DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office
701 Fifth Avenue, Suite 1600
Seattle, WA 98104

NOTICE OF TERMINATION OF
MEDICARE PROVIDER AGREEMENT
IMPORTANT NOTICE – PLEASE READ CAREFULLY

April 21, 2015

Scott Burpee, Owner
Judy Moore, Administrator
Safe Haven Hospital of Pocatello
1200 Hospital Way
Pocatello, ID 83201

CMS Certification Number: 13-4011

Re: Complaint survey completed 04/03/2015 and CoPs not met
Termination from the Medicare program effective 04/27/2015
Appeal rights

Dear Mr. Burpee & Ms. Moore:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Safe Haven Hospital of Pocatello no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. This is to notify you that effective **April 27, 2015** the Secretary of the Department of Health and Human Services intends to terminate its provider agreement with Safe Haven Hospital of Pocatello.

I. BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a psychiatric hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a psychiatric hospital is found to be out of compliance with the Medicare Conditions of Participation, the facility no longer meets the requirements for participation as a provider of services in the Medicare program.

The Social Security Act Section 1866(b) authorizes the Secretary to terminate a psychiatric hospital's Medicare provider agreement if the psychiatric hospital no longer meets the regulatory requirements for a psychiatric hospital. Regulations at 42 CFR § 489.53 authorize the Centers for Medicare and Medicaid Services to terminate Medicare provider agreements when a provider, such as Safe Haven Hospital of Pocatello, no longer meets the Conditions of Participation.

On April 3, 2015, the Idaho Bureau of Facility Standards (State survey agency) completed a complaint survey at your facility and notified you about an Immediate Jeopardy finding regarding the Medicare Conditions of Participation (Cop). Briefly, the combined effect of systemic failures resulted in patients experiencing serious harm and placed the health and safety of all patients residing in the facility in immediate jeopardy. In addition, the governing body failed to provide oversight and supervision necessary to ensure patients were protected from abuse and neglect and received safe and appropriate psychiatric, medical, and nursing services. The Immediate Jeopardy was not removed by the end of the survey. The following Conditions of Participation are not met:

42 CFR § 482.12	Governing Body (Immediate Jeopardy – Not Abated)
42 CFR § 482.13	Patient Rights (Immediate Jeopardy – Not Abated)
42 CFR § 482.21	Quality Assessment and Performance Improvement Program
42 CFR § 482.22	Medical Staff (Immediate Jeopardy – Not Abated)
42 CFR § 482.23	Nursing Services (Immediate Jeopardy – Not Abated)
42 CFR § 482.43	Discharge Planning

These deficiencies limit the capacity of Safe Haven Hospital of Pocatello to furnish services of an adequate level and quality. The details of the above deficiencies were sent to you by the State survey agency.

II. PUBLIC NOTICE OF TERMINATION

In accordance with 42 CFR § 489.53(d), legal notice of our action will be published in the local newspaper (Idaho State Journal) on April 24, 2015.

III. APPEAL RIGHTS

If you do not agree with this determination, you may request a hearing before an administrative law judge (ALJ) of the Departmental Appeals Board in accordance with 42 CFR §§ 498.40 through 498.78. A request for hearing must be filed **electronically** no later than **sixty (60) calendar days** after the date you receive this notice. 42 CFR § 498.40. You should file your request for an appeal (accompanied by a copy of this letter) through the Departmental Appeals Board Electronic Filing System website (DAB E-file) at https://dab.efile.hhs.gov . Please note: All documents must be submitted in Portable Document Format ("pdf").

You are **required** to e-file your appeal request unless you do not have access to a computer or internet service. In such circumstances, you may file in writing, but must provide an explanation as to why you cannot file submissions electronically and request a waiver from e-filing in the mailed copy of your request for a hearing.

A written request for appeals must also be filed no later than sixty (60) calendar days from the date you receive this notice, and must be submitted to the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Ave, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. 42 CFR § 498.40(b)(1). It should also specify the basis for contending that the findings and conclusions are incorrect. 42 CFR § 498.40(b)(2). You may be represented by counsel at a hearing at your own expense.

Should you choose to exercise your right to appeal, please forward a copy of that appeal to:

Chief Counsel
Office of General Counsel, DHHS
701 Fifth Avenue, Suite 1600
Seattle, WA 98104

IV. PAYMENT FOR MEDICARE PATIENTS AFTER TERMINATION

To facilitate the appropriate movement and placement of Medicare patients from the hospital upon termination of your Medicare provider agreement, payments for those Medicare patients who were admitted to your facility prior to April 27, 2015 and who remained in your facility on April 27, 2015, may be permitted for up to a maximum of thirty (30) days after the effective date of termination in accordance with 42 CFR § 489.55(a). Under 42 CFR § 441.11(a), Medicaid payments may also continue for services rendered for up to a maximum of 30 days following the termination date.

V. REINSTATEMENT AFTER TERMINATION (42 CFR § 489.57)

When a provider agreement has been terminated by CMS under 42 CFR § 489.53, a new agreement with that provider will not be accepted unless CMS finds: (a) that the reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur; and (b) that the provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

If you have any questions, please contact Aileen Renolayan of my staff at (206) 615-2041 or by email at aileen.renolayan@cms.hhs.gov.

Sincerely,

Steven Chickering,
Associate Regional Administrator
Western Division of Survey & Certification

cc: Idaho Bureau of Facility Standards
Office of General Counsel, DHHS

IDAHO DEPARTMENT OF HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

CERTIFIED MAIL: 7000 1670 0011 3315 1583

May 26, 2015

Scott Burpee, administrator
Safe Haven Hospital Of Pocatello
1200 Hospital Way
Pocatello, ID 83201

RE: Safe Haven Hospital Of Pocatello, License #59

Dear Mr. Burpee:

This is to advise you of the findings of the Licensure survey at Safe Haven Hsopital Of Pocatello, which was concluded on April 3, 2015.

The Idaho hospital licensing rules at IDAPA 16.03.14.061 define substantial compliance as "Substantial compliance means a facility is substantial compliance with these rules when there are no deficiencies which endanger the health, safety, or welfare of residents."

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction State Form-2567 listing State licensure deficiencies which verify the hospital is not in substantial compliance with the Idaho hospital licensing rules found at IDAPA 16.03.14. The health, safety, and welfare, of all hospital patients. The negative practices resulted in one patient sustaining fractures to both shoulders and a shatterd hip (Refer to BB527), and lead to the death of three other patients (Refer to BB463).

In lieu of action to revoke the hospital's license, the Department proposes the hospital enter into a written compliance agreement. The agreement includes the following seven components:

1. The hospital agrees not to admit patients until the Department receives and approves a Plan of Correction for the 4/3/15 survey.

2. The facility will have onsite psychiatric and medical physician services available to meet patient needs and regulatory requirements. The physicians must available to physically be at the hospital within 30 minutes.

3. The facility will achieve accreditation and deemed status for a psychiatric hospital via the Joint Commission and will maintain such status for a minimum of 5 years.

4. The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing or its equivalent from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill.

5. The staffing pattern must ensure a registered nurse on duty 24 hours each day.

6. The clinical director, service chief or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology, or the American Osteopathic Board of Neurology and Psychiatry.

7. Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program.

The formal written agreement is attached. If you choose to accept the terms of the compliance agreement, please sign and date the agreement and return it to this office. The Bureau Chief will sign and date the document and a copy will be sent to you.

If you accept the agreement, please provide a Plan of Correction in the spaces provided on the right side of each sheet, prior to admitting patients.

<u>An acceptable plan of correction (PoC) contains the following elements</u>:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the sc into compliance, and that the facility remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

- The administrator's signature and the date signed on page 1 of the State Form 2567.

Please keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626, option 4.

Sincerely,

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/sc
Enclosures

Safe Haven Hospital & Care Center of Pocatello

1200 Hospital Way, Pocatello, ID. 83201

Phone (208) 232-2570 option 2 Fax (208)232-5654

July 28, 2015

Karen Nielson, Hospital Administrator
Safe Haven Hospital of Pocatello
1200 Hospital Way
Pocatello, ID 83201

RECEIVED
JUL 29 2015
FACILITY STANDARDS

Debra Ransom, Chief
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009

Dear Ms. Ransom:

This letter is to advise you that Safe Haven Hospital of Pocatello has completed the Statement of Deficiencies/Plan of Correction in the findings of the Bureau of Facility Standards Licensure survey which was concluded on April 3, 2015.

The Statement of Deficiencies/Plan of Correction has been completed and addressed for compliance and acceptance. In accordance to the Idaho hospital licensing rules IDAPA 16.03.14; please find enclosed the Statement of Deficiencies/Plan of Correction State Form 2567, as completed and addressed for substantial compliance.

Sincerely,

Karen Nielson

Karen Nielson, Administrator
Safe Haven Hospital of Pocatello

Safe Haven Hospital & Care Center of Pocatello

1200 Hospital Way, Pocatello, ID. 83201 Phone (208) 232-2570 x 2 Fax (208)232-5654

POC Definitions:

Organization – Safe Haven Healthcare Corporation
Administrator – Behavioral Hospital Administrator
CNO – Chief Nursing Officer
GB – Governing Board
GB Bylaws – Governing Board Bylaws
LIP- Licensed Independent Practitioner
MAR - Medication Administration Records
MS – Medical Staff
MS Bylaws – Medical Staff Bylaws
MD – Medical Director
Hospital – Safe Haven Healthcare Behavioral Hospital
PT's – Psychiatric Technicians
COO – Chief Operations Officer
CFO – Chief Financial Officer
CEO – Safe Haven Healthcare Chief Executive Officer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	134011		C **04/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN HOSPITAL OF POCATELLO	**1200 HOSPITAL WAY** **POCATELLO, ID 83201**

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A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation of your Psychiatric Hospital completed 3/30/15 through 4/03/15. The surveyors conducting the survey were: Susan Costa, RN, HFS, Team Lead Laura Thompson, RN, BSN, HFS Nancy Bax, RN, BSN, HFS Gary Guiles, RN, HFS During the survey it was determined that deficient practices at the following four Conditions of Participation, placed the health and safety of patients in immediate jeopardy of serious harm, impairment, or death and had the potential to impact all patients receiving services at the facility. 42 CFR §482.12 Condition of Participation: Governing Body, 42 CFR 482.13, Condition of Participation: Patient's Rights, 42 CFR §482.22 Condition of Participation: Medical Staff, 42 CFR §482.23 Condition of Participation: Nursing Services, The co-owner of the facility was notified of the immediate jeopardy verbally on 4/03/15 at 5:00 PM, and by letter on 4/07/15. The following acronyms were used in this report: ALF - Assisted Living Facility BID - twice daily BM - bowel movement BUN - Blood, Urea, Nitrogen laboratory test	A 000		

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

05/26/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 000	Continued From page 1 CBC - Complete Blood Count cc - cubic centimeter CHF - Congestive Heart Failure CMP - Complete Metabolic Panel CNO - Chief Nursing Officer COPD - Chronic Obstructive Pulmonary Disease CPR - cardiopulmonary resuscitation DM - Diabetes Mellitus ED - Emergency Department EKG - Electrocardiogram EMS - Emergency Medical Services Free T4 - Thyroid Hormone, a blood test to evaluate thyroid function GERD - Gastroesophageal reflux disease Hgb A1C - Hemoglobin A1C, a blood test to provide information about a person's average levels of blood glucose over 2-3 months HTN - Hypertension H&P - History and Physical IC - Infection Control ICTP - Interdisciplinary Comprehensive Treatment Plan ICU - Intensive Care Unit IM - Intramuscular IV - Intravenous LIP - Licensed Independent Practitioner LMSW - Licensed Masters Social Worker LOC - Level of Consciousness LPN - Licensed Practical Nurse MAR - Medication Administration Record MD - Medical Doctor mg - milligram mg/dl - milligrams per deciliter MRSA - Methicillin Resistant Staphylococcus aureus NCP - Nursing Care Plan NP -Nurse Practitioner PEG tube - Percutaneous Endoscopic	A 000		

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A 000	Continued From page 2 Gastrostomy tube PI - Performance Improvement po - by mouth POC - Plan of Care PRN - as needed Pt - Patient P.T. - Psychiatric Technician PT/INR - Prothrombin Time/ International Normalized Ratio, a blood test to measure blood clotting times PTSD - Post- Traumatic Stress Disorder QAPI - Quality Assessment Performance Improvement RD - Registered Dietician RN - Registered Nurse R/O - Rule Out ROM - Range of Motion RPR - Rapid Plasma Reagin, a screening test for syphilis SNF - Skilled Nursing Facility SNF AIT - Skilled Nursing Facility Administrator in Training SS - Social Services TO - Telephone Order TSH - Thyroid Stimulating Hormone UA - Urine analysis UTI - Urinary Tract Infection VO- Verbal Order VS - Vital Signs	A 000		
A 043	482.12 GOVERNING BODY 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 ...	A 043		

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A 043	Continued From page 3 This CONDITION is not met as evidenced by: Based on staff interview and review of medical records, policies, incident reports, Medical Staff Bylaws, QAPI documents, and meeting minutes, it was determined the hospital's Governing Board failed to assume responsibility for determining, implementing, and monitoring policies and failed to oversee the hospital's QAPI program. The Governing Board failed to provide oversight and supervision necessary to ensure patients were protected from abuse and neglect and received safe and appropriate psychiatric, medical, and nursing services. This resulted in deficient practices that placed the health and safety of one or more patients in immediate jeopardy of serious harm, impairment, or death, and had the potential to impact all patients receiving services at the facility. Findings include: 1. Refer to A049 as it relates to the Governing Body's failure to ensure it held the Medical Staff accountable for the quality of care provided. 2. Refer to A057 as it relates to the failure of the Governing Body to ensure the Administrator assumed responsibility for managing the hospital, including developing and monitoring systems of care. 3. Refer to A064 as it relates to the failure of the Governing Body to ensure Medicare patients were under the care of a doctor of medicine or a doctor of osteopathy. 4. Refer to A093 as it relates to the failure of the Governing Body to ensure written policies and procedures for the appraisal of emergencies,	A 043		

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A 043	Continued From page 4 including the hospital's responsibilities for initial treatment and referral, had been developed. 5. Refer to A115 Condition of Participation for Patient Rights as it relates to the failure of the Governing Body to ensure patients' rights were protected and promoted and as it relates to the failure of the hospital to identify, and respond to, patients' initial and ongoing needs. This resulted in the use of physical and chemical restraints by staff that were not trained which resulted in patient injuries. 6. Refer to A263 Condition of Participation for QAPI as it relates to the failure of the Governing Body to ensure a hospital wide data driven QAPI program was fully developed, implemented, and maintained. 7. Refer to A338 Condition of Participation for Medical Staff as it relates to the failure of the Governing Body to ensure the Medical Staff was organized, and was responsible for the quality of medical care provided to patients. 8. Refer to A385 Condition of Participation for Nursing Services as it relates to the failure of the Governing Body to ensure nursing services were organized and supervised to effectively meet the health care and psychiatric needs of patients. 9. Refer to A799 Condition of Participation for Discharge Planning as it relates to the failure of the Governing Body to ensure a discharge planning process was in place that met the needs of all patients. These systemic negative practices seriously	A 043		

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A 043	Continued From page 5 impeded the ability of the hospital to provide safe and effective services.	A 043		
A 049	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by: Based on staff interview and review of Medical Staff Bylaws and meeting minutes, it was determined the hospital's Governing Board failed to ensure it held the Medical Staff accountable for the quality of care provided. The lack of oversight by the Governing Board resulted in a lack of participation in patient care by the Medical Staff. Findings include: A Boise psychiatrist served as Medical Director for the hospital through 3/31/15. In this report he is referred to as the prior Medical Director. 1. Three Governing Board meetings were documented between 1/01/14 and 3/31/15. Meeting minutes documented the prior Medical Director was present at all 3 meetings. These included: "Governing Board Committee Minutes" were dated 1/16/14. The minutes stated the prior Medical Director stated he would teleconference the treatment team meeting with the hospital. "Governing Board Committee Minutes" were dated 4/29/14. The minutes stated the prior Medical Director again stated he would teleconference the treatment team meeting with	A 049		

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A 049	Continued From page 6 the hospital. "Governing Board Committee Minutes" were dated 7/24/14. The minutes stated the prior Medical Director stated he would go to the hospital 1 time a month. The minutes stated The prior Medical Director mentioned concerns regarding increased falls and medication errors, nursing staff issues, and a request for an EKG machine. No other discussion of the medical staff at Governing Board meetings was documented. The Co-owner was interviewed on 4/01/15 at 9:30 AM. She confirmed these were the only Governing Board meeting minutes available and confirmed the lack of documentation of Medical Staff activities. 2. "SAFE HAVEN HOSPITAL BYLAWS OF THE GOVERNING BOARD," not dated, stated "PATIENT CARE. It is Hospital policy that every patient shall be under the care of a physician...a physician shall be on duty or on call at all times and shall provide onsite supervision when necessary." Further, the Bylaws stated "The Governing Board requires quarterly meetings of the Medical Staff." The prior Medical Director was interviewed on 4/02/15 beginning at 4:45 PM. He confirmed he had served as Medical Director from 9/25/13 through 3/31/15. He stated while he was Medical Director the Medical Staff consisted of 2 psychiatrists, including himself, another psychiatrist, and a Family Practice Physician.	A 049		

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A 049	Continued From page 7 The prior Medical Director stated no Medical Staff meetings had been held during the 18 months he was the Medical Director. The prior Medical Director stated there was no documentation of Medical Staff Activities. The prior Medical Director stated the hospital had no peer review program or other process to evaluate members of the Medical Staff. The prior Medical Director stated during his time as Medical Director he lived in Boise, Idaho which is approximately 235 miles from the hospital. He stated he had not treated any patients at the hospital. He stated he started visiting the hospital in 2014. He stated since then he had been coming to the hospital one time a month until 2 or 3 months ago. He stated his activities at the hospital were not documented. The prior Medical Director stated psychiatric care was primarily provided by one NP. He stated 2 other NPs served as her backup when she was not available. He stated the primary NP was supervised by the other psychiatrist who lived in Florida. He stated a Family Practice Physician also had privileges at the hospital to provide for patients' medical care. The prior Medical Director stated he had not had contact with the Family Practice Physician. The Family Practice Physician was interviewed on 4/01/15 beginning at 1:30 PM. The Family Practice Physician stated he did not know the name of the prior Medical Director and had not met him. The Family Practice Physician stated he worked at a wound clinic and was not	A 049		

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A 049	Continued From page 8 available to the hospital until after 3:00 PM. The Florida psychiatrist was interviewed on 4/03/15 beginning at 1:55 PM. She stated she last visited the hospital in February of 2015. She said she was scheduled to come to the hospital on April 9, 13, 14, and 15 of 2015 and then she would not come to the hospital again until the end of May 2015. She stated she did not directly supervise the NPs. She stated she did not know if the hospital had a formal process to supervise NPs. The Governing Board did not ensure the Medical Staff was organized. The Governing Board did not ensure the Medical Staff was accountable. The Governing Board did not ensure physicians examined and treated patients. The Governing Board did not ensure the Medical Staff monitored and evaluated medical care provided to patients. The Governing Board failed to enforce its Bylaws. 3. "BYLAWS OF THE MEDICAL STAFF OF SAFE HAVEN HOSPITAL," not dated, stated NPs were defined as Allied Health Professionals. Article VIII Section I of the bylaws stated "All Allied Health Professionals providing direct patient care in the hospital shall do so under the direct supervision of the attending psychiatrist." The Florida psychiatrist was interviewed on 4/03/15 beginning at 1:55 PM. She stated all direct services were provided by NPs. She stated she teleconferenced with the primary NP 2 times a week. She stated she did not directly supervise the NPs. She stated she did not know	A 049		

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A 049	Continued From page 9 if the hospital had a formal process to supervise NPs. The Governing Board did not enforce Medical Staff Bylaws to directly supervise the NPs.	A 049		
A 057	482.12(b) CHIEF EXECUTIVE OFFICER The governing body must appoint a chief executive officer who is responsible for managing the hospital. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, policies, incident reports, Medical Staff Bylaws, QAPI documents, and meeting minutes, it was determined the hospital's Governing Board failed to ensure the Administrator assumed responsibility for managing the hospital, including developing and monitoring systems of care. This resulted in the inability of the hospital to provide necessary services to promote the health and safety of patients. Findings include: The governing body must appoint a chief executive officer who is responsible for managing the hospital. 1. No person was designated to be responsible for managing the hospital. Upon arrival at the facility on 3/30/15 at approximately 1:15 PM, surveyors were greeted by an employee who introduced himself as the Administrator in Training for the attached SNF. He stated the Administrator of the hospital was out of town for the week. He stated he was the hospital's liaison for the surveyors. He stated he did not work for the hospital and did not know	A 057		

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A 057	Continued From page 10 about much about the hospital. When interviewed later on 4/01/15 at 9:05 AM, the SNF AIT stated nobody was appointed as Acting Administrator for the hospital while the Administrator was out of town that week. During an interview on 4/01/15 at 9:35 AM, the Co-owner of the hospital stated the Administrator was out of town for a week and no one was designated to oversee clinical services while she was out of town. In addition to not having an Administrator at the time of the survey, the hospital also lacked a CNO. The Administrator was interviewed by phone on 4/02/15 beginning at 2:15 PM. She stated she assumed the role of the Interim CNO in January 2015 when the former CNO resigned. She stated there was no documentation stating she was the Interim CNO. She stated an Acting CNO had not been appointed while she was out of town. During an interview on 4/01/15 at 9:35 AM, the Co-owner of the hospital stated the CNO resigned in January and they were currently looking for a replacement. She stated the Administrator was currently acting as CNO. During an interview on 4/01/15 beginning at 9:05 AM, RN C, the Charge Nurse, stated nobody was designated as Acting CNO while the Administrator was out of town. She stated she did not know who to call if there was a nursing problem. During an interview on 4/03/15 at 10:10 AM, RN E stated she thought the Administrator was also	A 057		

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A 057	Continued From page 11 the CNO. She stated there had been no formal announcement but she assumed the Administrator took over the CNO role. She stated she did not know who the Acting Administrator was or who the Acting CNO was on the date of the interview (while the Administrator was out of town.) During an interview on 4/02/15 at 5:00 PM, RN B stated her first day on the job was 3/23/15. She stated it was her understanding there was no CNO. When asked who she would call with a question or problem, she stated she did not know. The Administrator failed to appoint an onsite Administrator in her absence and failed to officially appoint a CNO and inform nursing staff of who to contact if nursing issues arose. 2. The Administrator did not implement a treatment planning process. The policy "ICTP, Comprehensive," dated 1/31/12, stated "An ICTP that includes measurable objectives and time tables to meet the patient's mental, psychological, and psychosocial needs shall be developed for each patient." The policy included a procedure to develop and monitor a comprehensive treatment plan for patients. The policy and procedure were not followed. The records of 17 patients (#1 - #17) with an admission date range of 9/24/14 to 3/31/15, were reviewed. None of the 17 patient records contained a documented treatment plan. Goals were not identified, and interventions were not	A 057		

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A 057	Continued From page 12 specified in order to direct staff in caring for these patients. During an interview on 4/03/15 at 10:30 AM, the NP stated ITCPs had not been developed since the CNO left in January. She confirmed patients currently did not have ITCPs. On 4/02/15 beginning at 11:50 AM, a Treatment Team group consisting of RN C, the Director of Social Services, and the Program Director was observed. They discussed patients' needs and progress at the hospital. They did not develop or document written treatment plans. The Director of Social Services stated the group reviewed patients' problem lists but she said there were no written treatment plans. She stated she was not aware of a procedure to develop and review treatment plans. The Administrator failed to ensure patients had written treatment plans to direct staff. 3. The Administrator did not ensure processes were developed and maintained to evaluate persons with medical and psychiatric emergencies. Refer to A93 as it relates to the failure of the hospital to develop written policies and procedures for the appraisal of emergencies, including the hospital's responsibilities for initial treatment and referral. 4. The Administrator did not ensure patients' rights were protected and promoted. Refer to A115 as it relates to the lack of staff training and monitoring regarding the safe use of restraints and seclusion and the inability of the hospital to	A 057		

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A 057	Continued From page 13 protect patients from harm. 5. The Administrator did not ensure a comprehensive QAPI program was developed and maintained. Refer to A263 as it relates to lack of a QAPI program that collected and utilized data to analyze hospital processes and suggest ways to improve patient care. 6. The Administrator did not ensure the Medical Staff was organized and accountable for medical care provided to patients. Refer to A338 as it relates to the failure of the Medical Staff to provide basic care and services and to monitor medical care provided to patients. 7. The Administrator did not ensure nursing services were organized. Refer to A385 as it relates to the failure of the nursing service to meet the nursing needs of patients with acute and chronic medical and psychiatric conditions. 8. The Administrator did not ensure the discharge planning program was sufficient to meet the needs of patients. Refer to A799 as it relates to the inability of the discharge planning program to identify patients' discharge planning needs and implement plans to meet patients' needs.	A 057		
A 064	482.12(c)(1) CARE OF PATIENTS - PRACTITIONERS [...the governing body must ensure that the following requirements are met:] Every Medicare patient is under the care of: (i) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to	A 064		

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A 064	Continued From page 14 delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism); (ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license; (iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform; (iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices; (v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated on x-ray to exist; or (vi) A clinical psychologist as defined in §410.71 of this chapter, but only with respect to clinical psychologist services as defined in §410.71 of this chapter and only to the extent permitted by State law. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital's Governing Board failed to ensure 14 of 14 Medicare patients (#1, #2, #3, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, and #16), whose records were reviewed, were under the care of a doctor of medicine or a doctor of osteopathy. The lack of care by a physician prevented the hospital from providing comprehensive care to patients. Findings include: Safe Haven Hospital of Pocatello specialized in	A 064		

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A 064	Continued From page 15 the treatment of patients with psychiatric conditions. Fourteen Medicare patients, whose records were reviewed, were treated at the hospital for psychiatric illnesses. None of these patients had documented examinations or treatment by a psychiatrist. Examples include: a. Patient #1's medical record documented a 40 year old male who was a patient in the hospital from 3/26/15 to 3/31/15. His face sheet identified him as a Medicare patient. His diagnoses schizoaffective disorder, substance dependence, and PTSD. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. b. Patient #2's medical record documented a 65 year old female admitted to the hospital from 3/25/15 to 3/31/15. Her face sheet identified her as a Medicare patient. Her psychiatric diagnoses were psychosis, delusions, and paranoia. Her record did not contain documentation that she was examined or treated by a physician for her psychiatric disorders. c. Patient #3's medical record documented a 79 year old female admitted to the hospital from 9/24/14 to 10/03/14. Her face sheet identified her as a Medicare patient. Her psychiatric diagnoses were psychosis and dementia. Her record did not contain documentation that she was examined or treated by a physician for her psychiatric disorders. d. Patient #6's medical record documented a 69 year old male admitted to the hospital on 3/16/15,	A 064		

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A 064	Continued From page 16 with diagnoses of psychotic disorder with delusions, dementia, and chronic depression. He was discharged on 3/24/15. His face sheet identified him as a Medicare patient. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. e. Patient #7's medical record documented a 39 year old male admitted to the hospital on 3/23/15, with diagnoses of scizoaffective disorder and bipolar disorder. He was discharged on 4/01/15. His face sheet identified him as a Medicare patient. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. f. Patient #8's medical record documented a 65 year old male admitted to the hospital on 3/06/15, with diagnoses of dementia, psychosis, and PTSD. He was discharged on 4/02/15. His face sheet identified him as a Medicare patient. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. g. Patient #9's medical record documented a 69 year old male admitted to the hospital on 3/25/15, with diagnoses of schizoaffective disorder and borderline personality disorder. He was discharged on 4/02/15. His face sheet identified him as a Medicare patient. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. h. Patient #10's medical record documented a 67 year old male admitted to the hospital on	A 064		

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A 064	Continued From page 17 11/07/14. His face sheet identified him as a Medicare patient. His psychiatric diagnoses were conduct disorder and depression. He expired at the hospital on 11/17/14. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. i. Patient #11's medical record documented a 66 year old female admitted to the hospital on 11/25/14. Her face sheet identified her as a Medicare patient. Her psychiatric diagnoses were psychosis, bipolar disorder and congenital brain injury with mental disability. Patient #11 was transferred to an acute care hospital on 11/29/14. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. j. Patient #12's medical record documented an 87 year old male who was a patient in the hospital from 12/26/14 to 12/30/14. His face sheet identified him as a Medicare patient. His diagnoses were psychosis and dementia. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. k. Patient #13's medical record documented a 69 year old male who was a patient in the hospital from 1/01/15 to 1/05/15. His face sheet identified him as a Medicare patient. His diagnoses were psychosis and depression. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. l. Patient #14's medical record documented a 51	A 064		

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A 064	Continued From page 18 year old male who was a patient in the hospital from 2/24/15/15 to 2/27/15. His face sheet identified him as a Medicare patient. His diagnoses were schizoaffective disorder and suicidal ideation. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. m. Patient #15's medical record documented a 60 year old man who was a patient in the facility from 3/15/15 to 3/26/15. His face sheet identified him as a Medicare patient. His diagnoses were Schizoaffective Disorder and Borderline Personality Disorder. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. n. Patient #16's medical record documented a 77 year old male who was a patient in the hospital from 3/15/15 to 3/26/15. His face sheet identified him as a Medicare patient. His diagnoses were psychotic disorder, dementia, and chronic depression. His record did not contain documentation that he was examined or treated by a physician for his psychiatric disorders. Patients (#1, #2, #3, #6, #7, #9, #10, #11, #13, #14, #15, and #16 all had 1 visit by the Family Practice Physician to conduct a history and physical. However, he did not admit or discharge patients or participate in their psychiatric care. Patients #8 and #12 had a history and physical conducted by the PA and were not seen by a physician during their hospitalization. One psychiatrist participated in the care of patients at the hospital. She was interviewed on	A 064		

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A 064	Continued From page 19 4/03/15 beginning at 1:55 PM. She stated she lived in Florida. She stated she did not see patients or provide any direct services. She stated no psychiatrist provided services directly to patients at the hospital. She stated all direct services were provided by 1 NP with 2 NPs as her backups. She stated she did not directly supervise the NPs. She stated she did not document her services to the hospital except for her co-signature on psychiatric evaluations and discharge summaries. Medicare patients were not under the care of a physician.	A 064		
A 093	482.12(f)(2) EMERGENCY SERVICES If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: Based on staff interview and review of documents, it was determined the hospital's Governing Board failed to ensure written policies and procedures for the appraisal of emergencies, including the hospital's responsibilities for initial treatment and referral, had been developed. This directly impacted the care of 1 of 1 patient (#5), who was discharged from the hospital and who returned seeking emergency care. The lack of direction to staff for the appraisal of emergencies had the potential to delay the treatment of persons with emergency medical conditions. Findings include: 1. Safe Haven Hospital of Pocatello specialized	A 093		

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A 093	Continued From page 20 in the treatment of patients with psychiatric conditions. It did not operate an ED or routinely evaluate patients for admission. Instead, it relied on other hospitals and community physicians to determine if patients were appropriate for admission. Patient #5 was a 55 year old male admitted to the hospital from 3/09/15 to 3/25/15, for schizophrenia and depression. Patient #5's medical record documented he was discharged from the facility on 3/25/15 at 3:30 PM, to a local homeless shelter. A timeline, provided on 4/03/15 at 3:30 PM by the SNF AIT, outlined the events that happened after Patient #5's discharge from the facility: - Patient #5 was discharged at 3:30 PM - Patient #5 was refused admittance to shelter because it was not open - Patient #5 returned to shelter at 9 PM and was refused admittance again - Patient #5 returned to shelter at 1 AM and was refused admittance. He was reportedly bleeding from an unknown source at this time. Police were contacted by a shelter staff member. - During the course of the evening (the time was not documented) Patient #5 returned to the hospital and requested assistance. The staff member who went to the door refused to let him in stating the hospital did not offer emergency services. The staff member told Patient #5 he needed to leave. Patient #5 "returned banging on the doors and windows of the facility a couple more times. Finally the nurse called the police and he took off."	A 093		

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A 093	Continued From page 21 - Patient #5 went to the hospital's corporate office around 7:15 AM on 3/27/15. He did not have any personal belongings, wallet or ID. His face was "badly banged up." He had tape across his nose. - The corporate office found placement for Patient #5 in an ALF. The Director of Social Services was interviewed on 4/03/15 at 3:40 PM. She confirmed Patient #5's discharge and subsequent return to the hospital. Patient #5 presented to the hospital requesting treatment. Staff turned him away without providing an assessment of his condition. 2. RN E, the charge nurse on duty, was interviewed on 4/03/15 beginning at 10:10 AM. She stated, if a person came to the hospital and requested emergency care, staff would tell him to go to the acute care hospital for medical screening. She looked at policies on her computer. She stated she did not think there was a policy to direct staff if persons requested emergency care. The hospital had not developed policies to direct staff if persons came to the hospital and requested emergency care.	A 093		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, record review, staff interview, review of staff and patient grievances, incident reports, and policies, it was determined	A 115		

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(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 115	Continued From page 22 the hospital failed to ensure 1) patients were protected from abuse and neglect, 2) treatment and nursing POCs were developed and implemented, 3) sufficient numbers of trained staff were available to safely care for patients with behavioral concerns, 4) restraints and seclusion were safely and appropriately implemented by trained staff, and 5) staff were trained to meet patients' behavioral and health care needs. This resulted in 1 of 3 sanple patients (#8), who were placed in restraints or seclusion, sustaining bilateral arm fractures and a shatter pelvis, 5 unidentified patients who submitted written grievances experiencing mental anguish and fear, and endangered the health and safety of all patients residing in the facility. Findings include: 1. Refer to A117 as it relates to the failure of the facility to inform each patient or patient's representative, of the patient's rights, in advance of furnishing or discontinuing patient care. 2. Refer to A122 as it relates to the failure of the facility to review, investigate, and respond to patient grievances. 3. Refer to A130 as it relates to the facility's failure to include the patient and/or family in the development and implementation of the plan of care. 4. Refer to A131 as it relates to the facility's failure to ensure patient participation in treatment planning. 5. Refer to A143 as it relates to the failure of the facility to ensure patients' privacy during	A 115		

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A 115	Continued From page 23 physician and NP assessments and evaluations. 6. Refer to A144 as it it relates to the facility's failure to ensure patients health and safety were not placed in immediate jeopardy and that all patients were provided care in a safe setting. 7. Refer to A145 as it relates to the facility's failure to ensure patients were free from all forms of abuse, neglect, and harassment. This resulted in immediate jeopardy to the health and safety of all patients residing in the facility. 8. Refer to A154 as it relates to the failure of the facility to ensure patients were not inappropriately restrained, placed in seclusion, or chemically restrained. 9. Refer to A164 as it relates to the failure of the facility to use less restrictive interventions before implementing chemical and physical restraints. 10. Refer to 165 as it relates to the failure of the facility to ensure the use of restraint as the least restrictive intervention. 11. Refer to A166 as it relates to the failure of the facility to modify patients' plan of care when restraints, seclusion, or chemical restraints were implemented. 12. Refer to A167 as it relates to the failure of the facility to ensure staff were trained in appropriate restraint and seclusion techniques. 13. Refer to A168 as it relates to the failure of the facility to ensure physician and NP orders were in place when implementing restraints and	A 115		

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A 115	Continued From page 24 seclusion. 14. Refer to A178 as it relates to the failure of the facility to ensure patients were assessed face to face within 1 hour after implementation of seclusion or restraint for violent behavior. 15. Refer to A185 as it relates to the failure of the facility to ensure documentation of the type of restraint interventions used. 16. Refer to A186 as it relates to the failure of the facility to ensure documentation of attempts of less restrictive interventions prior to implementation of restraint and/or seclusion. 17. Refer to A194 as it relates to the failure of the facility to ensure staff were trained and utilized safe restraint and seclusion techniques. 18. Refer to A200 as it relates to the failure of the facility to require appropriate staff education, training, and knowledge in the use of nonphysical intervention skills. 19. Refer to A206 as it relates to the failure of the facility to ensure all patient care staff had education, training, and certification in cardiopulmonary resuscitation. The cumulative effect of these systemic failures prevented the facility from ensuring patients were protected from serious harm and provided care in a safe and effective manner. The co-owner of the facility was verbally notified of the Immediate Jeopardy to patients' health and safety on 4/03/15 at 5:00 PM, and in writing on	A 115		

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A 115	Continued From page 25 4/07/15.	A 115		
A 117	482.13(a)(1) PATIENT RIGHTS: NOTICE OF RIGHTS A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. This STANDARD is not met as evidenced by: Based on record review, and staff interview, it was determined the hospital failed to ensure patients and/or their representatives were informed of all of their rights in advance of providing services. This impacted 2 of 17 patients (#11 and #13) whose records were reviewed and had the potential to impact all patients receiving services at the hospital. Failure to inform patients of their rights limited their ability to make informed decisions about their care. Findings include: 1. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14, from a skilled nursing facility, with diagnoses of psychosis, bipolar disorder and congenital brain injury with mental disability. Patient #11's medical record for her hospital admission of 11/25/14 to 11/29/14, was reviewed. Her record included a letter of guardianship and conservatorship. The letter stated Patient #11 was impaired to the extent she was unable to make responsible decisions. Patient #11's record did not include documentation of contact with her guardian, to	A 117		

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A 117	Continued From page 26 obtain consent for services or to discuss patient rights, care planning or treatment. Patient #11's record did not include a signed receipt of notice of patient rights. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it did not include consent forms, receipt of notice of patient rights or documentation of contact with her guardian. The facility failed to inform Patient #11, and her guardian, of her rights. 2. Patient #13 was a 69 year old male admitted to the hospital on 1/01/15, with diagnoses of psychosis and depression. Patient #13's medical record for his hospital admission of 1/01/15 to 1/05/15, was reviewed. His record did not include a signed receipt of notice of patient rights. During an interview on 4/01/15 at 4:20 PM, RN C reviewed Patient #13's record and confirmed it did not include a receipt of notice of patient rights. The facility failed to inform Patient #13 of his rights.	A 117		
A 122	482.13(a)(2)(ii) PATIENT RIGHTS: GRIEVANCE REVIEW TIME FRAMES At a minimum: The grievance process must specify time frames for review of the grievance and the provision of a response.	A 122		

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A 122	Continued From page 27 This STANDARD is not met as evidenced by: Based on review of the facility's grievance file and staff interview it was determined the facility failed to review, investigate and resolve patient grievances within a reasonable time frame. This resulted in potential for poor quality of care and placed patients at risk of harrassment and abuse by staff. Findings include: A facility policy titled "Grievances/Complaints," effective 9/13/11, included the following procedures: -Grievances will be collected from a locked box by the Administrator/designee Monday through Friday, excluding holidays. -The administrator or designee will be responsible for grievance complaint investigation. -Upon receipt of a written grievance complaint, the Administrator/designee will investigate the allegations and develop a report of such findings within 24 hours of receiving the grievance complaint. This policy was not followed. Examples include: 1. One grievance written by a patient dated 12/15/14, stated "Nurse [name] and teck (sic) [P.T. D] co-insided (sic) one with the other to force me into an arguable (sic) instance that lead to an anxiety attack." The back section of the form, used to indicate the grievance was addressed, and resolved, was blank. 2. A grievance written by a patient dated 12/15/14, stated "[P.T. D] was near the TV. I	A 122		

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A 122	Continued From page 28 walked in sat down on the reclyner (sic) and asked if I could watch TV. And he said 'We are not doin that crap and that's just how it is.' With attitude." The form included a question "How do you want the suggestion/grievance corrected?" The patient wrote "I want him to stop belittling the patients." The back section of the form, used to indicate the grievance was addressed, and resolved, was blank. 3. A grievance written by a patient dated 12/15/14, stated "I was sitting eating my dinner and [patient name] started talking about his girlfriend. [P.T. D] pops off said something sexual about his girlfriend. That got [patient name] to get very upset & [patient name] said i'll kill you before you touch my girl. [P.T. D] popped off and said that will get you more time here & [patient name] exploded." The form included a question "How do you want the suggestion/grievance corrected?" The patient wrote "I want him to stop belittling the patients when no one is around. His attitude is horrible." The back section of the form, used to indicate the grievance was addressed, and resolved, was blank. 4. Another grievance, dated 12/15/14, complained of P.T. D's disrespect towards patients when asking about a smoke break. The writer of the grievance did not include any further details related to the incident. The form included a question "How do you want the suggestion/grievance corrected?" The patient wrote "He need to talke (sic) beter (sic) to clients and tret (sic) us beter (sic). We are people." The back section of the form, used to indicate the grievance was addressed, and resolved, was	A 122		

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A 122	Continued From page 29 blank. 5. A grievance, written by a patient dated 3/28/15, stated "[P.T. D] AM tech. My 2nd day here I complained that he just threw my belongings in my room. He was told not to talk or even look at me but he continued to do so. Today (Saturday) he starts making comments to me 1st thing when I woke up. I've been ignoring it and staying in my room most of the day. I've said thank you to him; have a good lunch, thanks when he lit my cigs, and staying in my room all day to avoid him. Now he's on the phone talking about me, saying I'm the one being an ass to someone. I'm so sad. Today I get to see my service puppy and should be happy. This was approved by [name of NP]. He walked by me while ago saying I can't see my dog. Also another staff let me keep muscle rub, dog treats for tonight & some trail mix. He tore my room up in a search but I was compliant. This harrasment is not right. He even brings others ice but not me when I asked." The grievance did not include documentation of investigation or resolution. 6. In a grievance dated 3/26/15, a patient wrote "[tech name] was belittling me, condescending me, made me keep begging making negative comments, faces, telling me to sit down. Refuses to light my cig. She got another patient upset when she finally...lit one. I went to a corner, sat in the sun. Then 2 other patients came over to me. We sat and enjoyed our smokes...with no discussion of incidents. When I told her Thank You, she loudly says to [another tech] "someone is going to lose smoke privleges." The form included a question "How do you want the suggestion/grievance	A 122		

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A 122	Continued From page 30 corrected?" The patient wrote "Remind the staff we are their paycheck, adults, and attempting (with their help) to better ourselves. Snide comments, looks, etc from them is Never OK." The grievance did not include documentation of investigation or resolution. During an interview on 4/03/15 at 4:20 PM, the Program Director stated patients could complete a form titled "Suggestion/Grievance/Compliment" and insert it in a box on the nursing unit. He stated it was his responsibility to retrieve the forms from the box, sort and distribute them to the appropriate person. He stated he gave forms related to nursing to the CNO, and all others to the Administrator. However, since the CNO resigned on 1/24/15, all forms were given to the acting Administrator. He stated after a grievance was resolved, the action taken was documented on the back of the form and the form was returned to him to be filed in the Grievance binder. During the same interview, the Program Director stated he had given 6-12 grievances to the Administrator in the last 2-3 months, however, the grievances had not been returned to him for filing. He stated as far as he knew, no action had been taken to resolve the grievances submitted in the last 2-3 months. During an interview on 4/03/15 at 5:00 PM, the Co-Owner confirmed the grievances had not been addressed, and was not able to provide an explanation for the failure of the facility to investigate, take action, and resolve the grievances.	A 122		

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A 122	Continued From page 31 The facility failed to review, investigate, and respond to patient grievances.	A 122		
A 130	482.13(b)(1) PATIENT RIGHTS:PARTICIPATION IN CARE PLANNING The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure patients or their representatives participated in the development and implementation of plans of care for 17 of 17 patients (#1- #17) whose records were reviewed. This failure resulted in the inability of patients to make informed decisions regarding their care, including medications, treatments and discharge plans. Findings include: The records of 17 patients (#1 - #17) with admission date range of 9/24/14 to 3/31/15, were reviewed. The 17 patient records did not include treatment plans or nursing care plans. Goals were not identified, and interventions were not initiated to identify a course of treatment and minimize the risk of complications related to psychiatric or medical diagnoses. During an interview on 4/03/15 at 10:15 AM, the NP confirmed the records did not include treatment plans or nursing care plans. She stated the CNO was responsible for creating the treatment plan, however, the facility did not currently have a CNO, so treatment plans were not being created.	A 130		

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A 130	Continued From page 32 During an interview on 4/01/15 at 9:35 AM, the co-owner of the hospital stated the CNO resigned in January and they were currently looking for a replacement. During an interview on 4/01/15 at 9:20 AM, RN C stated in the past treatment plans were developed by the CNO. She stated the nurses did not have time to create treatment plans. Additionally, she said, "We don't have a DON [CNO] so it's not happening." The facility failed to ensure patients were included in the development of a plan of care.	A 130		
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure patients or their representatives were involved in care planning and treatment, for 3 of 17 patients (#11, #13, and #15) whose records were reviewed. This had the potential to result in the inability of patients or their representatives to make informed decisions about their care.	A 131		

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A 131	Continued From page 33 Findings include: 1. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14, from a skilled nursing facility, with diagnoses of psychosis, bipolar disorder and congenital brain injury with mental disability. Patient #11's medical record for her hospital admission of 11/25/14 to 11/29/14, was reviewed. Her record included a letter of guardianship and conservatorship. The letter stated Patient #11 was impaired to the extent she was unable to make responsible decisions. Patient #11's record did not include documentation of contact with her guardian, to obtain consent for services or to discuss care planning and treatment. Patient #11's record did not include an admission agreement or a consent for services. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it did not include signed consent forms. Additionally, she confirmed there was no documentation of contact with Patient #11's guardian. The facility failed to obtain consent for services from Patient #11's guardian, and failed to include her guardian in decisions regarding her care. 2. Patient #13 was a 69 year old male admitted to the hospital on 1/01/15, with diagnoses of psychosis and depression. Patient #13's medical record for his hospital	A 131		

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A 131	Continued From page 34 admission of 1/01/15 to 1/05/15, was reviewed. His record did not include a signed consent for services or an admission agreement. Additionally, his record did not include a care plan or treatment plan developed and discussed with Patient #13. During an interview on 4/01/15 at 4:20 PM, RN C reviewed Patient #13's record and confirmed it did not include a signed consent for services or indication of his participation in development of his treatment plan. The facility failed to obtain consent for services from Patient #13, and failed to allow him the opportunity to make informed decisions about his care. 3. Patient #15 was a 60 year old man who was a patient in the facility from 3/15/15 to 3/26/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. A nurses note, dated 3/23/15 at 6:15 PM, documented Patient #15 refused to take an increased dose of Seroquel. The note stated "Pt [patient] verbalizes not being happy about Provider making changes in his medication without talking to him first." During an interview on 3/30/15 at 3:35 PM, the NP stated she met with the psychiatrist by teleconference 2 times a week, and discussed all patients treatment plans. She confirmed the psychiatrist did not see Patient #15. During an interview on 4/03/15 at 10:15 AM, the NP reviewed the record and confirmed there was	A 131		

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A 131	Continued From page 35 no documentation of Patient #15's involvement in his treatment plan. Patient #15 was not given the opportunity to be involved in decisions regarding his medication changes.	A 131		
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observations, record review, and staff interview, it was determined the facility failed to ensure personal privacy was provided for 2 of 7 current patients (#9 and #17) whose care was observed, and had the potential to impact all patients receiving care at the facility. This had the potential to result in patient confidentiality not being protected. Findings include: 1. The unit was locked with double doors that opened into a large hallway. The hallway to the right was short, and had two leather oversized chairs against the wall. The chairs were facing the hallway, and on multiple occaisions providers were observed speaking with family and/or patients. The area was open, close to patient rooms and the locked unit doors. Patients and staff were observed to walk by the individuals in the chairs. a. On 4/01/15 at 2:00 PM, Patient #9 was observed with his wife, talking to the social worker. He was in a wheelchair, and his wife was sitting in the large leather chair, talking with the social worker in the other chair. Their conversation was overheard by a surveyor, they	A 143		

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(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 143	Continued From page 36 were discussing Patient #9's pending discharge, and plans for his placement. It was in a high traffic area, staff, visitors, and patients could hear confidential information. b. During an interview on 4/03/15 at 3:45 PM, the Director of Social Services confirmed that patient and family meetings are often conducted in the sitting area at the end of the hallway. 2. The dining/multipurpose room included a couch, large recliner chairs, a large table surrounded by chairs, a TV, and craft supplies. Meals were served in the room. Group activities were also completed in the room. Patient and provider interviews, evaluations, and other interactions were observed in the room as follows: a. On 4/01/15 at 4:00 PM, the NP was observed talking with Patient #20, who was admitted to the facility the night before. The conversation was overheard by 3 other patients sitting at a table playing scrabble, as well as, a surveyor, and the other staff that were in the room. The patient was sitting at the dining table, facing the open doorway that went into the hall, and close to the patio area where patients could go outside. The location of the patient and the NP was in a high traffic area. The conversation continued for approximately 30 minutes, during which time the patient disclosed personal information, and stated that he was feeling suicidal and homicidal. b. During a tour of the facility on 3/30/15 beginning at 2:00 PM, an open notebook was observed on the dining table. The book included patient information related to bathing schedules,	A 143		

