- Non-compliance will be addressed via re-education.
- Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard.
- The PI director will report for a minimum of 3 months for any POC's from an RCA.
- The director of PI will review that all programs present aggregated data as required to report to the PI committee. If a program does not. The program/committee will be communicated that they must make up the report by the next committee.
- Any program or committee that does not report timely on their data will also be required to report to CEO unless already excused.
-

Individual Responsible:
Director of PI and Risk

Date Completed:

2/13/2019

A 273 Plan of Correction for Each specific deficiency Cited:
The hospital failed to collect, aggregate and analyze data to improve patient outcomes puts patients at risk of substandard care.

Procedure/process for implementing the plan of correction:

- Performance improvement dashboard has been updated for the 2019 year to include but not limited to benchmarks and targets for corrective actions identified.
- Performance and Improvement committee has updated the meeting minutes template to include supplemental data provided with the aggregation now into the meeting minutes template.
- The minutes taker of the PI committee has been educated to keep detail of the aggregated and analyzed data and ensure it is specifically in the meeting minutes.
- The meeting minutes template has been revised to also identify if corrective actions are required from identified data.
- The new created variance log for incident reports has been created to include severity, location, and shift in an effort to assist in identifying trends and patterns when analyzed and aggregated.
- A quarterly score card has been created to notify staff of data collected at the hospital and will be updated on the quarterly basis.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Departments will be required to report on the monthly basis identified corrective action plans as well as aggregated and analyzed data for their departments for discussion

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- The Governing board will review and discuss the information provided, and request action plans as to identified issues.

Individual Responsible:
Director of PI and Risk

Date Completed:

2/13/2019

A 283 Plan of Correction for Each specific deficiency Cited:

The hospital failed to develop projects and action plans based on results of data.

Procedure/process for implementing the plan of correction:

- Performance improvement dashboard has been updated for the 2019 year to include but not limited to benchmarks and targets for corrective actions identified.
- Performance and Improvement committee has updated the meeting minutes template to include supplemental data provided with the aggregation now into the meeting minutes template.
- The minutes taker of the PI committee has been educated to keep detail of the aggregated and analyzed data and ensure it is specifically in the meeting minutes.
- The meeting minutes template has been revised to also identify if corrective actions are required from identified data.
- The new created variance log for incident reports has been created to include severity, location, and shift in an effort to assist in identifying trends and patterns when analyzed and aggregated.
- A quarterly score card has been created to notify staff of data collected at the hospital and will be updated on the quarterly basis in order to identify ways to improve patient care.
- The annual PI plan was delayed for the annual report in order to add the aggregated and analyzed data so the information could be discussed and recommendations and improvements on patient outcomes.
-

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Departments will be required to report on the monthly basis identified corrective action plans as well as aggregated and analyzed data for their departments for discussion

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- The Governing board will review and discuss the information provided, and request action plans as to identified issues.

Individual Responsible:
Director of PI and Risk

Date Completed:

2/13/2019

POC ITEM#1

(A 286#1) Plan of Correction for Each specific deficiency Cited:

-The hospital failed to place the incident report in the incident log as it was still being completed by all attributing departments. The incident report was provided immediately to surveyors prior to any requests.

-The hospital failed to identify an unknown substance from coming onto the program unit due to the patient either ingesting or impacting it up his rectum.

Procedure/process for implementing the plan of correction:

- On February 11 & 12, 2019 nursing staff were re-educated on the proper procedures of reporting incident reports via an educational tool provided by the Clinical Excellence educator. Any person that has not completed by 3/1/2019 will be required to complete prior to working a shift
- A new secure drop box was created for all variance reports to be placed upon completion in order to centrally locate a collection place for both floors.
- Patient's are searched upon admission but it is not a requirement to x-ray every patient prior to admission. Skin checks and room checks are conducted in order to mitigate possible events of contraband on units. The mitigation plan of room checks is what identified the patient.
- A new process initiated to ensure 100% compliance and follow up of all reported adverse events. Incident reports will be placed in a secure, locked container on the floors, accessible by pharmacy, nursing director, and risk management. The CNO and pharmacy director will review each submitted report to assign severity, risk, and follow up necessary for each patient. Items requiring medical follow up are brought to the attention of risk and the medical director for follow up.
- Reminder cards (primer cards) were created and given to departments and units on the process.
-