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A 143	Continued From page 37 oral intake, bowel movements, and other personal information. A P.T. was asked about the book. She stated it was for the techs to record patients' ADL information. She stated it was usually kept in the dining area for the staff to enter their documentation. During an interview on 4/02/15 at 8:45 AM, Patient #17 stated she did not feel that her privacy was protected. She stated interviews with the providers occurred in the dining area, or "down the hall." She stated her room just had a bed and no chair, so she was not able to talk with anyone in her room. During an interview on 4/02/15 at 5:00 PM, the NP was asked about her conversation with the patient in the dining room. She confirmed the activity was an "Initial Psychiatric Evaluation," and she stated she had first obtained his permission to talk in that area. The NP then stated she does not have a private area to talk to patients. She stated she routinely met with patients in the dining area. The facility did not ensure patient privacy and confidentiallity was maintained.	A 143		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation, record review, staff interview, review of grievance documentation and review of policies, it was determined the hospital failed to 1) respond to patient and staff written	A 144		

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A 144	Continued From page 38 allegations of abuse, 2) investigate serious patient injuries to determine cause and implement corrective actions, and 3) ensure sufficient numbers of trained staff were available to safely care for patients with behavioral concerns 4) ensure patients were not subjected to abuse by staff 5) ensure patients were under the care of physician 6) ensure patients were provided with health services necessary prevent their deterioriation and death. This resulted in 1 of 3 sample patients (#8) for whom restraints and/or seclusion were used, sustaining bilateral arm fractures and a shatter pelvis, 5 unidentified patients who submitted written grievances experiencing mental anguish and fear, 3 patients (#10, #11, #12) experiencing health deterioration and death due to lack of health service. The multiple systemic system failures, individually, and in combination, endangered the health and safety of 6 of 6 patients (#7, #9, #17, #18, #19, and #20) residing in the facility during the survey, as well as, all future admissions. Findings include: 1. Refer to A145 as it relates to the failure of the facility to ensure patients were protected from abuse. 2. Refer to A347 as it relates to the failure of the hospital to provide basic medical care and oversight, necessary to protect patients from serious harm or death. 3. Refer to 395 as it relates to the failure of the facility to provide patients with health services necessary to avoid physical deterioration and death.	A 144		

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A 144	Continued From page 39 The cumulative effect of these serious systemic failures prevented the faciliy from providing care and services necessary to protect patients from serious injury, harm, or death.	A 144		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on observation, record review, staff interview, review of staff and patient grievances and review of policies, it was determined the hospital failed to 1) respond to patient and staff written allegations of abuse, 2) investigate serious patient injuries to determine the cause and implement corrective actions, and 3) ensure sufficient numbers of trained staff were available to safely care for patients with behavioral concerns. This resulted in 1 of 3 sample patients (#8) for whom restraints and/or seclusion were used, sustaining bilateral arm fractures and a shatter pelvis, 5 unidentified patients who submitted written grievances experiencing mental anguish and fear, and endangered the health and safety of all patients receiving services at the facility. Findings include: A facility policy titled "Abuse and neglect policy/Inservice," included the following definitions: -Physical Abuse includes slapping, hitting, bruising, beating, or any other intentional act that causes someone physical pain, injury, or suffering. Physical abuse also includes excessive forms of restraints use to confine	A 145		

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A 145	Continued From page 40 someone against their will. - Emotional Abuse is threatening, humiliating, or intimidation an individual and causing them emotional pain, distress or anguish. Emotional abuse can be verbal or non-verbal; It includes insults, yelling and threats of harm or isolation. - Neglect takes place when, intentionally or not, a caregiver fails to support the physical, emotional or social needs of the resident. Neglect can include denying food or medications, health services, or contact with friends and family. The policy also noted, "The first thing that occurs when a staff member is accused of abusing a resident is that the accused goes on immediate suspension. The administrator (or designee) will investigate the allegation of abuse. If the allegation of abuse is substantiated the appointed member of administration will call and report all of our findings to the Bureau of facility standards. If the suspected abuse case is determined to be abuse the staff member is then dismissed as an employee." The facility grievance and complaint logs was reviewed. They contained numerous patient and staff complaints that included allegations of abuse. There was no documentation the complaints and grievances were reviewed, acknowledged, or investigated by facility administration. No actions were taken to ensure patients were protected from further abuse. Examples include: 1. Patient #8 was a 65 year old male admitted to the facility on 3/06/15 for care related to	A 145		

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A 145	Continued From page 41 dementia, psychosis, HTN, and PTSD. His medical record from 3/06/15 to 3/24/15 was reviewed, as well as, records from ED visits on 3/23/15 and 3/24/15, and admission at an acute care facility were reviewed. Patient #8 was not protected from harm as follows: a. During an interview on 4/03/15 beginning at 4:00 PM, P.T. H described an event that occurred when she requested assistance from a peer. She stated P.T. D did not like Patient #8. She stated when Patient #8 exhibited aggressive behavior, P.T. D was the first to jump in to restrain him. She described an incident that occurred on Sunday 3/22/15. She stated Patient #8 did not sleep for about a day and a half, and he was agitated. She stated Patient #8 grabbed her by the throat, she brought his hand down and then went to get the assistance from P.T. D. When he entered the room, Patient #8 tried to punch P.T. D, so he grabbed Patient #8 with his arms under Patient #8's armpits and pulled his arms up and outward. Patient #8 attempted to fight him off, and P.T. D held him again in that manner and threw him face down on the bed, with his body on him to pin him down. Patient #8 was held down until after the RN gave him a shot. She stated she felt that P.T. D used excessive force, and reported the incident to the RN on duty. P.T. H stated she has submitted grievances about P.T. D's behavior, but felt no action has been taken by the facility. She also stated she had not received Mandt or any kind of restraint training since her hire at the facility. P.T. H stated Patient #8 slept most of the day on 3/22/15, and then when he got up, he was noted to be 'shuffling' around, dragging his legs, like he	A 145		

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A 145	Continued From page 42 could not put pressure on his legs and not walking like he usually did. P.T. H demonstrated to the surveyors a slow shuffling movement, as well as, the hold maneuver P.T. D used on Patient #8. It was similar to a Full Nelson wrestling move. She said she had filed complaints against P.T. D at least once a week since January, 2015. P.T. H stated P.T. D leaves his 1:1 assignments unsupervised, he picks on patients to provoke behavior, and says things intentionally to make patients angry. Nurses notes documentation on 3/23/15 at 10:45 AM, noted Patient #8 was observed by facility staff to have a seizure. He was observed to yell, bring his hands upwards about shoulder height, and fall straight back, landing flat on the floor. His seizure lasted approximately 2-2.5 minutes. After the seizure was over, paramedics were called to take him to the ED of an acute care hospital for assessment. He was transported to the hospital by EMS, and was not accompanied by facility staff. An incident report was not initiated by the RN or the NP which described the seizure, or the transfer to acute care hospital. At the acute care hospital Patient #8 was noted to be poetical, sleepy, and non-verbal. X-Rays of were taken of Patient #8's cervical, lumbar, and thoracic spine. Labs were drawn. He was determined to be stable to be discharged the same day to return to Safe Haven with a tech and the van driver. The staff [P.T. A] that arrived to pick up Patient #8, was interviewed. She stated that when she removed the pulse oximeter sensor from his finger, he winced in pain. She stated he was	A 145		

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A 145	Continued From page 43 unable to stand up, and was transferred to the wheelchair with assistance from the van driver and the ED RN. A physical assessment by an RN was not completed when Patient #8 arrived back at the facility. Patient #8 was noted to be sleepy, was placed in bed, and remained there throughout the night. Staff documented that night "Pt appeared tired, He did not eat very much. Pt slept thru the night, talking in his sleep. Pt stated in loud voice 'NO, NO' when staff changed his clothes and took vitals." The P.T. assigned to Patient #8 on 3/24/15 day shift, documented "Pt resting/sleeping AM. Talking restless sleep. Appears [to be] having night terrors (?) talking in sleep saying 'Don't Push Me Down,' 'I hate cigarettes.' Pt stating he is in pain, mentions heart hurting - very lethargic. Ate some lunch, appears more alert. Complaining of cramp pain." On 3/24/15, at 8:40 AM, P.T. C noted Patient #8 was in bed and was not acting like he normally did and grimaced with movement of his right leg, and when she moved his left arm, he grimaced. The patient was administered Tylenol for pain at 10:30 AM. Patient #8 was sent back to the ED on 3/24/15, after a text order was received from the MD on 3/24/15 at 2:30 PM, stating "Send pt to the ER for x-rays of bilateral upper & lower extremities d/t [due to] decreased ROM & grimacing [with] movement." An admission H&P from the receiving hospital,	A 145		

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A 145	Continued From page 44 dictated on 3/24/15 at 10:06 PM, noted: "...was brought to the ER in return today, because of significant altered mental status and inability to respond or speak, which he had been doing previously. Upon arrival in the ER, the patient was examined and family notably reported that the patient was repeatedly lifting his left leg and moaning in apparent pain." The H&P noted "Diffuse intermittent bruising across body, Bruising appears to be old and near staging with no large mass effect of bruising noted, but left arm bruise is quite large on the medial and superior aspect of upper arm." A consultation report, dictated 3/25/15 at 10:02 AM, noted: "...There is a question of seizure versus stroke. His initial workup was negative. He was then taken to the Emergency Department as noted above on [March 24th], where a chest, abdomen, and pelvis CT revealed a comminuted right acetabular fracture. The patient was also found to have rhabdomyolysis and lactic acidosis. He was admitted to the Intensive Care Unit for further monitoring. Orthopedics was consulted. Because of bruising on his upper arms, bilateral Humeri x-rays were performed today, on March 25th, demonstrating bilateral completely displaced two part proximal humerus fractures." At the hospital where Patient #8 was admitted, in a progress note on 3/25/15 at 6:44 PM, an RN documented a meeting with Patient #8's family and the Orthopedic Surgeon that was held that afternoon at 12:00 PM: " Dr.[name] met with patient's wife and son. Dr. [name] reviewed injury findings. He explained	A 145		

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A 145	Continued From page 45 the injury pattern was strange and not consistent. He explained the significance of the hip fracture. He discussed that the hip fracture is so complex that it will need to be repaired at [another hospital in another state]. He explained that without repair, the patient would need to heal as is. Once fracture is healed, he would anticipate that patient would not have any motion in his extremity and it would continue to be very painful. He would likely be bedridden the remainder of his life. He also reported to wife and son that patient had bilateral humerous fractures. These fractures appear to be in about the same spot that is not consistent with a fall. He explained that both humerus fractures would need repairing with pins and possibly ORIF [Open Reduction and Internal Fixation]. He has also noted some bruising on the right lower extremity and plans to take the patient to radiology for further radiology exams." An investigation of the restraint, seizure, and care leading to Patient #8's admission at the receiving hospital was not completed by the facility. b. Patient #8 was not protected from self harm while in seclusion and from the verbal and physical aggression of other patients. Examples include: * 3/14/15, In a narrative note attached to an Occurrence Report, written by a P.T., indicated Patient #8 was in the dining room. He was noted to have a verbal interchange with another patient, both Patient #8 and the other patient started yelling and hitting each other. Patient #8 was noted to be restrained by a total of 4 staff. He	A 145		

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A 145	Continued From page 46 was taken to his room by the 4 staff, and medicated by the RN. * On 3/16/15, an Emergency Treatment Override Order for Seclusion, dated 3/16/15 and signed by an NP at 9:30 PM, documented Patient #8 was placed in Seclusion for violent/self destructive behavior to himself and others. The NP documented he spoke with Patient #8 through the seclusion room door, and Patient #8 was noted to be highly agitated. He also documented Patient #8 had bloody knuckles related to hitting doors prior to being placed in seclusion. Patient #8 received Haldol 5 mg IM before being placed in seclusion. Nurses notes from 6:15 PM to 9:20 PM included the following documentation: "Pt behavior became more and more agitated. Staff attempt to deescalate. Pt told staff to 'get out' and then pushed staff into the wall. Pt exit seeking then came away from doors and charged staff with his fist doubled up and then punched staff in arm. After he hit staff he went by staff and punched fire door which caused knuckles to bleed. Pt attempted to strike this nurse and grabbed this nurse by wrists. Fellow nurse assisted in removal of pt hands from wrists and escorted pt to seclusion room. Pt resisted and staff continued to escort pt to seclusion. Order for seclusion obtained by provider and Zyprexa 10 mg IM which was unavailable. Provider then ordered Haldol 5 mg. Pt hitting the walls and window on seclusion door. " * A nurses note, dated 3/18/15 from 5:00 PM to 8:00 PM, described Patient #8's aggressive behavior. "Medication nurse attempted to give patient a PRN by mouth for agitation, this was ineffective, patient refused. While staff continued	A 145		

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A 145	Continued From page 47 to attempt to get the patient to de-escalate, he was getting into the face of staff and patients. He was raising his fists at his 1:1 and this nurse. Patient began to shove and hit at this nurse and another staff. After more attempts at trying to de-escalate the patient, the patient was escorted into the seclusion room. Restraint protocol started. PRN medication given IM by RN. Patient banging his fists, feet and shoulders into the walls and door of the seclusion room. Attempts to get the patient to stop were unsuccessful. This continues for over 40 minutes." The facility failed to ensure Patient #8 was protected from staff abuse, assualt by other patients, and self harm. 2. The following staff and patients grievances and staff interviews include allegations of staff to patient abuse by P.T. D. The written staff and patient grievances did not include evidence of investigation, action, or resolution. They further demonstrate the facility was aware of, yet failed to act, to formal reports of by P.T. D's abusive behavior: Patient Grievances - a. One grievance dated 12/15/14, the patient wrote "Nurse [name] and teck [P.T. D] co-insided one with the other to force me into an arguable instance that lead to an anxiety attack." The back section of the form to indicate the grievance was addressed, and resolved, remained blank. b. A grievance dated 12/15/14, stated "[P.T. D] was near the TV. I walked in sat down on the	A 145		

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A 145	Continued From page 48 reclyner (sic) and asked if I could watch TV. And he said 'We are not doin that crap and that's just how it is.' With attitude." The form included a question "How do you want the suggestion/grievance corrected?" The patient wrote "I want him to stop belittling the patients." The back section of the form to indicate the grievance was addressed, and resolved, remained blank. c. A grievance dated 12/15/14, a patient wrote "I was sitting eating my dinner and [patient name] started talking about his girlfriend. [P.T. D] pops off said something sexual about his girlfriend. That got [patient name] to get very upset & [patient name] said i'll (sic) kill you before you touch my girl. [P.T. D] popped off and said that will get you more time here & [patient name] exploded." The form included a question "How do you want the suggestion/grievance corrected?" The patient wrote "I want him to stop belittling the patients when no one is around. His attitude is horrible." The back section of the form to indicate the grievance was addressed, and resolved, remained blank. d. Another grievance dated 12/15/14, by a different patient, complained of P.T. D's disrespect to patients when asking about a smoke break. The form included a question "How do you want the suggestion/grievance corrected?" The patient wrote "He need to talke (sic) beter (sic) to clients and tret (sic) us beter (sic). We are people." The back section of the form to indicate the grievance was addressed, and resolved, remained blank. e. In a grievance dated 3/28/15, a patient wrote	A 145		

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A 145	Continued From page 49 "[P.T. D] AM tech - My 2nd day here I complained that he just threw my belongings in my room. He was told not to talk or even look at me but he continued to do so. Today (Saturday) he starts making comments to me 1st thing when I woke up. I've been ignoring it and staying in my room most of the day. I've said thank you to him; have a good lunch, thanks when he lit my cigs, and staying in my room all day to avoid him. Now he's on the phone talking about me, saying I'm the one being an ass to someone. I'm so sad. Today I get to see my service puppy and should be happy. This was approved by [name of NP]. He walked by me while ago saying I can't see my dog. Also another staff let me keep muscle rub, dog treats for tonight & some trail mix. He tore my room up in a search but I was compliant. This harassment is not right. He even brings others ice but not me when I asked." The grievance did not include documentation of an investigation, actions take, or resolution. Staff Interviews and grievances - a. P.T. E stated that he did not get along with P.T. D. He stated P.T. D was bossy to residents as well as, other P.T.'s. He stated P.T. D would tease residents, and intentionally push them to the point of eliciting negative behaviors. He described an incident when P.T. D had a 1:1 and while walking down the hall with the resident, tapped him on the far shoulder. The resident would look around as if looking to see who was tapping him. He stated the resident thought he was going crazy. P.T.E described another incident in 2/2015 when	A 145		

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A 145	Continued From page 50 a resident was acting out, and he demonstrated how P.T. D grabbed the resident around his arms from behind, and sat him on the floor forcibly. P.T. E was questioned as to who was in charge of nursing at the hospital, and he stated he did not know. He said he knew who was the Administrator, but had never met the CNO, and did not know if the hospital had one. b. Submitted by P.T. E on 3/30/15: "My first Saturday working at Safe Haven, I watched P.T. D walk behind patients, tap them on shoulder and move to other side or kind of hide from them. I have also heard him tell a patient to "Shut up, you are annoying." P.T. D pawns off his 1:1's a lot more often than he should, going out to sneak off for smokes with the girls. Flirts a little with co-workers. This occurred on 2/07/15. P.T. D and I also on this day argued a little because he came up to me, pointed and told me I needed to catch up on Q 15's (every 15 minute patient checks) and to do it now. I asked him to please not delegate to me but to ask me to do something. That's when he walked away and said 'whatever.' Before working on this day I wanted to change schedule and work the weekends. After working I changed my mind and almost decided to just quit my job. He teases a lot of our patients and can be pretty inappropriate towards both patients and co-workers with the jokes and teasing." As of 5:00 PM on 4/03/15 no action had been by the facility to investigate the allegations and protect patients from potential abuse or mistreatment. c. Submitted by P.T. I, on 3/30/15: In the allegations P.T. I noted P.T. D engaged in	A 145		

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A 145	Continued From page 51 inappropriate sexual behavior towards her, which made her feel intimidated and afraid to come to work. She further stated "...on March 21st I was with a patient 1:1 and I asked P.T. D to take a patient to the restroom and he took the patient and left her in the hall and left outside. P.T. D is verbally abusive to patients, saying things like 'If you don't respect me, I will take away all your privileges from you." As of 5:00 PM on 4/03/15 no action had been by the facility to investigate the allegations and protect patients from potential abuse, neglect, or mistreatment. During an interview on 4/03/15 at 5:00 PM, the Co-Owner confirmed the grievances had not been addressed, and was not able to provide an explanation for the failure of the facility to investigate, take action, and resolve the grievances. The facility did not ensure patients were protected from abuse. 3. A policy "Staffing of Nursing Care, Acuity Based," effective 1/04, stated "To provide safe, effective nursing care designed to support improvements and innovations in nursing practice based on both the needs of the patients to be served and the mission statement. The plan supports both standards of nursing practice and nursing standards of care. The CNO of Safe Haven is responsible and accountable to ensure that consistent standards are utilized. This plan provides an overview of the unit, which includes staffing plans based on acuity data and core staffing date. Staffing is based upon patient	A 145		

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A 145	Continued From page 52 census and acuity. Based on census and patient acuity, the needs of the unit are evaluated on a shift or partial shift basis by the Staffing Coordinator, in collaboration with the charge nurse, in order to provide optimal patient care that is fiscally sound." The following algorithm was included in the policy based on patient census: a. Day shift staffing requirements -1 RN per shift -1 to 5 patients, 1 P.T. -6 to 8 patients, 1.5 P.T. -9 to 13 patients, 2 P.T.s -14 patients, 3 P.T.s -1 to 6 patients, 0 LPN -7 to 10 patients, 1 LPN -11-14 patients, 1.33 LPNs b. Night shift staffing requirements -1 RN per shift -1 to 8 patients, 1 P.T. -9 to 14 patients, 1.5 P.T.s -1 to 8 patients, 0 LPN	A 145		

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A 145	Continued From page 53 -9 to 14 patients, 1 LPN The algorithm in the policy stated core staffing consisted of a minimum of 1 RN and 1 P.T. The policy stated, "Psych tech [psychiatric technicians] shifts- if the staffing ladder accounts for 1.5 aides, this means that one full 12 hour shift is approved and one 6 hour shift is approved. The hours may be divided amongst the scheduled Psych tech staff at the direction of the Charge RN as long as the hours stay within the approved total of 18 hours." Additionally, the policy stated "LPN shifts- if the staffing ladder accounts for 1.33 LPN's, this means that one full 8 hour shift from 0700- 1500 [7:00 AM to 3:00 PM] is approved. At a census of 11 the LPN staff may then cover the remaining four hours of the 12 hour shift to 1900 [7:00PM]. The hours may not be allotted any other way." Assignment sheets were done for each 12 hour shift, day and night. The assignment sheet included sections for patient's names, level of monitoring, names of P.T.s working, and 2 hour time periods for the shift. The name of the RN in charge and the date were listed at the top of the form, it also differentiated whether it was the assignments for day or night shift. The bottom of the assignment sheet also included a section with an algorithm. The algorithm was used for staffing the facility with P.T.s depending on the census. The section for P.T.s was numbered 1 through 5, with their names written next to the numbers. The number, corresponding to the P.T., was written in the columns broken down into 2 hour	A 145		

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A 145	Continued From page 54 time periods for the shift. The 2 hour time period columns corresponded to patient names. For example: P.T. 1 would be assigned from 6:00 AM to 8:00 AM with one patient, then from 8:00 AM to 10:00 AM P.T. 1 would be assigned to another patient. P.T.'s would not be assigned to 1 patient for the entire 12 hour shift. According to the assignment sheets reviewed they would rotate between the patients. The algorithm at the bottom of the assignment sheet was used for determining staffing of the facility. The algorithm for staffing P.T.s was based on census, rather than acuity. The algorithm was listed as follows: - Patient census 0, P.T. 0 hours - Patient census 1, P.T. 8 hours - Patient census 2-5, P.T. 12 hours - Patient census 6-10, P.T. 16 hours - Patient census 11-12, P.T. 24 hours - Patient census 13-14, P.T. 26 hours The policy, assignment sheet, and algorithms did not include using aides from the adjoining SNF when additional staff was required for patient restraint. A maximum of 14 patients would be admitted at one time. If a patient was being monitored as a 1:1 (close monitoring of the patient was required and the assigned P.T. must be within arm's reach of the patient at all times), 1 tech would be	A 145		

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A 145	Continued From page 55 assigned for monitoring the patient and was not included in the algorithm. A policy, "Suicide/Homicide Precautions Protocol," revised 10/12, stated a precaution level was assigned for the protection of patients requiring a safety intervention. The following precaution levels were identified and defined: -15 minute checks: Patient was observed every 15 minutes for safety -Line of sight (LOS): Keep patient in the line of sight at all times -1:1 monitoring: Observation with 1:1 contact at all times On 12/05/14 at 4:30 AM, an "Occurrence Report," completed by the RN on duty, documented a patient had an altercation with his roommate. The report included a nurses note documenting the patient was placed on "1:1/LOS." The policy did not include a definition for "1:1/LOS." During an interview on 4/01/15 at 4:55 PM, RN C confirmed an assignment sheet was to be filled out for each shift. She stated an LPN was scheduled for medications if the patient census was greater than 8, otherwise the LPN worked 7:00 AM to 11:00 AM and came back and worked 5:00 PM to 9:00 PM. RN C stated she coordinated the staffing of P.T.s. RN C stated P.T.s worked a 12 hour shift, but depending on the algorithm they may work 4 hours, 8 hours, or the full 12 hours. She explained when 16 hours were allotted based on census, 1 P.T. would	A 145		

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A 145	Continued From page 56 work 12 hours and another P.T. would work for 4 hours. RN C stated staffing of P.T.s was not acuity or behaviorally based, but is based on the algorithm. During an interview on 4/02/15 at 5:05 PM, RN B confirmed the algorithm was what she used to schedule the P.T. hours. She further confirmed staffing for P.T.s was based on census and algorithm, it was not acuity or behaviorally based. Use of the staffing algorithm, without consideration of patient acuity was not sufficient to ensure patient needs were met, as follows: On 3/07/15 at 3:15 PM, a P.T. note attached to an "Occurrence Report," stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. Patient #8's record did not include documentation of the actions which were necessary to "redirect" Patient #8 to his room. On 3/08/15 at 2:00 PM, an "Occurrence Report," completed by the RN on duty documented Patient #8 was aggressive to another patient and that P.T.s were unable to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. During an observation on 4/02/15 at 12:00 PM, 5	A 145		

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A 145	Continued From page 57 patients were currently in the facility. In the dayroom there were 2 patients and 2 P.T.s present. One patient was in her assigned room, and 1 patient was observed walking in the hall. Another P.T. was observed in the nursing station behind a locked door. No RN was observed on the unit. After approximately 5 minutes, the RN was observed entering the patient unit from the other side of the locked doors. An interview was conducted with P.T. E at 12:10 PM on 4/02/15. He stated there were 5 patients in the hospital and 3 of the patients were on 1:1 monitoring. P.T. E stated he did not feel staffing was adequate that day because only 3 P.T.s were scheduled to work. Three patients required 1:1 monitoring, therefore, the 2 remaining patients were not assigned a P.T. During an interview on 4/02/15 at 5:05 PM, RN B stated she was a concerned about safety at the facility. She stated staffing was based on census rather than acuity. Therefore, additional staff were not added when 1 or more patients exhibited behaviors that required close observation and possible intervention, to prevent injury to themselves or others. Further, Patient #13's record documented he was a patient in the hospital from 1/01/15 to 1/05/15, with diagnoses of psychosis and depression. His record included a social service progress note, dated 1/05/15. The note stated "When SS discussed discharges with [NP] she reported that due to staffing [patient] was being discharged." During an interview on 4/03/15 at 2:45 PM, the SS Assistant who wrote the note stated she	A 145		

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A 145	Continued From page 58 remembered the conversation with the NP. She stated during the Treatment Team meeting it was determined there was not enough staff to take care of the number of patients currently in the hospital, therefore someone had to be discharged. She stated Patient #13 was closest to his planned discharge date so he was the one to be discharged. The facility failed to ensure staffing levels were sufficient to ensure individual patient's needs, including safety, were met. 3. Also refer to A395 as it relates immediate jeopardy to patients' health and safety as a result of the facility's failure to provide health services necessary to prevent the physical deterioration and subsequent death of 3 patients.	A 145		
A 154	482.13(e) USE OF RESTRAINT OR SECLUSION Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to ensure methods of restraint and seclusion were only imposed to ensure the immediate physical safety of the patient or others and/or were	A 154		

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A 154	Continued From page 59 discontinued at the earliest possible time for 2 of 3 patients (#4 and #15) who were restrained and whose records were reviewed. This resulted in the potential for the unnecessary use of restraint. Findings include: 1. Patient #15 was a 60 year old man admitted to the facility on 3/15/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. The facility's policy, "Refusal of Medications and Treatments-Treatment Override," effective 6/19/11, stated "Admitted patients have the right to refuse specific modes of treatment. Possessing this right, they are entitled to due process proceedings prior to being administered medication treatment against their will, unless involuntary treatment is necessary because of emergency. During hospitalization, involuntary administration of medication treatment may be used when an emergency exists or a patient is deemed to be gravely disabled or dangerous. Override of a patient's treatment refusal can occur provided certain conditions are met." Patient #15's record included documentation of medication administration under "show of force" by hospital staff. The incident was documented as follows: -A nurses note, dated 3/17/15 at 11:10 AM, and signed by the RN, stated "Due to his agitation, this nurse was instructed to attempt to get the patient to take oral Geodon. Patient refused. At that time, the Provider [name of NP] left the room and got a show of force (men) and the medication nurse [name of nurse] who had some	A 154		

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A 154	Continued From page 60 Geodon injectable. After a short explanation, the patient agreed to take the PO pill. However, even though the patient was asked to open his mouth and show that he had indeed swallowed the pill, after a short period of time, the patient had removed the medication from his mouth and threw it on the table. The Provider, again, left the room to get a show of force at which time the patient was convinced to take the injection. He was unhappy about this." Patient #15's record did not document an emergency situation in which he was a danger to himself or others, at the time of the medication administration. During an interview on 4/01/15 at 4:45 PM, the RN reviewed Patient #15's record and confirmed it documented the use of intimidation related to medication administration. The facility failed to ensure Patient #13's right to refuse medication, and to be free from intimidation. 2. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an ALF. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included documentation of physical restraint by staff for verbal aggression. A nurses note signed by the RN, dated 3/08/15 at 8:00 AM, documented Patient #4 became agitated and started yelling at other patients and staff. The RN documented Patient #4 was	A 154		

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A 154	Continued From page 61 threatening a peer with physical aggression and was physically redirected to his room. There was no documentation of what preceeded Patient #4's agitation and verbal aggression towards his peer. The RN documented she was unable to verbally redirect Patient #4 . It was unclear whether the RN attempted verbal redirection prior to his agitation or after he was physically redirected to his room. There was no documentation, other than verbal redirection, to indicate non-physical interventions were attempted to address Patient #4's negative behaviors prior to use of a physical restraint. During an interview on 4/01/15 at 3:00 PM, the RN reviewed the record and confirmed physical redirection was considered a restraint. She confirmed there was no documentation related to what preceeded his agitation and yelling. The RN confirmed the record was not clear whether any other interventions were attempted prior to restraining Patient #4. Patient #4's record did not include documentation of non-physical interventions attempted prior to physical restraint.	A 154		
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on review of patient records, policies, and staff interviews, it was determined the facility	A 164		

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A 164	Continued From page 62 failed to ensure less restrictive interventions were attempted before implementing physical restraints and seclusion for 2 of 3 patients (#4 and #8) for whom seclusion and/or physical restraints were used. This resulted in a lack of appropriate assessment to determine if a less restrictive intervention may have prevented unnecessary use of restraint and or seclusion. Findings include: 1. Patient #8's record documented a 65 year old male who was at the facility from 3/06/15 to 3/24/15 for psychiatric services related to dementia, and psychosis with behavioral disturbances. Additional diagnoses included HTN and PTSD. a. Patient #8 was physically restrained and secluded on multiple incidents without evidence of less restrictive interventions used or considered. Examples include: - On 3/07/15 at 9:00 AM, an "Occurrence Report," written by the RN on duty, noted Patient #8 hit a staff member and another patient. He was noted to be restrained by P.T. D. Additionally, the Occurrence Report documented Patient #8 had another physical altercation with P.T. D, his behavior escalated, and he struck a patient. The report documented he was physically restrained, and administered an IM injection. A corresponding P.T. note, untimed, stated "Pt. was pacing the floor-fist clenched tight - yelling out, threatening hands, male tech tryed (sic) to get him under a more controlled mind - Pt swung his elbow up and hit the tech on his jaw." Patient #8 was placed on 1:1 status, and	A 164		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN HOSPITAL OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(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 164	Continued From page 63 remained on that status throughout his stay at the facility. Patient #8's record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection. Patient #8's record did not include documentation of less restrictive alternatives tried or considered prior to the use of restraint. -A P.T. note, attached to an "Occurrence Report" dated 3/07/15 at 3:15 PM stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. He was then given an injection of Geodon IM 20 mg. A second P.T. note attached to the Occurrence Report, documented by P.T D on 3/07/15 at 4:00 PM, stated "I was walking in the hall to the front door cause the door bell rang when [Patient #8] swung at me, I blocked that hit, then after he elbowed me in chin." Patient #8's record did not include documentation of the actions necessary to "redirect" Patient #8 to his room or if he was blocked from leaving the room. Additionally his record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection. Patient #8's record did not include documentation of less restrictive alternatives tried or considered prior to the use of restraint. - On 3/08/15, an "Occurrence Report," written by the RN on duty, noted at 9:30-10:30 AM, Patient	A 164		

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A 164	Continued From page 64 #8 became agitated and was threatening P.T. D. The report indicated P.T. D performed a Mandt hold on Patient #8, and then 4 employees were required to assist him back to his room. A nurses note documented at 10:50 AM on 3/08/15, also stated Patient #8 continued to "go after staff" and was given an IM injection of 20 mg Geodon. The nurses note went on to say that after the injection Patient #8 continued to require physical redirection by staff. There was no documentation of antecedents to the behaviors that occurred prior to Patient #8 becoming agitated and subsequently, aggressive. A nurses note documented on the same date at 11:00 AM, stated Patient #8 was "physically assisted" to the seclusion room. Patient #8's record did not include documentation of less restrictive alternatives tried or considered prior to the use of restraint. - An "Occurrence Report," dated 3/08/15 at 2:00 PM, was completed by the RN on duty. The RN documented Patient #8 was aggressive to another patient and that P.T.s were able to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF. Patient #8 was given an injection but did not calm down until 5:00 PM according to the documentation on the Report. Patient #8's record did not include documentation of less restrictive alternatives tried or considered prior to the use of restraint, required to give the IM injection. - On 3/12/15, Patient #8's MAR indicated he was administered Geodon 20 mg IM at 3:00 PM. The	A 164		

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A 164	Continued From page 65 P.T. narrative indicated Patient #8 was visited by his son, and complained of pain, for which he was medicated with Tylenol at 5:00 PM. A nurses note, also documented at 3:00 PM on 3/12/15, stated "Patient seems to be agitating another patient, which in turn seems to agitate the patient. Patient pacing and getting louder. Medicated per MAR." Patient #8's record did not include documentation of less restrictive alternatives tried or considered prior to the use of restraint, required to give the IM injection. - On 3/14/15, an Occurrence Report, written by the RN on duty, noted at 4:00 PM, Patient #8 was involved in a physical altercation with another patient. The report documented he was physically redirected by staff, and was assisted to his room. In his room he began to swing at staff, was restrained on a total of 4 times, and administered Zyprexa IM. In a narrative note attached to Occurrence Report, written by a P.T., indicated Patient #8 was in the dining room. He was noted to have a verbal interchange with another patient, both Patient #8 and the other patient started yelling and hitting each other. There was no documentation in Patient #8's record of less restrictive interventions tried or considered prior to the use of restraints. -A P.T. note, documented on 3/21/15 at 6:30 AM, indicated Patient #8 was agitated and P.T. D came to help and Patient #8 was restrained twice. Patient #8's record did not include documentation of less restrictive alternatives tried or considered prior to the use of restraint.	A 164		

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A 164	Continued From page 66 b. Patient #8's record did not include evidence the above incidents were thoroughly investigated and causal analyses completed. There was no documentation of actions taken or follow up completed. Patient #8's record did not include a treatment and/or care plan. Individualized interventions directed at reducing or eliminating the need for behavioral restraints and seclusion were not developed and implemented for Patient #8. These failed practices precluded the facility from taking proactive steps to reduce the number of restraints and seclusion and ensure less restrictive interventions were utilized for Patient #8. During an interview on 4/02/15 beginning at 10:45 AM, the NP reviewed Patient #8's record and confirmed there was no documentation of less restrictive interventions before restraints were implemented. She stated male staff members would increase Patient #8's agression, and confirmed the male staff were summoned to assist when Patient #8's agitation escalated. Patient #8 was physically restrained and placed in seclusion without evidence that less restrictive interventions tried or considered. 2. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an ALF. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included the following	A 164		

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A 164	Continued From page 67 documented incidents of physical restraint. A nurses note signed by the RN, dated 3/08/15 at 8:00 AM, documented Patient #4 became agitated and started yelling at other patients and staff. The RN documented Patient #4 was verbally threatening a peer with physical aggression. Patient #4 was physically removed to his room. There was no documentation what preceeded Patient #4's agitation and verbal aggression towards his peer. Additionally, there was no documentation how the RN intervened prior to physically restraining Patient #4. A nurses note signed by the RN, dated 3/14/15 at 4:05 PM, documented Patient #4 was yelling and shaking his fist at peers. There was no documentation what preceeded Patient #4's yelling and threatening manner. The RN documented Patient #4 was physically seperated from his peer. There was no documentation of interventions the RN attempted to address Patient #4's verbal aggression before he was physically restrained. Patient #4's record did not include a nursing or treatment care plan for interventions related to his verbal aggression and agitation. During an interview on 4/01/15 at 3:00 PM, RN C reviewed Patient #4's record and confirmed there was no documentation of less restrictive interventions before restraints were implemented Patient #4 was physically restrained without evidence that less restrictive interventions tried or considered.	A 164		
A 165	482.13(e)(3) PATIENT RIGHTS: RESTRAINT OR	A 165		

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A 165	Continued From page 68 SECLUSION The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient or others from harm. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure that physical restraints used were the least restrictive to ensure safety. This directly impacted 2 of 3 sample patients (#4 and #8) for whom restraints were used. This resulted in the potential excessive restraints to be used, when less intrusive ones would suffice. Findings include 1. Patient #8's record documented a 65 year old male who was at the facility from 3/06/15 to 3/24/15 for psychiatric services related to dementia, and psychosis with behavioral disturbances. Additional diagnoses included HTN and PTSD. - On 3/07/15 at 9:00 AM, an "Occurrence Report," written by the RN on duty, noted Patient #8 hit a staff member and another patient. He was noted to be restrained by P.T. D. Additionally, the Occurrence Report documented Patient #8 had another physical altercation with P.T. D, his behavior escalated, and he struck a patient. The report documented he was physically restrained, and administered an IM injection. Patient #8 was placed on 1:1 status, and remained on that status throughout his stay at the facility. The types of restraints used by staff to restrain Patient #8 were not specified.	A 165		

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A 165	Continued From page 69 Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. -A P.T. note attached to an "Occurrence Report" dated 3/07/15 at 3:15 PM stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. He was then given an injection of Geodon IM 20 mg. Patient #8's record did not include documentation of the actions were necessary to "redirect" Patient #8 to his room. Additionally his record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. - On 3/08/15, an "Occurrence Report," written by the RN on duty, noted at 9:30-10:30 AM, Patient #8 became agitated and was threatening P.T. D. The report indicated P.T. D performed a Mandt hold on Patient #8, and then 4 employees were required to assist him back to his room. There was no documentation in Patient #8's record that described the type of Mandt restraint used. A nurses note documented at 10:50 AM on 3/08/15 also stated Patient #8 continued to "go after staff" and was given an IM injection of 20 mg Geodon. The type of restraint used to allow the IM injection was not specified. The nurses note went on to say that after the injection Patient #8	A 165		

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A 165	Continued From page 70 continued to require physical redirection by staff. There was no documentation to describe the "redirection " used by staff. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. - An "Occurrence Report," dated 3/08/15 at 2:00 PM, was completed by the RN on duty. The RN documented Patient #8 was aggressive to another patient and that P.T.s were able to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. Patient #8 was given an injection but did not calm down until 5:00 PM according to the documentation on the Report. The type of restraint used to allow for the IM injection and actions of the SNF male aide were not described. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. - On 3/12/15, Patient #8's MAR indicated he was administered Geodon 20 mg IM at 3:00 PM. The P.T. narrative indicated Patient #8 was visited by his son, and complained of pain, for which he was medicated with Tylenol at 5:00 PM. A nurses note, also documented at 3:00 PM on 3/12/15, stated "Patient seems to be agitating another patient, which in turn seems to agitate the patient. Patient pacing and getting louder. Medicated per MAR." The type of restraint used to restrain Patient #8 to allow the IM injection, was not documented. Patient #8's record did not include evidence that the least restrictive type of restraint necessary to protect Patient #8 and others was used.	A 165		

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A 165	Continued From page 71 - On 3/14/15, an "Occurrence Report", written by the RN on duty, noted at 4:00 PM, Patient #8 was involved in a physical altercation with another patient. The report documented he was physically redirected by staff, and was assisted to his room. In his room he began to swing at staff, was restrained on a total of 4 occasions, and administered Zyprexa IM. There was no documentation to describe the "redirection" used by staff or the technique used to assist him to his room. Additionally, there was no documentation describing the type of restraints used the 4 restraints. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. -On 3/16/15 Patient #8's MAR stated he received Haldol 5 mg IM at 8:55 PM. His record included an "Emergency Treatment Override Orders for Seclusion," completed by the NP and RN at 9:30 PM. He was noted to be agitated, hit the staff, punched the fire door, his knuckles were bleeding. A nurses note, dated 3/16/15 at 7:40 PM indicated Patient #8 He was escorted to the seclusion room after grabbing the RN's wrist. The nurses note indicated Patient #8 resisted and staff continued to escort him to seclusion. It further stated "Staff into seclusion room and stabilized pts arms" and Haldol injection given. There was no documentation in Patient #8's record that described how staff "escorted" him to the seclusion room or the type of restraint used to stabilize his arms. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used.	A 165		

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A 165	Continued From page 72 - A 3/18/15 at 6:05 PM Emergency Treatment Override Orders for Hold and Restraint form, indicated Patient #8 was physically restrained using a "Staff Hold" to allow for an IM injection of Geodon 20 mg and placement in seclusion. A tech note documented at the time of the incident, stated Patient #8 was agitated and combative at the beginning of the shift and that he was getting worked up from other patients. There was no documentation describing the type of restraint hold used. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. -A P.T. note, documented on 3/21/15 at 6:30 AM, indicated Patient #8 was agitated and P.T. D came to help and Patient #8 was restrained twice. The type of restraints used were not described. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. During an interview on 4/02/15 beginning at 10:45 AM, the NP reviewed Patient #8's record and confirmed there was no documentation of less restrictive interventions before restraints were implemented. She stated male staff members would increase Patient #8's agression, and confirmed the male staff were summoned to assist when Patient #8's agitation escalated. The facility failed to ensure staff specifically described the type of restraints, redirections, escorts, and holds used. This precluded the facility from ensuring the least restrictive restraint	A 165		

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A 165	Continued From page 73 interventions were used. 2. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an ALF. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. -On 3/08/15 at 8:00 AM, the RN documented Patient #4 became agitated and started yelling at other patients and staff. The RN documented Patient #4 was verbally threatening a peer with physical aggression. Patient #4 was physically removed to his room. There was no documentation what preceeded Patient #4's agitation and verbal aggression towards his peer. The RN did not include a description of what type of restraint was used to phyically remove Patient #4. Additionally, there was no documentation how the RN or other staff members intervened prior to physically restraining Patient #4. Patient #4's record did not include evidence that the least restrictive type of restraint necessary to protect Patient #4 and others was used. -On 3/14/15 at 4:05 PM, the RN documented Patient #4 was yelling and shaking his fist at peers. The RN documented Patient #4 was physically seperated from his peer. There was no documentation what preceeded Patient #4's yelling and threatening manner. The RN did not include a description of what type of restraint was used to physically seperate Patient #4 from the other patient. Patient #4's record did not include evidence that the least restrictive type of restraint necessary to protect Patient #4 and others was used.	A 165		

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A 165	Continued From page 74 During an interview on 4/01/15 at 3:00 PM, RN C reviewed the record and confirmed Patient #4 was physically restrained. She confirmed there was no documentation of less restrictive interventions prior to using physical restraints. RN C confirmed the record did not have documentation describing the physical restraints used. The facility failed to ensure staff specifically described the type of restraints, redirections, escorts, and holds used. This precluded the facility from ensuring the least restrictive restraint interventions were used.	A 165		
A 166	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on review of hospital policy, record review, and staff interview, it was determined the facility failed to ensure the patients' POCs were modified to reflect the use of restraint or seclusion for 3 of 3 patients (#4, #8 and #15) for whom restraints or seclusion were used. This resulted in a lack of direction to staff regarding ways to decrease restraint/seclusion usage and ways to keep the patient safe. Findings include: 1. Patient #8's record documented a 65 year old male who was at the facility from 3/06/15 to 3/24/15 for psychiatric services related to dementia, and psychosis with behavioral disturbances. Additional diagnoses included HTN and PTSD. He experienced the following	A 166		

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A 166	Continued From page 75 incidents of restraint and seclusion: - On 3/07/15 at 9:00 AM, an "Occurrence Report," written by the RN on duty, noted Patient #8 hit a staff member and another patient. He was noted to be restrained by P.T. D. Additionally, the Occurrence Report documented Patient #8 had another physical altercation with P.T. D, his behavior escalated, and he struck a patient. The report documented he was physically restrained, and administered an IM injection. Patient #8 was placed on 1:1 status, and remained on that status throughout his stay at the facility. The types of restraints used by staff to restrain Patient #8 were not specified. -A tech note attached to an "Occurrence Report" dated 3/07/15 at 3:15 PM stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. He was then given an injection of Geodon IM 20 mg. Patient #8's record did not include documentation of the actions were necessary to "redirect" Patient #8 to his room. Additionally his record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection. - On 3/08/15, an "Occurrence Report," written by the RN on duty, noted at 9:30-10:30 AM, Patient #8 became agitated and was threatening P.T. D. The report indicated P.T. D performed a Mandt hold on Patient #8, and then 4 employees were	A 166		

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	134011		C 04/03/2015

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A 166	Continued From page 76 required to assist him back to his room. There was no documentation in Patient #8's record that described the type of Mandt restraint used. A nurses note documented at 10:50 AM on 3/08/15 also stated Patient #8 continued to "go after staff" and was given an IM injection of 20 mg Geodon. The type of restraint used to allow the IM injection was not specified. The nurses note went on to say that after the injection Patient #8 continued to require physical redirection by staff. There was no documentation to describe the "redirection " used by staff. - An "Occurrence Report," dated 3/08/15 at 2:00 PM, was completed by the RN on duty. The RN documented Patient #8 was aggressive to another patient and that P.T.s were able to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. Patient #8 was given an injection but did not calm down until 5:00 PM according to the documentation on the Report. The type of restraint used to allow for the IM injection and actions of the SNF male aide were not described. - On 3/12/15, Patient #8's MAR indicated he was administered Geodon 20 mg IM at 3:00 PM. The P.T. narrative indicated Patient #8 was visited by his son, and complained of pain, for which he was medicated with Tylenol at 5:00 PM. A nurses note, also documented at 3:00 PM on 3/12/15, stated "Patient seems to be agitating another patient, which in turn seems to agitate the patient. Patient pacing and getting louder. Medicated per MAR." The type of restraint used to restrain Patient #8 to allow the IM injection, was not documented.	A 166		

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A 166	Continued From page 77 - On 3/14/15, an "Occurrence Report", written by the RN on duty, noted at 4:00 PM, Patient #8 was involved in a physical altercation with another patient. The report documented he was physically redirected by staff, and was assisted to his room. In his room he began to swing at staff, was restrained on a total of 4 occasions, and administered Zyprexa IM. There was no documentation to describe the "redirection" used by staff or the technique used to assist him to his room. Additionally, there was no documentation describing the type of restraints used the 4 restraints. -On 3/16/15 Patient #8's MAR stated he received Haldol 5 mg IM at 8:55 PM. His record included an "Emergency Treatment Override Orders for Seclusion," completed by the NP and RN at 9:30 PM. He was noted to be agitated, hit the staff, punched the fire door, his knuckles were bleeding. A nurses note, dated 3/16/15 at 7:40 PM indicated Patient #8 He was escorted to the seclusion room after grabbing the RN's wrist. The nurses note indicated Patient #8 resisted and staff continued to escort him to seclusion. It further stated "Staff into seclusion room and stabilized pts arms" and Haldol injection given. There was no documentation in Patient #8's record that described how staff "escorted" him to the seclusion room or the type of restraint used to stabilize his arms. - A 3/18/15 at 6:05 PM Emergency Treatment Override Orders for Hold and Restraint form, indicated Patient #8 was physically restrained using a "Staff Hold" to allow for an IM injection of Geodon 20 mg and placement in seclusion. A	A 166		

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A 166	Continued From page 78 tech note documented at the time of the incident, stated Patient #8 was agitated and combative at the beginning of the shift and that he was getting worked up from other patients. There was no documentation describing the type of restraint hold used. -A tech note, documented on 3/21/15 at 6:30 AM, indicated Patient #8 was agitated and P.T. D came to help and Patient #8 was restrained twice. The type of restraints used were not described. The NP was interviewed on 4/03/15 beginning at 10:30 AM. She stated patients did not have nursing POCs or treatment plans. She stated it was the CNO's job to develop those plans. She said since the CNO resigned in January, 2015, POCs and treatment plans were not developed. Patient #8 did not have a POC or treatment plan to modify and incorporate restraints and seclusion into. 2. Patient #15 was a 60 year old man who was a patient in the facility from 3/15/15 to 3/26/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. Patient #15's record included "EMERGENCY TREATMENT OVER RIDE ORDERS FOR HOLD AND RESTRAINT" dated 3/17/15 at 12:45 PM, signed by RN C and the NP. The form documented "seclusion room" as the type of physical restraint. Patient #15's record documented he was placed in the facility's seclusion room on 3/17/15, from	A 166		

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A 166	Continued From page 79 12:45 to 1:45 PM. Patient #15's record did not include documentation of updates to his POC during or after the use of seclusion. Patient #15's record did not include a nursing or a treatment plan of care. During an interview on 4/01/15 at 4:45 PM, RN C reviewed Patient #15's record and confirmed it did not include a nursing or treatment plan of care, therefore, there was no update in his plan of care related to the use of seclusion. The facility failed to ensure a plan of care for Patient #15 was developed and updated to include use of seclusion. 3. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an ALF. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included the following documented incidents of physical restraint. A nurses note signed by the RN, dated 3/08/15 at 8:00 AM, documented Patient #4 became agitated and started yelling at other patients and staff. The RN documented Patient #4 was verbally threatening a peer with physical aggression. Patient #4 was physically removed to his room. There was no documentation what preceeded Patient #4's agitation and verbal aggression towards his peer. Additionally, there was no documentation how the RN intervened	A 166		