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Program directors will review incident reports from the previous day to ensure all reports of incidents were reported.
- Program Directors and nursing supervisors will check in with shifts and ensure all incidents have been reported and written correctly via a daily checklist being completed.
- CNO, Program directors, and any other Department Heads pertaining to the incident reports will review on a weekly basis the variance log. The log includes the daily count of incidents ensuring that it matches the variance log when reported to the Risk Director.
- If variances are found not reported the staff and supervisor will be re-educated. If non-compliance is continued than a new corrective action plan will be created.
- (Please refer to A 144)- 20% medical records a week from 2/28/2019 forward will be audited. This audit will continue until 90% compliance for 3 months is achieved. If compliance drops below 90% organizationally for two consecutive months than a new corrective action plan will be created and continued monitoring until 90% at 3 months compliance achieved.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Program directors will aggregate and analyze via the created checklist for their reports on the weekly basis and will be turned into the CNO.
- Non-compliance will be addressed via re-education.
- Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard.

Individual Responsible:
Director of PI and Risk

Date Completed:

3/9/2019

POC ITEM #2

(A286#2) Plan of Correction for Each specific deficiency Cited:

- Hospital failed to review corrective actions for follow up of the actual corrective action plans.

Procedure/process for implementing the plan of correction:

- The Adverse event referred was reviewed with directors to ensure that the POC was still compliant. Any changes to the POC for items were documented and placed into the event file.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Any future reportable events requiring RCA will have a monthly report out for 3 months to the PI committee to ensure that all POC's are within compliance.
- All Corrective action plans current at SPBH are reviewed for a 90% compliance rating for 3 months to ensure compliance.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- The PI director will report for a minimum of 3 months for any POC's from an RCA.

Individual Responsible:

Director of PI and Risk

Date Completed:

3/9/2019

(A 308) Plan of Correction for Each specific deficiency Cited:

The hospital failed to review and aggregate hospital clinical services contracts through the PI Committee.

Procedure/process for implementing the plan of correction:

- Directors were given copies of their clinical contracts to review and aggregate data to present to the CFO for contract renewal and review by the PI Committee.
- A job posting has been created to hire a person to review and collect data on contracting services. The employee will review expectations and monitor performance on a monthly basis and create a report to the CFO to be presented to the PI committee at least once a year.
- Establish a chain of reporting structure to ensure that all applicable meeting minutes are reported to the PI committee.
- Processes and Procedures to be modified to reflect this additional step.
- Pharmacy & Therapeutics Committee minutes to be modified to reflect the format desired by the PI committee.
- The Pharmacy and P&T committee are integrated into the PI committee historically. Noncompliance was found with the introduction of the new contracting company. The contracting company had to be retrained on 2/28/2019 ensuring they are communicating and attending the PI committee and providing data, analysis and corrective actions.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- The CFO will que all contracts with the director responsible for the contract 30 days prior to

due date.

- The Contracting services employee will create a calendar with annual due dates for contract review by the PI committee. The employee will notify the chairperson of PI of contracts needing annual review to be placed on the agenda.
- In the month of September of every year, clinical services contracts will be presented and reviewed for the previous year's compliance by the director of clinical services.
-

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- The que list created by the CFO will be reviewed by the CFO to ensure all contracts are up to date. If a contract is not up to date the CFO will alert the CEO and the supervising director of the contract.
- The CFO will provide a numerator (contracts in compliance) over a denominator (total contracts) on the performance improvement dashboard.
- The PI director will notify the CEO and department responsible for any missing data or information required at the PI committee meeting. This is also reflected in the PI committee minutes.
- P&T and Pharmacy will report their aggregated and analyzed data to the PI committee on a monthly basis.

Individual Responsible:
Director of PI and Risk

Date Completed:

3/9/2019

(A 385) Plan of Correction for Each specific deficiency Cited:

The hospital failed to ensure sufficient numbers of nursing staff were available

Procedure/process for implementing the plan of correction:

- Please Cross Reference Plans of corrections for:
  - A0392
  - A0396
  - A0398
  - A0405

- Career Fair was held on January 5, 2019. 5 MHTs were made offers the day of the fair.
- 5 New MHTs, 1 prn RN, 1 agency staff RN were in NEO the week of January 21, 2019
- Have conducted multiple interviews and offered positions to 4 MHTs, 4 agency nurses, 1 RN and 1 LPN
- During the week of January 28, 2019, 36 hours of time was specifically set up were for interviews.
- Every unit has been staffed with an RN since the survey. CNO and/or Program Directors have worked the units as needed.
- During each shift one additional nurse will be assigned as a float nurse to fill in as needed or will be placed into the staffing by the nursing supervisor.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Interviews and hiring will continue and maintained
- 1 Agency nurse will become SPBH employees
- CNO will maintain a position control on at least a quarterly basis

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- HR department will provide a turn over report to the PI committee.
- Position Control will be reviewed at least quarterly

Individual Responsible:

CNO

Date Completed:

3/9/20192019

(A 392) Plan of Correction for Each specific deficiency Cited:

The hospital failed to provide an adequate number of trained registered nurses (RN), licensed practical nurses (LPN), and mental health technicians (MHT)

Procedure/process for implementing the plan of correction:

- Every unit will be staffed with a registered nurse and adequate staff to care for patients.
- The Governing Board has reviewed and Approved on 2/27/19 that one additional RN will be scheduled in case of call offs or a RN not report for the shift.
- If an RN calls off from shift, RN's are called to come in to fill the space left empty by the unavailable RN.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Interviews and hiring will continue and maintained
- Position control will be maintained in a manner to provide adequate care to the number of patients present on the unit.
    - The hospital's staffing grid is utilized for adequate staffing numbers.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- HR department provide a turn over report to PI committee monthly.
- Position Control will be reviewed and reported at least quarterly to the QAPI team

Individual Responsible:

CNO

Date Completed:

3/9/2019

(A 396) Plan of Correction for Each specific deficiency Cited:

The hospital failed to incorporate medical and psychiatric issues into treatment plans.

Procedure/process for implementing the plan of correction:

- On February 11 & 12, 2019 nursing staff were re-educated on the proper procedures of completing treatment plans via an educational tool provided by the CNO. Any person that has not completed by 3/1/2019 will be required to complete prior to working a shift.
- Educations included but was not limited to, purpose of treatment plans, how to fill out a treatment plan, review of treatment plans, and adding additional medical or psychiatric problems to the treatment plan.
- Sample treatment plans have been created for new employee orientation so each new employee is able to see and review sample plans.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- During treatment teams, each patient will be reviewed to identify any new and ongoing psychiatric and/ or medical issues that are being treated or deferred. Each issue will be placed on the treatment plan accordingly.
- 20% of treatment plans from 2/28/2019 forward will be audited weekly. This audit will continue until 90% compliance for 3 months is achieved. If compliance drops below 90% organizationally for two consecutive months than a new corrective action plan will be created and continued monitoring until 90% at 3 months compliance achieved.
- Program directors, Director of Clinical Services, Chief Nursing Officer, and or Excellence Educator will audit new admissions within 48 hours to ensure treatment plan compliance and inclusiveness of all issues.
    - 2 Auditors will be hired prior to February 13, 2019 to complete chart audits on each patient's chart.
- If a treatment plan is not completed, the Program Director and/or Excellence Educator will meet with the nurse that admitted the patient and discuss the incident.
    - If the nurse has difficult completing the treatment plan again, he/she will be asked to audit 5 sample or actual treatment plans and to make recommendations for completion. On actual treatment plan, the nurse will correct any deficiencies.
    - If the nurse continues to have difficulties completing the treatment plan as educated and taught, the disciplinary process will be followed.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Chief Nursing Officer will aggregate and analyze via the created checklist for their reports on the weekly basis.
- Non-compliance will be addressed via re-education. Continuing non-compliance will be addressed using the disciplinary process.
- Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard.