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A 166	Continued From page 80 prior to physically restraining Patient #4. A nurses note signed by the RN, dated 3/14/15 at 4:05 PM, documented Patient #4 was yelling and shaking his fist at peers. There was no documentation what preceeded Patient #4's yelling and threatening manner. The RN documented Patient #4 was physically seperated from his peer. There was no documentation of interventions the RN attempted to address Patient #4's verbal aggression before he was physically restrained. Patient #4's record did not include a nursing POC or treatment plan. During an interview on 4/01/15 at 3:00 PM, RN C reviewed the record and confirmed there were no nursing or treatment care plans for Patient #4, therefore it was not updated. Patient #4's record did not have a care or treatment plan to address his physical and verbal aggression.	A 166		
A 167	482.13(e)(4)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on review of hospital policy and personnel files, and staff interview, it was determined the facility failed to ensure restraints were safely implemented for 1 of 3 patients	A 167		

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A 167	Continued From page 81 reviewed (#8) for whom restraints and seclusion were used. This resulted in an inability of the facility to ensure physical restraints and seclusion were implemented in a safe and appropriate manner. Findings include: 1. Patient #8's record documented a 65 year old male who was at the facility from 3/06/15 to 3/24/15 for psychiatric services related to dementia, and psychosis with behavioral disturbances. Additional diagnoses included HTN and PTSD. During an interview on 4/03/15 at 4:00 PM, P.T. H stated she was a P.T. on duty the day before Patient #8 had the seizure on 3/23/15. She stated she did not have Mandt or any kind of restraint training since her hire at the facility. P.T. H stated she witnessed an event that she reported to the RN on duty, but felt no action was taken. She stated P.T. D did not like Patient #8, and stated that P.T. D did not want to be his 1:1. She stated when Patient #8 had aggressive behavior; P.T. D would be the 1st to jump in to restrain him. P.T. H stated on Sunday 3/22/15, Patient #8 did not sleep for about a day and a half, and he was agitated. She stated that about 6:30 AM, she asked him if he was tired, Patient #8 stated "yes," so she took him to his room. She stated he sat on the bed, then Patient #8 grabbed her by the throat, she brought his hand down and then went to get assistance from P.T. D. When they entered the room, Patient #8 tried to punch P.T.D so he grabbed Patient #8 with his arms under Patient #8's armpits and pulled his arms up	A 167		

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A 167	Continued From page 82 and outward. (Similar to a Full Nelson wrestling move). Patient #8 attempted to fight him off, and P.T.D held him again in that manner and threw him face down on the bed, with his body on him to pin him down. He asked P.T. H to hold Patient #8's legs. He held Patient #8 down until after the RN gave him a shot. P.T. D's personnel file was reviewed. It did not include evidenc of Mandt training. The reported type of restraint is not an approved Mandt or other therapeutic hold and presents a danger to patients. Patient #8 was not restrained in a safe and appropriate manner. 2. The facility policy "Use of Seclusion and Restraint," dated 1/25/14, defined restraint as "Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition." The Administrator was interviewed on 4/02/15 at 2:15 PM. She stated that all direct patient care staff were trained in Mandt technique for patient restraint. She stated the only physical holds used in the facility were Mandt holds, and although they would be "hands on," they were Mandt holds, and not considered a restraint. This was inconsistent with the definition included in the hospital's policy	A 167		

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A 167	Continued From page 83 During an interview on 4/03/15 at 4:10 PM, the SNF AIT stated the hospital required all direct care staff to complete Mandt training upon hire and annually. He stated the hospital provided the training several times a year. The Mandt Systems website, accessed 4/07/15, stated "The Mandt System is a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others." The personnel records of eighteen direct care employees were reviewed, including 8 RN, 2 LPN, 7 P. T. and 1 Program Assistant. The employee files of RN B and H, LPN A and B, P.T. B, D, E, F and G, and the Program Assistant did not contain documentation of Mandt training. The employee files of RN C, D, E and G, and P.T. A and C contained Mandt training certificates that were expired. Two staff files included evidence of current Mandt training. During an interview on 4/03/15 at 3:30 PM, the Human Resources Director confirmed the hospital required annual Mandt training for all direct care staff members. She reviewed the personnel files and confirmed 10 of the 18 files reviewed did not include documentation of Mandt training, and 6 of the 18 records reviewed contained Mandt training certificates that were expired. The facility failed to ensure staff were sufficiently trained to safely and appropriately perform restraints.	A 167		
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 168		

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A 168	Continued From page 84 The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on review of patient records, facility policy, and staff interviews, it was determined the facility failed to ensure physician orders were obtained for the use of restraint for 2 of 3 sample patients (#4 and #8) who were restrained or placed in seclusion. This resulted in patients being restrained and secluded without evidence of physician oversight and input. Findings include: A facility policy "Restraints," effective 1/25/12, stated "All seclusion and restraint shall be ordered by a physician credentialed by Safe Haven Hospital." No orders were found for the following restraints: 1. Patient #8's record documented a 65 year old male who was at the facility from 3/06/15 to 3/24/15 for psychiatric services related to dementia, and psychosis with behavioral disturbances. Additional diagnoses included HTN and PTSD. Patient #8 experienced the following incidents of restraint, for which a LIP or physician order was not found in his record. - On 3/07/15 at 9:00 AM, an "Occurrence	A 168		

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A 168	Continued From page 85 Report," written by the RN on duty, noted Patient #8 hit a staff member and another patient. He was noted to be restrained by P.T. D. Additionally, the Occurrence Report documented Patient #8 had another physical altercation with P.T. D, his behavior escalated, and he struck a patient. The report documented he was physically restrained, and administered an IM injection. Patient #8 was placed on 1:1 status, and remained on that status throughout his stay at the facility. The types of restraints used by staff to restrain Patient #8 were not specified. -A P.T. note attached to an "Occurrence Report" dated 3/07/15 at 3:15 PM stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. He was then given an injection of Geodon IM 20 mg. Patient #8's record did not include documentation of the actions were necessary to "redirect" Patient #8 to his room. Additionally his record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection. - On 3/08/15, an "Occurrence Report," written by the RN on duty, noted at 9:30-10:30 AM, Patient #8 became agitated and was threatening P.T. D. The report indicated P.T. D performed a Mandt hold on Patient #8, and then 4 employees were required to assist him back to his room. There was no documentation in Patient #8's record that described the type of Mandt restraint used. A	A 168		

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A 168	Continued From page 86 nurses note documented at 10:50 AM on 3/08/15 also stated Patient #8 continued to "go after staff" and was given an IM injection of 20 mg Geodon. The type of restraint used to allow the IM injection was not specified. The nurses note went on to say that after the injection Patient #8 continued to require physical redirection by staff. There was no documentation to describe the "redirection " used by staff. - An "Occurrence Report," dated 3/08/15 at 2:00 PM, was completed by the RN on duty. The RN documented Patient #8 was aggressive to another patient and that P.T.s were able to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. Patient #8 was given an injection but did not calm down until 5:00 PM according to the documentation on the Report. The type of restraint used to allow for the IM injection and actions of the SNF male aide were not described. - On 3/12/15, Patient #8's MAR indicated he was administered Geodon 20 mg IM at 3:00 PM. The P.T. narrative indicated Patient #8 was visited by his son, and complained of pain, for which he was medicated with Tylenol at 5:00 PM. A nurses note, also documented at 3:00 PM on 3/12/15, stated "Patient seems to be agitating another patient, which in turn seems to agitate the patient. Patient pacing and getting louder. Medicated per MAR." The type of restraint used to restrain Patient #8 to allow the IM injection, was not documented. - On 3/14/15, an "Occurrence Report", written by the RN on duty, noted at 4:00 PM, Patient #8 was	A 168		

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A 168	Continued From page 87 involved in a physical altercation with another patient. The report documented he was physically redirected by staff, and was assisted to his room. In his room he began to swing at staff, was restrained on a total of 4 occasions, and administered Zyprexa IM. There was no documentation to describe the "redirection" used by staff or the technique used to assist him to his room. Additionally, there was no documentation describing the type of restraints used the 4 times he was restrained in his room. -On 3/16/15 Patient #8's MAR stated he received Haldol 5 mg IM at 8:55 PM. His record included an "Emergency Treatment Override Orders for Seclusion," completed by the NP and RN at 9:30 PM. He was noted to be agitated, hit the staff, punched the fire door, his knuckles were bleeding. A nurses note, dated 3/16/15 at 7:40 PM indicated Patient #8 He was escorted to the seclusion room after grabbing the RN's wrist. The nurses note indicated Patient #8 resisted and staff continued to escort him to seclusion. It further stated "Staff into seclusion room and stabilized pts arms" and Haldol injection given. There was no documentation in Patient #8's record that described how staff "escorted" him to the seclusion room or the type of restraint used to stabilize his arms. - A 3/18/15 at 6:05 PM Emergency Treatment Override Orders for Hold and Restraint form, indicated Patient #8 was physically restrained using a "Staff Hold" to allow for an IM injection of Geodon 20 mg and placement in seclusion. A tech note documented at the time of the incident, stated Patient #8 was agitated and combative at the beginning of the shift and that he was getting	A 168		

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A 168	Continued From page 88 worked up from other patients. There was no documentation describing the type of restraint hold used. -A P.T. note, documented on 3/21/15 at 6:30 AM, indicated Patient #8 was agitated and P.T. D came to help and Patient #8 was restrained twice. The type of restraints used were not described. During an interview on 4/02/15 at 10:45 AM, the NP reviewed Patient #8's record and confirmed there were no orders for the incidents that physical restraints were implemented. She stated she was not at the facility each time the restraint incidents occurred. Patient #8 was restrained on multiple occassions without physician authorization. 2. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an ALF. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included documentation of physical restraint by staff for verbal aggression. A nurses note signed by the RN, dated 3/08/15 at 8:00 AM, documented Patient #4 became agitated and started yelling at other patients and staff. The RN documented Patient #4 was threatening a peer with physical aggression. There was no documentation what preceeded Patient #4's agitation and verbal aggression towards his peer. Patient #4 was physically restrained and taken to his room by staff.	A 168		

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SAFE HAVEN HOSPITAL OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

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A 168	Continued From page 89 Patient #4's record did not include orders for physical restraints. Additionally, there was no documentation of the type of restraint or hold which was used by staff when he was moved to his room. During an interview on 4/01/15 at 3:00 PM, the RN reviewed the record and confirmed the documentation of physical restraint. She stated physically moving a patient to their room was considered a restraint. The RN confirmed there were no orders for the physical restraint. Patient #4's record did not include orders for physical restraint used by staff members.	A 168		
A 178	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention -- o By a-- - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. This STANDARD is not met as evidenced by: Based on review of patient records, facility policies, and staff interview, it was determined the facility failed to ensure patients were evaluated by an authorized trained practitioner	A 178		

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A 178	Continued From page 90 within 1 hour of the initiation of restraint or seclusion for 2 of 3 patients (#4 and #8), who were restrained and whose records were reviewed. The failure to evaluate patients that were restrained or placed in seclulsion had the potential for missed opportunities to identify factors that may have contributed to the negative behavior, as well as, identification of immediate medical or behavioral needs. Findings include: 1. Patient #8's record documented a 65 year old male who was at the facility from 3/06/15 to 3/24/15 for psychiatric services related to dementia, and psychosis with behavioral disturbances. Additional diagnoses included HTN and PTSD. Patient #8 experienced the following incidents of restraint, for which a one hour face to face medical and psychiatric assessment was not documented. - On 3/07/15 at 9:00 AM, an "Occurrence Report," written by the RN on duty, noted Patient #8 hit a staff member and another patient. He was noted to be restrained by P.T. D. Additionally, the Occurrence Report documented Patient #8 had another physical altercation with P.T. D, his behavior escalated, and he struck a patient. The report documented he was physically restrained, and administered an IM injection. Patient #8 was placed on 1:1 status, and remained on that status throughout his stay at the facility. The types of restraints used by staff to restrain Patient #8 were not specified. There was no documentation of a one hour face to face assessment for the two restraint incidents.	A 178		

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A 178	Continued From page 91 -A tech note attached to an "Occurrence Report" dated 3/07/15 at 3:15 PM stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. He was then given an injection of Geodon IM 20 mg. Patient #8's record did not include documentation of the actions were necessary to "redirect" Patient #8 to his room. Additionally his record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection. There was no documentation of a one hour face to face assessment for the two restraint incidents. - On 3/08/15, an "Occurrence Report," written by the RN on duty, noted at 9:30-10:30 AM, Patient #8 became agitated and was threatening P.T. D. The report indicated P.T. D performed a Mandt hold on Patient #8, and then 4 employees were required to assist him back to his room. There was no documentation in Patient #8's record that described the type of Mandt restraint used. A nurses note documented at 10:50 AM on 3/08/15 also stated Patient #8 continued to "go after staff" and was given an IM injection of 20 mg Geodon. The type of restraint used to allow the IM injection was not specified. The nurses note went on to say that after the injection Patient #8 continued to require physical redirection by staff. There was no documentation to describe the "redirection " used by staff. There was no documentation of a one hour face to face	A 178		

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A 178	Continued From page 92 assessment for the restraints used. - An "Occurrence Report," dated 3/08/15 at 2:00 PM, was completed by the RN on duty. The RN documented Patient #8 was aggressive to another patient and that P.T.s were able to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. Patient #8 was given an injection but did not calm down until 5:00 PM according to the documentation on the Report. The type of restraint used to allow for the IM injection and actions of the SNF male aide were not described. There was no documentation of a one hour face to face assessment for the restraints used. - On 3/12/15, Patient #8's MAR indicated he was administered Geodon 20 mg IM at 3:00 PM. The P.T. narrative indicated Patient #8 was visited by his son, and complained of pain, for which he was medicated with Tylenol at 5:00 PM. A nurses note, also documented at 3:00 PM on 3/12/15, stated "Patient seems to be agitating another patient, which in turn seems to agitate the patient. Patient pacing and getting louder. Medicated per MAR." The type of restraint used to restrain Patient #8 to allow the IM injection, was not documented. There was no documentation of a one hour face to face assessment for the restraint required for the IM injection. - On 3/14/15, an "Occurrence Report", written by the RN on duty, noted at 4:00 PM, Patient #8 was involved in a physical altercation with another	A 178		

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A 178	Continued From page 93 patient. The report documented he was physically redirected by staff, and was assisted to his room. In his room he began to swing at staff, was restrained on a total of 4 occasions, and administered Zyprexa IM. There was no documentation to describe the "redirection" used by staff or the technique used to assist him to his room. Additionally, there was no documentation describing the type of restraints used the 4 restraints. There was no documentation of a one hour face to face assessment for the restraints used. -On 3/16/15 Patient #8's MAR stated he received Haldol 5 mg IM at 8:55 PM. His record included an "Emergency Treatment Override Orders for Seclusion," completed by the NP and RN at 9:30 PM. He was noted to be agitated, hit the staff, punched the fire door, his knuckles were bleeding. A nurses note, dated 3/16/15 at 7:40 PM indicated Patient #8 He was escorted to the seclusion room after grabbing the RN's wrist. The nurses note indicated Patient #8 resisted and staff continued to escort him to seclusion. It further stated "Staff into seclusion room and stabilized pts arms" and Haldol injection given. There was no documentation in Patient #8's record that described how staff "escorted" him to the seclusion room or the type of restraint used to stabilize his arms. There was no documentation of a one hour face to face assessment for the restraints and seclusion used. - A 3/18/15 at 6:05 PM Emergency Treatment Override Orders for Hold and Restraint form, indicated Patient #8 was physically restrained	A 178		

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A 178	Continued From page 94 using a "Staff Hold" to allow for an IM injection of Geodon 20 mg and placement in seclusion. A tech note documented at the time of the incident, stated Patient #8 was agitated and combative at the beginning of the shift and that he was getting worked up from other patients. There was no documentation describing the type of restraint hold used. There was no documentation of a one hour face to face assessment for the restraints and seclusion used. -A tech note, documented on 3/21/15 at 6:30 AM, indicated Patient #8 was agitated and P.T. D came to help and Patient #8 was restrained twice. The type of restraints used were not described. There was no documentation of a one hour face to face assessment for the restraints used. During an interview on 4/02/15 at 10:45 AM, the NP reviewed Patient #8's record and confirmed the episodes in which he was physically restrained and/or placed in seclusion a 1 hour face to face was not documented. The facility failed to ensure a 1 hour face to face evalualtion was performed after the use of restraints and seclusion. 2. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an assisted living facility. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included documentation of physical restraint by staff for verbal aggression.	A 178		

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A 178	Continued From page 95 A nurses note signed by the RN, dated 3/08/15 at 8:00 AM, documented Patient #4 became agitated and started yelling at other patients and staff. The RN documented Patient #4 was threatening a peer with physical aggression. There was no documentation what preceeded Patient #4's agitation and verbal aggression towards his peer. Patient #4 was physically restrained and taken to his room by staff. During an interview on 4/01/15 at 3:00 PM, the RN reviewed the record and confirmed the documentation of physical restraint. She stated physically moving a patient to their room was considered a restraint. The RN confirmed a 1 hour face to face was not performed. Patient #4's record did not include documentation a 1 hour face to face was performed after the use of restraint.	A 178		
A 185	482.13(e)(16)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of the following:] A description of the patient's behavior and the intervention used. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the facility failed to ensure the records of 3 of 3 patients (#3, #4 and #8) for whom restraints were used, documented the type of restraint interventions used. The created the risk of patients being subjected to inappropriate, and potentially harmful, restraint techniques. Finding include:	A 185		

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A 185	Continued From page 96 1. Patient #8's record documented a 65 year old male who was at the facility from 3/06/15 to 3/24/15 for psychiatric services related to dementia, and psychosis with behavioral disturbances. Additional diagnoses included HTN and PTSD. - On 3/07/15 at 9:00 AM, an "Occurrence Report," written by the RN on duty, noted Patient #8 hit a staff member and another patient. He was noted to be restrained by P.T. D. Additionally, the Occurrence Report documented Patient #8 had another physical altercation with P.T. D, his behavior escalated, and he struck a patient. The report documented he was physically restrained, and administered an IM injection. Patient #8 was placed on 1:1 status, and remained on that status throughout his stay at the facility. The types of restraints used by staff to restrain Patient #8 were not specified. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. -A P.T. note attached to an "Occurrence Report" dated 3/07/15 at 3:15 PM stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. He was then given an injection of Geodon IM 20 mg. Patient #8's record did not include documentation of the actions were necessary to "redirect" Patient #8 to	A 185		

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A 185	Continued From page 97 his room. Additionally his record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. - On 3/08/15, an "Occurrence Report," written by the RN on duty, noted at 9:30-10:30 AM, Patient #8 became agitated and was threatening P.T. D. The report indicated P.T. D performed a Mandt hold on Patient #8, and then 4 employees were required to assist him back to his room. There was no documentation in Patient #8's record that described the type of Mandt restraint used. A nurses note documented at 10:50 AM on 3/08/15 also stated Patient #8 continued to "go after staff" and was given an IM injection of 20 mg Geodon. The type of restraint used to allow the IM injection was not specified. The nurses note went on to say that after the injection Patient #8 continued to require physical redirection by staff. There was no documentation to describe the "redirection " used by staff. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. - An "Occurrence Report," dated 3/08/15 at 2:00 PM, was completed by the RN on duty. The RN documented Patient #8 was aggressive to another patient and that P.T.s were able to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. Patient #8 was given an injection but did not calm down until 5:00 PM according to the documentation on the Report. The type of	A 185		

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A 185	Continued From page 98 restraint used to allow for the IM injection and actions of the SNF male aide were not described. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. - On 3/12/15, Patient #8's MAR indicated he was administered Geodon 20 mg IM at 3:00 PM. The P.T. narrative indicated Patient #8 was visited by his son, and complained of pain, for which he was medicated with Tylenol at 5:00 PM. A nurses note, also documented at 3:00 PM on 3/12/15, stated "Patient seems to be agitating another patient, which in turn seems to agitate the patient. Patient pacing and getting louder. Medicated per MAR." The type of restraint used to restrain Patient #8 to allow the IM injection, was not documented. Patient #8's record did not include evidence that the least restrictive type of restraint necessary to protect Patient #8 and others was used. - On 3/14/15, an "Occurrence Report", written by the RN on duty, noted at 4:00 PM, Patient #8 was involved in a physical altercation with another patient. The report documented he was physically redirected by staff, and was assisted to his room. In his room he began to swing at staff, was restrained on a total of 4 occasions, and administered Zyprexa IM. There was no documentation to describe the "redirection" used by staff or the technique used to assist him to his room. Additionally, there was no documentation describing the type of restraints used the 4 restraints. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used.	A 185		

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A 185	Continued From page 99 -On 3/16/15 Patient #8's MAR stated he received Haldol 5 mg IM at 8:55 PM. His record included an "Emergency Treatment Override Orders for Seclusion," completed by the NP and RN at 9:30 PM. He was noted to be agitated, hit the staff, punched the fire door, his knuckles were bleeding. A nurses note, dated 3/16/15 at 7:40 PM indicated Patient #8 He was escorted to the seclusion room after grabbing the RN's wrist. The nurses note indicated Patient #8 resisted and staff continued to escort him to seclusion. It further stated "Staff into seclusion room and stabilized pts arms" and Haldol injection given. There was no documentation in Patient #8's record that described how staff "escorted" him to the seclusion room or the type of restraint used to stabilize his arms. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. - A 3/18/15 at 6:05 PM Emergency Treatment Override Orders for Hold and Restraint form, indicated Patient #8 was physically restrained using a "Staff Hold" to allow for an IM injection of Geodon 20 mg and placement in seclusion. A tech note documented at the time of the incident, stated Patient #8 was agitated and combative at the beginning of the shift and that he was getting worked up from other patients. There was no documentation describing the type of restraint hold used. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. -A P.T. note, documented on 3/21/15 at 6:30 AM,	A 185		

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A 185	Continued From page 100 indicated Patient #8 was agitated and P.T. D came to help and Patient #8 was restrained twice. The type of restraints used were not described. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. During an interview on 4/02/15 beginning at 10:45 AM, the NP reviewed Patient #8's record and confirmed there was no documentation of the type of restraints the staff used when he was restrained. The NP stated she took Mandt training in 2010, when she worked at the facility as an RN, but her certification expired. The NP was unable to describe the methods of restraint the staff used when physically restraining Patient #8. The facility failed to ensure staff specifically described the type of restraints, redirections, escorts, and holds used on Patient #8. 2. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an assisted living facility. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included documentation of physical restraint by staff for verbal aggression. A nurses note signed by the RN, dated 3/08/15 at 8:00 AM, documented Patient #4 became agitated and started yelling at other patients and staff. The RN documented Patient #4 was threatening a peer with physical aggression. There was no documentation what preceeded	A 185		

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A 185	Continued From page 101 Patient #4's agitation and verbal aggression towards his peer. Patient #4 was physically restrained and taken to his room by staff. During an interview on 4/01/15 at 3:00 PM, the RN reviewed the record and confirmed the documentation of physical restraint. She stated physically moving a patient to their room was considered a restraint. Patient #4's record did not include documentation of the type of restraint used. 3. Patient #15 was a 60 year old man who was a patient in the facility from 3/15/15 to 3/26/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. A nurses note, documented at 9:00 PM on 3/22/15, stated Patient #15 eloped, was followed by hospital staff, hit and spit at hospital staff, and was "escorted back to the hospital by 2 male staff. The note further stated Patient #15 continued to be upset and when he returned he punched the entry door and slammed his door multiple times. Patient #15 was documented as stating he wanted the police called so he could go to jail. There was no documentation of the type of "escort" used by the 2 male staff to return Patient #15 to the hospital. In an interview on 4/01/15 at 4:45 PM RN C reviewed Patient #15's record and confirmed the escort back to the facility was considered a restraint. Patient #15's record did not include documentation of the type of restraint used.	A 185		

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A 186	482.13(e)(16)(iii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of] Alternatives or other less restrictive interventions attempted (as applicable); This STANDARD is not met as evidenced by: Based on review of patient records, policies, and staff interviews, it was determined the facility failed to ensure less restrictive alternatives were attempted before implementing physical restraints and seclusion for 2 of 3 patients (#4 and #8) for whom seclusion and physical restraints were used. This resulted in a lack of appropriate assessment to determine if a less restrictive intervention may have prevented unnecessary use of restraint and or seclusion. Findings include: 1. Patient #8's record documented a 65 year old male who was at the facility from 3/06/15 to 3/24/15 for psychiatric services related to dementia, and psychosis with behavioral disturbances. Additional diagnoses included HTN and PTSD. Facility staff did not document the type of restraints, holds, redirection, and assistance used for Patient #8. A treatment plan or POC was not found in Patient #8's record, to guide staff on individualized less intrusive interventions to utilize. Patient #8 experienced the following incidents of restraints without specific documentation of alternative intervention used. - On 3/07/15 at 9:00 AM, an "Occurrence	A 186		

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A 186	Continued From page 103 Report," written by the RN on duty, noted Patient #8 hit a staff member and another patient. He was noted to be restrained by P.T. D. Additionally, the Occurrence Report documented Patient #8 had another physical altercation with P.T. D, his behavior escalated, and he struck a patient. The report documented he was physically restrained, and administered an IM injection. Patient #8 was placed on 1:1 status, and remained on that status throughout his stay at the facility. The types of restraints used by staff to restrain Patient #8 were not specified. -A P.T. note attached to an "Occurrence Report" dated 3/07/15 at 3:15 PM stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. He was then given an injection of Geodon IM 20 mg. Patient #8's record did not include documentation of the actions were necessary to "redirect" Patient #8 to his room. Additionally his record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection. - On 3/08/15, an "Occurrence Report," written by the RN on duty, noted at 9:30-10:30 AM, Patient #8 became agitated and was threatening P.T. D. The report indicated P.T. D performed a Mandt hold on Patient #8, and then 4 employees were required to assist him back to his room. There was no documentation in Patient #8's record that described the type of Mandt restraint used. A	A 186		

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A 186	Continued From page 104 nurses note documented at 10:50 AM on 3/08/15 also stated Patient #8 continued to "go after staff" and was given an IM injection of 20 mg Geodon. The type of restraint used to allow the IM injection was not specified. The nurses note went on to say that after the injection Patient #8 continued to require physical redirection by staff. There was no documentation to describe the "redirection " used by staff. Patient #8's record did not include evidence that the least restrictive type of restraints necessary to protect Patient #8 and others were used. - An "Occurrence Report," dated 3/08/15 at 2:00 PM, was completed by the RN on duty. The RN documented Patient #8 was aggressive to another patient and that P.T.s were able to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. Patient #8 was given an injection but did not calm down until 5:00 PM according to the documentation on the Report. The type of restraint used to allow for the IM injection and actions of the SNF male aide were not described. - On 3/12/15, Patient #8's MAR indicated he was administered Geodon 20 mg IM at 3:00 PM. The P.T. narrative indicated Patient #8 was visited by his son, and complained of pain, for which he was medicated with Tylenol at 5:00 PM. A nurses note, also documented at 3:00 PM on 3/12/15, stated "Patient seems to be agitating another patient, which in turn seems to agitate the patient. Patient pacing and getting louder. Medicated per MAR." The type of restraint used to restrain Patient #8 to allow the IM injection, was not documented.	A 186		

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A 186	Continued From page 105 - On 3/14/15, an "Occurrence Report", written by the RN on duty, noted at 4:00 PM, Patient #8 was involved in a physical altercation with another patient. The report documented he was physically redirected by staff, and was assisted to his room. In his room he began to swing at staff, was restrained on a total of 4 occasions, and administered Zyprexa IM. There was no documentation to describe the "redirection" used by staff or the technique used to assist him to his room. - A 3/18/15 at 6:05 PM Emergency Treatment Override Orders for Hold and Restraint form, indicated Patient #8 was physically restrained using a "Staff Hold" to allow for an IM injection of Geodon 20 mg and placement in seclusion. A tech note documented at the time of the incident, stated Patient #8 was agitated and combative at the beginning of the shift and that he was getting worked up from other patients. There was no documentation describing the type of restraint hold used. -A P.T. note documented on 3/21/15 at 6:30 AM, indicated Patient #8 was agitated and P.T. D came to help and Patient #8 was restrained twice. The type of restraints used were not described. During an interview on 4/02/15 beginning at 10:45 AM, the NP reviewed Patient #8's record and confirmed there was no documentation of less restrictive interventions before restraints were implemented. She stated male staff members would increase Patient #8's agression, and confirmed the male staff were summoned to	A 186		

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A 186	Continued From page 106 assist when Patient #8's agitation escalated. The NP confirmed there were no Treatment or Behavioral POC's initiated to address his agitation. Patient #8 was physically restrained and placed in seclusion no less than 8 times without evidence that less restrictive interventions tried or considered. 2. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an assisted living facility. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included the following documented incidents of physical restraint. A nurses note signed by the RN, dated 3/08/15 at 8:00 AM, documented Patient #4 became agitated and started yelling at other patients and staff. The RN documented Patient #4 was verbally threatening a peer with physical aggression. Patient #4 was physically removed to his room. There was no documentation what preceeded Patient #4's agitation and verbal aggression towards his peer. Additionally, there was no documentation how the RN intervened prior to physically restraining Patient #4. A nurses note signed by the RN, dated 3/14/15 at 4:05 PM, documented Patient #4 was yelling and shaking his fist at peers. There was no documentation what preceeded Patient #4's yelling and threatening manner. The RN documented Patient #4 was physically seperated from his peer. There was no documentation of	A 186		

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A 186	Continued From page 107 interventions the RN attempted to address Patient #4's verbal aggression before he was physically restrained. Patient #4's record did not include a nursing or treatment care plan for interventions related to his verbal aggression and agitation. During an interview on 4/01/15 at 3:00 PM, RN C reviewed the record and confirmed there were no nursing or treatment care plans for Patient #4. Individualized treatment and nursing care plans were not developed and implemented for Patient #4, to promote the use of use of least restrictive alternatives.	A 186		
A 194	482.13(f) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or Seclusion: Staff Training Requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff. This STANDARD is not met as evidenced by: Based on review of hospital policy and personnel files, and staff interview, it was determined the facility failed to ensure restraints were safely implemented for 1 of 3 patients reviewed (#8) for whom restraints and seclusion were used. This resulted in an inability of the facility to ensure physical restraints and seclusion were implemented in a safe and appropriate manner. Findings include: 1. Patient #8's record documented a 65 year old male who was at the facility from 3/06/15 to 3/24/15 for psychiatric services related to	A 194		

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A 194	Continued From page 108 dementia, and psychosis with behavioral disturbances. Additional diagnoses included HTN and PTSD. During an interview on 4/03/15 at 4:00 PM, P.T. H stated she was a P.T. on duty the day before Patient #8 had the seizure on 3/23/15. She stated she did not have Mandt or any kind of restraint training since her hire at the facility. P.T. H stated she witnessed an event that she reported to the RN on duty, but felt no action was taken. She stated P.T. D did not like Patient #8, and stated that P.T. D did not want to be his 1:1. She stated when Patient #8 had aggressive behavior; P.T. D would be the 1st to jump in to restrain him. P.T. H stated on Sunday 3/22/15, Patient #8 did not sleep for about a day and a half, and he was agitated. She stated that about 6:30 AM, she asked him if he was tired, Patient #8 stated "yes," so she took him to his room. She stated he sat on the bed, then Patient #8 grabbed her by the throat, she brought his hand down and then went to get assistance from P.T. D. When they entered the room, Patient #8 tried to punch P.T.D so he grabbed Patient #8 with his arms under Patient #8's armpits and pulled his arms up and outward. (Similar to a Full Nelson wrestling move). Patient #8 attempted to fight him off, and P.T.D held him again in that manner and threw him face down on the bed, with his body on him to pin him down. He asked P.T. H to hold Patient #8's legs. He held Patient #8 down until after the RN gave him a shot. P.T. D's personnel file was reviewed. It did not include evidenc of Mandt training.	A 194		

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A 194	Continued From page 109 The reported type of restraint is not an approved Mandt or other therapeutic hold and presents a danger to patients. Patient #8 was not restrained in a safe and appropriate manner. 2. The facility policy "Use of Seclusion and Restraint," dated 1/25/14, defined restraint as "Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition." The Administrator was interviewed on 4/02/15 at 2:15 PM. She stated that all direct patient care staff were trained in Mandt technique for patient restraint. She stated the only physical holds used in the facility were Mandt holds, and although they would be "hands on," they were Mandt holds, and not considered a restraint. This was inconsistent with the definition included in the hospital's policy During an interview on 4/03/15 at 4:10 PM, the SNF AIT stated the hospital required all direct care staff to complete Mandt training upon hire and annually. He stated the hospital provided the training several times a year. The Mandt Systems website, accessed 4/07/15, stated "The Mandt System is a comprehensive, integrated approach to preventing, de-escalating, and if	A 194		

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A 194	Continued From page 110 necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others." The personnel records of eighteen direct care employees were reviewed, including 8 RN, 2 LPN, 7 P. T. and 1 Program Assistant. The employee files of RN B and H, LPN A and B, P.T. B, D, E, F and G, and the Program Assistant did not contain documentation of Mandt training. The employee files of RN C, D, E and G, and P.T. A and C contained Mandt training certificates that were expired. Two staff files included evidence of current Mandt training. During an interview on 4/03/15 at 3:30 PM, the Human Resources Director confirmed the hospital required annual Mandt training for all direct care staff members. She reviewed the personnel files and confirmed 10 of the 18 files reviewed did not include documentation of Mandt training, and 6 of the 18 records reviewed contained Mandt training certificates that were expired. The facility failed to ensure staff were sufficiently trained to safely and appropriately perform restraints. 3. Also refer to A185 as it relates to the failure of the facility to specifically describe the type of restraints used to manage patients' behavior. This failure precludes the facility from ensuring the interventions used are safe and appropriate.	A 194		
A 196	482.13(f)(1) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training intervals. Staff must be trained and able	A 196		

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A 196	Continued From page 111 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 review of personnel files and staff interview, it was determined the hospital failed to ensure all appropriate staff (RN B, C, D, E, G and H, LPN A and B, P.T. A, B, C, D, E, F and G, and the Program Assistant) were trained and able to demonstrate competency in the application of restraints, implementation of seclusion, and in providing care for a patient in restraint or seclusion. This resulted in an unsafe environment for all patients. Findings include: The hospital's policy titled Restraints, effective 1/25/12, outlined training requirements related to restraint and seclusion for direct care staff. It stated all direct care staff would receive ongoing training in the causes of threatening behaviors, and techniques used to prevent injury. Additionally, it stated staff who are authorized to physically apply restraint or seclusion received additional training in physical holding techniques and take down procedures. During an interview on 4/03/15 at 4:10 PM, the SNF AIT stated the hospital required all direct care staff to complete Mandt training upon hire and annually. He stated the hospital provided the training several times a year. The Mandt	A 196		

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A 196	Continued From page 112 Systems website, accessed 4/07/15, stated "The Mandt System is a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others." The personnel records of eighteen direct care employees were reviewed, including 8 RN, 2 LPN, 7 P. T. and 1 Program Assistant. The employee files of RN B and H, LPN A and B, P.T. B, D, E, F and G, and the Program Assistant did not contain documentation of Mandt training. The employee files of RN C, D, E and G, and P.T. A and C contained Mandt training certificates that were expired. During an interview on 4/03/15 at 3:30 PM, the Human Resources Director confirmed the hospital required annual Mandt training for all direct care staff members. She reviewed the personnel files and confirmed 10 of the 18 files reviewed did not include documentation of Mandt training, and 6 of the 18 records reviewed contained Mandt training certificates that were expired. Appropriate hospital personnel were not trained in the care of patients in restraint or seclusion.	A 196		
A 200	482.13(f)(2)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (ii) The use of nonphysical intervention skills.	A 200		

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A 200	Continued From page 113 This STANDARD is not met as evidenced by: Based on review of personnel files and staff interview, it was determined the hospital failed to ensure all appropriate staff (RN B, C, D, E, G and H, LPN A and B, P.T. A, B, C, D, E, F and G, and the Program Assistant) were trained and able to demonstrate competency in the use of non-physical intervention to redirect a patient and prevent a patient situation from escalating. This had the potential to result in an unsafe environment for all patients. Findings include: The hospital's policy titled Restraints, effective 1/25/12, stated seclusion and restraint would be used in emergency situations only when "Positive, individualized, alternative nonphysical intervention procedures have failed." During an interview on 4/03/15 at 4:10 PM, the SNF AIT stated the hospital required all direct care staff to complete Mandt training upon hire and annually. He stated the hospital provided the training several times a year. The Mandt Systems website, accessed 4/07/15, stated "The Mandt System is a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others." The personnel records of eighteen direct care employees were reviewed, including 8 RN, 2 LPN, 7 P. T. and 1 Program Assistant. The employee files of RN B and H, LPN A and B, P.T. B, D, E, F and G, and the Program Assistant did not contain documentation of Mandt training. The employee files of RN C, D, E and G, and	A 200		

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A 200	Continued From page 114 P.T. A and C contained Mandt training certificates that were expired. During an interview on 4/03/15 at 3:30 PM, the Human Resources Director confirmed the hospital required annual Mandt training for all direct care staff members. She reviewed the personnel files and confirmed 10 of the 18 files reviewed did not include documentation of Mandt training, and 6 of the 18 records reviewed contained Mandt training certificates that were expired. The facility failed to ensure staff responsible for the care of psychiatric patients were appropriately trained in the use of nonphysical intervention techniques.	A 200		
A 206	482.13(f)(2)(vii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification. This STANDARD is not met as evidenced by: Based on review of personnel records and staff interview, it was determined the hospital failed to ensure all appropriate staff were certified in the use of cardiopulmonary resuscitation. This resulted in an unsafe environment for all patients. Findings include:	A 206		

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SAFE HAVEN HOSPITAL OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

(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 206	Continued From page 115 The personnel records of eighteen direct care employees were reviewed, including 8 RN, 2 LPN, 7 P.T. and 1 Program Assistant. The records of RN A, C and H, LPN B, and P.T. A, B, D, E and F, and the Program Assistant did not contain documentation of CPR certification. The records of RN E, LPN A, and P.T. C contained CPR certificates that were expired. During an interview on 4/03/15 at 3:30 PM, the Human Resources Director confirmed all direct care staff were required to have current CPR certification. She reviewed the personnel records and confirmed 13 of the 18 records reviewed did not include documentation of current CPR certification. Appropriate hospital personnel were not certified in cardiopulmonary resuscitation.	A 206		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	A 263		

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A 263	Continued From page 116 This CONDITION is not met as evidenced by: Based on staff interview and review of policies and QAPI documents, it was determined the hospital failed to ensure a hospital wide data driven QAPI program was fully developed, implemented, and maintained. This resulted in the hospital's inability to monitor its services and improve the quality of patient care based on relevant data. Findings include: 1. Refer to A273 as it relates to the failure of the hospital to ensure the QAPI program showed measurable improvement in indicators and the failure to analyze quality indicators. Additionally, refer to A273 as it relates to the hopital's failure to use data to monitor the effectiveness and safety of services, and to specify the frequency and detail of data collection. 2. Refer to A283 as it relates to the failure of the hospital to ensure the QAPI program used data to identify opportunities for improvement and failed to identify high-risk, high-volume, or problem prone areas in order to focus its QAPI program. 3. Refer to A286 as it relates to the failure of the hospital to ensure the QAPI program identified adverse patient events, analyzed their causes, and implemented actions to prevent further adverse events. 4. Refer to A297 as it relates to the failure of the hospital to ensure distinct quality improvement projects were developed and conducted. 5. Refer to A309 as it relates to the failure of the	A 263		

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A 263	Continued From page 117 hospital to ensure the Governing Board defined and maintained a hospital wide QAPI program. The cumulative effect of these negative systemic practices prevented the hospital from identifying deficient practices and taking action to correct them.	A 263		
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (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 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:	A 273		

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A 273	Continued From page 118 Based on staff interview and review of policies and QAPI documents, it was determined the hospital failed to ensure the QAPI program showed measurable improvement in indicators and failed to analyze quality indicators. The hospital failed to use data to monitor the effectiveness and safety of services. The hospital failed to specify the frequency and detail of data collection. This prevented the hospital from identifying ways to improve care. Findings include: 1. The hospital's policy titled "QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN" was dated effective 6/01/13. The policy stated the hospital would organize "Performance Improvement Teams" to address "quality/departmental concerns." The policy stated an interdisciplinary "PI Committee" would meet "...at least monthly" to review and analyze data, review the status and effectiveness of PI projects, and discuss the need for additional projects. The policy was not specific. For example, the policy had a section for "Data Collection" which contained general language such as "Data collection will be incorporated into existing processes and procedures" and "Data will be tracked and trended." Under the section labeled "Action to be Taken," the plan stated "Actions may include" and contained a list of items such as "Changing Process or System." The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She stated the hospital had ongoing quality activities but a plan had not been developed that defined the overall	A 273		

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A 273	Continued From page 119 QAPI program and directed staff as to how to carry out those activities. A specific QAPI plan, including quality indicators, priorities, and time frames, was not documented between 1/01/14 and 3/31/15. 2. No plan to assess processes of care for patients had been developed. For example, the hospital did not assess its medication delivery system, nursing care provided to patients, discharge planning process, system to obtain laboratory testing, or other processes related to caring for patients. The hospital did monitor the percentage of safety checks being conducted and the percentage of patients who attended groups. However, there was no plan to use this data to examine ways to increase compliance. An untitled and undated document listed QAPI goals. There was no documentation to show how long these items had been measured or how the data would be used. The goals included: a. Safety checks will be completed 100% of the time with each shift. b. No major prohibited items will be found. c. A 10% decrease in falls within the next 30 days. d. All infections will be tracked. e. All skin problems will be tracked. f. Staff will have no "occurrences" in the next 30 days. g. The hospital will have "...zero medication	A 273		

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A 273	Continued From page 120 errors." h. The hospital will have a decrease of "other occurrences" within 30 days. i. Patients will attend at least 70% of groups. Data summaries for 2014: a. Data summaries stated compliance with contraband checks in January 2014 was 69% on days and 84.5% on nights. The percentages rose and fell throughout the year. The summary for November 2014 was 57% on days and 57% on nights. The rates rose again in December 2014 with 90% on days and 100% on nights being completed for both months. Although it improved at the end of the year, the goal was not met for 2014. The reasons for improvement or decline were not analyzed. The only action documented to improve compliance for the entire year was education to remind staff to complete the checks. b. Data summaries stated contraband items were found each month in 2014. No analysis was documented and no action was taken to address the failure to meet the goal. c. Data summaries stated falls were recorded each month in 2014. The goal was not clear. The number or falls was not adjusted to account for changes in the hospital's census. The number of falls varied widely from 1 in February to 18 in September. There was no analysis of causes for the falls other than patient diagnosis. There was no documentation action was taken to decrease the number of falls. d. The hospital was required to monitor and	A 273		

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A 273	Continued From page 121 track infections per regulation. The goal did not reflect any analysis of infections or promote actions to decrease the number of infections. e. The goal for skin problems did not define the terms. Reported skin problems included injuries such as abrasions from patients hitting a wall, bruises, old scabs, and scratches as well as rashes and a pressure sore. There was no documented analysis of causes or refinement of the problem. f. The goal for staff occurrences did not define the terms. Reported staff occurrences included a smashed finger, back injuries, a fall, and a seizure. There was no documented analysis of causes or refinement of of the problem. g. Data summaries stated medication errors were recorded each month in 2014. The number of errors varied from month to month. There was no analysis of causes. No corrective action was documented. The goal of zero medication errors was not achieved and it is questionable whether this was a realistic goal. There was no documentation to demonstrate that staff questioned achievability of the goal or that the goal was modified in order to achieve compliance. h. Other occurrences were not defined. Summaries for 2014 noted events including: i. A patient who was allergic to strawberries ate strawberry jam in February 2014. ii. A patient left against medical advice in March 2014.	A 273		

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A 273	Continued From page 122 iii. A patient dropped an oxygen canister on his foot in June 2014. iv. A separate summary stated 3 occurrences were reported from April through June 2014 but the summary did not state what those occurrences were. v. A summary noted 4 occurrences were reported in September 2014 but did not state what those occurrences were. vi. A summary documented 2 patient to patient altercations and 1 incident of destruction of property in October 2014. vii. A summary documented an overdose, a death, and arm scratches in November 2014. viii. A December 2014 summary noted 2 patient to patient altercations, seizures, self-harm occurrences, and a patient with a physical decline. A specific analysis of the above occurrences was not documented. The goal was not refined and no plan to decrease the number of occurrences was documented. i. The goal of attendance at groups was largely met. Analysis of the data and action taken affecting the percentage of compliance was not documented. The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She stated she had only been at the hospital for 2 days but confirmed the unclear goals and the lack of investigation documentation. The hospital failed to analyze quality indicators or to use data to monitor the effectiveness and safety of services.	A 273		

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A 273	Continued From page 123 3. None of the above goals included a plan to gather data, including the frequency and detail of data collection. The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She confirmed the QAPI goals did not include the frequency and detail of data collection. She stated she was not aware of a QAPI plan that included these items. The hospital failed to specify the frequency and detail of data collection.	A 273		
A 283	482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (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 124 This STANDARD is not met as evidenced by: Based on staff interview and review of QAPI documents, it was determined the hospital failed to ensure the QAPI program used data to identify opportunities for improvement. Also, the hospital failed to identify high-risk, high-volume, or problem prone areas in order to focus its QAPI program. This prevented the hospital from analyzing its processes in order to improve them. Findings include: 1. The goals the hospital used in 2014 included: a. Safety checks will be completed 100% of the time with each shift. b. No major prohibited items will be found. c. A 10% decrease in falls within the next 30 days. d. All infections will be tracked. e. All skin problems will be tracked. f. Staff will have no "occurrences" in the next 30 days. g. The hospital will have "...zero medication errors." h. The hospital will have a decrease of "other occurrences" within 30 days. i. Patients will attend at least 70% of groups. Data summaries for 2014: a. Data summaries stated compliance with contraband checks in January 2014 was 69% on days and 84.5% on nights. The percentages rose and fell throughout the year. The summary for November 2014 was 57% on days and 57% on nights. The rates rose again in December	A 283		

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A 283	Continued From page 125 2014 with 90% on days and 100% on nights being completed for both months. Although it improved at the end of the year, the goal was not met for 2014. There was no documentation to show the data gathered was used to improve compliance with contraband checks. The reasons for improvement or decline were not analyzed. The only action documented to improve compliance for the entire year was education to remind staff to complete the checks. b. There was no documentation to show the data gathered was used to decrease the number of prohibited items patients kept. Data summaries stated contraband items were found each month in 2014. No analysis was documented and no action was taken to address the failure to meet the goal. c. There was no documentation to show the data gathered was used to decrease the number of falls. Data summaries stated falls were recorded each month in 2014. The number of falls was not adjusted to account for changes in the hospital's census. The number of falls varied widely from 1 in February 2014 to 18 in September 2014. There was no analysis of causes for the falls other than patient diagnosis. There was no documentation action was taken to decrease the number of falls. d. There was no documentation to show the data gathered was used to prevent infections. The hospital was required to monitor and track infections per regulation. No analysis of infections was documented. No actions to	A 283		

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A 283	Continued From page 126 decrease the number of infections was documented. e. There was no documentation to show the data gathered was used to decrease the number of skin problems. There was no documented analysis of causes. No actions to decrease the number of skin problems was documented. f. There was no documentation to show the data gathered was used to decrease the number of staff occurrences. There was no documented analysis of causes of staff occurrences. No actions to decrease the number of staff occurrences was documented. g. There was no documentation to show the data gathered was used to decrease medication errors. Data summaries stated medication errors were recorded each month in 2014. The number of errors varied from month to month. There was no analysis of causes. No corrective action was documented. h. Other occurrences were not defined. Summaries for 2014 noted events including: i. A patient who was allergic to strawberries ate strawberry jam in February 2014. ii. A patient left against medical advice in March 2014. iii. A patient dropped an oxygen canister on his foot in June 2014. iv. A separate summary stated 3 occurrences were reported from April through June 2014 but the summary did not state what those occurrences were. v. A summary noted 4 occurrences were	A 283		

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A 283	Continued From page 127 reported in September 2014 but did not state what those occurrences were. vi. A summary documented 2 patient to patient altercations and 1 incident of destruction of property in October 2014. vii. A summary documented an overdose, a death, and arm scratches in November 2014. viii. A December 2014 summary noted 2 patient to patient altercations, seizures, self-harm occurrences, and a patient with a physical decline. There was no documentation to show the data gathered was used to decrease the number of other occurrences. A specific analysis of the above occurrences was not documented. No plan to decrease the number of other occurrences was documented. The goal of attendance at groups was largely met. Analysis of the data and action taken affecting the percentage of compliance was not documented. The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She stated she had only been at the hospital for 2 days. She said she did not know of other QAPI documents with more information. She stated she did not know how data had been used to improve care. The hospital failed to use hospital data to assess care. The lack of data prevented the hospital from identifying opportunities for improvement. 2. A specific QAPI plan, including quality indicators, priorities, and time frames, was not documented between 1/01/14 and 3/31/15. No	A 283		

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A 283	Continued From page 128 documents that identified high-risk, high-volume, or problem-prone areas to assess were present. The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She stated she did not know of other QAPI documents with more information. The hospital did not identify high-risk, high-volume, or problem-prone areas for evaluation.	A 283		
A 286	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (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.	A 286		

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A 286	Continued From page 129	A 286		

This STANDARD is not met as evidenced by:
Based on staff interview and review of medical records, QAPI documents, and policies, it was determined the hospital failed to ensure the QAPI program identified adverse patient events, analyzed their causes, and implemented actions to prevent further adverse events. This negatively affected the care of 3 of 17 patients (#5, #8, #10) whose records were reviewed. This impeded the hospital's ability to develop measures to prevent further adverse events. Findings include:

1. Patient #8 was a 65 year old male admitted to the facility on 3/06/15 for care related to dementia, psychosis, HTN, and PTSD. His medical record from 3/06/15 to 3/24/15 was reviewed, as well as records from ED visits on 3/23/15 and 3/24/15 at an acute care facility were reviewed.

Patient #8's medical record from the receiving hospital stated he was admitted with 2 upper arm fractures and 1 hip fracture.

A Pocatello police detective was interviewed on 3/31/15 beginning at 11:25 AM. He stated he had come to the hospital on 3/27/15 and talked with staff about allegations of abuse to Patient #8.

The Co-Owner was interviewed on 4/02/15 beginning at 12:45 PM. She stated an incident report had not been filed related to the fractures

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A 286	Continued From page 130 and potential abuse. She stated an investigation of events had not begun until 4/01/15. She stated action had not been taken related to the events. The hospital failed to investigate a dangerous adverse patient event and failed to take action to protect patients. 2. Patient #5 was a 55 year old male admitted to the hospital from 3/09/15 to 3/25/15, for schizophrenia and depression. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local homeless shelter. The shelter had limited hours and did not open until 5:00 PM. A timeline was received on 4/03/15 at 3:30 PM from the SNF AIT, which outlined the events that happened after Patient #5's discharge from the facility: - Patient #5 was discharged at 3:30 PM. - Patient #5 was refused admittance to shelter because it was before 5:00 PM. - Patient #5 returned to shelter at 9:00 PM and was refused admittance. - Patient #5 returned to shelter at 1:00 AM and was refused admittance. He was reportedly bleeding from an unknown source at this time. Police were contacted by a shelter staff member. - During the course of the evening (the time was not documented) Patient #5 returned to the hospital and requested assistance. The staff member who went to the door refused to let him in stating the hospital did not offer emergency services. The staff member told Patient #5 he	A 286		

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A 286	Continued From page 131 needed to leave. Patient #5 "returned banging on the doors and windows of the facility a couple more times. Finally the nurse called the police and he took off." - Patient #5 went to the hospital's corporate office around 7:15 AM on 3/27/15. He did not have any personal belongings, wallet or ID. His face was "badly banged up." He had tape across his nose. - The corporate office found placement for Patient #5 in an ALF. The Director of Social Services was interviewed on 4/03/15 at 3:40 PM. She confirmed Patient #5's discharge and subsequent return to the hospital. She stated an incident report had not been written. She said she was not aware of an investigation into the events. The hospital failed to investigate a dangerous adverse patient event. 3. Patient #10 was a 67 year old male admitted to the hospital on 11/07/14. His psychiatric diagnoses were conduct disorder and depression. Additional diagnoses included history of a stroke, seizure disorder, non-insulin dependent diabetes, and constipation. Patient #10 expired at the hospital on 11/17/14. Patient #10's record documented his weight upon admission as 132.2 pounds. Patient #10's record documented a steady decline in weight during his stay. On 11/17/14 Patient #10's weight was documented as 123 pounds, a loss of 9.2 pounds in 10 days. Patient #10's record documented the frequent refusal of meals. Patient #10's record included a flow sheet that	A 286		

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A 286	Continued From page 132 documented no bowel movement on all shifts, from 11/07/14 to 11/17/14. Additionally, the nursing admission assessment did not document his last bowel movement prior to admission. Patient #10's nursing and P.T. notes documented weight loss, complaints of pain and nausea, poor intake and lack of bowel movements, however, there was no documentation these significant finding were reported to his MD. Patient #10's History and Physical by the MD was dated 11/07/14. There were no progress notes to indicate the MD saw Patient #10 after 11/07/14 and his death on 11/17/14. There was no documentation of the medical care or nursing care that Patient #10 received prior to his death. The MD was interviewed on 4/01/15 beginning at 1:30 PM. He confirmed no investigation had been conducted into Patient #10's death or care. The hospital failed to investigate events leading to Patient #10's death and failed to evaluate the medical care provided. 4. A "SAFE HAVEN INVESTIGATION REPORT," completed on 10/07/14, stated Patient #23, who had dementia, wandered into Patient #22's room. The report stated Patient #22 thought Patient #23 was going to rape her and she struck him in the left eye. The Patient #23 suffered 2 small lacerations. Witness statements were gathered. Nursing notes surrounding the event were reviewed.	A 286		

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A 286	Continued From page 133 The report concluded there was no attempted rape. No investigation was documented regarding staff monitoring and supervision of patients. The person responsible for investigations no longer worked at the hospital and was not available for interview. The hospital failed to analyze the event to prevent further injuries to patients. 5. A "Patient Occurrence Report," completed on 11/18/14, documented Patient #24 was a 62 year old male who was admitted on 11/14/14. The report included "NURSE'S NOTES," dated 11/15/14 at 3:50 PM which stated the Patient #24 reported he had "overdosed" on 7 Oxycodone, a narcotic pain reliever. "NURSE'S NOTES," dated 11/15/14 at 4:00 PM, stated the patient was lying down and told staff he had taken "at least 70 Oxy, whatever was left in the bottles." The note stated he was alert but drowsy. At 4:03 PM, orders were received to transport the patient to a nearby Emergency Department. At 4:05 PM, a note stated the patient was blue, was not breathing, and had no pulse. CPR was initiated and the patient was transferred. He was treated at another hospital and was transferred back to Safe Haven on 11/16/14 at 12:30 AM. Witness statements were obtained. A "Root Cause Analysis Worksheet," not dated, was completed. The worksheet stated the patient obtained a large amount of pain medication and tried to commit suicide. The worksheet stated "WHY?" and included 5	A 286		

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A 286	Continued From page 134 answers. These included "Inventory possibly not thoroughly checked by staff...Personal search of pt was possibly not done or not done thoroughly...Possible incomplete room and personal checks...Depression...Borderline Trait." The analysis did not determine whether staff followed the policy regarding contraband checks or if the policy was sufficient to protect patients. The analysis did not assess if emergency care provided to the patient was sufficient. The worksheet stated the plan was to hold staff accountable for contraband checks and "By educating staff and making them accountable for doing them right." The person who conducted the root cause analysis no longer worked at the hospital and was not available for interview. The hospital failed to sufficiently analyze the event to prevent further injuries to patients. 6. A "Patient Occurrence Report," completed 12/08/14, documented Patient #25 hit Patient #26 with a drawer taken from an end table. The investigation noted the Patient #26, who was assaulted, had a 1 to 1 caregiver assigned to him. A "Root Cause Analysis Worksheet," not dated, was completed. The worksheet stated Patient #26 was physically assaulted by Patient #25. The worksheet stated "WHY?" and included 5 answers. These included Dementia...labile...Aggression...Confusion...Psychosis [not otherwise specified]." The analysis did not examine how Patient #25 was able to get the weapon (the drawer) or how the Patient #25 was able to assault the victim without the 1 to 1 staff	A 286		

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A 286	Continued From page 135 intervening to prevent the attack. No recommendations were made to prevent further attacks. The person who conducted the root cause analysis no longer worked at the hospital and was not available for interview. The hospital failed to sufficiently analyze the event to prevent further injuries to patients. 7. The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She stated the hospital did not have a specific procedure to conduct causal analyses of adverse patient events. The hospital failed to develop procedures to investigate adverse patient events. 8. Data summaries stated falls were recorded each month in 2014. An untitled and undated document listed QAPI goals. These included a 10% decrease in falls within the next 30 days. At the time there were only 2 falls for that month. The goal was not clear. The number or falls was not adjusted to account for changes in the hospital's census. The number of falls varied widely from 1 in February to 18 in September. There was no analysis of causes for the falls other than patient diagnosis. There was no documentation action was taken to decrease the number of falls. No further documents were available that tracked or analyzed falls as of 4/01/15. The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She stated she	A 286		

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A 286	Continued From page 136 had only been at the hospital for 2 days but confirmed it did not appear as if falls were being analyzed or actions were taken to reduce falls. Falls were not analyzed. 9. Data summaries stated medication errors were recorded each month in 2014. The number of errors varied from month to month. There was no analysis of causes. No corrective action was documented except to "educate" nurses. An undated document titled "Medication Errors" summarized medication errors for 2014. It stated "The Problem Goal for 2014 was to have no medication errors each month. This did not occur and needs to be re-evaluated and goal change to try and decrease medication errors for each month. For the year 2015 QAPI will take a closer look and track exactly what medication errors are occurring and who is responsible, in order to better pinpoint the problems that exist." No further documents were available that tracked or analyzed medication errors as of 4/01/15. The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She confirmed it did not appear as if medication errors were being analyzed Medication errors were not analyzed.	A 286		
A 297	482.21(d) QAPI PERFORMANCE IMPROVEMENT PROJECTS As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects. (1) The number and scope of distinct	A 297		

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A 297	Continued From page 137 improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations. (2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate measurable improvement in indicators related to health outcomes. (3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. (4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort. This STANDARD is not met as evidenced by: Based on staff interview and review of policies and QAPI documents, it was determined the hospital failed to ensure distinct quality improvement projects were developed and conducted. This prevented the hospital from analyzing process in order to identify ways to improve care. Findings include: 1. The hospital's policy titled "QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN" was dated effective 6/01/13. The policy stated the hospital would conduct "PI projects." The policy stated the projects would last between 3 and 12 months and would be interdisciplinary. No PI projects that included an in depth review of	A 297		

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A 297	Continued From page 138 processes related to patient care were documented from 1/01/14 through 3/31/15. The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She stated the hospital had not conducted PI projects since at least 1/01/14. The hospital failed to conduct distinct quality improvement projects.	A 297		
A 309	482.21(e)(1), (e)(2), (e)(5) QAPI 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: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, QAPI documents, and policies, it was	A 309		

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A 309	Continued From page 139 determined the hospital's Governing Board failed to ensure the QAPI program defined and maintained a hospital wide QAPI program. This prevented the hospital from analyzing and improving care. Findings include: 1. The hospital's policy titled "QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN" was dated effective 6/01/13. The policy was not specific. For example, the policy had a section for "Data Collection" which contained general language such as "Data collection will be incorporated into existing processes and procedures" and "Data will be tracked and trended." Under the section labeled "Action to be Taken," the plan stated "Actions may include" and contained a list of items such as "Changing Process or System." A specific plan for QAPI activities and oversight was not documented. The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She stated the hospital had ongoing quality activities but a plan had not been developed that defined the overall QAPI program and directed staff as to how to carry out those activities. The Governing Board failed to define the QAPI program. 2. The hospital's policy titled "QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN" was dated effective 6/01/13. The policy did not define the role of the Governing Board except to state it would review the QAPI program and plan annually.	A 309		

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A 309	Continued From page 140 Three Governing Board meetings were documented from 1/01/14 to 3/31/15. "Governing Board Committee Minutes," dated 1/16/14, mentioned goals and tracking for contraband, skin issues, restraints and the readiness of a blood glucose machine. "Governing Board Committee Minutes," dated 4/29/14, repeated verbatim the language from the 1/16/14 minutes. "Governing Board Committee Minutes," dated 7/24/14, mentioned the number of infections, skin problems, falls, staff occurrences, and readmissions. None of the Governing Board Minutes documented discussion or analysis of QAPI data or plans or projects. The SNF AIT was the hospital liaison with surveyors in the absence of the Administrator. He was the was interviewed on 4/02/15 beginning at 3:20 PM. He confirmed these were all of the Governing Board Minutes and no other documentation of the Board's involvement with the QAPI program was available. The Governing Board failed to oversee and monitor the QAPI program. 3. No PI projects that included an in depth review of processes related to patient care were documented from 1/01/14 through 3/31/15. The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She stated the hospital had not conducted PI projects since at least 1/01/14.	A 309		

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A 309	Continued From page 141 The Governing Board failed to ensure the QAPI program included PI projects.	A 309		
A 338	482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on staff interview and review of medical records, Medical Staff Bylaws and contracts, it was determined the facility failed to ensure the Medical Staff was organized and was responsible for the quality of medical care provided to patients. The Medical Staff failed to provide basic care for patients and failed to monitor the care practitioners did provide. This resulted in patients with unmet medical needs. A determination of immediate jeopardy was identified at A347 for the failure of the hospital to provide basic medical care and oversight. This systemic failure had the potential to result in serious harm or death to all patients receiving services at the facility. Findings include: 1. Refer to A347 as it relates to the facility's failure to ensure the Medical Staff was well organized and was responsible to the hospital's Governing Board. In addition refer to A347 as it relates to the failure of the hospital to ensure the medical staff assumed responsibility for care provided to patients or that an individual physician was responsible for the conduct of the Medical Staff. The Co-owner of the facility was verbally notified of the Immediate Jeopardy to patients' health and	A 338		

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A 338	Continued From page 142 safety on 4/03/15 at 5:00 PM, and in writing on 4/07/15.	A 338		
A 347	482.22(b)(1), (2), (3) MEDICAL STAFF ORGANIZATION & ACCOUNTABILITY The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy. (3) The responsibility for organization and conduct of the medical staff must be assigned only to one of the following: (i) An individual doctor of medicine or osteopathy. (ii) A doctor of dental surgery or dental medicine, when permitted by State law of the State in which the hospital is located. (iii) A doctor of podiatric medicine, when permitted by State law of the State in which the hospital is located. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, Medical Staff Bylaws and contracts, it was determined the hospital failed to ensure the Medical Staff was well organized and was responsible to the hospital's Governing Board. In addition, the hospital failed to ensure the medical staff assumed responsibility for care provided to	A 347		

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A 347	Continued From page 143 patients or that an individual physician was responsible for the conduct of the Medical Staff. This affected the care of 17 of 17 patients (#1 - #17) whose records were reviewed. The lack of care and oversight by the medical staff had the potential to result in serious harm or death to all patients receiving services at the facility. Findings include: 1. PATIENT CARE BY THE MEDICAL STAFF: a. Medical care was provided by 1 Family Practice Physician and 1 PA who served as his backup. A "PROFESSIONAL SERVICES AGREEMENT: MEDICAL SERVICES," dated 5/01/12, stated the Family Practice Physician would provide "including but not limited to, histories and physicals and basic medical care to patients at Safe Haven Hospital." The agreement stated the physician would be available by phone and come to the hospital when necessary for "basic medical services and care." This was not done. Medical services were not sufficient to meet patients medical needs. Examples include: i. Patient #10 was a 67 year old male admitted to the hospital on 11/07/14. His psychiatric diagnoses were conduct disorder and depression. Additional diagnoses included history of a stroke, seizure disorder, non-insulin dependent diabetes, and constipation. Patient #10 expired at the hospital on 11/17/14. Patient #10's record included an Inpatient Psychiatric Evaluation, completed by the NP on	A 347		

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A 347	Continued From page 144 11/07/14. The evaluation documented he was admitted from an assisted living facility due to verbally aggressive behaviors, inappropriate defecation and inappropriate sexual behavior. The evaluation "He has a bowel obsession....he refused to use the bathroom." Patient #10's record included an "ADMISSION HISTORY AND PHYSICAL," completed by the MD on 11/07/14. It documented Patient #10 had a bowel obsession and refused to use the bathroom. Additionally, it documented possible anorexia (loss of appetite) stating "He is on Megace without a diagnosis otherwise." Nursing 2015 Drug Handbook listed indications for Megace, including anorexia, or unexplained significant weight loss. On 11/07/14 Patient #10's record documented his weight upon admission as 132.2 pounds. On 11/09/14 Patient #10's weight was documented as 129.9 pounds, a loss of 2.3 pounds in 2 days. On 11/11/14 Patient #10's weight was documented as 127.4 pounds, a loss of 4.8 pounds in 4 days. A nurses note signed by the RN on 11/15/14 at 10:10 PM, documented patient #10 vomited, the Family Practice Physician was notified, and an order for Phenergan for nausea was obtained. No documentation was present that the physician examined the patient. On 11/17/14 a Nursing flow sheet, signed by the RN at 7:50 AM, documented he complained of a stomach ache, however, it did not document a physical assessment, or the severity of the pain. A Nurses note signed by the RN at 8:05 AM,	A 347		

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A 347	Continued From page 145 documented Patient #10 ate very little and complained of a stomach ache. A Patient Behavior Shift Summary for the day shift, 6:00 AM to 6:00 PM, documented Patient #10 did not eat any of his meals and kept sliding out of his chair. Patient #10's weight was documented as 123 pounds, a loss of 9.2 pounds in 10 days. Patient #10's record included a flow sheet that documented he did not have a bowel movement on all shifts, from 11/07/14 to 11/17/14. His nursing admission assessment did not document his last bowel movement prior to admission, so it was unclear how long it was since his last bowel movement. A nurses note dated 11/17/14 at 5:00 PM, documented the MD was notified Patient #10 was not feeling well, and orders were received for 2 bowel medications, Dulcolax and Senna. No documentation was present that the physician examined the patient. A nurses note dated 11/17/14 at 5:55 PM, and signed by the RN, documented a CNA reported Patient #10 did not look well, and sounded "rattily [sic]." The RN's assessment noted hypoactive bowel sounds and crackles throughout his lungs. MD orders were obtained to transfer Patient #10 to the ED at an acute care hospital. The RN noted she placed phone calls to begin to arrange transport to the hospital. A nurses note dated 11/17/14 at 6:15 PM, documented staff reported Patient #10 was not breathing. The RN documented Patient #10 was unresponsive and 911 was called at that time. She also documented Patient #10 had a Do Not Resuscitate order. The circumstances of Patient	A 347		

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A 347	Continued From page 146 #10's death were not documented. Patient #10's record included a death certificate with date and time of death documented 11/17/14 at 6:20 PM. The cause of death was listed as cardiorespiratory failure. The certificate was signed by the Family Practice Physician. Except for the history and physical on 11/07/14, Patient #10's medical record did not contain documentation of a physical assessment by a physician for the 10 days he was hospitalized. During an interview on 4/01/15 at 2:00 PM, the Family Practice Physician confirmed there were no progress notes to indicate Patient #10 was examined by a physician after the history and physical on 11/07/14. The Family Practice Physician failed to monitor Patient#10's medical status for 10 days prior to his death. ii. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14. Her psychiatric diagnoses were psychosis, bipolar disorder and congenital brain injury with mental disability. Additional diagnoses included renal insufficiency, CHF and diabetes. Patient #11 was transferred to an acute care hospital on 11/29/14, where she was admitted to the ICU. She died at the acute care hospital on 12/31/14. An "ADMISSION HISTORY AND PHYSICAL," conducted on 11/26/14, stated Patient #11 was morbidly obese and had chronic edema that is bordering on lymphedema (swelling caused by obstruction of the lymph system).	A 347		

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A 347	Continued From page 147 Patient #11's record included a nurses note, dated 11/29/14 at 12:20 PM. The note stated the Family Practice Physician was notified Patient #11 had less than 75 cc's of urine output for the shift. Orders were obtained to start intravenous fluids and obtain blood for a complete metabolic panel, however, a nurses note stated the nurses were unable to insert the IV or draw the blood. A nurses note at 2:00 PM stated orders were received from the Family Practice Physician to transport Patient #11 to the ER at an acute care hospital. A nurses note at 3:10 PM stated Patient #11 was transported to the ER via the facility's van. Patient #11's ED record at the acute care hospital documented she was unresponsive, had a temperature of 92.5, blood pressure of 68/45, 3 + pitting edema in her lower extremities, and oxygen saturation level of 84% on 4 liters of oxygen. The Mayo Clinic website, accessed on 4/13/15, stated "Normal pulse oximeter readings range from 95 to 100 percent, under most circumstances. Values under 90 percent are considered low." The ED physician's assessment stated "[Patient #11] is critically ill with encephalopathy, septic shock, acute on chronic respiratory failure, acute on chronic kidney disease, and multiple medical problems." Patient #11 expired at the acute care hospital on 12/31/14. Patient #11's record did not document a physician examined her for medical follow up for the 3 days after her history and physical on	A 347		

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A 347	Continued From page 148 11/26/14. During an interview on 4/02/15 at 4:15 PM, the Family Practice Physician confirmed there were no progress notes to indicate Patient #11 was examined by a physician after the history and physical on 11/26/14. The Family Practice Physician failed to monitor Patient #11's medical status for 10 days prior to her transfer. iii. Patient #8's medical record documented a 65 year old male admitted on 3/06/15 for care related to dementia, psychosis, PTSD and HTN. A history and physical was documented by the Physician Assistant on 3/08/15. A nurses note, on 3/23/15 at 10:50 AM, documented Patient #8 had a generalized seizure lasting 2.5 minutes. Afterwards, he was treated at a nearby hospital ED. The record documented he returned to Safe Haven Hospital on 3/23/15 at 5:30 PM. On 3/24/15 at 2:50 PM, Patient #8 was again transferred to the ED at the other hospital for altered mental status. Patient #8's medical record from the receiving hospital documented he was admitted and was treated for fractures of both arms and 1 hip. No documentation was present stating Patient #8 was examined by a Safe Haven physician during his 18 day stay or by the PA except for the admission history and physical. RN C was interviewed on 4/01/15 beginning at 3:30 PM. She confirmed Patient #8's record did not contain physician documentation.	A 347		

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A 347	Continued From page 149 iv. Patient #12 was an 87 year old male admitted to the facility on 12/26/14 for psychiatric treatment related to dementia and psychosis. Additional diagnoses included chronic constipation and UTI. A History and Physical was documented by the PA on 12/28/14. Patient #12's admission orders included a mechanical soft diet with "Nectar thick" liquids. His admission orders also included an order for a Speech Therapy evaluation, however, his record did not indicate the evaluation was performed. In a nurses note dated 12/29/14 at 8:07 am, the RN documented Patient #12 had difficulty swallowing and had frequent coughing. A nurses note later that day, at 12:05 PM, documented Patient #12 had difficulty with swallowing and required small portions and nectar thick liquids. On 12/30/14 at 7:00 PM, the RN documented Patient #12 had decreased oxygen saturation levels at 81%. (Normal is above 90%.) The RN noted he was coughing and breathing shallowly. He was started on oxygen and was transferred to an acute care hospital. No documentation was present stating Patient #12 was examined by a physician during his 4 day stay or that he was examined by a medical practitioner after his history and physical. The Family Practice Physician was interviewed on 4/02/15 beginning at 4:15 PM. He stated he did not remember Patient #12. He agreed Patient #12's medical record did not document contact with a physician.	A 347		

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A 347	Continued From page 150 v. A medical history and physical was documented for all patients whose records were reviewed. Two medical records (Patients #8 and #12) documented the history and physicals were conducted by a Physician Assistant. The other records documented the history and physicals were conducted by a Family Practice Physician. The medical records of Patient #8 and Patient #12 did not contain documentation that any physician saw them during their hospitalization. None of the 17 medical records reviewed (Patients #1 - #17) contained documentation that patients were examined by the Family Practice Physician or the medical Physician Assistant except for the completion of the history and physical. The Family Practice Physician was interviewed on 4/02/15 beginning at 4:15 PM. When asked about the lack of practitioner visits, he stated if he had to see patients every day he would quit. RN B was interviewed on 4/02/15 beginning at 5:00 PM. She stated the Family Practice Physician was not responsive to nurses' queries about patients. She stated she had called the physician to clarify orders he had written. She stated the physician told her not to call him. She stated he would only accept text messages if she wished to communicate with him. The prior Medical Director was interviewed on 4/01/15 beginning at 1:30 PM. He stated the hospital had no peer review or other process to evaluate the care provided by physicians. The hospital failed to ensure initial and ongoing	A 347		

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A 347	Continued From page 151 medical care was provided by the Medical Staff. b. The Florida psychiatrist, interviewed on 4/03/15 beginning at 1:55 PM, said she had a teleconference with the primary NP 2 times a week. She stated she discussed with the NP all patients who were admitted to the hospital. She stated the NP conducted all Psychiatric Evaluations (a comprehensive assessment of patients' psychiatric status and needs on admission) and she, the physician, edited them. She stated she reviewed all patients' Discharge Summaries. She stated she was available by telephone for consultation most of the time. The Florida psychiatrist stated there was no record of her activities except for her co-signature on Psychiatric Evaluations and Discharge Summaries. The psychiatrist did not treat patients or document her activities. 2. MEDICAL STAFF OVERSIGHT: a. Safe Haven Hospital of Pocatello specialized in the treatment of patients with psychiatric conditions. The hospital did not have a functional medical staff. A contract with a psychiatrist, dated 9/25/13, documented he became Medical Director on that date. The psychiatrist was interviewed on 4/02/15 beginning at 4:45 PM. He confirmed he had served as Medical Director through 3/31/15. He stated he no longer worked for the hospital. He stated while he was Medical Director there were 3 physicians, including	A 347		

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A 347	Continued From page 152 himself, on the Medical Staff. The prior Medical Director stated during his time as Medical Director he lived in Boise, Idaho, which is approximately 235 miles from the hospital. He stated he had not treated any patients at the hospital. He stated he started visiting the hospital in 2014. He stated since then he had been coming to the hospital one time a month until 2 or 3 months ago. He stated his activities at the hospital were not documented. The prior Medical Director stated psychiatric care was primarily provided by one NP. He stated 2 other NPs served as her back up when she was not available. He stated the primary NP was supervised by a psychiatrist who lived in Florida. He stated a Family Practice Physician also worked at the hospital to provide for patients' medical care. The prior Medical Director stated he had not had contact with the Family Practice Physician. The Medical Director stated no Medical Staff meetings had been held while he was the Medical Director. The prior Medical Director stated there was no record of his activities at the hospital. He further stated the hospital did not have a peer review program or other process to evaluate care provided by members of the Medical Staff. When asked how the hospital ensured patients were under the care of a physician, the prior Medical Director referred the surveyor to the Florida physician. "BYLAWS OF THE MEDICAL STAFF OF SAFE HAVEN HOSPITAL," not dated, stated NPs were	A 347		

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A 347	Continued From page 153 defined as Allied Health Professionals. Article VIII Section I of the bylaws stated "All Allied Health Professionals providing direct patient care in the hospitals shall do so under the direct supervision of the attending psychiatrist." The psychiatrist in Florida was interviewed on 4/03/15 beginning at 1:55 PM. She stated she did not see patients or provide any direct services. She stated she lived in Florida. She stated all direct services were provided by NPs. She said she had a teleconference with the primary NP 2 times a week. She stated she discussed all patients who were admitted to the hospital with the NP. She stated the NP conducted all Psychiatric Evaluations (a comprehensive assessment of patients' psychiatric status and needs on admission) and she, the physician, edited them. She stated she reviewed all patients' Discharge Summaries. She stated she was available by telephone for consultation most of the time. The Florida psychiatrist stated there was no record of her activities except for her signature on Psychiatric Evaluations and Discharge Summaries. She stated she did not know if the hospital had a formal process to supervise the NPs. The Florida psychiatrist stated she had agreed to be the hospital's current Medical Director but said she had not signed the contract yet. She stated she last visited the hospital in February 2015. She said she was coming to the hospital on April 9, 13, 14, and 15 of 2015, and then she would not come to the hospital again until the end of May 2015.	A 347		

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A 347	Continued From page 154 The Florida psychiatrist stated the hospital did not have a peer review program or other process to evaluate members of the Medical Staff. The Family Practice Physician was interviewed on 4/01/15 beginning at 1:30 PM. He stated he did not know the name of the Medical Director and had not met him, referring to the Medical Director between September 2013 and March 2015. An RN was interviewed on 4/02/15 beginning at 5:00 PM. She stated she called the Family Practice Physician in mid-March 2015 to clarify some orders he had written. She stated the physician told her not to call him and he would only accept text messages if she wished to communicate with him. The Medical Staff did not oversee care at the hospital.	A 347		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, staff interview, and review of medical records and facility policies, it was determined the facility failed to ensure nursing services were organized and supervised to effectively meet the health care needs of psychiatric patients who had additional medical conditions and needed ongoing monitoring of their health status needs. This resulted in	A 385		

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A 385	Continued From page 155 immediate jeopardy to the health and safety of 3 patients and had the potential to affect the health and safety of all patients in the facility. Findings include: 1. Refer to A386 as it relates to the failure of the facility to ensure nursing services were organized under the authority of a director of nursing services. 2. Refer to A392 as it relates to the lack of adequate numbers of RNs, LPNs, and other personnel to ensure the patients' needs were met in a safe and timely manner. 3. Refer to A394 as it relates to the failure of the facility to ensure nursing personnel had valid and current licensure. 4. Refer to A395 as it relates to the failure of the facility to ensure a registered nurse provided each patient with initial and ongoing evaluation of his/her health care needs and supervised the delivery of nursing services. These failures led to the death of 3 patients and created the potential for all patients to sustain serious injury, harm or death. 5. Refer to A396 as it relates to the failure of the facility to ensure nursing staff developed and kept current, a care plan for each patient. 6. Refer to A405 as it relates to the failure of the facility to administer medications as ordered by the physician. The cumulative effects of these systemic failures significantly impede the ability of the hospital to	A 385		

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A 385	Continued From page 156 provide nursing services of sufficient scope and quality.	A 385		
A 386	482.23(a) ORGANIZATION OF NURSING SERVICES The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure nursing services were organized under the authority of a director of nursing services responsible for nursing staff and care provided in the hospital. This failure directly impacted 17 of 17 patients (#1 - #17), whose records were reviewed and had the potential to impact all patients receiving care at the hospital. This resulted in lack of oversight of nursing personnel, lack of development of patient interdisciplinary treatment plans, and negatively impacted the quality of care provided to patients. Findings include: A job description, titled "Chief Nursing Officer (CNO) - Hospital," revised 3/2015, listed duties and responsibilities. Responsibilities related to treatment plan process included: -"Consult and coordinate with health care team members to assess, plan, implement and evaluate resident care plans."	A 386		

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A 386	Continued From page 157 -"Consult patient, write long and short term goals and nursing interventions, and obtain patient signature." -"24 hour coverage is expected, if you cannot be reached, assign another person to cover." Upon arrival at the facility on 3/30/15 at approximately 1:15 PM, surveyors were greeted by an employee who introduced himself as the Administrator in Training for the attached SNF. He stated the Administrator of the hospital was out of town for the week. He stated the hospital's CNO resigned in January and they were currently interviewing to fill that role. During an interview on 4/01/15 at 9:35 AM, the co-owner of the hospital stated the CNO resigned in January and they were currently looking for a replacement. She stated the Administrator was currently acting as CNO. Additionally, she stated the Administrator was out of town for a week and no one was designated to oversee clinical services while she was out of town. During an interview on 4/01/15 at 9:20 AM, RN C stated nobody had been designated as acting CNO while the Administrator was on vacation. She stated she did not know who she would call if she needed to notify the CNO of an event. During an interview on 4/03/15 at 10:10 AM, RN E stated she thought the Administrator was also the CNO. She stated there had been no formal announcement but she assumed the Administrator took over the CNO role. She stated she did not know who the Acting Administrator was or who the Acting CNO was on the date of the interview (while the Administrator	A 386		

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A 386	Continued From page 158 was out of town). During an interview on 4/02/15 at 5:00 PM, RN B stated her first day on the job was 3/23/15. She stated it was her understanding there was no CNO. When asked who she would call with a question or problem, she stated she did not know. The facility failed to ensure nursing services were organized under the authority of a director of nursing services. 2. Refer to A392 as it relates to the facility's failure to ensure a CNO was appointed to ensure adequate numbers of RNs, LPNs, and other personnel were provided to meet the patients' needs in a safe and timely manner. 3. Refer to A396 as it relates to the facility's failure to ensure a CNO was appointed to ensure staff developed and kept current, a care plan for each patient.	A 386		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE 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 observation, review of policies, occurrence reports, and patient records, and staff interview, it was determined the facility failed to	A 392		

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A 392	Continued From page 159 provide adequate numbers of staff to meet patient needs in 5 of 5 months (December 2014 - April 2015) for which patient census information and occurrence reports were reviewed. This failure resulted in the facility's inability to effectively manage the inappropriate behaviors of Patients #8 and #21, resulted in the inappropriate discharge of Patient #13, and had the potential to adversely affect the health and safety needs of all patients receiving services at the facility. Findings include: 1. A policy "Staffing of Nursing Care, Acuity Based," effective 1/04, stated "To provide safe, effective nursing care designed to support improvements and innovations in nursing practice based on both the needs of the patients to be served and the mission statement. The plan supports both standards of nursing practice and nursing standards of care. The CNO of Safe Haven is responsible and accountable to ensure that consistent standards are utilized. This plan provides an overview of the unit, which includes staffing plans based on acuity data and core staffing date. Staffing is based upon patient census and acuity. Based on census and patient acuity, the needs of the unit are evaluated on a shift or partial shift basis by the Staffing Coordinator, in collaboration with the charge nurse, in order to provide optimal patient care that is fiscally sound." The following algorithm was included in the policy based on patient census: Day shift staffing requirements -1 RN per shift	A 392		

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A 392	Continued From page 160 -1 to 5 patients, 1 P.T. -6 to 8 patients, 1.5 P.T.s -9 to 13 patients, 2 P.T.s -14 patients, 3 P.T.s -1 to 6 patients, 0 LPN -7 to 10 patients, 1 LPN -11-14 patients, 1.33 LPNs Night shift staffing requirements -1 RN per shift -1 to 8 patients, 1 P.T. -9 to 14 patients, 1.5 P.T.s -1 to 8 patients, 0 LPN -9 to 14 patients, 1 LPN The algorithm in the policy stated core staffing consisted of a minimum of 1 RN and 1 P.T. The policy stated, "Psych tech [psychiatric technicians] shifts- if the staffing ladder accounts for 1.5 aides, this means that one full 12 hour shift is approved and one 6 hour shift is approved. The hours may be divided amongst the scheduled Psych tech staff at the direction of the Charge RN as long as the hours stay within the approved total of 18 hours."	A 392		

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A 392	Continued From page 161 Additionally, the policy stated "LPN shifts- if the staffing ladder accounts for 1.33 LPN's, this means that one full 8 hour shift from 0700- 1500 [7:00 AM to 3:00 PM] is approved. At a census of 11 the LPN staff may then cover the remaining four hours of the 12 hour shift to 1900 [7:00PM]. The hours may not be allotted any other way." Assignment sheets were completed for each 12 hour shift, day and night. The assignment sheet included sections for patients' names, level of monitoring, names of P.T.s working, and 2 hour time periods for the shift. The name of the RN in charge and the date were listed at the top of the form. It also differentiated whether it was the assignments for day or night shift. The bottom of the assignment sheet also included a section with an algorithm. The algorithm was used for staffing the facility with P.T.s depending on the census. The section for P.T.s was numbered 1 through 5, with their names written next to the numbers. The number corresponding to the P.T. was written in the columns broken down into 2 hour time periods for the shift. The 2 hour time period columns corresponded to patient names. For example: P.T. 1 would be assigned from 6:00 AM to 8:00 AM with one patient, then from 8:00 AM to 10:00 AM, P.T. 1 would be assigned to another patient. P.T.s would not be assigned to 1 patient for the entire 12 hour shift. According to the assignment sheets reviewed, they would rotate between the patients. The algorithm at the bottom of the assignment sheet was used for determining staffing of the facility. The algorithm for staffing P.T.s was	A 392		

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A 392	Continued From page 162 based on census, rather than acuity. The algorithm was listed as follows: - Patient census 0, P.T. 0 hours - Patient census 1, P.T. 8 hours - Patient census 2-5, P.T. 12 hours - Patient census 6-10, P.T. 16 hours - Patient census 11-12, P.T. 24 hours - Patient census 13-14, P.T. 26 hours A maximum of 14 patients could be admitted at one time. If a patient was being monitored as a 1:1 (close monitoring of the patient was required and the assigned P.T. must be within arm's reach of the patient at all times), 1 tech would be assigned for monitoring the patient and was not included in the algorithm. A corresponding policy for close monitoring, titled "Suicide/Homicide Precautions Protocol," revised 10/12, stated a precaution level was assigned for the protection of patients requiring a safety intervention. The following precaution levels were identified and defined: -15 minute checks: Patient was observed every 15 minutes for safety -Line of sight (LOS): Keep patient in the line of sight at all times -1:1 monitoring: Observation with 1:1 contact at all times	A 392		

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A 392	Continued From page 163 On 4/01/15 at 4:55 PM, RN C confirmed an assignment sheet was to be filled out for each shift. She stated an LPN was scheduled for medications if the patient census was greater than 8, otherwise the LPN worked 7:00 AM to 11:00 AM and came back and worked 5:00 PM to 9:00 PM. RN C stated she coordinated the staffing of P.T.s. RN C stated P.T.s worked a 12 hour shift, but depending on the algorithm they may work 4 hours, 8 hours, or the full 12 hours. She explained when 16 hours were allotted based on census, 1 P.T. would work 12 hours and another P.T. would work for 4 hours. RN C stated staffing of P.T.s was not acuity or behaviorally based, but was based on the algorithm. During an interview on 4/02/15 at 5:05 PM, RN B confirmed the algorithm was what she used to staff the P.T. hours. She further confirmed staffing for P.T.s was based on census and algorithm, it was not acuity or behaviorally based. However, the use of the staffing algorithm, without consideration of patient acuity was not sufficient to ensure patient needs were met, as follows: a. During an observation on 4/02/15 at 12:00 PM, 5 patients were observed at the facility. In the dayroom there were 2 patients and 2 P.T.s present. One patient was in her assigned room, and 1 patient was observed walking in the hall. A third P.T. was observed in the nursing station behind a locked door. No RN was observed on the unit. After approximately 5 minutes, the RN was observed entering the patient unit from the	A 392		

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A 392	Continued From page 164 other side of the locked doors. An interview was conducted with P.T. E at 12:10 PM on 4/02/15. He stated there were 5 patients in the hospital and 3 of the patients were on 1:1 monitoring. P.T. E stated he did not feel staffing was adequate that day because only 3 P.T.s were scheduled to work. Three patients required 1:1 monitoring, therefore, the 2 remaining patients were not assigned a P.T. During an interview on 4/02/15 at 5:05 PM, RN B stated she was a concerned about safety at the facility. She stated staffing was based on census rather than acuity. Therefore, additional staff were not added when 1 or more patients exhibited behaviors that required close observation and possible intervention, to prevent injury to themselves or others. b. On 3/07/15 at 3:15 PM, a P.T. note attached to an "Occurrence Report," stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. Additionally, on 3/08/15 at 2:00 PM, an "Occurrence Report," completed by the RN on duty, documented Patient #8 was aggressive to another patient and that P.T.s were unable to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital.	A 392		

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A 392	Continued From page 165 The actions of the SNF male aide were not described. The hospital's policy, assignment sheet, and algorithms did not include using aides from the adjoining SNF when additional staff were required for patient restraint. c. On 12/05/14 at 4:30 AM, an "Occurrence Report," completed by the RN on duty, documented Patient #21 had an altercation with his roommate. The report included a nurses note documenting Patient #21 was placed on "1:1/LOS." However, the facility's "Suicide/Homicide Precautions Protocol," did not include a definition for "1:1/LOS." Without clear instruction to staff, it would not be possible to determine if adequate numbers of staff were present to meet patient needs. d. Patient #13's record documented he was a patient in the hospital from 1/01/15 to 1/05/15, with diagnoses of psychosis and depression. His record included a social service progress note, dated 1/05/15. The note stated "When SS discussed discharges with [NP] she reported that due to staffing [patient] was being discharged." During an interview on 4/03/15 at 2:45 PM, the SS Assistant who wrote the note stated she remembered the conversation with the NP. She stated during the Treatment Team meeting it was determined there were not enough staff to take care of the number of patients that were in the hospital, therefore someone had to be discharged. She stated Patient #13 was closest to his planned discharge date so he was the one	A 392		

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A 392	Continued From page 166 who was discharged. The facility failed to ensure adequate number of staff were provided to meet patients' health and safety needs.	A 392		
A 394	482.23(b)(2) LICENSURE OF NURSING STAFF The nursing service must have a procedure in place to ensure that hospital nursing personnel for whom current licensure is required have a valid and current licensure. This STANDARD is not met as evidenced by: Based on review of employee records and staff interview, it was determined the hospital failed to ensure nursing personnel for whom licensure is required had valid and current licenses, for 4 of 11 nurses (LPN A, and RN C, E and F) whose records were reviewed. Failure to ensure appropriate and current licensure had the potential to interfere with the quality and safety of patient care. Findings include: The personnel records of 9 RNs were reviewed for evidence of current RN licensure. RN E's record included a limited RN license that expired on 11/24/13. There was no verification of a current license. RN C and RN F's records included RN licenses that expired on 8/31/13. There was no verification of current licenses. The personnel records of 2 LPNs were reviewed for evidence of current LPN licensure. LPN A's record included a license that expired on 8/31/12. There was no verification of a current license. During an interview on 4/03/15 at 3:30 PM, the Human Resources Director reviewed the	A 394		

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A 394	Continued From page 167 employee files and confirmed the 4 nurses' records did not include evidence of current licensure. The hospital failed to ensure all nursing staff were currently licensed to practice.	A 394		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on review of clinical records, hospital policies, and staff interviews, it was determined the facility failed to ensure an RN provided sufficient supervision and assessment of patients' needs to ensure appropriate patient care was provided for 10 of 17 patients (#1, #5, #7, #8, #10, #11, #12, #16, #15 and #17) whose records were reviewed. The lack of nursing assessment and oversight resulted in the lack of interventions and physician notification of deterioration in patients' medical conditions which led to the death of 3 patients (#10, #11, and #12) and had the potential to adversely impact the health and safety of all patients receiving services at the facility. Findings include: 1. The hospital failed to provide nursing services necessary to identify and address patients' deteriorating health status, which contributed to the deaths of Patients #10, #11, and #12, as follows: a. Patient #10 was a 67 year old male admitted to the hospital on 11/07/14, from an ALF. His psychiatric diagnoses were conduct disorder and	A 395		

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A 395	Continued From page 168 depression. Additional diagnoses included history of a stroke, seizure disorder, non-insulin dependent diabetes, and constipation. Patient #10 expired at the hospital on 11/17/14. Patient #10's record included an Inpatient Psychiatric Evaluation, completed by the NP on 11/07/14. The evaluation documented he was admitted from an ALF due to verbally aggressive behaviors, inappropriate defecation and inappropriate sexual behavior. The evaluation stated "He has a bowel obsession....he refused to use the bathroom." Patient #10's record included an Admission History and Physical, completed by the MD on 11/07/14. It documented Patient #10 had a bowel obsession and refused to use the bathroom. Additionally, it documented possible anorexia (loss of appetite) stating "He is on Megace without a diagnosis otherwise." Nursing 2015 Drug Handbook listed indications for Megace, including anorexia, or unexplained significant weight loss. Patient #10's Psychiatric Evaluation and History and Physical indicated risks related to bowel function and poor appetite. Patient #10 exhibited signs and symptoms of physical decline related to bowel function and weight loss. However, his symptoms were not addressed by the nursing staff, thoroughly assessed or reported to the MD or mid level practitioner. Examples include: On 11/07/14: -Patient #10's record documented his weight upon admission as 132.2 pounds.	A 395		

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A 395	Continued From page 169 On 11/09/14: -Patient #10's weight was documented as 129.9 pounds, a loss of 2.3 pounds in 2 days. On 11/10/14: -A Nursing flow sheet, signed by the RN at 3:06 AM, documented Patient #10 complained of pain rated as a 4 on a scale of 1-10, however, the location of the pain was not documented. -A nurses note, signed by the RN at 7:55 AM, documented Patient #10 refused to come to breakfast and stated he was "hurting," however, it did not document an assessment of the pain to determine the severity or location of his pain. On 11/11/14: -Patient #10's weight was documented as 127.4 pounds, a loss of 4.8 pounds in 4 days. On 11/12/14: -A nurses note, signed by the RN at 11:50 AM, documented Patient #10 was agitated about being in pain, however, it did not document an assessment of the pain to determine the severity or location of his pain. -A meal intake flow sheet documented Patient #10 refused dinner. On 11/14/14: -A nurses note, signed by the RN at 3:50 AM, documented Patient #10 vomited, however, it did not document a physical assessment was completed. -A nurses note, signed by the RN at 11:00 AM, documented Patient #10 had a small appetite, and when encouraged to eat lunch, he refused. -A meal intake flow sheet documented Patient #10 refused dinner.	A 395		

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A 395	Continued From page 170 On 11/15/14: -Patient #10's medication administration record documented he was given Mylanta 30 cc po for nausea, at 3:55 AM. -A nurses note, signed by the RN at 8:15 AM, documented he was eating very little. -The meal intake flow sheet documented Patient #10 refused breakfast and lunch. His intake at dinner was not documented. -A nurses note, signed by the RN at 10:10 PM, documented Patient #10 vomited, his physician was notified, and a new medication order was obtained. However, there was no documentation of a physical assessment or Patient #10's response to the medication, including the effectiveness. On 11/16/14: -A nurses note signed by the RN at 8:05 AM, documented he ate very little and complained of a stomach ache, however, it did not document a physical assessment or the severity of the pain. -A nurses note, signed by the RN at 12:05 PM, documented he refused most of his lunch. -A nurses note, signed by the RN at 6:05 PM, documented Patient #10 refused to come to dinner. On 11/17/14: -A nursing flow sheet, signed by the RN at 7:50 AM, documented he complained of a stomach ache, however, it did not document a physical assessment or the severity of the pain. -A nurses note, signed by the RN at 8:05 AM, documented Patient #10 ate very little and complained of a stomach ache. -A Patient Behavior Shift Summary for the day	A 395		

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SAFE HAVEN HOSPITAL OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

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A 395	Continued From page 171 shift, 6:00 AM to 6:00 PM, documented Patient #10 did not eat any of his meals and kept sliding out of his chair. -Patient #10's weight was documented as 123 pounds, a loss of 9.2 pounds in 10 days. Patient #10's record included a flow sheet that documented he did not have a bowel movement on all shifts, from 11/07/14 to 11/17/14. His nursing admission assessment did not document his last bowel movement prior to admission, so it was unclear how long it was since his last bowel movement. Patient #10's admission assessment, completed by the RN on 11/07/14, stated his abdomen was round and bowel sounds were present, however, his record did not document another nursing assessment of his abdomen prior to 11/17/14, to determine distension, tenderness, or quality of bowel sounds. Patient #10's medication orders included Hydrocodone/APAP to be given 4 times per day. According to Nursing 2015 Drug Handbook, constipation is a very common adverse effect of Hydrocodone. It stated constipation should be treated aggressively. However, Patient #10's record did not document physician notification of his constipation. Patient #10's admission physician orders included a Fleet's enema to be given as needed if no bowel movement in 3-4 days. However, administration of a Fleet's enema was not documented during his 10 day hospitalization. Patient #10's record documented the MD was called on 11/15/14, to report his nausea and vomiting. A medication for nausea was ordered and administered. However, his record did not	A 395		

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A 395	Continued From page 172 document the MD was contacted the following day to report his continued complaints of nausea and stomach pain, as well as, his weight loss and lack of bowel movements. A nurses note dated 11/17/14 at 5:00 PM, documented the MD was notified Patient #10 was not feeling well, and orders were received. However, his record did not document the MD was notified of his weight loss, complaints of pain and nausea, and lack of bowel movements. Patient #10's record included an order dated 11/17/14, untimed, for Dulcolax 5 mg, 2 tablets to be given every 12 hours for 3 doses, and Senna-S, 2 tablets to be given daily. Patient #10's MAR documented a 6:00 PM dose of Dulcolax was given, however, it did not document his condition at the time it was administered, or if he had difficulty swallowing the 2 tablets. A nurses note dated 11/17/14 at 5:55 PM, and signed by the RN, documented a P.T. reported Patient #10 did not look well, and sounded "rattily." The RN's assessment noted hypoactive bowel sounds and crackles throughout his lungs. MD orders were obtained to transfer Patient #10 to the ED at an acute care hospital. The RN noted she placed phone calls to begin to arrange transport to the hospital. A nurses note dated 11/17/14 at 6:15 PM, documented staff reported Patient #10 was not breathing. The RN documented Patient #10 was unresponsive and 911 was called at that time. Patient #10's record included a death certificate with date and time of death documented on 11/17/14 at 6:20 PM. The cause of death was listed as cardiorespiratory failure.	A 395		