Individual Responsible:

CNO

Date Completed:

3/9/2019

A398 #1 and #2 Plan of Correction for Each specific deficiency Cited:
The hospital failed to ensure that contracted nurses received documented hospital orientation, and failed to complete annual agency staff performance evaluations.

Procedure/process for implementing the plan of correction:

- HR will provide each department with annual evaluations due.
- Departments will be responsible for completing all annual evaluations due.
- Evaluations completed for nurses 3/9/19
- Each contract has a specific evaluation either in the actual contract or in an addendum to the contract.
- Orientation for contract nursing staff receive the same competencies as our employees. Contract nurses are oriented to the hospital prior to working the units. The HR director ensures that the competencies are completed and documented in the tracking system prior to the contracted individual working the unit.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- HR will send out a tracker at the beginning of every month to directors with a list of due items. Items will include but not limited to annual evaluations and annual evaluations due for the month.
- HR will report to CEO if evaluations were not completed on time.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- HR will report for at minimum 6 months to the PI committee as a dashboard item of annual evaluations due.
- Items will have a numerator (completed on time) and a denominator (total number of evaluations due for the month)

Individual Responsible:
Director of Human Resources

Date Completed:

3/9/2019

A 405 Plan of Correction for Each specific deficiency Cited:
The hospital staff failed to follow its procedure for transcribing physician orders to the medication administration record

Procedure/process for implementing the plan of correction:

- 100% of nursing staff will be trained by February 12, 2019 that all orders must be transcribed and scanned to the Pharmacy within 2 hours of the order being written 24 hours per day.

- Smokey Point Behavioral Health has implemented remote order entry and verification so orders are verified and processed 24 hours per day.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Auditors will audit 100% of the charts to ensure orders are being transcribed and faxed within 2 hours of the order being written.
- Any deficiencies will be reported to the Program Director, Excellence Educator, and Chief Nursing Officer. The nurse will be re-educated on the correct process for order transcription and 24 hour chart checks.
- If the same nurse has a deficiency again, the disciplinary process will be followed.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Order transcription rates will be submitted to the QAPI team on a monthly basis until at 95% for 3 months and then quarterly. If an issue arises again, the report will go back to a monthly basis reporting.

Individual Responsible:
CNO/Designee

Date Completed:

February 13, 2019

(A 454) Plan of Correction for Each specific deficiency Cited:

The hospital failed to ensure medical staff promptly signed and authenticated verbal or telephone orders taken by a nurse for initiation of seclusion or restraint

Procedure/process for implementing the plan of correction:

- Reeducated 100% of nursing staff on S/R paperwork and need for provider to sign next time on unit - within 24 hours. Education was provided to staff on February 11 & 12, 2019. Any unavailable staff will be required to complete the education prior to working their next shift by 3/1/2019.
- Reeducated 100% of nursing staff that all TORB orders must be signed within 24 hours and the need for the provider to sign next time on unit. Education was provided on February 11 & 12, 2019. Any unavailable staff will be required to complete the education prior to working the next shift.
- Medical Staff were re-educated by the Clinical Excellence Educator on 2/28/19 in the Medical Staff Meeting.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Program Directors will be responsible to complete, but with assistance from identified staff will review all S/R and TORB orders within 24 hours of occurrence and ensure documentation is correct.
- Nursing staff will be educated that during the 24 hour chart check to ensure the TORB or S/R order is flagged for the physician.
  - Nursing staff will remind the next shift that the order needs to be signed.
  - Nursing staff will be educated and required to submit a 24 hour chart checklist to the

Program Director/Designee for review.

- The Program Director will report to the Chief Nursing Officer the number of orders not signed within 24 hours.
- The Chief Nursing Officer will aggregate and analyze the data and report on a monthly basis to the PI committee until 90 % percent has been achieved and PI, and GB have approved to stop reporting.

- If documentation is incorrect, the Program Director/Designee will re-educate the nurse.
  - If the nurse has another incident, he/she will be required to develop a primer card describing the process of orders being signed within 24 hours.
  - If the nurse has another incident, the disciplinary process will be implemented.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- The Chief Nursing Officer will aggregate and analyze the data and report on a monthly basis to the PI committee until 90 % percent has been achieved and PI, and GB have approved to stop reporting.

Individual Responsible:

CNO

Date Completed:

3/9/ 2019

(A 505) Plan of Correction for Each specific deficiency Cited:

The Hospital failed ensure medication storage areas are devoid of outdated or otherwise unusable medications

Procedure/process for implementing the plan of correction:

- Nurses re-educated on labeling of mulitidose vials
- Checking multidose vials to ensure accuracy and labeling added to Program Director's checklist

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Program Directors will submit their checklist five days per week to CNO
- CNO will review checklist to ensure complete
- Pharmacy will place new insulin vials in a secured, tamper-evident container with expiration date reminders.
  - Nursing will remove the vial, write the expiration (28 days after opening), and place in the refrigerator, as is current practice. The tamper-evident vial is returned to pharmacy.
- Multidose vial expirations will be monitored by Program Director/ (RNs) 5 days a week starting 2/28/2019. This audit will continue until 90% compliance for 3 months is achieved. If compliance drops below 90% organizationally for two consecutive months than a new corrective action plan will be created and continued monitoring until 90% at 3 months compliance.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- A report will be provided to PI Committee on a quarterly basis showing these items have been checked as indicated.

Individual Responsible:

CNO

Date Completed:

3/9/ 2019

A 629 Plan of Correction for Each specific deficiency Cited:
The hospital failed to ensure that patients with medical conditions or histories that necessitate dietary consults received consults or that consults ordered by dieticians were conducted

Procedure/process for implementing the plan of correction:

- A new dietary consult form was created and approved on 2/9/2019
- 100% of nursing staff were re-educated to completion of orders to ensure that medical conditions necessitated the correct process.
- Program directors and designees audit for appropriate dietary reviews upon admission and ensure recommendations are followed through.
- Physicians were re-educated on the process of dietary consults and the dietary form on 2/28/2019 in Medical Executive Committee. This included to ensure that dietary recommendations are reviewed for appropriateness per recommendation.
- The Physician will review the dietary recommendation and will document as to approving the dietary recommendation or rationale for not ordering.
- Nursing will weighed upon admission then weekly therefore unless ordered more frequently from the provider in order to ensure whether patient require a dietary consult. Any patient with a decrease or increase of more than 10% will require a dietary consult.
- Nursing Staff are currently scheduled for 3/7/2019-3/8/2019 to have mandatory staff meetings. This also included training to weekly weights included was training pertaining to review of admission assessment nutritional screening.
- Physician orders will be reviewed for any dietary consult needs.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- If dietary consults are found to not be completed, the Program Director will discuss the situation with the nurse completing the admission.
- If the nurse continues to not correctly complete Dietitian consults, the disciplinary process will be followed
- Dietary consults will be reviewed on each new admission. Program Directors will ensure consult is completed and recommendations on the chart.
- Dietitian recommendations will be placed in the order section of the chart and flagged. The provider will review the recommendations and agree or disagree to order.

- Once the medical staff have approved the dietary recommendations, a copy will be sent to the Dietitian.
- Medical staff have been educated by February 13, 2019 on the new process for Dietary Consults.
- Weekly weights and the nutritional screenings from new admission nursing orders for dietary will be scanned daily to the CNO for review 3 days a week to ensure that patients are being tracked for dietary consults and follow up. compliance drops below 90% organizationally for two consecutive months than a new corrective action plan will be created and continued monitoring until 90% at 3 months compliance. Orders will be reviewed nightly by and scanned to the CNO to ensure provider follow up, by and order being written approval of the dietary recommendation or justification for not approving the dietary recommendation.
-

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Monthly dietitian order report will be presented to the PI committee. This will continue until compliance has been 100% for 3 months. Then will be reported on quarterly basis.