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A 395	Continued From page 173 During an interview on 4/01/15 at 4:30 PM, the RN reviewed Patient #10's record and confirmed he lost 9.2 pounds and his bowels did not move during his hospitalization. She stated the MD should have been notified of his weight loss and bowel status, as well as his complaints of pain and nausea. During an interview on 4/01/15 at 2:00 PM, the MD stated he would have expected the nurses to inform him of Patient #10's significant weight loss. Additionally, he stated he should have been informed by the nurses that Patient #10 complained of pain and nausea, and did not have a bowel movement for 10 days. During an interview on 4/03/15 at 1:15 PM, the NP stated the nurses did not inform her of Patient #10's weight loss or lack of bowel movements during his hospitalization. However, the NP's notes, dated 11/16/14, the day prior to Patient #10 death, stated he was "...improving on his current medications as evidenced by no sexually inappropriate behavior towards staff or other patients, and no inappropriate defecation noted." Patient #10's admission evaluations documented he was at risk for weight loss and bowel complications. During his 10 day hospitalization he complained of pain and nausea, had no bowel movements, and lost 7% of his body weight. However, he was not thoroughly assessed by the nursing staff, and significant signs and symptoms were not reported to the MD. Therefore, interventions were not initiated to address his medical problems and Patient #10 died at the hospital on 11/17/14.	A 395		

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A 395	Continued From page 174 b. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14, from a SNF. Her psychiatric diagnoses were psychosis, bipolar disorder and congenital brain injury with mental disability. Additional diagnoses included renal insufficiency, CHF and diabetes. Patient #11 was transferred to an acute care hospital on 11/29/14, where she was admitted to the ICU. She died at the acute care hospital on 12/31/14. The National Institutes of Health website, accessed 4/08/15, defined renal insufficiency as "the slow loss of kidney function over time. The main job of the kidneys is to remove wastes and excess water from the body." It defined CHF as "a condition in which the heart can't pump enough blood to meet the body's needs. The weakening of the heart's pumping ability causes blood and fluid to back up into the lungs, and the buildup of fluid in the feet, ankles and legs, called edema." Patient #11's record included a nursing admission assessment, dated 11/25/14, and signed by RN C. The cardiac section of the assessment included check boxes to document location and degree of edema, however, the boxes were blank with a question mark next to them. Therefore, it was unclear if Patient #11 had edema at the time of admission to the facility. Her record did not document additional assessments of edema during her hospitalization. Patient #11's record included a document titled "Treatment Plan." Problem 4, dated 11/26/14, was identified as renal insufficiency. However,	A 395		

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A 395	Continued From page 175 there was no plan documented to address her renal insufficiency, and the document did not include interventions, notes or updates. CHF was not identified as a problem on the treatment plan. Patient #11's record included admission orders, signed by the RN on 11/25/14, and signed by the NP on 11/26/14, that contained orders for laboratory tests, including a CMP. The National Institutes of Health website, accessed 4/08/15, stated a CMP includes BUN and creatinine levels, tests done to assess kidney function. Patient #11's record documented her blood was drawn and sent to the laboratory on 11/26/14, however, her record did not contain results of the blood tests, and there was no documentation to indicate the results were reviewed by the RN, NP or MD. Patient #11's Inpatient Psychiatric Evaluation documented a diagnosis of diabetes. Her admission orders, signed by the NP on 11/26/14, included a Hgb A1C laboratory test. A Hgb A1C shows the average blood sugar over the previous 2-3 months to measure how well the diabetes is being controlled. Patient #11's record documented her blood was drawn for a Hgb A1C and sent to the lab on 11/26/14, however, her record did not include results of her Hgb A1C. Additionally, her record did not include evidence of random blood sugar readings. Therefore, her diabetes was not monitored during her hospitalization. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it	A 395		

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A 395	Continued From page 176 did not include results of her blood tests. She stated it was possible Patient #11's blood was not drawn, or the tests were completed but the results were not obtained and put in her record. RN C stated it was the responsibility of the ward clerk to access laboratory results on-line and put them in the patient's chart, and stated that was not always done. She stated the RN was responsible to follow up on laboratory results if the results are not in the patient's record. Additionally, it was the RN's responsibility to report abnormal results to the MD. Patient #11's record included a nurses note, dated 11/26/14 at 3:30 PM, that documented a foley catheter was inserted. Her record also included an intake and output flow sheet. The flow sheet documented a fluid intake of 2640 ccs between 11/26/14 at 5:00 PM and 11/27/14 at 7:30 PM. The first documentation of foley catheter urine output was 310 ccs on 11/27/14 at 7:30 PM, 28 hours after the catheter was inserted. This indicated a urine output of approximately 11 ccs per hour. The Lippencott Manual of Nursing Practice, 10th edition, released 5/2013, stated a urinary output of less than 30 ccs per hour is abnormally low and should be reported to the physician. However, Patient #11's low urine output and discrepancy between intake and output was not reported to the MD. Patient #11's flow sheet documented a fluid intake of 2840 ccs in the next 24 hours. However, it documented only 200 ccs of urine was emptied from the foley catheter bag on 11/28/14 at 7:07 PM, in the same 24 hour period.	A 395		

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A 395	Continued From page 177 This indicated a urine output of approximately 8 ccs per hour. Patient #11's record did not document her weight at the time of her admission. The first weight recorded was 315.4 pounds on 11/27/14. Her weight was documented as 318 pounds on 11/28/14, indicating a 2.6 pound weight gain in one day. Per the Mayo Clinic website, accessed on 4/09/15, a rapid weight gain can be a sign of fluid retention due to insufficient cardiac or renal function. However, Patient #11's low urine output, discrepancy between intake and output, and significant weight gain were not reported to the MD. Patient #11's nursing admission assessment documented her respiratory status was normal and her lung sounds were clear. A nurses note, dated 11/28/14 at 9:40 PM, stated lung sounds were diminished in all lobes. The note did not document the MD was notified of the change in her respiratory status. Patient #11's urine output was documented as 100 ccs on 11/29/14 at 6:30 AM, approximately 11.5 hours after the last measurement. This indicated a urine output of approximately 9 ccs per hour. Patient #11's fluid intake during the same period was documented as 960 ccs. Patient #11's blood pressure, documented on 11/29/14 at 6:30 AM, was 80/50. The National Institutes of Health website, accessed 4/08/15, stated a blood pressure less than 90/60 is abnormally low. Patient #11's record did not documented her low blood pressure, low urine output, and discrepancy between intake and	A 395		

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A 395	Continued From page 178 output for a 3 day period were reported to the MD. Patient #11's record included a nurses note, dated 11/29/14 at 12:20 PM. The note stated the MD was notified Patient #11 had less than 75 ccs of urine output for the shift. Orders were obtained to start intravenous fluids and obtain blood for a CMP, however, a nurses note stated the nurses were unable to insert the IV or draw the blood. A nurses note at 2:00 PM stated orders were received to transport Patient #11 to the ED at an acute care hospital. A nurses note at 3:10 PM stated Patient #11 was transported to the ED via the facility's van. A Social Services Progress Note, dated 11/30/14 at 9:00 AM, documented Patient #11 was in the acute care hospital's ICU due to renal insufficiency. She expired at the acute care hospital on 12/31/14. Patient #11's ED record at the acute care hospital documented she was unresponsive, had a temperature of 92.5, blood pressure of 68/45, 3 + pitting edema in her lower extremities, and oxygen saturation level of 84% on 4 liters of oxygen. The Mayo Clinic website, accessed on 4/13/15, stated: - Normal body temperature ranges between 97 and 99. - "Swelling of the foot, ankle and leg can be severe enough to leave an indentation, or 'pit,' when you press on the area. This swelling (edema) is the result of excess fluid in your tissues - often caused by congestive heart	A 395		

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A 395	Continued From page 179 failure..." - "Normal pulse oximeter readings range from 95 to 100 percent, under most circumstances. Values under 90 percent are considered low." Patient #11's laboratory results while in the ED included a BUN of 37 (normal value 7-25) and creatinine of 2.3 (normal value 0.6-1.0), indicating decreased kidney function. The ED physician's assessment stated "[Patient #11] is critically ill with encephalopathy, septic shock, acute on chronic respiratory failure, acute on chronic kidney disease, and multiple medical problems." The acute care hospital's death summary stated "The [Patient #11] was admitted on 11/29/14, with recurrent healthcare-associated pneumonia and aspiration pneumonias. After a lengthy hospital stay, with very little progression despite BiPAP and other modalities, the patient's status continued to decline. Family members were contacted, decision was made to place the patient on comfort care measures. On the evening of 12/31/2014, patient passed away from respiratory failure secondary to recurrent healthcare associated pneumonias." Patient #11's record did not document the MD was notified of her decreased urine output, rapid weight gain or low blood pressure. During an interview on 4/01/15 at 4:00 PM, RN C stated the P.T.s empty the catheter bags and document the urine output on their flow sheet. Additionally, the P.T.s were responsible for obtaining patient weights daily and vital signs, including blood	A 395		

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A 395	Continued From page 180 pressure, every shift. She stated the RNs do not always review the flow sheets documenting intake/output, weights and vital signs. RN C reviewed Patient #11's record and stated the P.T.s should have reported her decreased urinary output to the RN on duty, so the MD could be notified. However, RN B stated she did not think the P.T.s had been instructed when to report intake/output levels or discrepancies. She confirmed Patient #11 should have been weighed daily and her weight gain should have been reported to the RN. During an interview on 4/03/15 at 12:55 PM, the NP stated she was not notified of Patient #11's low urine output. She stated a urine output of less than 40 cc's per hour should be reported to the physician. During an interview on 4/02/15 at 4:15 PM, the MD stated he was not notified of Patient #11's weight gain, diminished lung sounds or low blood pressure. He stated he was not notified of her decreased urine output until 11/29/14 at 12:20 PM. Patient #11 was known to have a history of renal insufficiency and CHF. Her record documented adequate fluid intake, however her urine output, ranging from 8-11 cc's per hour, was well below the normal output of at least 30 cc's per hour. Her weight gain of 2.6 pounds in 24 hours was an additional indication of possible renal or congestive heart failure. Patient #11's record did not document an assessment of edema. The nurses did not promptly notify Patient #11's physician of her decreased urine output, rapid weight gain, diminished lung sounds or low blood	A 395		

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A 395	Continued From page 181 pressure. Therefore, her symptoms were not addressed in a timely manner, and medical care at the acute care hospital was delayed. c. Patient #12 was an 87 year old male admitted to the facility on 12/26/14, for psychiatric treatment related to dementia and psychosis. Additional diagnoses included chronic constipation and UTI. Patient #12's admission orders included a mechanical soft diet with "Nectar thick" liquids. His admission orders also included an order for a Speech Therapy evaluation, however, his record did not indicate an evaluation was performed. A nurses note, dated 12/29/14 at 8:07 AM, and signed by the RN, documented Patient #12 required assistance with meal and fluid intake, his diet was changed to pureed consistency until his Speech Therapy evaluation could be completed. She also noted Patient #12 had difficulty swallowing and had frequent coughing. On the nurses note later that day, at 12:05 PM, the RN documented Patient #12 had difficulty with swallowing and required small portions and nectar thick liquids. That evening at 7:45 PM, the RN documented Patient #12 was calling for help. He wanted water, so she assisted him with drinking a cup of water. She noted the Medication Nurse also gave him 8 ounces of fluids. The nurse did not indicate if Patient #12 was receiving thickened liquids. She documented Patient #12 coughed and sputtered after drinking.	A 395		

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A 395	Continued From page 182 On 12/30/14 at 1:00 PM, the RN documented in the nurses notes that Patient #12 continued to choke on his food. At 7:00 PM, the RN documented Patient #12 had decreased oxygen saturation at 81%. The RN noted he was coughing and breathing shallow, his lips were bluish in color, and he was started on oxygen. She noted EMS was called and Patient #12 was transferred to an acute care hospital. Patient #12's record included documentation he was admitted to the hospital with a diagnosis of aspiration pneumonia. Per the Mayo Clinic website, accessed on 4/16/15, "Aspiration pneumonia occurs when you inhale food, drink, vomit or saliva into your lungs." Patient #12's record noted he was placed on comfort measures and died 1/19/15. Patient #12's record included a form titled "ADL Sheets." The form included documentation by the P.T.s of such activities for each patient including oral hygiene, toileting, bowel and bladder elimination, skin care, and meal intake. Patient #12's form documented he had no bowel movements in the 5 days that he was at the facility. His medication record included orders for Dulcolax 5 mg BID, and indicated he received the medication throughout his stay. Additionally, Patient #12's MAR included PRN medications of Senna 1 tablet BID, (none were given), Milk of Magnesia 30 ml, BID, (for which he received 1 dose on 12/29/14), and Fleets enema, ordered	A 395		

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A 395	Continued From page 183 for constipation/no BM for 3-4 days, (which was not administered). Patient #12's record did not indicate his physician was notified of his constipation. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #12's record and confirmed Speech Therapy was ordered, and was not able to find evidence an evaluation took place. She stated the ward clerk would call when an evaluation was ordered, but stated there was no method to follow up to ensure the speech therapist was notified. The RN stated she was not aware that Patient #12 was documented as having no bowel movement for 5 days. She stated the nursing staff depended on the P.T.s to alert them when a patient had not had a BM. Patient #12's record included orders for a Speech Therapy evaluation, which was not performed. His record indicated on 12/29/14, on 3 separate occasions, he was having difficulty with swallowing fluids, his medications, and his food, and he was not treated for constipation. Patients #10, #11, and #12's records documented significant decline in their health status which was not identified, assessed or reported to the MD, which contributed to their deaths. During an interview on 4/01/15 at 2:00 PM, the MD stated the nurses in the facility are "psych" nurses, and he did not expect them to do "heavy medical nursing." He stated "If patients are sick we send them out." He stated if the hospital was expected to provide medical care, "They need to train the nurses."	A 395		

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A 395	Continued From page 184 Due to the inability of the nursing staff to identify, address, and report significant health concerns, the facility would not be able to ensure the health and safety of the patients receiving services at the facility. This placed all patients in immediate jeopardy and at risk of suffering serious harm, impairment and death. The co-owner of the facility was notified of the immediate jeopardy verbally on 4/03/15, and in writing on 4/07/15. 2. A policy "Skin Assessment & Care," revised 9/09/12, stated "Skin assessments will be done upon admission, by an RN, to facility within the first (24) hours. After completion of the initial skin assessment the patient shall be monitored for skin issues weekly and as the need arises." Additionally, surgical wounds were to be monitored for signs or symptoms of infection. The policy was not implemented, as follows: a. Patient #5 was admitted to the hospital on 3/09/15 to 3/25/15. His H&P documented he had numerous abdominal surgeries over the previous 5 months, including post-operative complications. The H&P documented Patient #5 had a midline surgical incision which was being held with large retention sutures with rubber tubing around them that bridged over the incision. The physician documented in the H&P the sutures were to be removed in 2 days. Patient #5's record included a weekly skin integrity review sheet. The review sheet included 2 entries dated 3/09/15 and 3/23/15.	A 395		

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	134011		C **04/03/2015**

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A 395	Continued From page 185 On 3/09/15, the LPN documented Patient #5 had scabs with multiple open areas, redness at the incision site, and drainage. There were no measurements documented and no description of the drainage. On 3/23/15, the LPN documented Patient #5 had open area at the incision site with redness in color. There were no measurements documented. Patient #5's record did not include documentation that his skin was assessed by nursing during week 2 of his admission. A nursing note signed by the RN, dated 3/12/15 at 7:15 AM, documented she had spoken to Patient #5 about removing his sutures. Patient #5 stated to the RN he would only allow his surgeon to remove them. There was no documentation the physician was notified. Additionally, there was no documentation in Patient #5's record whether the sutures were removed while he was at the facility. During an interview on 4/01/15 at 5:20 PM, the RN reviewed the record and confirmed wound assessments were required to be documented weekly. She confirmed Patient #5's wounds were not documented per policy and there were no measurements for Patient #5's post-operative wounds. Patient #5's wounds were not assessed and addressed by nursing staff in accordance with facility policy.	A 395		

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A 395	Continued From page 186 b. Patient #8 was admitted to the facility on 3/06/15. His medical record from 3/06/15 to 3/24/15, as well as records from ED visits on 3/23/15 and 3/24/15, at an acute care facility, were reviewed. Patient #8's record included an admission skin assessment on 3/07/15. His record also included a form titled "Weekly Skin Integrity Review Sheet." The sheet did not include any further skin assessments after 3/07/15. Patient #8 was due to have a skin assessment each week, due 3/14/15 and 3/21/15. The weekly sheet in Patient #8's record included an entry dated 3/19/15, with the word "refused." The record did not indicate any further attempts were made to assess his skin. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #8's record and confirmed skin assessments were not performed weekly as per facility policy. The RN stated if a patient refuses a skin check, the staff is supposed to then re-attempt, and a good opportunity is when the patient is showering. c. Patient #11's record included a skin assessment completed on 11/25/14, and signed by the RN. The assessment documented 2 blisters on her lower legs, measuring 6 cm by 2 cm, and 7 cm by 1 cm. The assessment documented dressings were applied to the blisters on Patient #11's lower legs. A nurses note, dated 11/28/14 at 4:45 pm, stated a blister on Patient #11's left lower leg ruptured and a dressing was applied. A nurses note,	A 395		

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A 395	Continued From page 187 dated 11/28/14 at 9:40 PM, stated blisters on Patient #11's right lower leg "popped" and were cleaned and wrapped in gauze. However, Patient #11's record did not include orders or protocols related to wound care, to include frequency, or products to be used to cleanse and cover the blisters. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed there were no orders or care plan related to wound care to her lower leg blisters. The facility failed to ensure skin assessments were completed and identified needs were appropriately addressed. 3. The hospital's policy "Nursing Process - Vital Signs" effective 8/23/11, stated "A daily assessment of vital signs and weight is completed on every patient, unless there is a reason to complete the vitals signs and/or weights more frequently." Additionally it stated "The RN assesses the patients' vital signs and refers significant problems to the MD or mid level provider for follow-up, evaluation, and treatment if needed." An additional hospital policy "Nursing Process - Weights protocol," effective 8/23/11, stated "All patients are weighed daily and the weights are documented in the patients chart." The policies were not implemented, as follows: a. A vital sign record form documented Patient #5 had a temperature of 100.9 at 2:00 PM on 3/12/15. There was no documentation the physician was notified. Additionally, there was	A 395		

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A 395	Continued From page 188 no documentation by the RN this was reassessed or addressed. At 8:30 PM on 3/12/15, the RN documented Patient #5 had a temperature measurement of 106 and felt hot with pain. The RN documented medication was given for his high temperature and pain. There was no documentation the physician was notified. During an interview on 4/01/15 at 5:20 PM, the RN reviewed the record and confirmed the physician should have been called for the elevated temperatures. Patient #5's abnormal vital signs were not assessed and addressed by nursing staff in accordance with facility policy. b. Patient #16 was a patient in the hospital from 3/15/15 to 3/26/15, with diagnoses of psychotic disorder, dementia with behavioral disturbance and chronic depression. Patient #16's record was reviewed on 4/03/15. His record did not include documentation of his weight. During an interview on 4/03/15 at 11:00 AM, the NP reviewed his record and confirmed his weight was not documented for the 4 days he was in the hospital. The NP stated patients were to be weighed daily. 5. Patients were not provided with appropriate diabetic care, as follows: a. Patient #1 was admitted to the facility on 3/26/15 to 3/31/15, from a local ED. His diagnoses included DM. Patient #1 was not	A 395		

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A 395	Continued From page 189 taking his medications prior to his hospitalization. The NP documented he had stopped taking them because Patient #1 was hoping he would die. His H&P, dated 3/26/15, and signed by the MD, documented Patient #1's blood glucose level was 296 mg/dl upon admission. The American Diabetes Association website accessed 4/7/15, stated a normal (non-diabetic) blood glucose means levels between 70 and 130 mg/dl before meals, and less than 180 two hours after starting a meal. Patient #1's record included physician verbal orders, dated 3/16/15 at 9:15 AM, to check his blood glucose level before each meal and at bedtime. The verbal order included a standard sliding scale for Humalog insulin (a quick acting insulin). The American Diabetes Association website, accessed 4/07/15, defined a sliding scale as a set of instructions for adjusting insulin on the basis of blood glucose test results, meals, or activity levels. The standard sliding scale ordered for Patient #1 included instructions to phone the physician if the blood glucose levels were lower than 70 mg/dl or greater than 450 mg/dl. A blood glucose log was included in Patient #1's record. The log documented blood glucose levels during Patient #1's admission. Patient #1's blood glucose levels were recorded as follows: - 3/27/15 at 9:00 PM: 540 mg/dl - 3/29/15 at 6:00 PM: 478 mg/dl -3/30/15 at 12:00 PM: 582 mg/dl	A 395		

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A 395	Continued From page 190 - 3/30/15 at 6:45 PM: 515 mg/dl There was no documentation in the nursing notes the physician was notified of the documented blood glucose levels greater than 450 mg/dl, as ordered. During an interview on 4/01/15 at 5:40 PM, the RN reviewed the record and confirmed the blood glucose level log. She confirmed the physician was not notified for each blood glucose reading greater than 450 mg/dl. The RN stated she did not discuss Patient #1's continued elevated blood glucose levels with the physician. Further, Patient #1's record included a nutritional assessment dated 3/31/15, and signed by the dietary manager. The Dietary Manager documented Patient #1 needed a carbohydrate controlled diet. However, his hospital admission orders did not include a diet order and there were no other orders documented in the record for a special diet. A nursing noted, dated 3/29/15 at 4:06 PM documented Patient #1 was offended when staff asked about his diet and eating habits. There was no further documentation regarding education related to DM or nutrition. During an interview on 4/03/15 at 1:40 PM, the NP reviewed the record and confirmed no special diet was ordered for Patient #1. She stated she did not read the recommendations from the RD or dietary manager in patient records. The NP stated if there were concerns, the RD or dietary manager would talk with her personally. The NP	A 395		

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A 395	Continued From page 191 confirmed the conversations are not documented in patients' records. The NP stated she did not address or assess medical problems with patients. She stated this was the responsibility of the MD. During an interview on 4/01/15 at 5:40 PM, the RN reviewed the record and stated "I never even see the dietary assessment." She stated she discussed Patient #1's diet with him, but this was not documented in the record. b. Patient #11's Inpatient Psychiatric Evaluation documented a diagnosis of diabetes. Her admission orders, signed by the NP on 11/26/14, included a Hgb A1C laboratory test. Patient #11's record documented her blood was drawn for a Hgb A1C and sent to the lab on 11/26/14, however, her record did not include results of her Hgb A1C. Additionally, her record did not include evidence of random blood sugar readings. Therefore, her diabetes was not monitored during her hospitalization. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it documented her blood was drawn and sent to the laboratory. She stated the results of the tests were available on-line through the laboratory's website, however, the results were not accessed, reviewed, or placed in Patient #11's record. She stated the unit clerk was responsible for obtaining the on-line results, however, the RN was responsible to ensure the results were obtained and reviewed. Additionally, RN C confirmed Patient #11's record did not include a nursing care plan related to her DM, therefore nursing	A 395		

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A 395	Continued From page 192 interventions were not developed to monitor her blood sugar levels. c. Patient #10's Inpatient Psychiatric Evaluation and H&P documented a diagnosis of diabetes. His admission orders, signed by the NP on 11/07/14, included a Hgb A1C laboratory test. Patient #10's record included an order for a Hgb A1C laboratory test, signed by the MD on 11/07/14. A telephone order from the MD, signed by the RN on 11/08/14, canceled the Hgb A1C, stating it was completed on 11/05/14, 2 days prior to admission. However, Patient #10's record did not include results of a Hgb A1C. Additionally, his record did not include evidence of random blood sugar readings. Therefore, his diabetes was not monitored during his hospitalization. During an interview on 4/01/15 at 4:30 PM, RN C reviewed Patient #10's record and confirmed it did not include results of a Hgb A1C. RN C confirmed a nursing care plan related to his DM was not created, therefore nursing interventions were not developed to monitor his blood sugar levels. During an interview on 4/03/15 at 1:15 PM, the NP reviewed Patient #10's record and confirmed the result of his Hgb A1C was not part of his record. Additionally, she confirmed his medical needs were not addressed during his hospitalization. d. Patient #17 was admitted to the facility on 3/27/15. Her diagnoses included Type II DM. A H&P, dated 3/28/15, documented as part of her admission evaluation, an A1C would be obtained.	A 395		

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A 395	Continued From page 193 However, an A1C was not ordered. Patient #17's record also documented she had DM and received an oral hypoglycemic medication twice daily, but a diabetic diet was not ordered on her admission orders. During an interview on 3/30/15 at 9:45 AM, RN C stated Patient #17 was on a regular diet. She reviewed Patient #17's record and confirmed the diet section of her admission orders remained blank. The RN stated an A1C was not ordered, therefore it had not been drawn. 6. Lab work and tests were not ordered and completed to meet the patients' medical needs, as follows: a. Patient #1's record included a Hospital Admission Order form dated 3/26/15, signed by the NP. Under the section Laboratory Tests the following tests were ordered: CMP, CBC, Free T4, TSH, RPR, UA, B12, and Folate. The H&P, dated 3/26/15, and signed by the medical physician documented Patient #1 would need a Hemoglobin A1C, ANA (antinuclear antibodies) panel, Rheumatoid Arthritis, and sedimentation rate. There were no orders documented for these laboratory tests. There was no documentation in Patient #1's record of the laboratory test results. A request was made on 3/30/15 at 3:20 for laboratory results. At 3:35 PM on 3/30/15, the laboratory test results were printed and given to the surveyor.	A 395		

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A 395	Continued From page 194 The laboratory results form included the results of the CMP, Hgb A1C, Rheumatoid Arthritis, ANA panel, and sedimentation rate. Patient #1's record did not include the results of the ordered CBC, Free T4, TSH, RPR, UA, B12, or Folate. During an interview on 3/30/15 at 4:05 PM, the NP reviewed Patient #1's record and confirmed the laboratory tests which she ordered on admission. She stated if the patient was transferred from a hospital or ED the results would be included with the transfer paperwork. The NP confirmed when laboratory results were ordered on the hospital admission sheet she expected the tests were done. She confirmed 7 of the ordered laboratory tests were not completed. During an interview on 4/01/15 at 1:55 PM, the MD confirmed that altough his H&P included recommendation that the tests be done, he did not write the orders for the laboratory tests. Patient #1's laboratory tests were not completed as ordered. b. Patient #5's hospital admission orders dated 3/09/15, included orders for the following tests: CMP, CBC, Free T4, TSH, RPR, UA, B12, Folate, and PT/INR. Patient #5's record had laboratory results dated 3/14/15, for UA and PT/INR. There were no other laboratory results in the record. The dietary manager documented a request for Patient #5's weight and 2 laboratory tests, a CMP and BMP. The record did not include orders for the laboratory tests requested.	A 395		

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A 395	Continued From page 195 During an interview on 4/01/15 at 5:20 PM, the RN reviewed the record. She confirmed the laboratory tests were not done as ordered. The RN stated she was unaware of the request for the laboratory tests. During an interview on 4/03/15 at 1:35 PM, the NP reviewed the record and confirmed the laboratory tests were not done as ordered. Additionally, Patient #5's record documented he was receiving Coumadin, a blood thinner, for a pulmonary embolism (a blood clot in the lung). According to the Drugs.com website, a national medication reference accessed 4/10/15, Coumadin may increase bleeding which could be dangerous or life threatening. The website further stated bleeding times must be monitored with frequent blood tests. Physician orders included in Patient #5's record documented he had 3 blood tests ordered to check his bleeding times on 3/14/15, 3/17/15, and 3/24/15. These were ordered by the facility pharmacist. Patient #5's Coumadin dosage was increased on 3/14/15 and 3/17/15. Patient #5's record did not include a nursing care plan which addressed his anticoagulation therapy or possibly increased bleeding times. During an interview on 4/01/15 at 5:20 PM, the RN confirmed the bleeding times were tested as ordered by the pharmacist. She confirmed there was no nursing care plan related to changes in his anticoagulation therapy, laboratory testing, or history of blood clots in the lung.	A 395		

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A 395	Continued From page 196 c. Patient #8's record included an order, written on 3/12/15 at 12:59 PM, for an EKG. His record did not include the results of the EKG, and the MAR included an empty space beside the word "EKG" on 3/12/15. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #8's record and confirmed Patient #8's EKG was not performed. 7. Patients were not adequately assessed after incidents and unusual occurrences, as follows: a. Patient #7 was admitted to the facility on 3/23/15 to 4/01/15. He was sent to a local hospital on 3/24/15 for an x-ray, the day after his admission, after punching a wall with his right hand the previous day. The nurses note for the previous day, 3/23/15, did not include documentation of Patient #7 hitting a wall. On 3/25/15 at 3:45 PM the nurses note documented Patient #7 refused to wear the splint prescribed for his right hand. On 3/31/15 at 7:00 PM the nurse documented Patient #7 complained of a vibrating sensation in his arm, she did not specify which arm. There was no further musculoskeletal assessment documented. However, Patient #7's discharge orders dated 4/01/15 at 11:40 AM documented he was to make an appointment with the orthopedic physician for follow up related to a boxer's fracture in his right hand. b. Patient #8 was admitted to the facility on 3/06/15. His medical record from 3/06/15 to 3/24/15 documented he was physically restrained on 9 occasions, and placed in seclusion 3 times	A 395		

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A 395	Continued From page 197 during his admission at the facility. Comprehensive evaluations were not documented after the events to assess for injury. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #8's record and confirmed assessments were not documented after the restraint and seclusion events. 8. Patients were not provided with appropriate bowel care, as follows: a. Patient #8's record included a form titled "ADL Sheets." The form included documentation of such activities for each patient including oral hygiene, toileting, bowel and bladder elimination, skin care, and meal intake. Patient #8's form documented he did not have a bowel movement from 3/06/15 to 3/14/15, a period of 8 days. Additionally, he did not have a bowel movement from 3/15/15 to 3/18/15, a period of 4 days. Patient #8's MAR included PRN orders for Milk of Magnesia 30 ml, BID, and Fleets enema, ordered for constipation/no BM for 3-4 days, The PRN medications were not administered. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #8's record confirmed the duration of 8 days and 4 days that he did not have documentation of a bowel movement. She stated the nursing staff depended on the P.T. staff to alert them when a patient has not had a BM. b. Patient #11's record Inpatient Psychiatric	A 395		

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SAFE HAVEN HOSPITAL OF POCATELLO	1200 HOSPITAL WAY POCATELLO, ID 83201

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A 395	Continued From page 198 Evaluation documented a history of constipation. Her record included a nursing admission assessment, completed on 11/25/14, and signed by the RN. The assessment documented her last bowel movement as "couple days ago." Patient #11's record included a flow sheet on which staff documented information, including bowel movements. The flow sheet indicated Patient #11 did not have a bowel movement during her 5 day hospitalization. Patient #11's admission orders, signed by the NP on 11/26/14, included Milk of Magnesia 30 ccs po every 12 hours as needed for constipation, and Fleets enema as needed for constipation after 3-4 days with no bowel movement. However, Patient #11 did not receive MOM or Fleets enema during her hospitalization. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed there was no documentation of a bowel movement during her hospitalization. The RN stated Patient #11's record did not include a nursing care plan related to constipation, therefore, no interventions were developed to monitor or report her lack of bowel movements to the MD. 9. Patients were not provided with appropriate care related to Hepatitis, as follows: a. Patient #15's Inpatient Psychiatric Evaluation completed by the NP on 3/15/15, and History and Physical completed by the MD on 3/15/15, documented diagnoses of Hepatitis B and C. Patient #15's record did not include a nursing	A 395		

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A 395	Continued From page 199 care plan to address his needs related to Hepatitis. Additionally, there was no documentation of a plan to prevent the transmission of Hepatitis to other patients and/or clinical staff. During an interview on 4/01/15 at 4:45 PM, RN C reviewed Patient #15's record and confirmed it did not include a nursing care plan. Additionally, she confirmed Patient #15 was not placed on precautions to prevent the possible transmission of Hepatitis B and C through his body fluids. b. Patient #1 was admitted to the facility on 3/26/15 to 3/31/15. His Admission H&P, completed on 3/26/15, and signed by the MD, documented diagnoses which included Hepatitis C. Patient #1's record did not include a nursing care plan to address his needs related to Hepatitis. Additionally, there was no documentation of a plan to prevent the transmission of Hepatitis to other patients and/or clinical staff. During an interview on 4/01/15 at 5:40 PM, the RN reviewed the record and confirmed she did not discuss or address his diagnosis of Hepatitis C. The facility failed to ensure patients' medical care needs were addressed.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN 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	A 396		

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A 396	Continued From page 200 This STANDARD is not met as evidenced by: Based on observation, medical record review, and staff interview it was determined the facility failed to ensure thorough nursing care plans were developed, evaluated, and revised for 17 of 17 patients (#1 - #17) whose records were reviewed. Lack of a complete care plan had the potential to result in unaddressed patient care needs and interfere with coordination of patient care among staff members. Findings include: During an interview on 4/03/15 at 10:15 AM, the NP stated a nursing care plan should be part of an interdisciplinary treatment plan, however, the development of a nursing care plan was the responsibility of the CNO, and as they did not currently have a CNO, it was not being done. During an interview on 4/01/15 at 4:00 PM, RN C stated the CNO was in charge of creating nursing care plans. She said, "We don't have a DON [CNO] so it's not happening." The records of 17 patients (#1 - #17) with admission date range of 9/24/14 to 3/31/15, were reviewed. The 17 patient records did not include nursing care plans to address patient needs. Goals were not identified, and interventions were not initiated to minimize the risk of complications related to psychiatric or medical diagnoses. Examples included, but were not limited to, the following: 1. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14, from a SNF. Her psychiatric diagnoses were psychosis, bipolar disorder and congenital brain injury with mental	A 396		

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A 396	Continued From page 201 disability. Patient #11's record included an Inpatient Psychiatric Evaluation, completed by the NP, and dated 11/26/15. It documented her medical problems as morbid obesity, diabetes, chronic renal insufficiency, chronic pain, CHF, hypoxia (inadequate oxygen supply to the body), epilepsy, hypothyroidism, constipation, edema, hyperlipidemia, and GERD. Patient #11's record included an Admission History and Physical, completed on 11/26/14 and signed by the MD. Continuing illnesses included chronic renal insufficiency, DM type 2, and CHF. Patient #11's record did not include a nursing care plan to address her needs related to her medical problems. Therefore, goals were not identified, and interventions were not initiated to minimize the risk of complications related to her co-morbidities. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it did not include a nursing care plan to address her co-morbidities of renal insufficiency, CHF, diabetes and constipation. RN C stated interventions were not developed at the time of Patient #11's admission, or updated during her hospitalization, to address her escalating symptoms. The facility did not ensure a nursing care plan was developed to address Patient #11's medical problems. 2. Patient #10 was a 67 year old male admitted to	A 396		

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A 396	Continued From page 202 the hospital on 11/07/14, from an ALF. His psychiatric diagnoses were conduct disorder and depression. Patient #10's record included an Inpatient Psychiatric Evaluation, completed by the NP on 11/07/14. The evaluation documented Patient #10 had a bowel obsession and refused to use the bathroom. It documented Patient #10's medical problems as hyperlipidemia, constipation, DM type 2, CVA (stroke), and chronic pain. Patient #10's record included an Admission History and Physical, completed on 11/07/14 and signed by the MD. Continuing illnesses included diabetes mellitus type 2, and possible anorexia (loss of appetite), stating "He is on Megace without a diagnosis otherwise." Nursing 2015 Drug Handbook listed indications for Megace, including anorexia, or unexplained significant weight loss. Patient #10's record did not include a nursing care plan to address his needs related to constipation, anorexia or diabetes. During an interview on 4/01/15 at 4:30 PM, RN C reviewed Patient #10's record and confirmed it did not include a nursing care plan. RN C confirmed a nursing care plan related to his DM was not created, therefore nursing interventions were not developed to monitor his blood sugar levels. During an interview on 4/03/15 at 1:15 PM, the NP reviewed Patient #10's record and stated she was not aware of his poor nutritional intake and	A 396		

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A 396	Continued From page 203 lack of bowel movements. She confirmed his medical needs were not addressed during his hospitalization. The facility did not ensure a nursing care plan was developed to address Patient #10's medical problems. 3. Patient #15 was a 60 year old man who was a patient in the facility from 3/15/15 to 3/26/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. Patient #15's Inpatient Psychiatric Evaluation completed by the NP on 3/15/15, and History and Physical completed by the MD on 3/15/15, documented diagnoses of Hepatitis B and C. The Centers for Disease Control and Prevention website, accessed 4/09/15, stated Hepatitis B and C can be transmitted through exposure to the body fluids of an infected individual. Patient #15's record did not include a nursing care plan to address his needs related to hepatitis. Additionally, there was no documentation of a plan to prevent the transmission of Hepatitis to other patients and/or clinical staff. During an interview on 4/01/15 at 4:45 PM, RN C reviewed Patient #15's record and confirmed it did not include a nursing care plan. Additionally, she confirmed Patient #15 was not placed on precautions to prevent the possible transmission of Hepatitis B and C through his body fluids. The facility did not ensure a nursing care plan was developed to address Patient #15's medical	A 396		

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A 396	Continued From page 204 needs and to prevent the spread of communicable disease. 4. Patient #1 was a 40 year old male admitted to the facility on 3/26/15 to 3/31/15, from a local ED. His psychiatric diagnoses included schizoaffective disorder, substance dependence, and PTSD. Patient #1's record included an Admission H&P, completed on 3/26/15 and signed by the MD. The H&P documented diagnoses which included insulin dependent DM, diabetic neuropathy of extremities, chronic back pain, and Hepatitis C. The record did not include a nursing care plan to address Patient #1's needs related to his medical problems. No goals were identified and interventions were not initiated to minimize the risk of complications related to his DM or to prevent the spread of his Hepatitis C while admitted to the facility. During an interview on 4/03/15 at 1:40 PM, the NP reviewed the record and stated she did not address or assess medical problems with patients. She stated this was the responsibility of the MD. During an interview on 4/01/15 at 5:40 PM, the RN reviewed the record and confirmed there was not a nursing care plan. 5. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia and depression.	A 396		

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A 396	Continued From page 205 Patient #5's record included an Inpatient Psychiatric Evaluation, completed on 3/10/15 and signed by the NP. It documented his medical problems were GERD, chronic pain, and a subtotal colectomy (removal of part of the colon). Patient #5's record included an Admission H&P, completed on 3/09/15 and signed by the MD. His continuing illnesses included post-operative pulmonary embolism, anticoagulation therapy, GERD, history of MRSA (Methicillin resistant Staphylococcus aureus), and COPD. The MD documented Patient #5 had retention sutures on his abdomen upon admission, and they would need to be removed. The record did not include a nursing care plan to address Patient #5's needs related to his medical problems. No goals were identified and interventions were not initiated to minimize the risk of complications related to his surgical incision or sutures, anticoagulation therapy, or to test or monitor for MRSA while admitted to the facility. During an interview on 4/01/15 at 5:20 PM, the RN reviewed the record and confirmed there was no nursing care plan to address Patient #5's medical issues. She confirmed Patient #5 should have been monitored for signs and symptoms of infection. The RN stated Patient #5 refused to have her or the MD remove his sutures in his abdomen. She confirmed there was no documentation this was discussed with the physician. The RN also stated she was unaware of Patient #5's history for MRSA. She stated his wounds were cultured for MRSA and came back negative. Further, the RN stated Patient #5's	A 396		

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A 396	Continued From page 206 bleeding times were tested as ordered by the pharmacist. She confirmed there was no nursing care plan related to changes in his anticoagulation therapy, laboratory testing, or history of blood clots in the lung. Nursing failed to ensure a nursing care plan was developed to address Patient #5's medical problems. 6. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an ALF. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included an Inpatient Psychiatric Evaluation, completed on 3/03/15 and signed by the NP. It documented his medical problems were seizures, hypothyroidism, organic brain syndrome, constipation, and history of tremors. Patient #4's record included an Admission H&P, completed on 3/02/15 and signed by the MD. His continuing illnesses included seizures, hypothyroidism, organic brain syndrome, tremors, history of urinary retention, and constipation. The record did not include a nursing care plan to address Patient #4's needs related to his medical problems. No goals were identified and interventions were not initiated to minimize the risk of complications related to his seizures or to address his constipation while admitted to the facility.	A 396		

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A 396	Continued From page 207 Patient #4's Inpatient Psychiatric Evaluation and Admission H&P included a diagnosis of seizures. The record did not include a care plan for monitoring for signs of seizure activity versus tremors. Additionally, there was not a nursing care plan for seizure precautions to maintain a safe environment. During an interview on 4/01/15 at 5:10 PM, the RN reviewed the record and confirmed there was no nursing care plan. She stated it was the CNO's responsibility to write those but since the previous CNO left in January of 2015, no care plans had been written. Nursing failed to ensure a care plan was developed and included in the record for Patient #4 for his medical problems. 7. Patient #7 was a 39 year old male admitted to the facility on 3/23/15 to 4/01/15, from an ALF. His psychiatric diagnoses included schizoaffective disorder, bipolar disorder, and substance abuse. Patient #7 was sent to a local hospital on 3/24/15 for an x-ray, the day after his admission, after punching a wall with his right hand the previous day. The nurse's note for the previous day, 3/23/15, did not include documentation of Patient #7 hitting a wall. Patient #7 was evaluated by the physician on 3/24/15 for his admission H&P. Under the section Review of Systems the physician documented Patient #7 had right hand pain. Patient #7 stated to the physician he hit a door. The physician documented Patient #7 had	A 396		

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A 396	Continued From page 208 swelling over the mid portion of his right hand and the area was tender when touched. On 3/25/15, the nursing note documented Patient #7 refused to wear the splint prescribed for his right hand. The nursing note did not have documentation the physician was notified. A nurses note dated 3/31/15, documented Patient #7 complained of a vibrating sensation in his arm. However, the note did not specify which arm. There was no further musculoskeletal assessment documented. The nursing note had no documentation the physician was notified. Patient #7's discharge orders documented he was to make an appointment with the orthopedic physician for follow up related to a boxer's fracture in his right hand. The facility did not have an occurrence report for Patient #7's hand fracture related to hitting a wall after admission. During an interview on 4/01/15 at 5:05 PM, the RN reviewed the record and confirmed Patient #7 had a fracture to his right hand. Additionally, she confirmed a nursing care plan related to his fractured hand was not developed, and interventions were not implemented to monitor his injury. Nursing failed to develop and document a care plan for Patient #7. 8. Patient #17 was a 21 year old female admitted to the facility on 3/27/15 for psychiatric treatment related to schizoaffective disorder, and borderline personality disorder. Additional diagnoses included Type II DM, PTSD, and mild mental	A 396		

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A 396	Continued From page 209 retardation. Patient #17's record did not include a nursing care plan to address her needs related to her medical problems. During an interview on 3/30/15 at 9:45 AM, RN C confirmed Patient #17's record did not include a Nursing POC or a Psychiatric Treatment POC. Patient #17's record did not include a Nursing plan of care. 9. Patient #12 was an 87 year old male admitted to the facility on 12/26/14 for psychiatric treatment related to dementia and psychosis. Additional diagnoses included chronic constipation and UTI. Patient #12's record did not include a nursing care plan to address his needs related to his medical problems. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #12's record and confirmed a nursing plan of care was not developed. Patient #12's record did not include a Nursing plan of care. 10. Patient #8 was a 65 year old male admitted to the facility on 3/06/15, for care related to dementia, psychosis, HTN, and PTSD. His medical record from 3/06/15 to 3/24/15, as well as, records from ED visits on 3/23/15, and 3/24/15, at an acute care facility, were reviewed. Patient #8's record did not include a Nursing plan	A 396		

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A 396	Continued From page 210 of care. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #8's record and confirmed a nursing plan of care was not developed. Patient #8's record did not include a Nursing plan of care. 11. Patient #2 was a 65 year old female who was a patient in the facility from 3/25/15 to 4/01/15, with diagnoses of psychotic disorder, dementia, chronic neuropathy, and asthma which required the use of oxygen. Patient #2's record did not include a nursing care plan. Her record did not include direction to staff to care for her psychosis, her memory, her neuropathic pain, or her asthma. An interview was conducted with the NP on 4/03/15 beginning at 3:50 PM. She confirmed Patient #15 did not have a documented nursing POC. The facility did not ensure a nursing care plan was developed to address Patient #2's psychiatric and medical needs. 12. Patient #3 was a 79 year old female who was a patient in the facility from 3/25/15 to 4/01/15, with diagnoses of psychosis, dementia, and chronic pain syndrome. Patient #3's record did not include a nursing care plan. Her record did not include direction to staff to care for her psychosis, her memory, or her chronic pain.	A 396		

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A 396	Continued From page 211 An interview was conducted with the NP on 4/03/15 beginning at 3:50 PM. She confirmed Patient #3 did not have a documented nursing POC. The facility did not ensure a nursing care plan was developed to address Patient #3's psychiatric and medical needs. 13. Patient #9 was a 55 year old male who was a patient in the facility from 3/25/15 to 4/02/15, with diagnoses of schizoaffective disorder, borderline personality disorder, asthma, chronic Hepatitis C, chronic pain, seizure disorder, and narcolepsy. Patient #9's record did not include a nursing care plan. His record did not include direction to staff to care for his schizoaffective disorder, borderline personality disorder, asthma, Hepatitis C, chronic pain, seizure disorder, or his narcolepsy. An interview was conducted with the NP on 4/03/15 beginning at 3:50 PM. She confirmed Patient #9 did not have a documented nursing POC. The facility did not ensure a nursing care plan was developed to address Patient #9's psychiatric and medical needs.	A 396		
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (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	A 405		

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A 405	Continued From page 212 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 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 staff interview, record review, policy review, and observation, it was determined the facility failed to ensure medications were properly dispensed and ordered for 9 of 17 patients (#1, #4, #5, #7, #8, #13, #15, #18, and #19) whose records were reviewed and/or medication administrations were observed. This failed practice resulted in the potential for errors in dosage, medication delivery, and possible adverse reactions. Findings include: 1. A hospital policy titled "Administration of Medications," revised 1/31/04, stated "Accurate patient identification will be made by photo identification. A photo of each patient will be placed in the MAR and one placed in the patient record." However, the patient records and MARs did not include patient photos.	A 405		

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A 405	Continued From page 213 Two nurses were observed on two separate days preparing and administering medications. The medication room was located in a small room behind the nurses' station. The MAR for each patient was in a binder. The MAR did not include a picture of the patient. When the medications were ready to be administered, the nurse left the medication room to give the medications to the patients. a. During an observation of medication administration on 3/30/15 beginning at 1:55 PM, LPN B was observed preparing and administering medications. LPN B was observed to take medications to two separate patients. i. LPN B approached Patient #18 and called out her first name. She gave her the medications without verification of her identity. Patient #18 asked LPN B what she was getting, and the LPN told her what the medication was. ii. LPN B then administered Patient #19's medication. She went to Patient #19 and stated "It's time for your medication." She did not verify Patient #19's identity. After administering the medication, she returned to the medication room to sign the MAR. b. During an observation of medication administration on 3/31/15 beginning at 1:45 PM, RN D was observed preparing and administering medications. RN D was observed to give medications to Patient #7 and Patient #18. She approached the patients and stated their names. She stated "I have your normal medications." Both Patient #7 and Patient #18, asked what	A 405		

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A 405	Continued From page 214 medications they were taking. RN D provided more information by naming the medication and why it was prescribed. Patients did not have wristbands with their identification on them, and there were no photographs in the MAR to identify patients by photo. During an interview on 3/30/15 beginning at 2:20 PM, LPN B stated wristbands with patient names and information were not used in the facility. During an interview on 3/31/15 at 1:55 PM, RN D stated patients did not wear wristbands with patient names or information on them. She stated she verified their identity by sight. During an interview on 4/01/15 beginning at 3:30 PM, RN C reviewed and confirmed the medication administration policy. She stated the facility at one time had a camera to take patient photos, but it broke and was not replaced. The facility failed to ensure the proper identity of patients prior to administering medication. 2. The patients' MAR included a section for the clinician to sign with their initials, to indicate the medication was administered. Each dose of medication administered would therefore have initials in the section under the corresponding date and time. However, nursing staff failed to document medications were administered, patient refusal of medications, as well as the reasons for refusal of medications. a. Patient #8 was a 65 year old male admitted to the facility on 3/06/15 for care related to dementia, psychosis, HTN, and PTSD. His	A 405		

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A 405	Continued From page 215 medical record from 3/06/15 to 3/24/15, as well as, records from ED visits on 3/23/15 and 3/24/15 at an acute care facility were reviewed. Patient #8's 3/16/15 MAR included 6 pages of medications that were scheduled to be routinely administered. The following medications were not documented as given: - Folic Acid 1 mg at 8:00 AM, - B Vitamin Complex 1 tablet at 8:00 AM, -Vitamin C 500 mg at 8:00 AM, - Metoprolol 12.5 mg at 8:00 AM, - Prazosin HCL 1 mg at 8:00 AM, - Aspirin 81 mg at 8:00 AM, - Lipitor 40 mg at 8:00 AM, - Levothyroxine 50 mcg at 8:00 AM, - Memantine 5 mg at 8:00 AM, - Prednisone 1 mg at 8:00 AM, - Venlafaxine 75 mg at 8:00 AM, - Cholecalciferol 5,000 units at 8:00 AM, - Multivitamin 1 tablet at 8:00 AM, During an interview on 4/01/15 beginning at 3:30 PM, RN C reviewed Patient #8's MAR. She confirmed the initials of the clinician were missing for the medications to be administered on 3/16/15 at 8:00 AM. RN C was not able to determine if the medications were not administered, or if the clinician did not sign for them. Patient #8's MAR did not reflect if medications were administered, refused, or not documented as given. b. Patient #15 was a 60 year old man admitted to the facility on 3/15/15, with diagnoses of	A 405		

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A 405	Continued From page 216 Schizoaffective Disorder and Borderline Personality Disorder. i. The back of Patient #15's MAR included a section titled "PRN and Medications Not Administered," to document the date, time, medication and reason for a PRN given or a medication not given. Patient #15's MAR included the following medications to be administered daily at 8:00 AM : -Vitamin D 1000 Units -Folic Acid 1 mg -B Vitamin Complex 1 tab -Vitamin C 500 mg On 3/15/15, 3/18/15, 3/19/15, 3/21/15, 3/23/15, 3/24/15, 3/25/15, and 3/26/15, the MAR included circled initials for the 4 medications, indicating the medications were not administered. However, there was no documentation on the back of the MAR stating the reason the medications were not administered. Patient #15's MAR included Zyprexa 10 mg po/IM twice a day, beginning 3/20/15. On 3/23/15, 3/24/15, and 3/26/15, the MAR included circled initials for the morning and evening doses. On 3/21/15, the MAR included circled initials for the morning dose. On 3/22/15, the MAR included circled initials for the evening dose. However, there was no documentation on the back of the MAR stating the reason the medication was not administered. ii. Nursing staff failed to document the time and/or reason PRN medications were administered to Patient #15.	A 405		

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A 405	Continued From page 217 - An entry on the MAR documented Zyprexa 10 mg IM was administered on 3/15/15, however, the time of administration was not documented. - Patient #15's MAR included Geodon 40 mg po (by mouth) PRN, and stated "can override with 20 mg IM if PO dose refused." An entry on the MAR documented Geodon 20 mg IM was given on 3/20/15. The time of administration was not documented. Additionally, there was no documentation of refusal of the po medication, or of the reason for the PRN medication. During an interview on 4/01/15 at 4:45 PM, RN C reviewed Patient #15's record and confirmed the reasons PRN medications were given and the reasons scheduled medications were not given was not documented on his MAR. Patient #15's MAR did not include documentation of the reason PRN medications were given, or the reason scheduled medications were not given. 3. Patient medication reconciliation was incomplete and nursing administered medications to patients without a provider order. a. Patient #15 was a 60 year old man admitted to the facility on 3/15/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. Patient #15's record included a MAR, that listed medications and the times they were to be administered to him by hospital staff. The MAR, effective 3/15/15, included Seroquel, Vitamin D,	A 405		

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A 405	Continued From page 218 Folic Acid, B Vitamin Complex, Vitamin C, MOM, antacid of choice, and Tylenol. However, Patient #15's record included a hospital admission order form dated 3/15/15, and signed by the RN and the NP. A section of the form included standing orders, which stated "Please put a check mark in the appropriate boxes." The boxes next to the following medications were not checked: - Vitamin D 1000 units daily - Folic Acid 1 mg daily - B Vitamin Complex 1 tab daily - Vitamin C 500 mg daily - MOM 30 cc by mouth every 12 hours for constipation - Antacid of choice 30 cc by mouth 4 times a day as needed - Tylenol 650 mg for mild discomforts Another section of the form included Patient #15's pre-admission medication, Seroquel, 300 mg daily. The section included boxes next to "Continue" and "Stop" to indicate if the medication was to be given while the patient was in the hospital. Neither box contained a check mark. During an interview on 4/01/15 at 3:25 PM, the hospital's pharmacist reviewed Patient #15's record and confirmed his admission orders, signed by the NP, did not include check marks next to the medications, making it unclear if they were to be administered. She stated she talked to the RN on duty on 3/16/15, who said the medications were to be given to Patient #15. She stated she did not speak with the NP who	A 405		

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A 405	Continued From page 219 signed the orders, to verify the medication orders. During an interview on 4/03/15 at 10:15 AM, the NP reviewed Patient #15's admission orders and confirmed the boxes were not checked. She stated the boxes should be checked by the provider to confirm the medications were to be administered. The facility failed to ensure Patient #15's medications were ordered by a provider. b. Patient #1 was a 40 year old male admitted to the facility on 3/26/15 to 3/31/15, from a local ED. His psychiatric diagnoses included schizoaffective disorder, substance dependence, and PTSD. Patient #1's record included a hospital admission order form dated 3/26/15, and signed by the NP. A section of the form included standing orders, which stated "Please put a check mark in the appropriate boxes." The boxes were not checked for the following medications: - Vitamin D 1000 units daily - Folic Acid 1 mg daily - B Vitamin Complex 1 tab daily - Vitamin C 500 mg daily Patient #1's MAR documented he received each of these medications daily from 3/26/15 to 3/31/15. During an interview on 4/03/15 at 4:40 PM, the NP reviewed the record and confirmed these medications were not ordered. She further	A 405		

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A 405	Continued From page 220 confirmed the medications were given to Patient #1 without an order. Medications were administered to Patient #1 without a provider order. c. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an ALF. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included a hospital admission order form dated 3/02/15, and signed by the NP. The admission order form included a section for medication reconciliation of current medications. Patient #4's current medications were listed in the medication reconciliation section with the name, dosage, route, and frequency. Twenty seven medications were listed. Next to the name of each medication were two boxes. One box was labeled "Continue" and the other box was labeled "Stop." Neither of the boxes were marked for the 27 current medications that were listed for Patient #4. A medication tracking record was created daily for Patient #4 during his admission. The medication tracking record listed the medications prescribed for Patient #4, including changes to his medications and dosages during his stay. PRN medications were also included on the form. Patient #4's current medications were listed on his MAR and the medication tracking record dated 3/02/15. He was receiving the medications beginning 3/02/15.	A 405		

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A 405	Continued From page 221 During an interview on 4/03/15 at 4:50 PM, the NP reviewed the record and confirmed Patient #4's current medications were not ordered on his admission to be continued. She further confirmed the medications were given to Patient #4 without an order. Patient #4's current medications were given without a provider order to continue them. d. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia and depression. Patient #5's record included a hospital admission order form dated 3/09/15, and signed by the NP. The admission order form included a section for medication reconciliation of current medications. Patient #5's current medications were listed in the medication reconciliation section with the name, dosage, route, and frequency. Eleven medications were listed. Next to the name of each medication were two boxes. One box was labeled "Continue" and the other box was labeled "Stop." Neither of the boxes were marked for the 11 current medications that were listed for Patient #5. A medication tracking record was created daily for Patient #5 during his admission. The medication tracking records listed the medications prescribed for Patient #5, including changes to his medications and dosages during his stay. PRN medications were also included on the form.	A 405		

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A 405	Continued From page 222 Patient #5's current medications were listed on his MAR and the medication tracking record dated 3/09/15. He was receiving the medications beginning 3/09/15. During an interview on 4/03/15 at 1:35 PM, the NP reviewed the record and confirmed Patient #5's current medications were not ordered on his admission to be continued. She further confirmed the medications were given to Patient #5 without an order. Patient #5's current medications were given without a provider order to continue them. e. Patient #7 was a 39 year old male admitted to the facility on 3/23/15 to 4/01/15, from an ALF. His psychiatric diagnoses included schizoaffective disorder, bipolar disorder, and substance abuse. Patient #7's record included a hospital admission order form dated 3/23/15. The admission order form included a section for standing orders and another section listed Patient #7's current medications. On the form it documented Patient #7 was currently taking 16 medications and those medications were to be continued. Additionally, the form included orders for Patient #7 to receive the standing order medications. The hospital admission order form was not signed by the psychiatrist or the NP. Patient #7's record included physician verbal orders for admission to the facility. A telephone order dated 3/23/15 at 7:10 PM, and signed by the RN, documented Patient #7 was admitted to	A 405		

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A 405	Continued From page 223 the facility and his current medications were to be continued. The telephone order did not include standing order medications. Patient #7's current medications were not listed on the order form. The admission order was not signed by the NP as of 4/03/15. The MAR's included in Patient #7's record documented he received the standing order medications daily beginning 3/24/15, until his discharge. Additionally, his current medications were listed and documented as taken daily by Patient #7 beginning on 3/23/15. During an interview on 4/03/15 at 4:50 PM, the NP reviewed the record and confirmed the admission order was not signed on either document. She confirmed Patient #7 was receiving medications listed on the medication reconciliation form. Medications were administered to Patient #7 without a signed order by a provider. 4. Nursing did not administer ordered medications to patients. Patient #13 was a 69 year old male admitted to the hospital on 1/01/15, with diagnoses of psychosis and depression. Patient 13's record included an order for Seroquel 25 mg to be given daily at bedtime. The order was signed by the NP on 1/04/15 at 6:05 PM. Patient #13's record included a medication administration record with a handwritten entry of	A 405		

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A 405	Continued From page 224 Seroquel 25 mg to be given daily at 8:00 PM. The entry noted the start date for the Seroquel was 1/05/15. Seroquel was not administered to Patient #13 at bedtime on 1/04/15, as ordered. During an interview on 4/01/15 at 4:20 PM, RN C reviewed Patient #13's record. She stated when a new medication is ordered the first dose should be given that day unless the order states otherwise. She confirmed Patient #13 should have been given a dose of Seroquel at bedtime on 1/04/15. During an interview on 4/03/15 at 11:10 AM, the NP who wrote the Seroquel order stated it was to be started on 1/04/15. She was unable to explain why Patient #13 did not receive the first dose at bedtime on 1/04/15. Patient #13 did not receive his medication as ordered.	A 405		
A 464	482.24(c)(4)(iii) CONTENT OF RECORD: CONSULTATIVE RECORDS [All records must document the following, as appropriate:] Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to ensure consultative findings were implemented in the plan of care for 2 of 17 patients (#1 and #5) whose records were reviewed. This resulted in a	A 464		

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A 464	Continued From page 225 lack of comprehensive and individualized treatment for patients admitted to the hospital and had the potential to negatively effect their treatment. Findings include: a. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia and depression. Patient #5's record included a nutritional assessment dated 3/11/15, and signed by the RD and dietary manager. The dietary manager documented she was unable to assess his caloric, protein, or fluid needs because no weight was documented in the record. She also documented no laboratory results were available in the record. The hospital admission orders dated 3/09/15, included orders for the following tests: CMP (complete metabolic panel), CBC (complete blood count), Free T4, TSH (thyroid stimulating hormone), RPR (a test for syphilis), UA (urinary analysis), B12, Folate, and PT/INR (prothrombin time and international normalized ratio.) Patient #5's record had laboratory results dated 3/14/15, for UA and PT/INR. There were no other laboratory results in the record. The dietary manager documented a request for Patient #5's weight and 2 laboratory tests, a CMP and BMP (basic metabolic panel). The record did not include orders for the laboratory tests requested. Patient #5 was not weighed until 3/14/15, 3 days after dietary requested the weight.	A 464		

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A 464	Continued From page 226 b. Patient #1 was a 40 year old male admitted to the facility on 3/26/15 to 3/31/15, from a local ED. His psychiatric diagnoses included schizoaffective disorder, substance dependence, and PTSD. Patient #1's record included a nutritional assessment dated 3/31/15, and signed by the dietary manager. The dietary manager documented Patient #1 needed a carbohydrate controlled diet. Included in the record were orders for blood glucose levels to be measured 4 times daily. Patient #1's blood glucose levels were consistently elevated from 172 mg/dl to 540 mg/dl during his admission. The hospital orders had no diet ordered for Patient #1 upon admission. There were no further orders documented in the record for a special diet. During an interview on 4/03/15 at 1:40 PM, the NP reviewed the records and confirmed no special diet was ordered for Patient #1. She stated she did not read the recommendations from the RD or dietary manager in patient records. The NP stated if there are concerns the RD or dietary manager would talk with her personally. The NP confirmed the conversations are not documented in patient's records. During an interview on 4/01/15 at 5:20 PM, RN C reviewed the record. She confirmed Patient #5's weight was not recorded until 3/14/15. The RN stated "I never even see the dietary assessment." She stated she was unaware of	A 464		

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A 464	Continued From page 227 the request for the laboratory tests and for Patient #5's weight. Patient's nutritional consultations and recommendations were not reviewed or implemented by a provider or nursing staff involved in their care.	A 464		
A 466	482.24(c)(4)(v) CONTENT OF RECORD: INFORMED CONSENT [All records must document the following, as appropriate:] Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent. This STANDARD is not met as evidenced by: Based on review of patient medical records, and staff interview, it was determined the hospital failed to ensure written consent forms for treatment and procedures were properly executed to include the signature of the patient or legal representative, 2 of 17 (#11 and #13) patients whose records were reviewed. This had the potential to result in treatment being provided without the consent of the patient or legal representative. Findings include: The hospital's policy, titled "Admission Procedure" effective 9/18/11, stated "Upon admission, the Social Worker or Charge RN must obtain Consent for Services. This form is signed by either the patient or the patient's legal guardian, and provides the hospital and associated physicians, the right to provide treatment..." This policy was not followed for all	A 466		

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A 466	Continued From page 228 patients. Examples include: 1. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14, from a skilled nursing facility, with diagnoses of psychosis, bipolar disorder and congenital brain injury with mental disability. Patient #11's medical record for her hospital admission of 11/25/14 to 11/29/14, was reviewed. Her record included a letter of guardianship and conservatorship. The letter stated Patient #11 was impaired to the extent she was unable to make responsible decisions. Patient #11's record did not include documentation of contact with her guardian, to obtain consent for services. Patient #11's record did not include a signed consent form. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it did not include a signed consent form, or documentation of contact with her guardian. Patient #11's medical record did not include an informed consent form signed by her legal guardian. 2. Patient #13 was a 69 year old male admitted to the hospital on 1/01/15, with diagnoses of psychosis and depression. Patient #13's medical record for his hospital admission of 1/01/15 to 1/05/15, was reviewed. His record did not include a signed consent form. During an interview on 4/01/15 at 4:20 PM, RN C	A 466		

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A 466	Continued From page 229 reviewed Patient #13's record and confirmed it did not include a signed consent form. Patient #13's medical record did not include a signed informed consent form.	A 466		
A 467	482.24(c)(2)(vi) CONTENT OF RECORD: ORDERS,NOTES,REPORTS [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure ordered test results and information necessary to monitor patients' conditions were documented in the record for 3 of 17 patients (#5, #10, and #11) whose records were reviewed. This failure had the potential to result in an incomplete record which may effect comprehensive patient care. Findings include: 1. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia and depression. Patient #5's record included a medical evaluation, which was completed on 3/10/15. The medical evaluation documented an extensive history of abdominal surgeries with associated complications over the last 5 months.	A 467		

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A 467	Continued From page 230 During 1 of his admissions Patient #5 was hospitalized for a 2 month period. At that time Patient #5 had a tracheostomy, PEG tube, MRSA, and repair of wound dehiscence with significant malnutrition problems. Upon his admission to the facility Patient #5 had large retention sutures to his abdomen which were to be removed 2 days after his admission to the hospital. a. On 3/09/15, the LPN documented Patient #5 had scabs with multiple open areas, redness at the incision site, and drainage. There were no measurements documented, and no description of the drainage. Additionally, there were no VS documented on the date of his admission. On 3/23/15, the LPN documented Patient #5 had open area at the incision site with redness in color. There were no measurements or drainage documented. The nurses notes did not include documentation regarding Patient #5's wounds or his history of MRSA. On 3/25/15 at 1:15 PM, the LMSW documented she spoke with an ALF and they indicated Patient #5 may be accepted if his wounds were cultured for MRSA and came back negative. A nursing note dated 3/25/15, documented Patient #5's wounds were cultured by the RN at 9:45 AM. There were no results from the wound culture in Patient #5's record. During an interview on 4/01/15 at 5:20 PM, RN C reviewed the record and confirmed the wound culture was done on the day of Patient #5's	A 467		

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A 467	Continued From page 231 discharge. She stated she was unaware of Patient #5's history of MRSA. RN C further confirmed weekly wound measurements were not completed. b. On 3/12/15 at 2:00 PM, the VS record documented Patient #5 had an elevated temperature of 100.9. There was no documentation the P.T. notified the RN of the elevated temperature. Additionally, there was no documentation the physician was notified or the temperature was treated with medication. On 3/20/15 at 8:44 PM, the nurses note documented Patient #5 had an elevated temperature of 100.4. There was no documentation the P.T. notified the RN of the elevated temperature. Additionally, there was no documentation the physician was notified or the temperature was treated with medication. During an interview on 4/01/15 at 5:20 PM, RN C reviewed the record and confirmed elevated temperatures were documented for Patient #5. RN C confirmed the MD was not notified of the elevated temperature measurements. Patient #5's record did not contain the information necessary to monitor his condition appropriately. 2. Patient #10 was a 67 year old male admitted to the hospital on 11/07/14, from an ALF. His psychiatric diagnoses were conduct disorder and depression. Additional diagnoses included history of a stroke, seizure disorder, non-insulin dependent diabetes, and constipation.	A 467		

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A 467	Continued From page 232 Patient #10's record included a nursing flow sheet, signed by the RN on 11/08/14 at 9:35 AM. The flow sheet contained sections to document assessment of Patient #10's physical and behavioral status, pain, and current safety precautions in effect. However, the flow sheet was blank. Patient #10's record did not include a nursing assessment for the day shift on 11/08/14. Patient #10's record included a nursing flow sheet, signed by the RN on 11/09/14, untimed. The flow sheet contained sections to document assessment of Patient #10's physical and behavioral status, pain, and current safety precautions in effect. However, the flow sheet was blank. Patient #10's record did not include a nursing assessment for the day shift on 11/09/14. During an interview on 4/01/15 at 4:30 PM, RN C reviewed Patient #10's record and confirmed the 2 nursing flow sheets were blank and there was no patient assessment documented during those 2 shifts. Patient #10 record did not include an assessment of his physical and behavioral status on every shift. 3. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14, from a SNF. Her psychiatric diagnoses were psychosis, bipolar disorder and congenital brain injury with mental disability. Additional diagnoses included renal insufficiency, CHF and diabetes. Patient #11's admission orders included the following laboratory tests: CMP, CBC, Free T4,	A 467		

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A 467	Continued From page 233 TSH, RPR, UA, B12, Folate, Depakote level and Hgb A1C. An entry on Patient #11's MAR, initialed by the RN, documented her blood was drawn and sent to the laboratory on 11/26/14. Patient #11's record included results of a UA. However, her record did not include results of the blood tests ordered at the time of admission. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it did not include results of the blood tests drawn on 11/26/14. She stated the laboratory results are available through the laboratory's website, and it was the responsibility of the unit clerk to access the website, print the results and put them in the patients' chart. RN C confirmed the test results were not always accessed online, printed and placed in the patient's chart. Patient #11's medical record did not include results of the laboratory tests completed on 11/26/14.	A 467		
A 468	482.24(c)(2)(vii) CONTENT OF RECORD: DISCHARGE SUMMARY [All records must document the following, as appropriate:] Discharge summary with outcome of hospitalization, disposition of care and provisions for follow-up care. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the facility failed to ensure discharge summaries were completed for 2 of 16 patients (#12 and #14) who were	A 468		

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A 468	Continued From page 234 discharged and whose records were reviewed. This resulted in the potential lack in continuity of care. Findings include: 1. Patient #14 was a 51 year old male admitted to the facility from 2/24/15 to 2/27/15, for psychiatric care related to schizoaffective disorder with acute exacerbation and suicidal ideation. Additional diagnoses included depression, paranoia, and hypothroidism. His record did not include a discharge summary. 2. Patient #12 was an 87 year old male admitted to the facility from 12/26/14 to 12/30/14, for psychiatric care related to dementia and psychosis. Additional diagnoses included UTI and constipation. His record did not include a discharge summary. During an interview on 4/03/15 at 3:40 PM, the NP reviewed Patient #12's record and confirmed it did not include a discharge summary. She stated the team of NP's and the Psychiatrist would share the load of dictating discharge summaries, and stated she knew some were overdue and should have been done. Discharge summaries were not included in closed records.	A 468		
A 799	482.43 DISCHARGE PLANNING The hospital must have in effect a discharge planning process that applies to all patients. The hospital's policies and procedures must be specified in writing. This CONDITION is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to	A 799		

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A 799	Continued From page 235 ensure identification of patients' discharge needs, patients' and/or family members were counseled on discharge needs, and reassessment of the patients' discharge plan for factors that affected care needs, or appropriateness of the discharge plan for patients. These failures had the potential to cause undue stress, increase the likelihood of readmission, and possible negative outcomes for all patients. Findings included: 1. Refer to A 806 as it relates to the facility's failure to evaluate each patients' capacity for self-care or the possibility of needing post hospital services. 2. Refer to A 810 as it relates to the facility's failure to ensure appropriate arrangements were made before discharge to avoid unnecessary delays in the discharge process. 3. Refer to A 821 as it relates to the facility's failure to reassess the discharge plan for factors affecting continuing care needs or the appropriateness of the discharge plan. 4. Refer to A 837 as it relates to the facility's failure to ensure patients were referred for follow-up or ancillary care as needed following hospitalization. 5. Refer to A 843 as it relates to the facility's failure to ensure that discharge planning was reassessed on an ongoing basis. The cumulative effect of these negative systemic practices significantly impeded the facility's ability to ensure discharge of patients was timely, ongoing and comprehensive, as well as	A 799		

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A 799	Continued From page 236 appropriate to each patient's individual needs.	A 799		
A 806	482.43(b)(1), (3), (4) DISCHARGE PLANNING NEEDS ASSESSMENT (1) The hospital must provide a discharge planning evaluation to the patients identified in paragraph (a) of this section, and to other patients upon the patient's request, the request of a person acting on the patient's behalf, or the request of the physician. (3) - The discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. (4) - The discharge planning evaluation must include an evaluation of the likelihood of a patient's capacity for self-care or of the possibility of the patient being cared for in the environment from which he or she entered the hospital. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure patients' capacity for self-care or need for post-hospital services was evaluated during the discharge process for 1 of 16 discharged patients (#5) whose records were reviewed. This failure had the potential to negatively impact patients who were discharged by placing them in an inappropriate aftercare setting and at risk of not receiving follow-up treatment as needed or ordered to maintain their health status. Findings include: 1. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia	A 806		

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A 806	Continued From page 237 and depression. Patient #5's psychiatric evaluation was completed on 3/10/15 by the NP. The psychiatric evaluation documented he did not know why he was admitted to the facility and included documentation that Patient #5's speech was slurred during the beginning of the interview, and he was oriented to self and only partially to place. The psychiatric evaluation further documented Patient #5 was "unaware of the world around him" and his judgment was "Markedly impaired." Patient #5 was to be assessed for dementia. Patient #5's record included a medical evaluation, which was completed on 3/10/15. The medical evaluation documented an extensive history of abdominal surgeries with associated complications over the last 5 months. During 1 of his admissions Patient #5 was hospitalized for a 2 month period. At that time Patient #5 had a tracheostomy, PEG tube, MRSA, and repair of wound dehiscence with significant malnutrition problems. Upon his admission to the facility Patient #5 had large retention sutures to his abdomen which were to be removed 2 days after his admission to the hospital. Patient #5's record included a social history completed by an LMSW on 3/13/15. The social history documented recommendations for coordination of discharge placement and aftercare, and Patient #5 was to return to an ALF. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local shelter. Included on his discharge medication list was an antibiotic	A 806		

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A 806	Continued From page 238 for infection. There was no follow up appointment scheduled with Patient #5's surgeon or a primary care provider. The discharge instructions documented his diagnoses as chronic schizophrenia with R/O dementia. Patient #5's record included an Inpatient Diagnoses form which documented he had schizophrenia, borderline intellectual functioning, and issues with primary support. On 3/23/15, a Psychiatric Progress Note documented Patient #5 had limited judgement and insight, and he had grave disability. The progress note further documented Patient #5 had an active mental disorder present and persistent inability to care for himself, or that he may be cared for in a less restrictive environment. There was no further documentation by the NP prior to his discharge. Additionally, Patient #5's discharge instructions included a medication list with an antibiotic for infection. Patient #5 had numerous abdominal surgeries, including post-operative complications, documented in his H&P, over the previous 5 months. Patient #5's record did not include progress notes from the MD after the initial H&P was completed. On 3/23/15, the LPN documented Patient #5 had an open area at the incision site with redness in color. There was no documentation of measurements of the open area. The discharge instructions did not include a scheduled follow up appointment with Patient #5's surgeon or a primary care provider. During an interview on 4/03/15 at 12:55 PM, the Director of Social Services reviewed the record and confirmed the discharge plan was for Patient #5 to return to an ALF. She stated the discharge	A 806		

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A 806	Continued From page 239 plan had not changed until the day of his discharge. The Director of Social Services confirmed Patient #5's follow-up and post-discharge needs were not comprehensively assessed. The facility failed to assess Patient #5's ability for self-care and post-hospital needs prior to his discharge.	A 806		
A 810	482.43(b)(5) TIMELY DISCHARGE PLANNING EVALUATIONS The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure discharge planning needs were identified and developed for 1 of 17 patients (#5) whose records were reviewed. This failure resulted in inappropriate discharge to a homeless shelter, rather than returning to an ALF setting. Findings include: 1. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia and depression. Patient #5's psychiatric evaluation was completed on 3/10/15 by the NP. The psychiatric evaluation documented he did not know why he was admitted to the facility and included documentation that Patient #5's speech was slurred during the beginning of the interview, and	A 810		

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	134011		C 04/03/2015

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A 810	Continued From page 240 he was oriented to self and only partially to place. The psychiatric evaluation further documented Patient #5 was "unaware of the world around him" and his judgment was "Markedly impaired." Patient #5 was to be assessed for dementia. Patient #5's record included a medical evaluation, which was completed on 3/10/15. The medical evaluation documented an extensive history of abdominal surgeries with associated complications over the last 5 months. During 1 of his admissions Patient #5 was hospitalized for a 2 month period. At that time Patient #5 had a tracheostomy, PEG tube, MRSA, and repair of wound dehiscence with significant malnutrition problems. Upon his admission to the facility Patient #5 had large retention sutures to his abdomen which were to be removed in 2 days after his admission to the hospital. Patient #5's record included social history completed by a LMSW on 3/13/15. The social history documented recommendations for coordination of discharge placement and aftercare, and Patient #5 was to return to an ALF. Social service progress notes documented working on Patient #5's discharge placement beginning on 3/14/15, 5 days after admission. The SS Assistant documented at 3:57 PM, she spoke with the Administrator for Patient #5's previous ALF and they would not take him back upon discharge. On 3/25/15 at 1:15 PM, the LMSW documented she spoke with an ALF and they indicated Patient #5 may be accepted if his wounds were cultured	A 810		

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A 810	Continued From page 241 for MRSA and came back negative. A nursing note dated 3/25/15, documented Patient #5's wounds were cultured by the RN at 9:45 AM. There were no results from the wound culture in Patient #5's record. The LMSW documented Patient #5 did not want to stay at the hospital and he wanted to go to the shelter. She documented Patient #5 was competent to make decisions, but did not necessarily make the best choices. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local shelter. During an interview on 4/03/15 at 12:55 PM, the Director of Social Services reviewed the record and confirmed the plan was for Patient #5 to return to his previous ALF. She confirmed the wound culture was not done prior to the day of discharge. During an interview on 4/01/15 at 5:20 PM, the RN reviewed the record and confirmed the wound culture was done on the day of Patient #5's discharge. The facility failed to ensure appropriate laboratory tests and arrangements were made for Patient #5 to prevent a delayed discharge.	A 810		
A 821	482.43(c)(4) REASSESSMENT OF A DISCHARGE PLAN The hospital must reassess the patient's discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff	A 821		

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A 821	Continued From page 242 interview, it was determined the hospital failed to reassess each patient's discharge plan for appropriateness for 2 of 17 patients (#5 and #13) whose records were reviewed. This had the potential to negatively effect patient discharge outcomes. Findings include: 1. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia and depression. Patient #5's record included a social history completed by an LMSW on 3/13/15. The social history documented recommendations for coordination of discharge placement and aftercare, and Patient #5 was to return to an ALF. Social service progress notes documented working on Patient #5's discharge placement beginning on 3/14/15, 5 days after admission. The SS Assistant documented at 3:57 PM, she spoke with the Administrator for Patient #5's previous ALF and they would not take him back upon discharge. On 3/25/15 at 1:15 PM, the LMSW documented she spoke with an ALF and they indicated Patient #5 may be accepted if his wounds were cultured for MRSA and came back negative. A nursing note dated 3/25/15, documented Patient #5's wounds were cultured by the RN at 9:45 AM. There were no results from the wound culture in Patient #5's record. The LMSW documented Patient #5 did not want to stay at the hospital and he wanted to go to the shelter. Patient #5 was discharged from the	A 821		

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A 821	Continued From page 243 facility on 3/25/15 at 3:30 PM, to a local shelter. During an interview on 4/03/15 at 12:55 PM, the Director of Social Services reviewed the record and confirmed the plan was for Patient #5 to return to his previous ALF. She confirmed the wound culture was not done prior to the day of discharge. The facility did not ensure Patient #5's discharge plan was reassessed and updated to reflect his wound affecting discharge placement. 2. Patient #13 was a 69 year old male admitted to the hospital on 1/01/15, with diagnoses of psychosis and depression. Patient #13's record included an order for Seroquel 25 mg to be given daily at bedtime. The order was signed by the NP on 1/04/15 at 6:05 PM. Per the Nursing 2015 Drug Handbook, Seroquel is an antipsychotic medication that requires careful monitoring, due to the risk of adverse reactions. Patient #13's record included a MAR with a handwritten entry of Seroquel 25 mg to be given daily at 8:00 PM. The entry noted the start date for the Seroquel was 1/05/15. Seroquel was not administered to Patient #13 at bedtime on 1/04/15, as ordered. Patient #13's record included a social service progress, dated 1/05/15. The note stated "When SS discussed discharges with [NP] she reported that due to staffing [patient] was being discharged."	A 821		

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A 821	Continued From page 244 During an interview on 4/03/15 at 2:45 PM, the SS Assistant who wrote the note confirmed Patient #13 was discharged on 1/05/15, to an ALF, due to lack of sufficient staff. Patient #13's nurses notes documented he was discharged to an ALF on 1/05/15 at 4:45 PM. He did not receive a dose of Seroquel prior to his discharge. Patient #13's record included a copy of discharge instructions, including discharge medication orders, that were sent to the ALF. The discharge medication order form included an area to document the number of antipsychotics ordered upon discharge, along with any special instructions. The section was blank, although Seroquel, an antipsychotic was included in his discharge medication orders. Additionally, there was no documentation stating he had not received Seroquel during his hospitalization. The ALF staff were not informed they would be administering his first dose, meaning he should be closely monitored for adverse effects. During an interview on 4/01/15 at 4:20 PM, RN C reviewed Patient #13's record. She stated when a new medication is ordered the first dose should be given that day unless the order states otherwise. She stated medications ordered for bedtime are administered at 8:00 PM. RN C confirmed Patient #13 should have been given a dose of Seroquel at 8:00 PM on 1/04/15. She reviewed the discharge instructions and confirmed the ALF staff was not informed Patient #13 did not receive Seroquel in the hospital. The facility did not ensure Patient #13's	A 821		

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A 821	Continued From page 245 discharge plan was reassessed and updated to reflect his new medication, and his unanticipated discharge.	A 821		
A 837	482.43(d) TRANSFER OR REFERRAL The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure referrals were made for follow-up or ancillary care for 1 of 16 patients (#5) who were discharged and whose records were reviewed. This failure had the potential to negatively impact discharged patients by resulting in deteriorated health status or possible readmission to an acute care facility. Findings include: 1. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia and depression. Patient #5's record included a medical evaluation, which was completed on 3/10/15. The medical evaluation documented an extensive history of abdominal surgeries with associated complications over the last 5 months. During 1 of his admissions Patient #5 was hospitalized for a 2 month period. At that time Patient #5 had a tracheostomy, PEG tube, and repair of wound dehiscence with significant malnutrition problems. Upon his admission to the facility Patient #5 had large retention sutures to his abdomen which were to be removed in 2	A 837		

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A 837	Continued From page 246 days of his admission to the hospital. Patient #5's record included social history completed by a LMSW on 3/13/15. The social history documented recommendations for coordination of discharge placement and aftercare, and Patient #5 was to return to an ALF. Patient #5's discharge instructions included a medication list with an antibiotic for infection. Patient #5 had numerous abdominal surgeries, including post-operative complications, documented in his H&P, over the previous 5 months. Patient #5's record did not include any progress notes from the medical physician after the initial H&P was completed. The H&P documented Patient #5 had a midline surgical incision which was being held with large retention sutures with rubber tubing around them that bridged over the incision. On 3/23/15, the LPN documented Patient j#5 had open area at the incision site with redness in color. There was no documentation of measurements of the open area. The discharge instructions did not include a scheduled follow up appointment with Patient #5's surgeon or a primary care provider. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local shelter. Included on his discharge medication list was an antibiotic for infection. There was no follow up appointment scheduled with Patient #5's surgeon or a primary care provider. An email, detailing events after Patient #5's discharge, was received by surveyors on 4/03/15 at 3:30 PM. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local shelter.	A 837		

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A 837	Continued From page 247 The email dated 4/03/15 at 2:32 PM, and written by the VP of the hospital, was addressed to the SNF AIT. The email documented a timeline of events that occurred after Patient #5's discharge from the hospital. Patient #5 was driven to the shelter by a hospital van after picking up his prescriptions. He was told by the shelter employees it was too early for admittance and to return between 5:00 and 6:00 PM. Patient #5 returned to the shelter several times over the course of the evening and he also went back to the facility requesting to be let in. He was refused admittance and went to the facility's corporate office the next morning. The corporate office then arranged for Patient #5 to be admitted to an ALF, after 2 encounters with police, missing personal effects, and a bloody face. There was no other documentation in the facility of Patient #5's return during the middle of the night on 3/25/15 Patient #5 was not referred or given a follow up appointment with his primary care provider or surgeon to monitor his post-operative incision or completion of his antibiotic regimen. During an interview on 4/03/15 at 12:55 PM, the Director of Social Services reviewed the record and confirmed the plan was for Patient #5 to return to his previous ALF. She confirmed the discharge plan did not include follow up with his surgeon or a primary care physician. During an interview on 4/01/15 at 5:20 PM, RN C reviewed the record and confirmed discharge orders did not include a follow-up appointment with his surgeon.	A 837		

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A 837	Continued From page 248 Patient #5's discharge orders did not include a follow-up appointment with a physician for his abdominal wounds.	A 837		
A 843	482.43(e) REASSESSMENT OF DISCHARGE PLANNING PROCESS The hospital must reassess its discharge planning process on an on-going basis. The reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs. This STANDARD is not met as evidenced by: Based on staff interview and review of quality documents, it was determined the hospital failed to ensure a system, including a review of discharge plans, had been developed and implemented to reassess its discharge planning process on an on-going basis. This seriously impeded the hospital's ability to analyze its discharge planning process and implement corrective actions. Findings include: A review of the hospital's discharge planning process, including a review of discharge plans, was not documented. The Director of Social Services was interviewed on 4/03/15 beginning at 1:50 PM. She stated the hospital did not have a system to review its discharge planning process. She stated the hospital did not review discharge plans for quality and completeness. The hospital did not review its discharge planning process.	A 843		

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint investigation of your Psychiatric Hospital completed 3/30/15 through 4/03/15. The surveyors conducting the survey were: Susan Costa, RN, HFS, Team Lead Laura Thompson, RN, BSN, HFS Nancy Bax, RN, BSN, HFS Gary Gulles, RN, HFS During the survey it was determined that deficient practices placed the health and safety of patients in immediate jeopardy of serious harm, impairment, or death and had the potential to impact all patients receiving services at the facility. The co-owner of the facility was notified of the immediate jeopardy verbally on 4/03/15 at 5:00 PM, and by letter on 4/07/15. The following acronyms were used in this report: ALF - Assisted Living Facility BID - twice daily BM - bowel movement BUN - Blood, Urea, Nitrogen laboratory test CBC - Complete Blood Count cc - cubic centimeter CHF - Congestive Heart Failure CMP - Complete Metabolic Panel CNO - Chief Nursing Officer COPD - Chronic Obstructive Pulmonary Disease CPR - cardiopulmonary resuscitation DM - Diabetes Mellitus ED - Emergency Department EKG - Electrocardiogram EMS - Emergency Medical Services	B 000	RECEIVED JUL 29 2015 FACILITY STANDARDS	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Nielson, RN | TITLE: Administrator | (X6) DATE: 7/28/2015

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B 000	Continued From page 1 Free T4 - Thyroid Hormone, a blood test to evaluate thyroid function GERD - Gastroesophageal reflux disease Hgb A1C - Hemoglobin A1C, a blood test to provide information about a person's average levels of blood glucose over 2-3 months HTN - Hypertension H&P - History and Physical IC - Infection Control ICTP - Interdisciplinary Comprehensive Treatment Plan ICU - Intensive Care Unit IM - Intramuscular IV - Intravenous LIP - Licensed Independent Practitioner LMSW - Licensed Masters Social Worker LOC - Level of Consciousness LPN - Licensed Practical Nurse MAR - Medication Administration Record MD - Medical Doctor mg - milligram mg/dl - milligrams per deciliter MRSA - Methicillin Resistant Staphylococcus aureus NCP - Nursing Care Plan NP -Nurse Practitioner PEG tube - Percutaneous Endoscopic Gastrostomy tube PI - Performance Improvement po - by mouth POC - Plan of Care PRN - as needed Pt - Patient P.T. - Psychiatric Technician PT/INR - Prothrombin Time/ International Normalized Ratio, a blood test to measure blood clotting times PTSD - Post- Traumatic Stress Disorder QAPI - Quality Assessment Performance Improvement	B 000		

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B 000	Continued From page 2 RD - Registered Dietician RN - Registered Nurse R/O - Rule Out ROM - Range of Motion RPR - Rapid Plasma Reagin, a screening test for syphilis SNF - Skilled Nursing Facility SNF AIT - Skilled Nursing Facility Administrator in Training SS - Social Services TO - Telephone Order TSH - Thyroid Stimulating Hormone UA - Urine analysis UTI - Urinary Tract Infection VO- Verbal Order VS - Vital Signs	B 000	Action to Correct Deficiency:	
BB115	16.03.14.200.01 Governing Body and Administration 200. GOVERNING BODY AND ADMINISTRATION. There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. (10-14-88) 01. Bylaws. The governing body shall adopt bylaws in accordance with Idaho Code, community responsibility, and identify the purposes of the hospital and which specify at least the following: (10-14-88) a. Membership of Governing Body, which consist of: (12-31-91) i. Basis of selecting members, term of office, and duties; and. (10-14-88)	BB115	Governing Body (GB) has been formed with the ultimate authority and responsibility for the operation of the Hospital. A full time administrator dedicated to the day to day management of the hospitals operations has been appointed as well as a Chief Nursing Officer (CNO) and the Medical Director (MD). These appointments allow for greater ability to facilitate change and also allows for closer monitoring of daily operations. GB bylaws have been adopted in accordance to Idaho Code. GB meetings to be held quarterly with a mandatory attendance requirement. Minutes of these meetings to be maintained and presented to the Organization. GB officers have appointed committees as needed in accordance to the size and scope of Hospital activities. Medical Staff (MS) appointments and reappointments have been made. Formal procedures have been established for appointment to the MS. The GB bylaws approve MS authority to evaluate the professional competence of applicants.	

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BB115	Continued From page 3 ii. Designation of officers, terms of office, and duties. (10-14-88) b. Meetings, (12-31-91) i. Specify frequency of meetings. (10-14-88) ii. Meet at regular intervals, and there is an attendance requirement. (10-14-88) iii. Minutes of all governing body meetings shall be maintained. (10-14-88) c. Committees, (12-31-91) i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88) ii. Minutes of all committee meetings shall be maintained; and reflect all pertinent business. (10-14-88) d. Medical Staff Appointments and Reappointments; (12-31-91) i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88) ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician practitioners who are granted clinical privileges. (10-14-88) iii. The procedure for appointment and	BB115	A third party company has been secured to provide quality assurance to all hospital visits. This company will conduct random samples of discharged patients quality of care. This information will then be reported back to the Organization on a monthly basis and relayed back to the Hospital Administrator. On admission patients/legal representative will be educated by the admitting nurse/designee on their Patient Rights and will receive a printed copy. The Patient Rights has also been posted at the nurse's station along with a direct number to Safe Haven's CEO and COO to report immediate concerns. How Action Improves Process: Formal written procedures established to address the daily operations and oversight of the hospital allowing for insight into change that will decrease adverse patient events. Staff will be held accountable to standards of care. Procedure for Implementation: GB to ensure the constant improvement of patient outcomes and satisfaction. Monitoring and Tracking: Governing Board meetings to be held quarterly in accordance to bylaws. Minutes to be kept of all proceedings and provided to Organization. Title of Person(s) Responsible: CEO, CFO, COO, Medical Director, Hospital Administrator, CNO	8/17/2015

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BB115	Continued From page 4 reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least biannually. (10-14-88) iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants, appointments and reappointments, curtailment of privileges, and delineation of privileges. (10-14-88) v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88) vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced. (10-14-88) e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. (10-14-88) f. The bylaws shall specify an appropriate and regular means of communication with the medical staff. (10-14-88) g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88) h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. (10-14-88)	BB115		

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BB115	Continued From page 5 i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88) j. The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. (10-14-88) k. The governing body shall appoint a chief executive officer or administrator, and shall designate in writing who will be responsible for the operation of the hospital in the absence of the administrator. (10-14-88) l. Bylaws shall be dated and signed by the current governing body. (10-14-88) m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of medical records, policies, incident reports, Medical Staff Bylaws, QAPI documents, and meeting minutes, it was determined the hospital's Governing Board failed to assume responsibility for determining, implementing, and monitoring policies and failed to oversee the hospital's QAPI program. The Governing Board failed to provide oversight and supervision necessary to ensure patients were protected from abuse and neglect and received safe and appropriate psychiatric, medical, and nursing services. This resulted in deficient practices that placed the health and safety of one or more patients in immediate jeopardy of serious harm, impairment, or death, and had the potential to negatively impact all patients receiving services	BB115		

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BB115	Continued From page 6 at the facility. Findings include: 1. Refer to BB116 as it relates to the Governing Board's failure to ensure the hospital Administrator provided sufficient operating direction over the hospital, necessary to ensure adequate numbers of qualified staff were provided to meet patient needs. 1. Refer to BB124 as it relates to the failure of the Governing Body, Administrator, and Medical Staff, to ensure a hospital-wide Quality Assurance program was fully developed, implemented, and maintained. 2. Refer to BB144 and BB146 as it relates to the Governing Body's failure to ensure it held the Medical Staff accountable for the quality of care provided. 3. Refer to BB173 as it relates to the Governing Board's failure to ensure nursing services were organized under the authority of a director of nursing services. 4. Refer to BB461 as it relates to the failure of the Governing Body to ensure a discharge planning process was in place that met the needs of all patients. 5. Refer to BB463 as it relates to the failure of the Governing Body to ensure nursing services were organized and supervised to effectively meet the health care and psychiatric needs of patients. This failure resulted in serious harm and death and placed the health and safety of all patients in immediate jeopardy. 6. Refer to BB527 as it relates to the failure of the Governing Body to ensure the safe handling	BB115		

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BB115	Continued From page 7 of patients' and effective implementation of system for reporting, investigation, and disposition of incidents and accidents. This failure resulted in serious injury of one patient and placed all patients at risk of serious harm, injury, or death. These systemic negative practices seriously impeded the ability of the hospital to provide safe and effective services.	BB115		
BB116	16.03.14.200.02 Administration 02. Administration. The governing body, through the administrator, shall provide appropriate physical facilities and personnel required to meet the needs of the patients and the community. (10-14-88) This Rule is not met as evidenced by: Based on observation, review of policies, occurrence reports, and patient records, and staff interview, it was determined the Governing Body and Administrator failed to provide appropriate personnel to meet patient needs in 5 of 5 months (December 2014 - April 2015) for which patient census information and occurrence reports were reviewed. This failure resulted in the facility's inability to effectively manage the inappropriate behaviors of Patients #8 and #21, resulted in the inappropriate discharge of Patient #13, and had the potential to adversely affect the health and safety needs of all patients receiving services at the facility. Findings include: 1. A policy "Staffing of Nursing Care, Acuity Based," effective 1/04, stated "To provide safe, effective nursing care designed to support improvements and innovations in nursing practice	BB116	Action to Correct Deficiency: The Governing Body, which includes the Hospital Administrator, CNO, and Medical Director , will approve appropriate staffing ratio based on acuity and census to meet the needs of the unit. Administration to ensure that Hospital is adequately staffed to meet patient and community needs. Charge RN to notify administration if staffing is inadequate to meet needs. Human Resource policy on absenteeism to be enforced to avoid staffing shortages. How Action to Improves Process: Staffing will remain sufficient to provide adequate care relative to patient census and acuity. Procedure for Implementation: New staff and present employees to be oriented to HR policy relative to absenteeism. Administration to be informed daily of census and acuity needs and adjust staffing as needed. Charge nurse to review staffing and census each shift and adjust schedule accordingly.	