Individual Responsible:

Dietitian & CNO

Date Completed:

3/9/2019

A 631 Plan of Correction for Each specific deficiency Cited:
The Hospital failed to review annually the diet manual.

Procedure/process for implementing the plan of correction:

- When Dietary Manager returned from vacation, the Diet Manual was located in his office. Dietitian, Dietary Manager, and CNO have adopted a location to maintain the Diet Manual at. Approval with signatures has been signed by Medical Staff and Dietitian.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Signatures will be added to the PI Plan to review every September

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- The CNO/Nurse Designee will ensure the Diet Manual is reviewed and signed annually in September.

Individual Responsible:

CNO & Dietitian

Date Completed:

February 8, 2019

ITEM #1 POC

(A 724 #1) Plan of Correction for Each specific deficiency Cited:

The hospital failed to review and check supplies along with its contracted service.

Procedure/process for implementing the plan of correction:

- A monitoring checklist has been created for supervisors rounding to review supplies for expiration dates. Any expired supplies will be destroyed.
- A policy regarding expired supplies was created.
- Staff will be re-educated on looking for expired supplies and what to do with it.
- Each unit cleaned and organized by Program Directors and staff on January 30, 2019.
- Organizing and stocking units added to Program Directors' and House Supervisors' checklist to be checked on daily basis.
- Nursing will no longer keep any supplies in the lab room.
- Units will be stocked on a daily basis. Expiration dates will be checked on supplies brought to the units.
- Listing will be developed of Central Service supplies and expiration dates. Containers of supplies will be marked with first expiration date.
- Reviewing contract for lab services and potential new contract for services. Maintaining the lab room and supplies, including expiration dates, will be part of the contract.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- The rounding log will be provided to the CNO by the program director including breakdown of the amount of expired supplies found on unit. The amount of expired supplies found per program will be reported by the CNO at PI committee for at least 3 months. If rounding has been consistent for the 3 months and 90% is maintained, then no further corrective action will be taken. If 90% drops for 2 consecutive months a new corrective action plan will be created.
- If any items are missed on the checklist, CNO and/or Program Director's will speak to the person who submitted.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- The rounding log created will be reported by program with aggregated data that is summarized at the monthly PI committee for a minimum of 3 months to ensure that expired supplies are being removed from the unit prior to use.

Individual Responsible:
CNO

Date Completed:
3/9/2019

ITEM #2 and 3 POC

(A 724 #2 and 3) Plan of Correction for Each specific deficiency Cited:

The hospital failed to ensure staff performed quality control checks for blood sugar point of care testing as required

Procedure/process for implementing the plan of correction:

- Pharmacy is now checking the Medication Room refrigerators one time each day.
- The crash cart drawers will be labeled with the earliest expiration date.
  - Prior to the expiration date, the crash cart supplies will be updated.
- Charge Nurses were re-educated on daily checking of the crash cart and labels with expiration dates.
- Crash cart check has been added to the Program Director's checklist
- Glucometer's daily control check log for the 2 glucometers on each floor
- 100% of nursing staff were re-educated to the glucometer daily checks
- Daily control check added to Program Director's checklist
- The night charge nurses/house supervisor will ensure the glucometer log will be completed daily.
- The program directors will verify the glucometer log.
  - Any variances will be immediately reported to the CNO.
  - Disciplinary processes will be followed
-

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Program Directors will submit their checklist to the CNO
- CNO will aggregate and analyze the checklists.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- A report will be provided to PI committee on a monthly basis showing these items have been checked as indicated until the report is 100% for 3 months, then quarterly reporting will take place.