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BB116	Continued From page 8 based on both the needs of the patients to be served and the mission statement. The plan supports both standards of nursing practice and nursing standards of care. The CNO of Safe Haven is responsible and accountable to ensure that consistent standards are utilized. This plan provides an overview of the unit, which includes staffing plans based on acuity data and core staffing date. Staffing is based upon patient census and acuity. Based on census and patient acuity, the needs of the unit are evaluated on a shift or partial shift basis by the Staffing Coordinator, in collaboration with the charge nurse, in order to provide optimal patient care that is fiscally sound." The following algorithm was included in the policy based on patient census: Day shift staffing requirements -1 RN per shift -1 to 5 patients, 1 P.T. -6 to 8 patients, 1.5 P.T.s -9 to 13 patients, 2 P.T.s -14 patients, 3 P.T.s -1 to 6 patients, 0 LPN -7 to 10 patients, 1 LPN -11-14 patients, 1.33 LPNs Night shift staffing requirements -1 RN per shift	BB116	Monitoring and Tracking: Audits of the shift schedule and census relative to patient acuity will be completed daily . QAPI Coordinator to track and trend staffing shortages quarterly. Title of Person(s) Responsible: Hospital Administrator, CNO, Charge RN for the shift, QAPI Coordinator A new policy and procedure has been created to ensure staffing is based on both patient acuity and census. This new algorithm will ensure optimal care for all patients. See attached policy and procedure.	8/17/2015 8/17/2015

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BB116	Continued From page 9 -1 to 8 patients, 1 P.T. -9 to 14 patients, 1.5 P.T.s -1 to 8 patients, 0 LPN -9 to 14 patients, 1 LPN The algorithm in the policy stated core staffing consisted of a minimum of 1 RN and 1 P.T. The policy stated, "Psych tech [psychiatric technicians] shifts- if the staffing ladder accounts for 1.5 aides, this means that one full 12 hour shift is approved and one 6 hour shift is approved. The hours may be divided amongst the scheduled Psych tech staff at the direction of the Charge RN as long as the hours stay within the approved total of 18 hours." Additionally, the policy stated "LPN shifts- if the staffing ladder accounts for 1.33 LPN's, this means that one full 8 hour shift from 0700- 1500 [7:00 AM to 3:00 PM] is approved. At a census of 11 the LPN staff may then cover the remaining four hours of the 12 hour shift to 1900 [7:00PM]. The hours may not be allotted any other way." Assignment sheets were completed for each 12 hour shift, day and night. The assignment sheet included sections for patients' names, level of monitoring, names of P.T.s working, and 2 hour time periods for the shift. The name of the RN in charge and the date were listed at the top of the form. It also differentiated whether it was the assignments for day or night shift. The bottom of the assignment sheet also included a section with an algorithm. The algorithm was used for staffing the facility with P.T.s depending on the census.	BB116		

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BB116	Continued From page 10 The section for P.T.s was numbered 1 through 5, with their names written next to the numbers. The number corresponding to the P.T. was written in the columns broken down into 2 hour time periods for the shift. The 2 hour time period columns corresponded to patient names. For example: P.T. 1 would be assigned from 6:00 AM to 8:00 AM with one patient, then from 8:00 AM to 10:00 AM, P.T. 1 would be assigned to another patient. P.T.s would not be assigned to 1 patient for the entire 12 hour shift. According to the assignment sheets reviewed, they would rotate between the patients. The algorithm at the bottom of the assignment sheet was used for determining staffing of the facility. The algorithm for staffing P.T.s was based on census, rather than acuity. The algorithm was listed as follows: - Patient census 0, P.T. 0 hours - Patient census 1, P.T. 8 hours - Patient census 2-5, P.T. 12 hours - Patient census 6-10, P.T. 16 hours - Patient census 11-12, P.T. 24 hours - Patient census 13-14, P.T. 26 hours A maximum of 14 patients could be admitted at one time. If a patient was being monitored as a 1:1 (close monitoring of the patient was required and the assigned P.T. must be within arm's reach of the patient at all times), 1 tech would be assigned for monitoring the patient and was not included in the algorithm.	BB116		

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BB116	Continued From page 11 A corresponding policy for close monitoring, titled "Suicide/Homicide Precautions Protocol," revised 10/12, stated a precaution level was assigned for the protection of patients requiring a safety intervention. The following precaution levels were identified and defined: -15 minute checks: Patient was observed every 15 minutes for safety -Line of sight (LOS): Keep patient in the line of sight at all times -1:1 monitoring: Observation with 1:1 contact at all times On 4/01/15 at 4:55 PM, RN C confirmed an assignment sheet was to be filled out for each shift. She stated an LPN was scheduled for medications if the patient census was greater than 8, otherwise the LPN worked 7:00 AM to 11:00 AM and came back and worked 5:00 PM to 9:00 PM. RN C stated she coordinated the staffing of P.T.s. RN C stated P.T.s worked a 12 hour shift, but depending on the algorithm they may work 4 hours, 8 hours, or the full 12 hours. She explained when 16 hours were allotted based on census, 1 P.T. would work 12 hours and another P.T. would work for 4 hours. RN C stated staffing of P.T.s was not acuity or behaviorally based, but was based on the algorithm. During an interview on 4/02/15 at 5:05 PM, RN B confirmed the algorithm was what she used to staff the P.T. hours. She further confirmed staffing for P.T.s was based on census and algorithm, it was not acuity or behaviorally based. However, the use of the staffing algorithm,	BB116		

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BB116	Continued From page 12 without consideration of patient acuity was not sufficient to ensure patient needs were met, as follows: a. During an observation on 4/02/15 at 12:00 PM, 5 patients were observed at the facility. In the dayroom there were 2 patients and 2 P.T.s present. One patient was in her assigned room, and 1 patient was observed walking in the hall. A third P.T. was observed in the nursing station behind a locked door. No RN was observed on the unit. After approximately 5 minutes, the RN was observed entering the patient unit from the other side of the locked doors. An interview was conducted with P.T. E at 12:10 PM on 4/02/15. He stated there were 5 patients in the hospital and 3 of the patients were on 1:1 monitoring. P.T. E stated he did not feel staffing was adequate that day because only 3 P.T.s were scheduled to work. Three patients required 1:1 monitoring, therefore, the 2 remaining patients were not assigned a P.T. During an interview on 4/02/15 at 5:05 PM, RN B stated she was a concerned about safety at the facility. She stated staffing was based on census rather than acuity. Therefore, additional staff were not added when 1 or more patients exhibited behaviors that required close observation and possible intervention, to prevent injury to themselves or others. b. On 3/07/15 at 3:15 PM, a P.T. note attached to an "Occurrence Report," stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15	BB116		

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BB116	Continued From page 13 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. Additionally, on 3/08/15 at 2:00 PM, an "Occurrence Report," completed by the RN on duty, documented Patient #8 was aggressive to another patient and that P.T.s were unable to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. The actions of the SNF male aide were not described. The hospital failed to provide adequate numbers of hospital personnel to meet Patient #8's behavioral needs.	BB116		
	c. On 12/05/14 at 4:30 AM, an "Occurrence Report," completed by the RN on duty, documented Patient #21 had an altercation with his roommate. The report included a nurses' note documenting Patient #21 was placed on "1:1/LOS." However, the facility's "Suicide/Homicide Precautions Protocol," did not include a definition for "1:1/LOS." Without clear instruction to staff, it would not be possible to determine if adequate numbers of staff were present to meet patient needs.		The CNO will provide an in-service directed toward all nursing staff that will include allowed abbreviations and their definitions. This will educate staff and ensure proper documentation and policies are being followed.	8/17/2015
	d. Patient #13's record documented he was a patient in the hospital from 1/01/15 to 1/05/15, with diagnoses of psychosis and depression. His record included a social service progress note, dated 1/05/15. The note stated "When SS discussed discharges with [NP] she reported that due to staffing [patient] was being discharged." During an interview on 4/03/15 at 2:45 PM, the		The previous hospital CNO also served as the Hospital Administrator and adjoined Skilled Nursing Facility Administrator. This arrangement failed to provide adequate oversight. A full time Hospital Administration and CNO have been hired that are dedicated to the management of hospitals daily operations and nursing services. The CNO will closely monitor staffing ratios to ensure all patient needs are being met. The Administrator will be notified of any concerns of inadequate staffing and take corrective action.	8/17/2015

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BB116	Continued From page 14 SS Assistant who wrote the note stated she remembered the conversation with the NP. She stated during the Treatment Team meeting it was determined there were not enough staff to take care of the number of patients that were in the hospital, therefore someone had to be discharged. She stated Patient #13 was closest to his planned discharge date so he was the one who was discharged. The facility failed to ensure adequate number of staff were provided to meet patients' health and safety needs. 2. The governing body failed to designate in writing who would be responsible for the operation of the hospital in the absence of the Administrator. Upon arrival at the facility on 3/30/15 at approximately 1:15 PM, surveyors were greeted by an employee who introduced himself as the Administrator in Training for the attached SNF. He stated the Administrator of the hospital was out of town for the week. He stated he was the hospital's liaison for the surveyors. He stated he did not work for the hospital and did not know about much about the hospital. When interviewed later on 4/01/15 at 9:05 AM, the SNF AIT stated nobody was appointed as Acting Administrator for the hospital while the Administrator was out of town that week. During an interview on 4/01/15 at 9:35 AM, the co-owner of the hospital confirmed the Administrator was out of town for a week and no one was designated to oversee clinical services while she was out of town. 3. Refer to BB144 as it relates to the failure of the	BB116	See also BB144	8/17/2015

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BB116	Continued From page 15 Governing Body and Administrator to ensure appropriate medical and psychiatric physicians were available to meet patients' needs. 4. Refer to BB173 as it relates to the failure of the Governing Body and Administrator to ensure a CNO provided nursing staff with the leadership necessary to meet patients' needs.	BB116	See also BB173	8/17/2015
BB117	16.03.14.200.03 Chief Executive Officer or Administrator 03. Chief Executive Officer or Administrator. The governing body through the chief executive officer shall establish the following policies, procedures or plans: (10-14-88) a. The hospital shall adopt a written personnel policy concerning qualification, responsibility, and condition of employment for each category of personnel. The policy and/or procedures shall contain the following elements: (10-14-88) i. Documentation of orientation of all employees to policies, procedures and objectives of the hospital. (10-14-88) ii. Job descriptions for all categories of personnel. (10-14-88) iii. Documentation of continuing education (inservice) for all patient care personnel. (10-14-88) b. There shall be a personnel record for each employee, which shall contain at least the following: (10-14-88)	BB117	See BB115, BB116 Action to Correct Deficiency: Revision of policies and procedures and staff to be educated on these revisions and reviewed annually or as needed. Policy and procedure manual to be kept in a centralized location. Job descriptions updated for each position in the Hospital. Reference checks and credentialing will be performed on all staff as needed. All staff will receive proper orientation and be responsible for continuing education requirements. Personnel records to be maintained with licensure and certifications in addition to mandatory vaccinations and diagnostic evaluations (i.e., PPD test), background checks, etc. How Action Improves Process: Positive patient outcomes related to staff education and awareness of hospital policy and procedures. Patient care will be improved by insuring that license and certified professionals provide direct patient care. Clear roles and responsibilities will improve staff performance and satisfaction. An interdisciplinary team approach will be utilized in all patient treatment planning and care.	

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	IDKT4M		C 04/03/2015

NAME OF PROVIDER OR SUPPLIER: SAFE HAVEN HOSPITAL OF POCATELLO

STREET ADDRESS, CITY, STATE, ZIP CODE: 1200 HOSPITAL WAY, POCATELLO, ID 83201

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BB117	Continued From page 16 i. Current licensure and/or certification status. (10-14-88) ii. The results of a Tuberculin Skin Test which shall be determined either by history of a prior positive, or by the application of a skin test prior to or within thirty (30) days of employment. If the skin test is positive, either by history or by current test, a chest X-ray shall be taken, or a report of the result of a chest X-ray taken within three (3) months preceding employment, shall be accepted. The Tuberculin Skin Test status shall be known and recorded and a chest X-ray alone is not a substitute. No subsequent annual chest X-ray or skin test is required for routine surveillance. (10-14-88) c. There shall be regularly scheduled departmental and interdepartmental meetings, appropriate to the needs of the hospital, and documentation of such meetings shall be available. (10-14-88) d. The chief executive officer shall serve as liaison between the governing body, medical staff and the nursing staff, and all other departments of the hospital. (10-14-88) e. Written policies and procedures shall be reviewed as needed. (10-14-88) This Rule is not met as evidenced by: Based on review of personnel records, policy review, and staff interview it was determined the Administrator failed to ensure staff received initial orientation and ongoing necessary to meet the needs of patients. The Administrator also failed to ensure the personnel files of RNs and LPNs contained evidence of current licensure. This had the potential to interfere with the quality and	BB117	Procedure for Implementation: Minutes will be kept daily of IDT meetings. Staff developer will coordinate orientation for all new staff members. New employees will receive a clear job description which will be provided during hiring process. Staff will provide HR with updated licensure, certificates, CE's, etc. Policy and procedures will be reviewed and revised by GB annually or more frequently as needed. Infection control nurse or designee to ensure staff are up to date on employee health statistics. Monitoring and Tracking: Licensure, certificates will be tracked by HR or designee. Designated committee members of Quality Assurance Program to gather necessary documentation. Findings to be reviewed with governing board at quarterly meeting. Title of Person(s) Responsible: Administrator, CNO, HR, Staffing Developer, Staffing Coordinator, Infection Control Coordinator, QAPI Nurse, Ward Clerk The previous hospital CNO also served as the Hospital Administrator and adjoined Skilled Nursing Facility Administrator. This arrangement failed to provide adequate oversight. A full time Hospital Administration and CNO have been hired that are dedicated to the management of hospitals daily operations and nursing services.	8/17/2015 8/17/2015

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BB117	Continued From page 17 safety of patient care and resulted in an unsafe environment for all patients. Findings include:	BB117		
	1. Refer to B173 as it relates to the Administrator's failure to ensure the CNO ensured staff licenses were current, staff received initial and ongoing training necessary to meet patients' behavioral and medical needs, and that appropriate nursing care was provided to all patients.		See also BB173	8/17/2015
	Refer to BB177 as it relates to the failure of the facility to ensure staff received orientation training to effectively perform their jobs.		See also BB177	8/17/2015
	Refer to BB178 as it relates to the failure of the facility to ensure staff received appropriate ongoing training.		See also BB178	8/17/2015
BB124	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: Based on review of policies, review of records, QAPI documents, and staff interview, it was determined the Governing Board failed to ensure the QAPI program was defined, maintained, and used data to identify opportunities for improvement or areas with problems to focus the program. Additionally, distinct quality	BB124	Action to Correct Deficit: A third party consultant was hired to help identify deficiencies and review/revise policy and procedures. A full time Hospital Administrator dedicated to the day to day management of the hospital operations has been appointed as well as a Chief Nursing Officer (CNO), Medical Director (MD) and an experienced QAPI Coordinator. Governing Body (GB) to attend regularly scheduled QAPI meetings. A fully developed, maintained and implemented QAPI Program will be in place. GB has been defined through revision of the GB Bylaws. GB, QAPI Coordinator, and third party consultant identified specific areas for improvement and committees were formed to address these areas of improvement. GB to determine what data are to be collected by QAPI.	

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BB124	Continued From page 18 improvement projects were not developed and conducted. These failures prevented the hospital from identifying ways to improve patient care through data gathering and analysis of findings. Findings include: 1. The hospital's policy titled Quality Assessment Performance Improvement Plan, dated 6/01/13, did not define the role of the Governing Board. The Governing Board, per policy, would review the QAPI program and plan annually. The policy stated the hospital would conduct "PI projects" and the projects would last between 3 and 12 months and would be interdisciplinary. The Quality Assessment Performance Improvement Plan policy further stated the hospital would organize "Performance Improvement Teams" to address "quality/departmental concerns." The policy stated an interdisciplinary "PI Committee" would meet "...at least monthly" to review and analyze data, review the status and effectiveness of PI projects, and discuss the need for additional projects. The policy was not specific. For example, a section titled "Data Collection" contained general language such as, "Data collection will be incorporated into existing processes and procedures" and "Data will be tracked and trended." Under the section labeled "Action to be Taken," the plan stated "Actions may include" and contained a list of items such as "Changing Process or System." A specific QAPI plan, including quality indicators, priorities, and time frames, was not documented between 1/01/14 and 3/31/15. There was no information as to how the Governing Board	BB124	A third party company has been secured to provide quality assurance to all hospital visits. This company will conduct random samples of discharged patients quality of care. This information will then be reported back to the Organization on a monthly basis and relayed back to the Hospital Administrator. On admission patients/legal representative will be educated by the admitting nurse/designee on their Patient Rights and will receive a printed copy. The Patient Rights has also been posted at the nurse's station along with a direct number to Safe Haven's CEO and COO to report immediate concerns. How Action Improves Process: The development of an interdisciplinary QAPI program will help eliminate adverse events by identifying opportunities for improvement. The QAPI program will provide direction to our facility to improve day to day operations and all patient outcomes. Procedure for Implementation: Governing Board meetings are scheduled quarterly with a mandatory attendance requirement. All designated committee members are to collect data, specified by the GB, and present all findings at quarterly meetings. GB will examine and identify performance improvement activities and a QAPI plan will be developed to meet attainable goals. Monitoring and Tracking: Adequate care and services will be monitored by several committees and presented to GB quarterly, or more often if necessary, to improve Hospital patient safety, outcomes, and satisfaction. Quarterly QAPI meetings will be held and the minutes retained to reflect content.	

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BB124	Continued From page 19 identified high risk, high volume, or problem-prone areas for data collection. The hospital did not have a QAPI plan which included measures to identify and prevent adverse events. a. An untitled and undated document listed QAPI goals. There was no documentation to show how long these items had been measured or how the data would be used. The goals included: - Safety checks will be completed 100% of the time with each shift. - No major prohibited items will be found. - A 10% decrease in falls within the next 30 days. - All infections will be tracked. - All skin problems will be tracked. - Staff will have no "occurrences" in the next 30 days. - The hospital will have "...zero medication errors." - - The hospital will have a decrease of "other occurrences" within 30 days. - Patients will attend at least 70% of groups. Data was collected during 2014, for each goal listed. There was no documentation, by the Governing Board, of a plan for a consistent method of data collection for each identified goal. Additionally, there was no documentation or plan for how the information gathered was analyzed, used for process improvements, or utilized in the development of PI projects. b. A summary of events for 2014, was documented on a monthly event report. The events, or occurrences, were related to both patients and staff. The events documented included: - A patient who was allergic to strawberries ate	BB124	Title of Person(s) Responsible: Governing Body, QAPI Coordinator	8/17/2015

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BB124	Continued From page 20 strawberry jam in February 2014. - A patient left against medical advice in March 2014. - A patient dropped an oxygen canister on his foot in June 2014. - A separate summary stated 3 occurrences were reported from April through June 2014 but the summary did not state what those occurrences were. - A summary noted 4 occurrences were reported in September 2014 but did not state what those occurrences were. - A summary documented 2 patient to patient altercations and 1 incident of destruction of property in October 2014. - A summary documented an overdose, a death, and arm scratches in November 2014. - A December 2014 summary noted 2 patient to patient altercations, seizures, self-harm occurrences, and a patient with a physical decline. There was no documentation to show the data gathered was used to decrease the frequency of occurrences. A specific analysis of the above occurrences was not documented. There was no plan documented by the Governing Board to decrease the number of reportable occurrences or events. Further, 3 Governing Board meetings were documented from 1/01/14 to 3/31/15. "Governing Board Committee Minutes," dated 1/16/14, mentioned goals and tracking for contraband, skin issues, restraints and the readiness of a blood glucose machine. "Governing Board Committee Minutes," dated 4/29/14, repeated verbatim the language from the 1/16/14 minutes. "Governing Board Committee Minutes," dated 7/24/14, mentioned the number of infections, skin	BB124		

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BB124	Continued From page 21 problems, falls, staff occurrences, and readmissions. None of the Governing Board Minutes documented discussion or analysis of QAPI data, plans, or projects. The SNF AIT was the hospital liaison with surveyors in the absence of the Administrator. He was interviewed on 4/02/15 beginning at 3:20 PM. He confirmed these were all of the Governing Board Minutes and no other documentation of the Board's involvement with the QAPI program was available. c. The Governing Body failed to ensure the QAPI program identified adverse patient events, analyzed their causes, and implemented actions to prevent further adverse events. Examples include: i. Patient #8 was a 65 year old male admitted to the facility on 3/06/15 for care related to dementia, psychosis, HTN, and PTSD. His medical record from 3/06/15 to 3/24/15 was reviewed, as well as records from ED visits on 3/23/15 and 3/24/15 at an acute care facility were reviewed. Patient #8's medical record from the receiving hospital stated he was admitted with 2 upper arm fractures and 1 hip fracture. A Pocatello police detective was interviewed on 3/31/15 beginning at 11:25 AM. He stated he had come to the hospital on 3/27/15 and talked with staff about allegations of abuse to Patient #8. The Co-Owner was interviewed on 4/02/15 beginning at 12:45 PM. She stated an incident	BB124		

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BB124	Continued From page 22 report had not been filed related to the fractures and potential abuse. She stated an investigation of events had not begun until 4/01/15. She stated action had not been taken related to the events. The Governing Body failed to ensure there was an investigation of a dangerous adverse patient event and failed to take action to protect patients. ii. Patient #5 was a 55 year old male admitted to the hospital from 3/09/15 to 3/25/15, for schizophrenia and depression. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local homeless shelter. The shelter had limited hours and did not open until 5:00 PM. A timeline was received on 4/03/15 at 3:30 PM from the SNF AIT, which outlined the events that happened after Patient #5's discharge from the facility: - Patient #5 was discharged at 3:30 PM. - Patient #5 was refused admittance to shelter because it was before 5:00 PM. - Patient #5 returned to shelter at 9:00 PM and was refused admittance. - Patient #5 returned to shelter at 1:00 AM and was refused admittance. He was reportedly bleeding from an unknown source at this time. Police were contacted by a shelter staff member. - During the course of the evening (the time was not documented) Patient #5 returned to the hospital and requested assistance. The staff member who went to the door refused to let him in stating the hospital did not offer emergency services. The staff member told Patient #5 he needed to leave. Patient #5 "returned banging on the doors and windows of the facility a couple	BB124		

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BB124	Continued From page 23 more times. Finally the nurse called the police and he took off." - Patient #5 went to the hospital's corporate office around 7:15 AM on 3/27/15. He did not have any personal belongings, wallet or ID. His face was "badly banged up." He had tape across his nose. - The corporate office found placement for Patient #5 in an ALF. The Director of Social Services was interviewed on 4/03/15 at 3:40 PM. She confirmed Patient #5's discharge and subsequent return to the hospital. She stated an incident report had not been written. She said she was not aware of an investigation into the events. The Governing Body failed to ensure there was an investigation of a dangerous adverse patient event. iii. Patient #10 was a 67 year old male admitted to the hospital on 11/07/14. His psychiatric diagnoses were conduct disorder and depression. Additional diagnoses included history of a stroke, seizure disorder, non-insulin dependent diabetes, and constipation. Patient #10 expired at the hospital on 11/17/14. Patient #10's record documented his weight upon admission as 132.2 pounds. Patient #10's record documented a steady decline in weight during his stay. On 11/17/14 Patient #10's weight was documented as 123 pounds, a loss of 9.2 pounds in 10 days. Patient #10's record documented the frequent refusal of meals. Patient #10's record included a flow sheet that documented no bowel movement on all shifts, from 11/07/14 to 11/17/14. Additionally, the nursing admission assessment did not document	BB124		

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BB124	Continued From page 24 his last bowel movement prior to admission. Patient #10's nursing and P.T. notes documented weight loss, complaints of pain and nausea, poor intake and lack of bowel movements, however, there was no documentation these significant finding were reported to his MD. Patient #10's History and Physical by the MD was dated 11/07/14. There were no progress notes to indicate the MD saw Patient #10 after 11/07/14 and his death on 11/17/14. There was no documentation of the medical care or nursing care that Patient #10 received prior to his death. The MD was interviewed on 4/01/15 beginning at 1:30 PM. He confirmed no investigation had been conducted into Patient #10's death or care. The Governing Body failed to investigate events leading to Patient #10's death and failed to evaluate the medical care provided. The Interim Quality Director was interviewed on 4/01/15 beginning at 3:05 PM. She stated the hospital had not conducted PI projects since at least 1/01/14. She stated the hospital had ongoing quality activities but a plan had not been developed that defined the overall QAPI program and directed staff as to how to carry out those activities. The Governing Board failed to define, oversee, and monitor the QAPI program.	BB124		
BB144	16.03.14.250.01 Medical Staff Qualifications and Privileges	BB144		

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BB144	Continued From page 25 250. MEDICAL STAFF. The hospital shall have an active medical staff organized under bylaws approved by the governing body and responsible to the governing body for the quality of all medical care provided the patients, and for the professional practices and ethical conduct of the members. (10-14-88) 01. Medical Staff Qualifications and Privileges. All medical staff members shall be qualified legally and professionally, for the privileges which they are granted. (10-14-88) a. Privileges shall be granted only on the basis of individual training, competence, and experience. (10-14-88) b. The medical staff, with governing body approval, shall develop and implement a written procedure for determining qualifications for medical staff appointment, and for determining privileges. (10-14-88) c. The governing body shall approve medical staff privileges within the limits of the hospital's capabilities for providing qualified support staff and equipment in specialized areas. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of medical records, Medical Staff Bylaws and contracts, it was determined the hospital failed to ensure the Medical Staff was well organized and was responsible to the hospital's Governing Board or that an individual physician was responsible for the conduct of the Medical Staff. This affected the care of 17 of 17 patients (#1 - #17) whose records were reviewed and resulted in the failure of the Medical Staff to assume responsibility for	BB144	See also BB115 Action to Correct Deficiency: An active Medical Staff (MS) has been organized under the MS bylaws (see attached) and approved by the Governing Body (GB). MS qualifications and privileges have been addressed and implemented under the MS bylaws. The Florida based psychiatrist is now residing full time in Pocatello and will be providing direct patient care for all new admission. She will also be participating in all daily meetings concerning treatment planning and patient care. How Action Improves Process: The process has been improved by a complete revision of the MS bylaws. The bylaws are specific to this facility and all of the terms outlined in IDAPA 60.3.14 have been addressed. The Medical Director will be responsible for the monitoring and tracking of assigned tasks by QAPI Coordinator. Procedure for Implementation: Credentialing and review process to be completed by Health Information Management (HIM). This process also to be overseen by Human Resources. The MS bylaws have been adopted by the GB and are strictly enforced, followed, and adhered to. Monitoring and Tracking: Compliance to Hospital Medical Bylaws will be monitored through required committee meetings 1 X monthly for 6 months than quarterly thereafter. Title of Person(s) Responsible: Organization's CEO, COO, CFO, Hospital Administrator, CNO, HIM, Human Resources	8/17/2015

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BB144	Continued From page 26 the care provided to patients. Findings include: 1. Safe Haven Hospital of Pocatello specialized in the treatment of patients with psychiatric conditions. The hospital's Bylaws included a policy "Patient Care," that was undated. The policy stated every patient shall be under the care of a physician. A physician shall be on duty or on call at all times, and shall provide onsite supervision when necessary. Additionally, the Bylaws stated the Governing Body required quarterly meetings of the Medical Staff. The hospital did not have a functional medical staff. A contract with a psychiatrist, dated 9/25/13, documented he became Medical Director on that date. The psychiatrist was interviewed on 4/02/15 beginning at 4:45 PM. He confirmed he had served as Medical Director through 3/31/15. He stated he no longer worked for the hospital. He stated while he was Medical Director there were 3 physicians (2 psychiatrists, including himself, and a Family Practice Physician). The prior Medical Director stated during his time as Medical Director he lived in Boise, Idaho, which is approximately 235 miles from the hospital. He stated he had not treated any patients at the hospital. He stated he started visiting the hospital in 2014. He stated since then he had been coming to the hospital one time a month to provide psychiatric oversight until 2 or 3 months ago, but there was no record of his activities at the hospital.	BB144		

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(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) COMPLETE DATE
BB144	Continued From page 27 The prior Medical Director stated a Family Practice Physician also worked at the hospital to provide for patients' medical care. The prior Medical Director stated he had not had contact with the Family Practice Physician. The prior Medical Director stated that during the 18 months he was Medical Director of the hospital, no Medical Staff meetings were held. He stated the hospital did not have a peer review program or other process to evaluate members of the Medical Staff or the care they provided. When asked how the hospital ensured patients were under the care of a physician, the prior Medical Director referred the surveyor to the Florida physician. The psychiatrist in Florida was interviewed on 4/03/15 beginning at 1:55 PM. She stated she did not see patients or provide any direct services. She stated she lived in Florida. The Florida psychiatrist stated she had agreed to be the hospital's current Medical Director but said she had not signed the contract yet. She stated she last visited the hospital in February 2015. She said she was coming to the hospital on April 9, 13, 14, and 15 of 2015, and then she would not come to the hospital again until the end of May 2015. The psychiatrist in Florida stated all direct services were provided by NPs. She stated she teleconferenced with the primary NP 2 times a week. She stated she discussed all patients who were admitted to the hospital with the NP. She stated the NP conducted all Psychiatric Evaluations (a comprehensive assessment of patients' psychiatric status and needs on admission) and she, the physician, edited them. She stated she reviewed all patients' Discharge	BB144		

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BB144	Continued From page 28	BB144		
	Summaries. She stated she was available by telephone for consultation most of the time. The Florida psychiatrist stated there was no record of her activities except for her signature on Psychiatric Evaluations and Discharge Summaries. The Florida psychiatrist stated the hospital did not have a peer review program or other process to evaluate members of the Medical Staff.			
	The Family Practice Physician was interviewed on 4/01/15 beginning at 1:30 PM. He stated he did not know the name of the prior Medical Director and had not met him. The Family Practice Physician stated he worked at a wound clinic and was not available to the hospital until after 3:00 PM.			
	An RN was interviewed on 4/02/15 beginning at 5:00 PM. She stated she called the Family Practice Physician in mid-March 2015 to clarify some orders he had written. She stated the physician told her not to call him and he would only accept text messages if she wished to communicate with him.			
	The Medical Staff did not oversee care at the hospital in accordance with hospital Bylaws.		A full time Hospital Administrator and Chief Nursing Officer have been appointed to enforce hospital medical Bylaws.	8/17/2015
	2. Refer to BB146 as it relates to the hospital's failure to ensure the Medical Staff assumed responsibility for care provided to patients #1 - #17.		See BB146	8/17/2015
	3. Refer to BB454 as it relates to the hospital's failure to ensure appropriate organization and staffing was provided to meet patients' inpatient psychiatric needs.		See BB454	8/17/2015

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BB146	Continued From page 29	BB146		
BB146	16.03.14.250.03 Required Hospital Functions 03. Required Hospital Functions. Each hospital shall have a mechanism in place to perform the following functions: (10-14-88) a. Coordinate all activities of the medical staff; and (10-14-88) b. Develop a hospital formulary and procedures for the choice and control of all drugs used in the hospital; and (10-14-88) c. Establish procedures to prevent and control infections in the hospital; and (10-14-88) d. Develop and monitor standards of medical records contents; and (10-14-88) e. Maintain communications between medical staff and the governing body of the hospital; and (10-14-88) f. Review clinical work of the medical staff. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of medical records and contracts, it was determined the Governing Body failed to ensure mechanisms were in place to review the clinical work of the Medical Staff. This affected the care of 17 of 17 patients (#1 - #17) whose records were reviewed. The lack of care and oversight by the medical staff had the potential to result in serious harm or death to all patients receiving services at the facility. Findings include: 1. Medical care was provided by 1 Family Practice Physician and 1 PA who served as his	BB146	Action to Correct Deficiency: Review of Medical Staff (MS) and services provided, to be completed by Governing Body (GB) which consists of a full time Hospital Administrator, CNO and Medical Director. These appointment were not in place at time of survey. The GB will be responsible for ensuring compliance to Bylaws of MS. Failure of physicians to follow contracts and Bylaws will be referred to the Organization for possible revision and/or cancellation of staff contracts. Medical Staff (MS) Bylaws have been completely revised to make them more adaptable to the facility's unique circumstances. The MS agree to abide by all of the Bylaws and sign a form stating their agreement. All MS members are expected to participate in the QAPI program and acceptance of the listed/ expected criteria of "Standards of Professional Practices" as listed in the Bylaws. Attending physicians are expected to attend weekly treatment team meetings to collaborate with, review and approve all treatment plans. Procedures to prevent and control infections have been developed. HIM will monitor for content, maintenance of communications, completeness, uniformity and MS clinical work. How Action Improves Process: Patient care will be greatly improved with the implementation of additional steps and requirements of the MS Bylaws. MD and HIM oversight of MS will result in improved patient outcomes. Compliance of staff to MS Bylaws in accordance with IDAPA 16.03.14.520.03 will provide increased patient care.	

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BB146	Continued From page 30 backup. A "PROFESSIONAL SERVICES AGREEMENT: MEDICAL SERVICES," dated 5/01/12, stated the Family Practice Physician would provide "including but not limited to, histories and physicals and basic medical care to patients at Safe Haven Hospital." The agreement stated the physician would be available by phone and come to the hospital when necessary for "basic medical services and care." This was not done. Medical services were not sufficient to meet patients medical needs. Examples include: a. Patient #10 was a 67 year old male admitted to the hospital on 11/07/14. His psychiatric diagnoses were conduct disorder and depression. Additional diagnoses included history of a stroke, seizure disorder, non-insulin dependent diabetes, and constipation. Patient #10 expired at the hospital on 11/17/14. Patient #10's record included an Inpatient Psychiatric Evaluation, completed by the NP on 11/07/14. The evaluation documented he was admitted from an assisted living facility due to verbally aggressive behaviors, inappropriate defecation and inappropriate sexual behavior. The evaluation stated "He has a bowel obsession....he refused to use the bathroom." Patient #10's record included an "ADMISSION HISTORY AND PHYSICAL," completed by the MD on 11/07/14. It documented Patient #10 had a bowel obsession and refused to use the bathroom. Additionally, it documented possible anorexia (loss of appetite) stating "He is on Megace without a diagnosis otherwise." Nursing 2015 Drug Handbook listed indications for	BB146	Procedure for Implementation: The MS Bylaws have addressed the guidelines as per IDAPA 16.03.14.520.03 and 42 CFR 482.12. MS sign acknowledgment of requirements. HIM oversight of MS will ensure compliance. MS attendance of weekly treatment meetings and participation in QAPI. Monitoring and Tracking: Monitored quarterly by Governing Body. Title of Person(s) Responsible: Organization's CEO, COO, CFO, Hospital Administrator, CNO, HIM, and Medical Director.	8/17/2015

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BB146	Continued From page 31 Megace, including anorexia, or unexplained significant weight loss. On 11/07/14 Patient #10's record documented his weight upon admission as 132.2 pounds. On 11/09/14, Patient #10's weight was documented as 129.9 pounds, a loss of 2.3 pounds in 2 days. On 11/11/14, Patient #10's weight was documented as 127.4 pounds, a loss of 4.8 pounds in 4 days. A nurses note signed by the RN on 11/15/14 at 10:10 PM, documented patient #10 vomited, the Family Practice Physician was notified, and an order for Phenergan for nausea was obtained. No documentation was present that the physician examined the patient. On 11/17/14 a Nursing flow sheet, signed by the RN at 7:50 AM, documented he complained of a stomach ache, however, it did not document a physical assessment, or the severity of the pain. A Nurses note signed by the RN at 8:05 AM, documented Patient #10 ate very little and complained of a stomach ache. A Patient Behavior Shift Summary for the day shift, from 6:00 AM to 6:00 PM, documented Patient #10 did not eat any of his meals and kept sliding out of his chair. Patient #10's weight was documented as 123 pounds, a loss of 9.2 pounds in 10 days. Patient #10's record included a flow sheet that documented he did not have a bowel movement on any shift, from 11/07/14 to 11/17/14. His nursing admission assessment did not document his last bowel movement prior to admission, so it was unclear how long it was since his last bowel movement. A nurses note, dated 11/17/14 at 5:00 PM,	BB146		

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BB146	Continued From page 32 documented the MD was notified Patient #10 was not feeling well, and orders were received for 2 bowel medications, Dulcolax and Senna. No documentation was present that the physician examined the patient. A nurses note dated 11/17/14 at 5:55 PM, and signed by the RN, documented a CNA reported Patient #10 did not look well and sounded "rattily [sic]." The RN's assessment noted hypoactive bowel sounds and crackles throughout his lungs. MD orders were obtained to transfer Patient #10 to the ED at an acute care hospital. The RN noted she placed phone calls to begin to arrange transport to the hospital. A nurses note dated 11/17/14 at 6:15 PM, documented staff reported Patient #10 was not breathing. The RN documented Patient #10 was unresponsive and 911 was called at that time. She also documented Patient #10 had a Do Not Resuscitate order. The circumstances of Patient #10's death were not documented. Patient #10's record included a death certificate with date and time of death documented 11/17/14 at 6:20 PM. The cause of death was listed as cardiorespiratory failure. The certificate was signed by the Family Practice Physician. Except for the history and physical on 11/07/14, Patient #10's medical record did not contain documentation of a physical assessment by a physician for the 10 days he was hospitalized. During an interview on 4/01/15 at 2:00 PM, the Family Practice Physician confirmed there were no progress notes to indicate Patient #10 was examined by a physician after the history and physical on 11/07/14.	BB146	The Hospital will meet the standard of care as outlined in IDAPA. Failure to do so of Medical Staff will be reported by GB to Organization to determine appropriate action.	8/17/2015

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BB146	Continued From page 33 The Family Practice Physician failed to monitor Patient #10's medical status for 10 days prior to his death. b. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14. Her psychiatric diagnoses were psychosis, bipolar disorder and congenital brain injury with mental disability. Additional diagnoses included renal insufficiency, CHF and diabetes. Patient #11 was transferred to an acute care hospital on 11/29/14, where she was admitted to the ICU. She died at the acute care hospital on 12/31/14. An "ADMISSION HISTORY AND PHYSICAL," conducted on 11/26/14, stated Patient #11 was morbidly obese and had chronic edema that was bordering on lymphedema (swelling caused by obstruction of the lymph system). Patient #11's record included a nurses note, dated 11/29/14 at 12:20 PM. The note stated the Family Practice Physician was notified Patient #11 had less than 75 cc's of urine output for the shift. Orders were obtained to start intravenous fluids and obtain blood for a complete metabolic panel, however, a nurses note stated the nurses were unable to insert the IV or draw the blood. A nurses note at 2:00 PM stated orders were received from the Family Practice Physician to transport Patient #11 to the ED at an acute care hospital. A nurses note at 3:10 PM stated Patient #11 was transported to the ED via the facility's van. Patient #11's ED record at the acute care hospital documented she was unresponsive, had a temperature of 92.5, blood pressure of 68/45, 3 + pitting edema in her lower extremities, and oxygen saturation level of 84% on 4 liters of	BB146	Education and training of all nurses on appropriate reporting protocol for significant patient changes. CNO to review nurse's flow sheets for completeness daily. HIM or designee to complete preliminary chart audit 24 hours after admission. This will be followed by a complete audit 48 and 72 hours after admission to ensure completeness of record. Policy effectiveness of the audit to be reviewed by GB via QAPI. See also BB463	8/17/2015

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BB146	Continued From page 34 oxygen. The Mayo Clinic website, accessed on 4/13/15, stated "Normal pulse oximeter readings range from 95 to 100 percent, under most circumstances. Values under 90 percent are considered low." The ED physician's assessment stated "[Patient #11] is critically ill with encephalopathy, septic shock, acute on chronic respiratory failure, acute on chronic kidney disease, and multiple medical problems." Patient #11 expired at the acute care hospital on 12/31/14. Patient #11's record did not document a physician examined her for medical follow up for the 3 days after her history and physical on 11/26/14. During an interview on 4/02/15 at 4:15 PM, the Family Practice Physician confirmed there were no progress notes to indicate Patient #11 was examined by a physician after the history and physical on 11/26/14. The Family Practice Physician failed to monitor Patient #11's medical status for 10 days prior to her transfer. c. Patient #8's medical record documented a 65 year old male admitted on 3/06/15 for care related to dementia, psychosis, PTSD and HTN. A history and physical was documented by the Physician Assistant on 3/08/15. A nurses note, on 3/23/15 at 10:50 AM, documented Patient #8 had a generalized seizure lasting 2.5 minutes. Afterwards, he was treated at a nearby hospital ED. The record documented he returned to Safe Haven Hospital on 3/23/15 at 5:30 PM. On 3/24/15 at 2:50 PM, Patient #8 was	BB146		

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BB146	Continued From page 35 again transferred to the ED at the other hospital for altered mental status. Patient #8's medical record from the receiving hospital documented he was admitted and was treated for fractures of both arms and 1 hip. No documentation was present stating Patient #8 was examined by a Safe Haven physician during his 18 day stay or by the PA except for the admission history and physical. RN C was interviewed on 4/01/15 beginning at 3:30 PM. She confirmed Patient #8's record did not contain physician documentation. d. Patient #12 was an 87 year old male admitted to the facility on 12/26/14 for psychiatric treatment related to dementia and psychosis. Additional diagnoses included chronic constipation and UTI. A History and Physical was documented by the PA on 12/28/14. Patient #12's admission orders included a mechanical soft diet with "Nectar thick" liquids. His admission orders also included an order for a Speech Therapy evaluation, however, his record did not indicate the evaluation was performed. In a nurses note dated 12/29/14 at 8:07 am, the RN documented Patient #12 had difficulty swallowing and had frequent coughing. A nurses note later that day, at 12:05 PM, documented Patient #12 had difficulty with swallowing and required small portions and nectar thick liquids. On 12/30/14 at 7:00 PM, the RN documented Patient #12 had decreased oxygen saturation levels at 81% (Normal is above 90%). The RN noted he was coughing and breathing shallowly. He was started on oxygen and was transferred to an acute care hospital.	BB146		

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BB146	Continued From page 36 No documentation was present stating Patient #12 was examined by a physician during his 4 day stay or that he was examined by a medical practitioner after his history and physical. The Family Practice Physician was interviewed on 4/02/15 beginning at 4:15 PM. He stated he did not remember Patient #12. He agreed Patient #12's medical record did not document contact with a physician. e. A medical history and physical was documented for all patients whose records were reviewed. Two medical records (Patients #8 and #12) documented the history and physicals were conducted by a Physician Assistant. The other records documented the history and physicals were conducted by a Family Practice Physician. The medical records of Patient #8 and Patient #12 did not contain documentation that any physician saw them during their hospitalization. None of the 17 medical records reviewed (Patients #1 - #17) contained documentation that patients were examined by the Family Practice Physician or the medical Physician Assistant except for the completion of the history and physical. The Family Practice Physician was interviewed on 4/02/15 beginning at 4:15 PM. When asked about the lack of practitioner visits, he stated if he had to see patients every day he would quit. RN B was interviewed on 4/02/15 beginning at 5:00 PM. She stated the Family Practice Physician was not responsive to nurses' queries about patients. She stated she had called the physician to clarify orders he had written. She	BB146		

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BB146	Continued From page 37 stated the physician told her not to call him. She stated he would only accept text messages if she wished to communicate with him. The prior Medical Director was interviewed on 4/01/15 beginning at 1:30 PM. He stated the hospital had no peer review or other process to evaluate the care provided by physicians. The hospital failed to ensure initial and ongoing medical care was provided by the Medical Staff. 2. Refer to BB173 as it relates to the failure of the hospital to ensure nursing services were organized and provided under the authority of a director of nursing services. 3. Refer to BB283 as it relates to the hospital's failure to ensure medical records included comprehensive information. 4. Refer to BB458 as it relates to the failure of the Medical Staff to oversee the use of physical restraints and forced treatments.	BB146	See also BB117 Action to Correct Deficiency:	
BB173	16.03.14.310.01 Director of Nursing Services 310. NURSING SERVICE. There shall be an organized nursing department with a plan that delineates authority, responsibility and duties of each category of nursing personnel, and a functional structure for cooperative planning and cooperation. An organizational chart shall be in the nursing service office and in all policy manuals. Job descriptions shall be available and in use which delineate responsibilities, functions or duties, and qualifications for each category of nursing positions. (10-14-88)	BB173	The Hospital has an organized Nursing department with a plan that delineates authority, responsibility and duties of each category of nursing personnel. All staff are educated and provided with an organizational flow chart. Job descriptions have been created with qualifications and responsibilities addressed. A qualified registered nurse has been appointed as the Chief Nursing Officer (CNO). The CNO oversees services implementation, organizes, coordinates, evaluates nursing service functions and staff, development and implementation of policies and procedures. The CNO provides direction to nursing staff as pertaining to patient care.	

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BB173	Continued From page 38 01. Director of Nursing Services. The nursing service shall be under the overall direction of a qualified registered nurse with education and experience commensurate with size and complexity of the hospital whose duties are as follows: (10-14-88) a. To organize, coordinate, and evaluate nursing service functions and staff; and (10-14-88) b. To be responsible for development and implementation of policies and procedures as they relate to care of patients; and (10-14-88) c. To select, promote, and terminate nursing staff; and (10-14-88) d. To establish a procedure to insure staff licenses are valid and current. (10-14-88) This Rule is not met as evidenced by: Based on observation, record review and staff interview, it was determined the hospital failed to ensure psychiatric nursing services were organized under the authority of a director of nursing services responsible for nursing staff and psychiatric nursing care provided in the hospital. This failure had the potential to impact all patients receiving care at the hospital. This also resulted in lack of oversight of nursing personnel, lack of valid and current nursing licenses, and negatively impacted the quality of care provided to patients. Findings include: 1. The facility's CNO position was vacant, and unofficially covered by an Administrator who was out of state at the time of the survey. a. The lack of a CNO resulted in the failure of the	BB173	How Action Improves Process: The CNO ensures adequate nursing services are provided to improve patient outcomes. Clear delineation of nursing roles and responsibilities have been addressed and formulated. The CNO provides guidance and direction to the nursing staff. Procedure For Implementation: A CNO has been hired to provide direction for nursing services. Organizational flow charts are included in employee handbooks and posted at the nurse's station to provide direction to staff. Job descriptions are provided at time the time of hire. Monitoring and Tracking: Monitoring and tracking of patient care issues by Governing Body, QAPI committee and HIM will ensure compliance of nursing staff. Staff job descriptions, orientation, personnel handbooks and employee evaluations will ensure expectations are met. Staff to provide and HR to maintain current licenses and certifications of all staff. Title of Person(s) Responsible: Governing Body, Nursing Staff, QAPI Coordinator, HIM, Human Resources.	8/17/2015

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BB173	Continued From page 39 hospital to ensure nursing personnel had valid and current licenses. i. The personnel records of 9 RNs were reviewed for evidence of current RN licensure. RN E's record included a limited RN license that expired on 11/24/13. There was no verification of a current license. RN C and RN F's records included RN licenses that expired on 8/31/13. There was no verification of current licenses. ii. The personnel records of 2 LPNs were reviewed for evidence of current LPN licensure. LPN A's record included a license that expired on 8/31/12. There was no verification of a current license. During an interview on 4/03/15 at 3:30 PM, the Human Resources Director reviewed the employee files and confirmed the 4 nurses' records did not include evidence of current licensure. The hospital failed to ensure all nursing staff were currently licensed to practice. 2. Refer to BB175 as it relates to the CNO's failure to ensure nursing care plans were developed, evaluated, and revised for each patient. 3. Refer to BB177 as it relates to the CNO's failure to ensure staff were provided initial training necessary to meet patients' medical and behavioral needs. 4. Refer to BB178 as it relates to as it relates to the CNO's failure to ensure staff were provided ongoing training necessary to meet patients' medical and behavioral needs.	BB173		

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BB173	Continued From page 40 5. Refer to BB182 as it relates to the CNO's failure to ensure an RN was designated to assume the CNO's duties when she was absent and that sufficient numbers of staff were provided to meet patients' needs. 6. Refer to BB226 as it relates to the CNO's failure to ensure ensure medications were properly dispensed and ordered. 7. Refer to BB454 as it relates to the hospital's failure to ensure adequate numbers of staff were provided to meet patients' needs. 8. Refer to BB463 as it relates to the failure of the hospital to ensure nursing services were under the direction of a CNO who would monitor, supervise, and evaluate nursing care provided to psychiatric patients, as well as, ensure adequate numbers of nursing and supportive personnel to provide for the medical and psychiatric needs of the patients.	BB173		
BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88)	BB175	See also BB173 Action to Correct Deficiency: A full time Hospital Administrator and Chief Nursing Officer (CNO) have been hired to ensure that Patient Care Plans are completed in a timely manner and maintained throughout hospitalization. All administration has been familiarized with policy and procedures regarding Patient Care Plans. The initial care plan will be completed by admitting nurse and completed with IDT input within 72 hours.	

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BB175	Continued From page 41 d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Based on observation, medical record review, and staff interview it was determined the facility failed to ensure thorough nursing care plans were developed, evaluated, and revised for 17 of 17 patients (#1 - #17) whose records were reviewed. Lack of a complete care plan had the potential to result in unaddressed patient care needs and interfere with coordination of patient care among staff members. Findings include: During an interview on 4/03/15 at 10:15 AM, the NP stated a nursing care plan should be part of an interdisciplinary treatment plan, however, the development of a nursing care plan was the responsibility of the CNO, and as they did not currently have a CNO, it was not being done. During an interview on 4/01/15 at 4:00 PM, RN C stated the CNO was in charge of creating nursing care plans. She said, "We don't have a DON [CNO] so it's not happening." 1. The records of 17 patients (#1 - #17) with an admission date range of 9/24/14 to 3/31/15, were reviewed. The 17 patient records did not include nursing care plans to address patient needs. Goals were not identified, and interventions were not initiated to minimize the risk of complications related to medical diagnoses. Examples included, but were not limited to, the following:	BB175	Social Services gathers all of the necessary pertinent information needed for patient admissions. Social Services/Program Director review identified problem listings with the legal patient representative (if necessary) within 72 hours of admission. Direct care staff are expected to become educated on Care Plans for each patient throughout hospitalization. Problem lists will be completed within 24 hours of admission by the Interdisciplinary Team (IDT). IDT meetings are daily, with days set aside to include patient/legal representatives to participate in treatment planning process. Chart audits are completed to review documentation. Treatment plans are reviewed and revised throughout the patient's hospitalization. In-service for all IDT members on Treatment Plan policy and procedures constantly evolves to ensure all patient care issues are addressed. How Action Improves Process: Patients receive competent and individualized care to meet their mental health and physical needs. Communications between IDT members and patient/legal representative, will result in improvement in patient care. Treatment Care Plans more accurately reflect patient conditions and needs on an ongoing basis. Patients/legal representatives have a clear understanding of treatment goals. IDT cohesion continues and increased improvement encourages continued team input from all IDT members.	