Individual Responsible:

CNO

Date Completed:

3/9/ 2019

A 726 Plan of Correction for Each specific deficiency Cited:

The hospital failed to ensure that staff were monitoring refrigeration temperatures to ensure proper cold holding of patient food items

Procedure/process for implementing the plan of correction:

- 100% of nursing staff were re-educated to the daily refrigerator checks.
- Daily refrigerator check added to Program Director's checklist.
- Dietary and nursing were re-educated on monitoring of refrigeration.
-

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- The night charge nurses/house supervisor will ensure the refrigerator log will be completed daily.
- The program directors will verify the refrigerator log.
  - Any variances will be immediately reported to the CNO.
  - Disciplinary processes will be followed
- Dietary will also report on a weekly basis to the PI director to ensure checks have been complete for 3 months of 100% compliance. An additional month of communication will be added for everyday of non-compliance and a new corrective action plan enacted if compliance drops below 95%.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- A monthly report will be provided to the PI committee until 100% compliance has been met for 3 months, then the report will be changed to quarterly.

Individual Responsible:

CNO/Nurse Designee

Date Completed:

February 13, 2019

A 749 # 1,2,and 3 Plan of Correction for Each specific deficiency Cited:

The hospital failed to ensure Infection Prevention training was provided to all staff.

The hospital failed to ensure appropriate isolation precautions were implemented.

The hospital failed to ensure medical treatment plans were implemented for patients with infections.

Procedure/process for implementing the plan of correction:

- Administrative Assistant will inform Excellence Educator/Infection Control Nurse when a new contract provider is scheduled to onboard. Excellence Educator/Infection Control Nurse will meet with the contract provider to ensure Infection Prevention training is completed.

- CNO/nursing designee will inform Excellence Educator/Infection Control Nurse when contract nursing staff are scheduled to onboard. Excellence Educator/Infection Control Nurse will meet with the contract nursing staff to ensure Infection Prevention training is completed.
- Medical providers were educated in appropriate use of isolation precautions on 1/10/2019 and follow up education was provided during Infection Control Committee Meeting on 2/5/19.
- Medical providers were educated on the need to order appropriate isolation precautions upon diagnosing a patient with an infection on 2/5/19.
- Nursing staff were educated on use of isolation precautions and the need to establish a treatment plan for infections and document follow through of the plan including implementation of isolation precautions on Feb 11 & 12.
- Medical providers were educated on the need to note any infection diagnosis on the Medical Consult Log for follow up by the Infection Control Nurse on 2/5/19.
- The excellence educator has audited 100% of files of required employees needing Seclusion & Restraint training in order to ensure Infection Prevention training is included for all required employees by February 12, 2019
- All employees requiring Infection Prevention training will be trained prior to February 13, 2019.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Infection Control Nurse/nursing designee will review the Medical Consult Log for new infections diagnosed 5 days a week and check to see that a medical treatment plan and appropriate isolation precautions are implemented. Re-education will be provided to any provider or nursing staff who do not meet expectations.
- A database will be created showing compliance with all training by HR and will be kept up to date.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- HR and the Excellence Educator will review files on a monthly basis to ensure all training for required staff have been completed and are in compliance.
- Infection Control Nurse will report compliance with implementing medical treatment plans and isolation precautions to Infection Control Committee Quarterly and provide a monthly report to QI Committee. Plan of correction will be revised if compliance rate falls below 90%.

Individual Responsible:

Infection Control Nurse/Excellence Educator/designee

Date Completed:

2/13/19

A 811 Plan of Correction for Each specific deficiency Cited:

- The hospital failed to include the family of a patient in the discharge planning process for 1 of 1 patients reviewed.

Procedure/process for implementing the plan of correction:

- On 6 February 2019, clinical services staff were re-educated on the proper procedures for contacting and conducting family sessions as it relates to the patient's care and discharge planning. Educations included

but was not limited to, purpose of family sessions, expectation of obtaining release of information from patients for family member, treatment team discussions about family involvement, where to place document in the active medical chart about family sessions, and conducting of family sessions on all patients, when possible.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Program directors, Director of Clinical Services, or Director of Nursing will randomly audit 10 charts weekly to ensure family contact and/ or sessions are documented.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Program directors, Director of Clinical Services, or Director of Nursing will aggregate and analyze via the created checklist for their reports on the weekly basis.
- Non-compliance will be addressed via re-education.
- Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard.

Individual Responsible:
Director of Clinical Services

Date Completed:

2/13/2019