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BB175	Continued From page 42 a. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14, from a SNF. Patient #11's record included an Inpatient Psychiatric Evaluation, completed by the NP, and dated 11/26/15. It documented her medical problems as morbid obesity, diabetes, chronic renal insufficiency, chronic pain, CHF, hypoxia (inadequate oxygen supply to the body), epilepsy, hypothyroidism, constipation, edema, hyperlipidemia, and GERD. Patient #11's record included an Admission History and Physical, completed on 11/26/14 and signed by the MD. Continuing illnesses included chronic renal insufficiency, DM type 2, and CHF. Patient #11's record did not include a nursing care plan to address her needs related to her medical problems. Therefore, goals were not identified, and interventions were not initiated to minimize the risk of complications related to her co-morbidities. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it did not include a nursing care plan to address her co-morbidities of renal insufficiency, CHF, diabetes and constipation. RN C stated interventions were not developed at the time of Patient #11's admission, or updated during her hospitalization, to address her escalating symptoms. The facility did not ensure a nursing care plan was developed to address Patient #11's medical problems. b. Patient #10 was a 67 year old male admitted to the hospital on 11/07/14, from an ALF. Patient #10's record included an Inpatient Psychiatric	BB175	Procedures for Implementation: Patient Care Plans are reviewed on an ongoing basis which allows for modifications throughout hospital stays and thoroughly meets and addresses patient care needs. Hand-off documentation between providers encourages and includes de-escalation techniques and current behaviors. Monitoring and Tracking: Staff nurses (and/or designees) complete 24 hour chart audits. Signatures of IDT members and the patient(s) are signed and dated at completion of Patient Care Plan(s). The QAPI program tracks and monitors timeliness and completeness of Patient Care Plans on an on-going basis for accuracy and all minutes from the monitoring and tracking process are made available for all staff members concerned. Title of Personnel Responsible: Hospital Administrator, CNO, Staff Nurses, Ward Clerk, QAPI Coordinator, Social Services Director, Program Director and the Medical Staff.	8/17/2015

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BB175	Continued From page 43 Evaluation, completed by the NP on 11/07/14. The evaluation documented Patient #10 had a bowel obsession and refused to use the bathroom. It documented Patient #10's medical problems as hyperlipidemia, constipation, DM type 2, CVA (stroke), and chronic pain. Patient #10's record included an Admission History and Physical, completed on 11/07/14 and signed by the MD. Continuing illnesses included diabetes mellitus type 2, and possible anorexia (loss of appetite), stating "He is on Megace without a diagnosis otherwise." Nursing 2015 Drug Handbook listed indications for Megace, including anorexia, or unexplained significant weight loss. Patient #10's record did not include a nursing care plan to address his needs related to constipation, anorexia or diabetes. During an interview on 4/01/15 at 4:30 PM, RN C reviewed Patient #10's record and confirmed it did not include a nursing care plan. RN C confirmed a nursing care plan related to his DM was not created, therefore nursing interventions were not developed to monitor his blood sugar levels. During an interview on 4/03/15 at 1:15 PM, the NP reviewed Patient #10's record and stated she was not aware of his poor nutritional intake and lack of bowel movements. She confirmed his medical needs were not addressed during his hospitalization. The facility did not ensure a nursing care plan was developed to address Patient #10's medical problems.	BB175		

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BB175	Continued From page 44 c. Patient #15 was a 60 year old man who was a patient in the facility from 3/15/15 to 3/26/15. Patient #15's Inpatient Psychiatric Evaluation completed by the NP on 3/15/15, and History and Physical completed by the MD on 3/15/15, documented diagnoses of Hepatitis B and C. The Centers for Disease Control and Prevention website, accessed 4/09/15, stated Hepatitis B and C can be transmitted through exposure to the body fluids of an infected individual. Patient #15's record did not include a nursing care plan to address his needs related to hepatitis. Additionally, there was no documentation of a plan to prevent the transmission of Hepatitis to other patients and/or clinical staff. During an interview on 4/01/15 at 4:45 PM, RN C reviewed Patient #15's record and confirmed it did not include a nursing care plan. Additionally, she confirmed Patient #15 was not placed on precautions to prevent the possible transmission of Hepatitis B and C through his body fluids. The facility did not ensure a nursing care plan was developed to address Patient #15's medical needs and to prevent the spread of communicable disease. d. Patient #1 was a 40 year old male admitted to the facility on 3/26/15 to 3/31/15, from a local ED. Patient #1's record included an Admission H&P, completed on 3/26/15 and signed by the MD. The H&P documented diagnoses which included insulin dependent DM, diabetic neuropathy of extremities, chronic back pain, and Hepatitis C. The record did not include a nursing care plan to address Patient #1's needs related to his medical	BB175		

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BB175	Continued From page 45 problems. No goals were identified and interventions were not initiated to minimize the risk of complications related to his DM or to prevent the spread of his Hepatitis C while admitted to the facility. During an interview on 4/03/15 at 1:40 PM, the NP reviewed the record and stated she did not address or assess medical problems with patients. She stated this was the responsibility of the MD. During an interview on 4/01/15 at 5:40 PM, the RN reviewed the record and confirmed there was not a nursing care plan. The facility did not ensure a nursing care plan was developed to address Patient #1's medical needs and to prevent the spread of communicable disease. e. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. Patient #5's record included an Inpatient Psychiatric Evaluation, completed on 3/10/15 and signed by the NP. It documented his medical problems were GERD, chronic pain, and a subtotal colectomy (removal of part of the colon). Patient #5's record included an Admission H&P, completed on 3/09/15 and signed by the MD. His continuing illnesses included post-operative pulmonary embolism, anticoagulation therapy, GERD, history of MRSA (Methicillin resistant Staphylococcus aureus), and COPD. The MD documented Patient #5 had retention sutures on his abdomen upon admission, and they would need to be removed. The record did not include a nursing care plan to	BB175		

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BB175	Continued From page 46 address Patient #5's needs related to his medical problems. No goals were identified and interventions were not initiated to minimize the risk of complications related to his surgical incision or sutures, anticoagulation therapy, or to test or monitor for MRSA while admitted to the facility. During an interview on 4/01/15 at 5:20 PM, the RN reviewed the record and confirmed there was no nursing care plan to address Patient #5's medical issues. She confirmed Patient #5 should have been monitored for signs and symptoms of infection. The RN stated Patient #5 refused to have her or the MD remove his sutures in his abdomen. She confirmed there was no documentation this was discussed with the physician. The RN also stated she was unaware of Patient #5's history for MRSA. She stated his wounds were cultured for MRSA and came back negative. Further, the RN stated Patient #5's bleeding times were tested as ordered by the pharmacist. She confirmed there was no nursing care plan related to changes in his anticoagulation therapy, laboratory testing, or history of blood clots in the lung. Nursing failed to ensure a nursing care plan was developed to address Patient #5's medical problems. f. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an ALF. Patient #4's record included an Inpatient Psychiatric Evaluation, completed on 3/03/15 and signed by the NP. It documented his medical problems were seizures, hypothyroidism, organic brain syndrome, constipation, and history of tremors.	BB175		

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BB175	Continued From page 47 Patient #4's record included an Admission H&P, completed on 3/02/15 and signed by the MD. His continuing illnesses included seizures, hypothyroidism, organic brain syndrome, tremors, history of urinary retention, and constipation. The record did not include a nursing care plan to address Patient #4's needs related to his medical problems. No goals were identified and interventions were not initiated to minimize the risk of complications related to his seizures or to address his constipation while admitted to the facility. Patient #4's Inpatient Psychiatric Evaluation and Admission H&P included a diagnosis of seizures. The record did not include a care plan for monitoring for signs of seizure activity versus tremors. Additionally, there was not a nursing care plan for seizure precautions to maintain a safe environment. During an interview on 4/01/15 at 5:10 PM, the RN reviewed the record and confirmed there was no nursing care plan. She stated it was the CNO's responsibility to write those but since the previous CNO left in January of 2015, no care plans had been written. Nursing failed to ensure a care plan was developed and included in the record for Patient #4 for his medical problems. g. Patient #7 was a 39 year old male admitted to the facility on 3/23/15 to 4/01/15, from an ALF. Patient #7 was sent to a local hospital on 3/24/15 for an x-ray, the day after his admission, after punching a wall with his right hand the previous day. The nurse's note for the previous day,	BB175		

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BB175	Continued From page 48 3/23/15, did not include documentation of Patient #7 hitting a wall. Patient #7 was evaluated by the physician on 3/24/15 for his admission H&P. Under the section Review of Systems the physician documented Patient #7 had right hand pain. Patient #7 stated to the physician he hit a door. The physician documented Patient #7 had swelling over the mid portion of his right hand and the area was tender when touched. On 3/25/15, the nursing note documented Patient #7 refused to wear the splint prescribed for his right hand. The nursing note did not have documentation the physician was notified. A nurses note dated 3/31/15, documented Patient #7 complained of a vibrating sensation in his arm. However, the note did not specify which arm. There was no further musculoskeletal assessment documented. The nursing note had no documentation the physician was notified. Patient #7's discharge orders documented he was to make an appointment with the orthopedic physician for follow up related to a boxer's fracture in his right hand. The facility did not have an occurrence report for Patient #7's hand fracture related to hitting a wall after admission. During an interview on 4/01/15 at 5:05 PM, the RN reviewed the record and confirmed Patient #7 had a fracture to his right hand. Additionally, she confirmed a nursing care plan related to his fractured hand was not developed, and interventions were not implemented to monitor his injury. Nursing failed to develop and document a care	BB175		

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BB175	Continued From page 49 plan for Patient #7. h. Patient #17 was a 21 year old female admitted to the facility on 3/27/15. Her diagnoses included Type II DM, PTSD, and mild mental retardation. Patient #17's record did not include a nursing care plan to address her needs related to her medical problems. During an interview on 3/30/15 at 9:45 AM, RN C confirmed Patient #17's record did not include a Nursing POC or a Psychiatric Treatment POC. Patient #17's record did not include a nursing plan of care. i. Patient #12 was an 87 year old male admitted to the facility on 12/26/14. His diagnoses included chronic constipation and UTI. Patient #12's record did not include a nursing care plan to address his needs related to his medical problems. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #12's record and confirmed a nursing plan of care was not developed. Patient #12's record did not include a nursing plan of care. j. Patient #8 was a 65 year old male admitted to the facility on 3/06/15. His diagnoses included HTN. However, his medical record from 3/06/15 to 3/24/15, as well as, records from ED visits on 3/23/15, and 3/24/15, at an acute care facility, were reviewed. Patient #8's record did not include a nursing plan	BB175		

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BB175	Continued From page 50 of care. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #8's record and confirmed a nursing plan of care was not developed. Patient #8's record did not include a nursing plan of care. k. Patient #2 was a 65 year old female who was a patient in the facility from 3/25/15 to 4/01/15, with diagnoses of chronic neuropathy and asthma which required the use of oxygen. Patient #2's record did not include a nursing care plan. Her record did not include direction to staff to care for her neuropathic pain or her asthma. An interview was conducted with the NP on 4/03/15 beginning at 3:50 PM. She confirmed Patient #15 did not have a documented nursing care plan. The facility did not ensure a nursing care plan was developed to address Patient #2's medical needs. l. Patient #3 was a 79 year old female who was a patient in the facility from 3/25/15 to 4/01/15, with diagnoses that included chronic pain syndrome. Patient #3's record did not include a nursing care plan. Her record did not include direction to staff to care for her chronic pain. An interview was conducted with the NP on 4/03/15 beginning at 3:50 PM. She confirmed Patient #3 did not have a documented nursing care plan.	BB175		

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BB175	Continued From page 51 The facility did not ensure a nursing care plan was developed to address Patient #3's medical needs. m. Patient #9 was a 55 year old male who was a patient in the facility from 3/25/15 to 4/02/15, with diagnoses of asthma, chronic Hepatitis C, chronic pain, seizure disorder and narcolepsy. Patient #9's record did not include a nursing care plan. His record did not include direction to staff to care for his asthma, Hepatitis C, chronic pain, seizure disorder, or narcolepsy. An interview was conducted with the NP on 4/03/15 beginning at 3:50 PM. She confirmed Patient #9 did not have a documented nursing plan of care. The facility did not ensure a nursing care plan was developed to address Patient #9's medical needs. 2. Refer to BB455 as it relates to the hospital's failure to ensure written treatment plans were developed to meet the psychiatric and psycho-social needs of each patient.	BB175	See also BB117 Action to Correct Deficiency: Staff Orientation and educations to be completed and monitored under the direction of Human Resource Director. An administrator has been hired and is coordinating with Human Resources to ensure that all employees are meeting requirements as outlined in hospital policy and procedures. How Action Improves Process: The hospital will ensure staff are trained in the use of none physical intervention techniques, restraint or seclusion.	
BB177	16.03.14.310.05 New Employee Orientation 05. New Employee Orientation. An orientation shall be given to all new employees of the nursing service. (10-14-88) This Rule is not met as evidenced by: Based on review of personnel files and staff interview, it was determined the hospital failed to ensure staff were provided with sufficient orientation training for 12 of 18 staff (RN A, B,	BB177		

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NAME OF PROVIDER OR SUPPLIER: SAFE HAVEN HOSPITAL OF POCATELLO

STREET ADDRESS, CITY, STATE, ZIP CODE: 1200 HOSPITAL WAY POCATELLO, ID 83201

(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) COMPLETE DATE
BB177	Continued From page 52 and H, LPN A and B, P.T. A, B, D, E, F and G, and the Program Assistant) whose personnel records were reviewed. This resulted in an unsafe environment for all patients due to staffs' inability to demonstrate competency in the application of behavior intervention techniques and a failure to ensure staff were certified in the use of cardiopulmonary resuscitation. Findings include: 1. The personnel records of 18 direct care employees were reviewed, including 8 RNs, 2 LPNs, 7 P. T. s and 1 Program Assistant. The personnel records did not include documentation of crucial orientation training, as follows: a. The hospital's policy titled Restraints, effective 1/25/12, outlined training requirements related to restraint and seclusion for direct care staff. It stated all direct care staff would receive ongoing training in the causes of threatening behaviors, and techniques used to prevent injury. The hospital's policy stated seclusion and restraint would be used in emergency situations only when "Positive, individualized, alternative nonphysical intervention procedures have failed." Additionally, it stated staff who are authorized to physically apply restraint or seclusion received additional training in physical holding techniques and take down procedures. During an interview on 4/03/15 at 4:10 PM, the SNF AIT stated the hospital required all direct care staff to complete Mandt training upon hire and annually. He stated the hospital provided the training several times a year. The Mandt Systems website, accessed 4/07/15, stated "The Mandt System is a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an	BB177	Procedure for Implementation: Staff developer will coordinate orientation for all new staff members. New employees will receive a clear job description which will be provided during hiring process. Staff will provide HR with updated licensure, certificates, CE's, etc. Policy and procedures will be reviewed and revised by GB annually or more frequently as needed. Infection control nurse or designee to ensure staff are up to date on employee health statistics. Monitoring and Tracking: HR / designee to complete employee file audit one month following hire and annually thereafter. To complete employee file audit, a checklist has been created. Licensure, certificates will be tracked by HR or designee. Designated committee members of Quality Assurance Program to gather necessary documentation. Findings to be reviewed with governing board at quarterly meeting. Title of Person(s) Responsible: Administrator, CNO, HR, Staffing Developer, Staffing Coordinator, Infection Control Coordinator, QAPI Nurse, Ward Clerk	8/17/2015

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BB177	Continued From page 53 individual poses a threat of harm to themselves and/or others." The employee files of RN B and H, LPN A and B, P.T. B, D, E, F and G, and the Program Assistant did not contain documentation of Mandt training. During an interview on 4/03/15 at 3:30 PM, the Human Resources Director reviewed the personnel files and confirmed 10 of the 18 files reviewed did not include documentation of Mandt training. The facility failed to ensure staff responsible for the care of psychiatric patients were appropriately trained in the use of nonphysical intervention techniques, restraint or seclusion. b. The records of RN A, C and H, LPN B, and P.T. A, B, D, E and F, and the Program Assistant did not contain documentation of CPR certification. During an interview on 4/03/15 at 3:30 PM, the Human Resources Director confirmed all direct care staff were required to have current CPR certification. She reviewed the personnel records and confirmed the lack of documentation of current CPR certification. Appropriate hospital personnel were not certified in cardiopulmonary resuscitation.	BB177	See also BB117 Action to Correct Deficiency: Personnel files will be updated and monitored by corporate Human Resource Director. An administrator has been hired and is coordinating with Human Resources to ensure that all employees are meeting requirements as outlined in hospital policy and procedures. How Action Improves Process: The hospital will ensure staff are trained in the use of none physical intervention techniques, restraint or seclusion.	
BB178	16.03.14.310.06 Inservice/Continuing Education 06. Inservice/Continuing Education. An ongoing educational program shall be developed, implemented and evaluated for nursing service. (10-14-88)	BB178		

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BB178	Continued From page 54 This Rule is not met as evidenced by: Based on review of personnel files and staff interview, it was determined the hospital failed to ensure staff received sufficient ongoing training for 7 of 18 (RN C, D, E and G, LPN A and P.T. A and C) whose personnel records were reviewed. This resulted in an unsafe environment for all patients due to staffs' inability to demonstrate competency in the application of behavior intervention techniques and a failure to ensure staff were currently certified in the use of cardiopulmonary resuscitation. Findings include: 1. The personnel records of 18 direct care employees were reviewed, including 8 RNs, 2 LPNs, 7 P. T.s and 1 Program Assistant. The personnel records did not include documentation of crucial ongoing training, as follows: a. The hospital's policy titled Restraints, effective 1/25/12, outlined training requirements related to restraint and seclusion for direct care staff. It stated all direct care staff would receive ongoing training in the causes of threatening behaviors, and techniques used to prevent injury. The hospital's policy stated seclusion and restraint would be used in emergency situations only when "Positive, individualized, alternative nonphysical intervention procedures have failed." Additionally, it stated staff who are authorized to physically apply restraint or seclusion received additional training in physical holding techniques and take down procedures. During an interview on 4/03/15 at 4:10 PM, the SNF AIT stated the hospital required all direct care staff to complete Mandt training upon hire and annually. He stated the hospital provided the training several times a year. The Mandt	BB178	Procedure for Implementation: Staff will be required to provide all licensures, certificates, CE's, etc to HR to update their employee files. They will also be expected to meet all requirements of the facility pertaining to their individual job duties. HR to track and monitor. Policy and procedures will be reviewed and revised by GB annually or more frequently as needed. Infection control nurse or designee to ensure staff are up to date on employee health statistics. Monitoring and Tracking: HR / designee to complete employee file audit one month following hire and annually thereafter. To complete employee file audit, a checklist has been created. Licensure, certificates will be tracked by HR or designee. Designated committee members of Quality Assurance Program to gather necessary documentation. Findings to be reviewed with governing board at quarterly meeting. Title of Person(s) Responsible: Administrator, CNO, HR, Staffing Developer, Staffing Coordinator, Infection Control Coordinator, QAPI Nurse, Ward Clerk	8/17/2015

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BB178	Continued From page 55 Systems website, accessed 4/07/15, stated "The Mandt System is a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others." The employee files of RN C, D, E and G, and P.T. A and C contained Mandt training certificates that were expired. During an interview on 4/03/15 at 3:30 PM, the Human Resources Director confirmed the hospital required annual Mandt training for all direct care staff members. She reviewed the personnel files and confirmed 6 of the 18 records reviewed contained Mandt training certificates that were expired. The facility failed to ensure staff responsible for the care of psychiatric patients were provided with ongoing training in the use of nonphysical intervention techniques, restraint or seclusion. b. The records of RN E, LPN A, and P.T. C contained CPR certificates that were expired. During an interview on 4/03/15 at 3:30 PM, the Human Resources Director confirmed all direct care staff were required to have current CPR certification. She reviewed the personnel records and confirmed the lack of documentation of current CPR certification. The hospital failed to provide ongoing training necessary to ensure appropriate hospital personnel were currently certified in cardiopulmonary resuscitation.	BB178		

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BB182	Continued From page 56	BB182	See also BB117	
BB182	16.03.14.310.10 Staff Assignments 10. Staff Assignments. Registered nurses shall make assignments for nursing care. (10-14-88) a. In the absence of the Director of Nursing Services, an RN shall be designated to assume the director's duties. (10-14-88) b. There shall be a registered nurse on duty at all times. (10-14-88) c. There shall be twenty-four (24) hour registered nurse coverage in critical care areas in accordance with Subsection 420.02.d. Exception: small hospitals may have an available registered nurse on call to the critical care unit, when there are no patients in the critical care unit. (12-31-91) d. No person will be assigned nursing duties (aides and orderlies included) who has been on duty in the facility during the preceding twelve (12) hours, except in an emergency. (10-14-88) e. There shall be sufficient numbers of nursing personnel in all categories to ensure quality of patient care. (10-14-88) f. Personnel who have a communicable disease, infectious wound or other transmittable conditions and who provide care or services to patients shall be required to implement protective infection control techniques approved by administration; or be required not to work until the infectious stage is corrected; or be reassigned to a work area where contact with others is not expected and likelihood of transmission of infection is absent; or seek other remedy to avoid spreading the employees infection. (10-14-88)	BB182	Action to Correct Deficiency: The Hospital has an organized Nursing department with a plan that delineates authority, responsibility and duties of each category of nursing personnel. All staff are educated and provided with an organizational flow chart. Job descriptions have been created with qualifications and responsibilities addressed. A qualified registered nurse has been appointed as the Chief Nursing Officer (CNO). In the absence of the CNO, an RN will be designated to assume the duties and responsibilities therein. How Action Improves Process: The CNO ensures adequate nursing services are provided to improve patient outcomes. Clear delineation of nursing roles and responsibilities have been addressed and formulated. The CNO provides guidance and direction to the nursing staff. Procedure For Implementation: A CNO has been hired to provide direction for nursing services. Organizational flow charts are included in employee handbooks and posted at the nurse's station to provide direction to staff. Job descriptions are provided at time the time of hire. Monitoring and Tracking: Monitoring and tracking of patient care issues by Governing Body, QAPI committee and HIM will ensure compliance of nursing staff. Staff job descriptions, orientation, personnel handbooks and employee evaluations will ensure expectations are met. Staff to provide and HR to maintain current licenses and certifications of all staff.	

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BB182	Continued From page 57 g. A registered nurse shall make assignments of nursing care to nursing assistants. (10-14-88) h. Private duty nurses shall be currently licensed in Idaho and shall comply with all hospital rules and regulations, and be under the general direction of the appropriate DNS. (10-14-88) i. Private duty nurses shall not be assigned to critical care areas unless properly oriented and fully trained to the policies and procedures of the hospital. (10-14-88) This Rule is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure nursing services were organized under the authority of a director of nursing services and that an RN was designated to assume responsibilities when the Director of Nursing was unavailable. This resulted in lack of oversight of nursing personnel, a lack of sufficient nursing personnel on duty, and negatively impacted the quality of care provided to patients. Findings include: 1. A job description, titled "Chief Nursing Officer (CNO) - Hospital," revised 3/2015, listed duties and responsibilities. One of the responsibilities listed was "24 hour coverage is expected, if you cannot be reached, assign another person to cover." During an interview on 4/01/15 at 9:35 AM, the co-owner of the hospital stated the CNO resigned in January and they were currently looking for a replacement. She stated the Administrator was currently acting as CNO. Additionally, she stated the Administrator/CNO was out of town for a	BB182	Title of Person(s) Responsible: Governing Body, Nursing Staff, QAPI Coordinator, HIM, Human Resources. A full-time CNO has been hired to assume Hospital duties. In the absence of a CNO, a qualified Registered Nurse will be appointed to assume those duties.	8/17/2015 8/17/2015

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BB182	Continued From page 58 week and no one was designated to oversee clinical services while she was out of town. During an interview on 4/01/15 beginning at 9:05 AM, RN C, the Charge Nurse, stated nobody was designated as Acting CNO while the Administrator was out of town. She stated she did not know who to call if there was a nursing problem. During an interview on 4/03/15 at 10:10 AM, RN E stated she thought the Administrator was also the CNO. She stated there had been no formal announcement but she assumed the Administrator took over the CNO role. She stated she did not know who the Acting Administrator was or who the Acting CNO was on the date of the interview (while the Administrator was out of town.) During an interview on 4/02/15 at 5:00 PM, RN B stated her first day on the job was 3/23/15. She stated it was her understanding there was no CNO. When asked who she would call with a question or problem, she stated she did not know. The Administrator was interviewed by phone on 4/02/15 beginning at 2:15 PM. She stated she assumed the role of the Interim CNO in January 2015 when the former CNO resigned. She stated there was no documentation stating she was the Interim CNO. She stated an Acting CNO had not been appointed while she was out of town. The Administrator was on leave, and failed to appoint an RN in her absence to serve as a temporary CNO, as well as, inform nursing staff of who to contact if nursing issues arose. 2. Refer to BB454 as it relates to the hospital's failure to ensure an adequate number of staff	BB182		

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BB182	Continued From page 59 were provided to meet patients' health, safety and inpatient psychiatric needs.	BB182		
BB226	16.03.14.330.06 Safe Handling of Drugs 06. Safe Handling of Drugs. In addition to the rules listed below, written policies and procedures which govern the safe dispensing and administration of drugs shall be developed by the pharmacy and therapeutics committee with the cooperation and the approval of the medical staff. (10-14-88) a. The pharmacist shall review the prescriber's original order or a direct copy thereof; and (10-14-88) b. The pharmacist shall develop a procedure for the safe mixture of parenteral products; and (10-14-88) c. All medications shall be administered by trained personnel in accordance with accepted professional practices and any laws and regulations governing such acts; and (10-14-88) d. Each dose of medication administered shall be properly recorded as soon as administered in the patient's medication record which is a separate and distinct part of the patient's medical record; and (10-14-88) e. Drug reactions and medication errors shall be reported to the attending physician and pharmacist in accordance with hospital policy. (10-14-88) This Rule is not met as evidenced by: Based on staff interview, record review, policy	BB226	Action to Correct Deficiency: The Hospital has contracted pharmaceutical services that are directed by a registered pharmacist with a drug storage area under their supervision and the needs of the patients. The pharmacist and MS have developed policies and procedures that minimize drug errors. All compounding, packaging and dispensing of drugs/biologicals is under the Pharmacist's supervision and in accordance with applicable standards of practice, consistent with Federal and State Law. Drug administration errors, adverse drug reactions and incompatibilities are immediately reported to attending physicians and addressed to the QAPI program. Information relating to drug interactions and information of drug therapy, side effects, toxicology, dosage, indication for use and routes of administration have been addressed through and educational process for all patient care staff. Policies, guidelines are in place for assurance of proper recording of patient medications by MS, MD, and Nursing. All admissions will be photographed and receive a wristband with two patient identifiers for further verification of identity and any medication or food allergies. The nurse administering medications will only administer medications to one patient at a time. Patients will be advised and educated about their medications prior to administration.	

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BB226	Continued From page 60 review, and observation, it was determined the facility failed to ensure medications were properly dispensed and ordered for 9 of 17 patients (#1, #4, #5, #7, #8, #13, #15, #18, and #19) whose records were reviewed and/or medication administrations were observed. This failed practice resulted in the potential for errors in dosage, medication delivery, and possible adverse reactions. Findings include: 1. A hospital policy titled "Administration of Medications," revised 1/31/04, stated "Accurate patient identification will be made by photo identification. A photo of each patient will be placed in the MAR and one placed in the patient record." During an interview on 3/30/15 beginning at 2:20 PM, LPN B stated wristbands with patient names and information were not used in the facility. During an interview on 3/31/15 at 1:55 PM, RN D also stated patients did not wear wristbands with patient names or information on them. She stated she verified their identity by sight. Two nurses were observed on two separate days preparing and administering medications. The medication room was located in a small room behind the nurses' station. The MAR for each patient was in a binder. However, the patient records and MARs did not include patient photos. When the medications were ready to be administered, the nurse left the medication room to give the medications to the patients. a. During an observation of medication administration on 3/30/15 beginning at 1:55 PM, LPN B was observed preparing and administering medications. LPN B was observed to take medications to two separate patients.	BB226	How Actions Improves Process: Adverse patient drug events will be reduced. Implementations will improve the patient medication process. With oversight of the medication process, adverse events will be eliminated and addressed. CNO has developed a new policy and procedure for the safe administration of medications. All staff will be in-serviced by CNO on policy and procedures. All recommendation by pharmacists will be adopted and implemented as deemed appropriate. Procedure for Implementation: GB, MS Bylaws have addressed the correct processes and procedures for drug intervention. Quality Assessment and PI programs are in place for implementation. The Pharmacist's development of procedures for safe mixture of parental products have been implemented. A formulary system has been established by the MS. Monitoring and Tracking: CNO will review MAR daily and any deviations to be reported to QAPI committee daily and GB quarterly. The Pharmacy Therapeutic Committee minutes are reviewed by the GB, MS, The Organization, Administrator and CNO for compliancy and for tracking purposes. The Pharmacist reports will address all concerns that have been identified. On admission patients/legal representative will be educated by the admitting nurse/designee on their Patient Rights and will receive a printed copy. The Patient Rights has also been posted at the nurse's station along with a direct number to Safe Haven's CEO and COO to report immediate concerns.	

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BB226	Continued From page 61 i. LPN B approached Patient #18 and called out her first name. She gave her the medications without verification of her identity. Patient #18 asked LPN B what she was getting, and the LPN told her what the medication was. ii. LPN B then administered Patient #19's medication. She went to Patient #19 and stated "It's time for your medication." She did not verify Patient #19's identity. After administering the medication, she returned to the medication room to sign the MAR. b. During an observation of medication administration on 3/31/15 beginning at 1:45 PM, RN D was observed preparing and administering medications. RN D was observed to give medications to Patient #7 and Patient #18. She approached the patients and stated their names. She stated "I have your normal medications." Both Patient #7 and Patient #18 asked what medications they were taking. RN D provided more information by naming the medication and why it was prescribed. Patients did not have wristbands with their identification on them, and there were no photographs in the MAR to identify patients by photo. During an interview on 4/01/15 beginning at 3:30 PM, RN C reviewed and confirmed the medication administration policy. She stated the facility at one time had a camera to take patient photos, but it broke and was not replaced. The facility failed to ensure the proper identity of patients prior to administering medication. 2. The patients' MAR included a section for the clinician to sign with their initials, to indicate the	BB226	Title of Person(s) Responsible: Facility Pharmacist, CNO, Medical Staff, Medical Director, Administrator, Nursing Staff, Ward Clerk and Medical Records Personnel	8/17/2015

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BB226	Continued From page 62	BB226		

medication was administered. Each dose of medication administered would therefore have initials in the section under the corresponding date and time. However, nursing staff failed to document medications were administered, patient refusal of medications, as well as the reasons for refusal of medications.

a. Patient #8 was a 65 year old male admitted to the facility on 3/06/15 for care related to dementia, psychosis, HTN, and PTSD. His medical record from 3/06/15 to 3/24/15, as well as records from ED visits on 3/23/15 and 3/24/15 at an acute care facility, were reviewed.

Patient #8's 3/16/15 MAR included 6 pages of medications that were scheduled to be routinely administered. The following medications were not documented as given:

- Folic Acid 1 mg at 8:00 AM,
- B Vitamin Complex 1 tablet at 8:00 AM,
-Vitamin C 500 mg at 8:00 AM,
- Metoprolol 12.5 mg at 8:00 AM,
- Prazosin HCL 1 mg at 8:00 AM,
- Aspirin 81 mg at 8:00 AM,
- Lipitor 40 mg at 8:00 AM,
- Levothyroxine 50 mcg at 8:00 AM,
- Memantine 5 mg at 8:00 AM,
- Prednisone 1 mg at 8:00 AM,
- Venlafaxine 75 mg at 8:00 AM,
- Cholecalciferol 5,000 units at 8:00 AM,
- Multivitamin 1 tablet at 8:00 AM,

During an interview on 4/01/15 beginning at 3:30 PM, RN C reviewed Patient #8's MAR. She confirmed the initials of the clinician were missing for the medications to be administered on 3/16/15 at 8:00 AM. RN C was not able to determine if the medications were not administered, or if the

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BB226	Continued From page 63 clinician did not sign for them. Patient #8's MAR did not reflect if medications were administered, refused, or not documented as given. b. Patient #15 was a 60 year old man admitted to the facility on 3/15/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. i. The back of Patient #15's MAR included a section titled "PRN and Medications Not Administered," to document the date, time, medication and reason for a PRN given or a medication not given. Patient #15's MAR included the following medications to be administered daily at 8:00 AM : -Vitamin D 1000 Units -Folic Acid 1 mg -B Vitamin Complex 1 tab -Vitamin C 500 mg On 3/15/15, 3/18/15, 3/19/15, 3/21/15, 3/23/15, 3/24/15, 3/25/15, and 3/26/15, the MAR included circled initials for the 4 medications, indicating the medications were not administered. However, there was no documentation on the back of the MAR stating the reason the medications were not administered. Patient #15's MAR included Zyprexa 10 mg po/IM twice a day, beginning 3/20/15. On 3/23/15, 3/24/15, and 3/26/15, the MAR included circled initials for the morning and evening doses. On 3/21/15, the MAR included circled initials for the morning dose. On 3/22/15, the MAR included circled initials for the evening dose. However, there was no documentation on the back of the	BB226		

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BB226	Continued From page 64 MAR stating the reason the medication was not administered. ii. Nursing staff failed to document the time and/or reason PRN medications were administered to Patient #15. - An entry on the MAR documented Zyprexa 10 mg IM was administered on 3/15/15, however, the time of administration was not documented. - Patient #15's MAR included Geodon 40 mg po (by mouth) PRN, and stated "can override with 20 mg IM if PO dose refused." An entry on the MAR documented Geodon 20 mg IM was given on 3/20/15. The time of administration was not documented. Additionally, there was no documentation of refusal of the po medication, or of the reason for the PRN medication. During an interview on 4/01/15 at 4:45 PM, RN C reviewed Patient #15's record and confirmed the reasons PRN medications were given and the reasons scheduled medications were not given was not documented on his MAR. Patient #15's MAR did not include documentation of the reason PRN medications were given, or the reason scheduled medications were not given. 3. Patient medication reconciliation was incomplete and nursing administered medications to patients without a provider order. a. Patient #15 was a 60 year old man admitted to the facility on 3/15/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. Patient #15's record included a MAR, that listed	BB226		

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BB226	Continued From page 65 medications and the times they were to be administered to him by hospital staff. The MAR, effective 3/15/15, included Seroquel, Vitamin D, Folic Acid, B Vitamin Complex, Vitamin C, MOM, antacid of choice, and Tylenol. However, Patient #15's record included a hospital admission order form dated 3/15/15, and signed by the RN and the NP. A section of the form included standing orders, which stated "Please put a check mark in the appropriate boxes." The boxes next to the following medications were not checked: - Vitamin D 1000 units daily - Folic Acid 1 mg daily - B Vitamin Complex 1 tab daily - Vitamin C 500 mg daily - MOM 30 cc by mouth every 12 hours for constipation - Antacid of choice 30 cc by mouth 4 times a day as needed - Tylenol 650 mg for mild discomforts Another section of the form included Patient #15's pre-admission medication, Seroquel, 300 mg daily. The section included boxes next to "Continue" and "Stop" to indicate if the medication was to be given while the patient was in the hospital. Neither box contained a check mark. During an interview on 4/01/15 at 3:25 PM, the hospital's pharmacist reviewed Patient #15's record and confirmed his admission orders, signed by the NP, did not include check marks next to the medications, making it unclear if they were to be administered. She stated she talked to the RN on duty on 3/16/15, who said the medications were to be given to Patient #15. She stated she did not speak with the NP who signed	BB226		

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BB226	Continued From page 66 the orders, to verify the medication orders. During an interview on 4/03/15 at 10:15 AM, the NP reviewed Patient #15's admission orders and confirmed the boxes were not checked. She stated the boxes should be checked by the provider to confirm the medications were to be administered. The facility failed to ensure Patient #15's medications were ordered by a provider. b. Patient #1 was a 40 year old male admitted to the facility on 3/26/15 to 3/31/15, from a local ED. His psychiatric diagnoses included schizoaffective disorder, substance dependence, and PTSD. Patient #1's record included a hospital admission order form dated 3/26/15, and signed by the NP. A section of the form included standing orders, which stated "Please put a check mark in the appropriate boxes." The boxes were not checked for the following medications: - Vitamin D 1000 units daily - Folic Acid 1 mg daily - B Vitamin Complex 1 tab daily - Vitamin C 500 mg daily Patient #1's MAR documented he received each of these medications daily from 3/26/15 to 3/31/15. During an interview on 4/03/15 at 4:40 PM, the NP reviewed the record and confirmed these medications were not ordered. She further confirmed the medications were given to Patient #1 without an order. Medications were administered to Patient #1	BB226		

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BB226	Continued From page 67 without a provider order. c. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an ALF. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included a hospital admission order form dated 3/02/15, and signed by the NP. The admission order form included a section for medication reconciliation of current medications. Patient #4's current medications were listed in the medication reconciliation section with the name, dosage, route, and frequency. Twenty seven medications were listed. Next to the name of each medication were two boxes. One box was labeled "Continue" and the other box was labeled "Stop." Neither of the boxes were marked for the 27 current medications that were listed for Patient #4. A medication tracking record was created daily for Patient #4 during his admission. The medication tracking record listed the medications prescribed for Patient #4, including changes to his medications and dosages during his stay. PRN medications were also included on the form. Patient #4's current medications were listed on his MAR and the medication tracking record dated 3/02/15. He was receiving the medications beginning 3/02/15. During an interview on 4/03/15 at 4:50 PM, the NP reviewed the record and confirmed Patient #4's current medications were not ordered on his admission to be continued. She further confirmed the medications were given to Patient #4 without an order.	BB226		

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BB226	Continued From page 68 Patient #4's current medications were given without a provider order to continue them. d. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia and depression. Patient #5's record included a hospital admission order form dated 3/09/15, and signed by the NP. The admission order form included a section for medication reconciliation of current medications. Patient #5's current medications were listed in the medication reconciliation section with the name, dosage, route, and frequency. Eleven medications were listed. Next to the name of each medication were two boxes. One box was labeled "Continue" and the other box was labeled "Stop." Neither of the boxes were marked for the 11 current medications that were listed for Patient #5. A medication tracking record was created daily for Patient #5 during his admission. The medication tracking records listed the medications prescribed for Patient #5, including changes to his medications and dosages during his stay. PRN medications were also included on the form. Patient #5's current medications were listed on his MAR and the medication tracking record dated 3/09/15. He was receiving the medications beginning 3/09/15. During an interview on 4/03/15 at 1:35 PM, the NP reviewed the record and confirmed Patient #5's current medications were not ordered on his admission to be continued. She further	BB226		

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BB226	Continued From page 69 confirmed the medications were given to Patient #5 without an order. Patient #5's current medications were given without a provider order to continue them. e. Patient #7 was a 39 year old male admitted to the facility on 3/23/15 to 4/01/15, from an ALF. His psychiatric diagnoses included schizoaffective disorder, bipolar disorder, and substance abuse. Patient #7's record included a hospital admission order form dated 3/23/15. The admission order form included a section for standing orders and another section listed Patient #7's current medications. On the form it documented Patient #7 was currently taking 16 medications and those medications were to be continued. Additionally, the form included orders for Patient #7 to receive the standing order medications. The hospital admission order form was not signed by the psychiatrist or the NP. Patient #7's record included physician verbal orders for admission to the facility. A telephone order dated 3/23/15 at 7:10 PM, and signed by the RN, documented Patient #7 was admitted to the facility and his current medications were to be continued. The telephone order did not include standing order medications. Patient #7's current medications were not listed on the order form. The admission order was not signed by the NP as of 4/03/15. The MAR's included in Patient #7's record documented he received the standing order medications daily beginning 3/24/15, until his discharge. Additionally, his current medications were listed and documented as taken daily by Patient #7 beginning on 3/23/15.	BB226		

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BB226	Continued From page 70 During an interview on 4/03/15 at 4:50 PM, the NP reviewed the record and confirmed the admission order was not signed on either document. She confirmed Patient #7 was receiving medications listed on the medication reconciliation form. Medications were administered to Patient #7 without a signed order by a provider. 4. Nursing did not administer ordered medications to patients. Patient #13 was a 69 year old male admitted to the hospital on 1/01/15, with diagnoses of psychosis and depression. Patient 13's record included an order for Seroquel 25 mg to be given daily at bedtime. The order was signed by the NP on 1/04/15 at 6:05 PM. Patient #13's record included a medication administration record with a handwritten entry of Seroquel 25 mg to be given daily at 8:00 PM. The entry noted the start date for the Seroquel was 1/05/15. Seroquel was not administered to Patient #13 at bedtime on 1/04/15, as ordered. During an interview on 4/01/15 at 4:20 PM, RN C reviewed Patient #13's record. She stated when a new medication is ordered the first dose should be given that day unless the order states otherwise. She confirmed Patient #13 should have been given a dose of Seroquel at bedtime on 1/04/15. During an interview on 4/03/15 at 11:10 AM, the NP who wrote the Seroquel order stated it was to be started on 1/04/15. She was unable to explain	BB226		

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BB226	Continued From page 71 why Patient #13 did not receive the first dose at bedtime on 1/04/15. Patient #13 did not receive his medication as ordered.	BB226		
BB283	16.03.14.360.12 Record Content 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant which includes his findings; and (10-14-88) ii. Progress notes written by the attending physician; and (10-14-88)	BB283	See BB124, BB175, BB460, BB461, BB462 Action to Correct Deficiency: Due to lack of Hospital Administrator oversight, HIM failed to ensure patient records were complete. Since the time of survey, a full time Administrator has been hired to oversee the day to day management of the hospital. HIM has implemented PI processes to enhance patient information/records through assigned tasks for prompt completion. A coding and records system has been implemented for accuracy. The system allows for timely retrieval of diagnosis and procedures in order to support medical care. Orders and protocols are consistent with nationally recognized and evidence-based guidelines. IDT to meet regularly with patients/legal representative throughout hospitalization for treatment planning. How Action Improves Process: Inclusion of accurate and sufficient data to the medical record will provide the evidence for diagnosis and warranted treatment and decrease negative patient outcomes. Procedure for Implementation: Revision of Hospital policies, MS bylaws, education to staff about changes and revisions. Daily audits of patient chart to be completed to ensure all necessary documentation is contained within. All contact with legally responsible person(s) will be documented throughout hospitalization.	

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BB283	Continued From page 72 iii. Progress notes written by the nursing personnel; and (10-14-88) iv. Progress notes written by allied health personnel. (10-14-88) f. Reports of special examinations including but not limited to: (10-14-88) i. Clinical and pathological laboratory findings; and (10-14-88) ii. X-ray interpretations; and (10-14-88) iii. E.K.G. interpretations. (10-14-88) g. Conclusions which include the following: (10-14-88) i. Final diagnosis; and (10-14-88) ii. Condition on discharge; and (10-14-88) iii. Clinical resume and discharge summary; and (10-14-88) iv. Autopsy findings when applicable. (10-14-88) h. Informed consent forms. (10-14-88) i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90) i. Name and affiliation of requestor; and (3-1-90) ii. Name and relationship of requestee; and (3-1-90)	BB283	Monitoring and Tracking: HIM to monitor program for completeness bi-weekly. Daily patient chart audit to be completed under the direction of HIM.QAPI to receive HIM reports for presentation to the GB at the quarterly meetings. Title of Person(s) Responsible: Nursing, MS, Hospital Administrator, CNO, Pharmacist, HIM, Ward Clerk, GB and Organization	8/17/2015

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BB283	Continued From page 73 iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when applicable. (3-1-90) This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure medical records included comprehensive information for 6 of 17 patients (#1, #5, #10, #11, #13, and #15) whose records were reviewed. This had the potential to result in the inability of patients or their representatives to make informed decisions about their care, a lack of comprehensive and individualized treatment for patients admitted to the hospital, and the potential for discharged patients to experience a deterioration in health status and/or possible readmission to an acute care facility. Findings include: 1. The facility failed to obtain consent for services and involve patients and their guardians in care decisions. a. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14, from a skilled nursing facility, with diagnoses of psychosis, bipolar disorder and congenital brain injury with mental disability. Patient #11's medical record for her hospital admission of 11/25/14 to 11/29/14 was reviewed. Her record included a letter of guardianship and conservatorship. The letter stated Patient #11 was impaired to the extent she was unable to make responsible decisions. Patient #11's record did not include documentation of contact with her guardian to	BB283		

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BB283	Continued From page 74 obtain consent for services or to discuss care planning and treatment. Patient #11's record did not include an admission agreement or a consent for services. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it did not include signed consent forms. Additionally, she confirmed there was no documentation of contact with Patient #11's guardian. The facility failed to obtain consent for services from Patient #11's guardian, and failed to include her guardian in decisions regarding her care. b. Patient #13 was a 69 year old male admitted to the hospital on 1/01/15, with diagnoses of psychosis and depression. Patient #13's medical record for his hospital admission of 1/01/15 to 1/05/15 was reviewed. His record did not include a signed consent for services or an admission agreement. Additionally, his record did not include a care plan or treatment plan developed and discussed with Patient #13. During an interview on 4/01/15 at 4:20 PM, RN C reviewed Patient #13's record and confirmed it did not include a signed consent for services or indication of his participation in development of his treatment plan. The facility failed to obtain consent for services from Patient #13, and failed to allow him the opportunity to make informed decisions about his care. c. Patient #15 was a 60 year old man who was a patient in the facility from 3/15/15 to 3/26/15, with	BB283		

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BB283	Continued From page 75 diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. A nurses note, dated 3/23/15 at 6:15 PM, documented Patient #15 refused to take an increased dose of Seroquel. The note stated "Pt [patient] verbalizes not being happy about Provider making changes in his medication without talking to him first." During an interview on 3/30/15 at 3:35 PM, the NP stated she met with the psychiatrist by teleconference 2 times a week, and discussed all patients treatment plans. She confirmed the psychiatrist did not see Patient #15. During an interview on 4/03/15 at 10:15 AM, the NP reviewed the record and confirmed there was no documentation of Patient #15's involvement in his treatment plan. Patient #15 was not given the opportunity to be involved in decisions regarding his medication changes. The facility failed to obtain consent for services and involve patients and their guardians in care decisions. 2. The hospital failed to ensure ordered test results and information necessary to monitor patients' conditions were documented, that consultative findings were implemented, and that discharge instructions included appropriate referrals or follow-up appointments when necessary. a. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia	BB283		

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BB283	Continued From page 76 and depression. i. Patient #5's record included a nutritional assessment dated 3/11/15, and signed by the RD and dietary manager. The dietary manager documented she was unable to assess his caloric, protein, or fluid needs because no weight was documented in the record. She also documented no laboratory results were available in the record. The hospital admission orders, dated 3/09/15, included orders for the following tests: CMP (complete metabolic panel), CBC (complete blood count), Free T4, TSH (thyroid stimulating hormone), RPR (a test for syphilis), UA (urinary analysis), B12, Folate, and PT/INR (prothrombin time and international normalized ratio). Patient #5's record had laboratory results dated 3/14/15, for UA and PT/INR. There were no other laboratory results in the record. The dietary manager documented a request for Patient #5's weight and 2 laboratory tests, a CMP and BMP (basic metabolic panel). The record did not include orders for the laboratory tests requested. Patient #5 was not weighed until 3/14/15, 3 days after dietary requested the weight. During an interview on 4/01/15 at 5:20 PM, RN C reviewed the record. She confirmed Patient #5's weight was not recorded until 3/14/15. The RN stated "I never even see the dietary assessment." She stated she was unaware of the request for the laboratory tests and for Patient #5's weight. Patient #5's nutritional consultations and recommendations were not reviewed or implemented by a provider or nursing staff	BB283		

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	IDKT4M		C 04/03/2015

NAME OF PROVIDER OR SUPPLIER: SAFE HAVEN HOSPITAL OF POCATELLO

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BB283	Continued From page 77 involved in their care. ii. On 3/12/15 at 2:00 PM, the VS record documented Patient #5 had an elevated temperature of 100.9. There was no documentation the P.T. notified the RN of the elevated temperature. Additionally, there was no documentation the physician was notified or the temperature was treated with medication. On 3/20/15 at 8:44 PM, the nurses note documented Patient #5 had an elevated temperature of 100.4. There was no documentation the P.T. notified the RN of the elevated temperature. Additionally, there was no documentation the physician was notified or the temperature was treated with medication. During an interview on 4/01/15 at 5:20 PM, RN C reviewed the record and confirmed elevated temperatures were documented for Patient #5. RN C confirmed the MD was not notified of the elevated temperature measurements. iii. Patient #5's record included a medical evaluation, which was completed on 3/10/15. The medical evaluation documented an extensive history of abdominal surgeries with associated complications over the last 5 months. During 1 of his admissions, Patient #5 was hospitalized for a 2 month period. At that time, Patient #5 had a tracheostomy, PEG tube, MRSA, and repair of wound dehiscence with significant malnutrition problems. Upon his admission to the facility, Patient #5 had large retention sutures to his abdomen which were to be removed 2 days after his admission to the hospital. On 3/09/15, the LPN documented Patient #5 had scabs with multiple open areas, redness at the	BB283		

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BB283	Continued From page 78 incision site, and drainage. There were no measurements documented, and no description of the drainage. Additionally, there were no VS documented on the date of his admission. On 3/23/15, the LPN documented Patient #5 had open area at the incision site with redness in color. There were no measurements or drainage documented. The nurses notes did not include documentation regarding Patient #5's wounds or his history of MRSA. On 3/25/15 at 1:15 PM, the LMSW documented she spoke with an ALF and they indicated Patient #5 may be accepted if his wounds were cultured for MRSA and came back negative. A nursing note dated 3/25/15, documented Patient #5's wounds were cultured by the RN at 9:45 AM. There were no results from the wound culture in Patient #5's record. During an interview on 4/01/15 at 5:20 PM, RN C reviewed the record and confirmed the wound culture was done on the day of Patient #5's discharge. She stated she was unaware of Patient #5's history of MRSA. RN C further confirmed weekly wound measurements were not completed. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local shelter. Patient #5's discharge instructions included a medication list with an antibiotic for infection. Patient #5 had numerous abdominal surgeries, including post-operative complications, documented in his H&P, over the previous 5 months. Patient #5's record did not include any progress notes from the medical physician after the initial H&P was	BB283		

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BB283	Continued From page 79 completed. The H&P documented Patient #5 had a midline surgical incision which was being held with large retention sutures with rubber tubing around them that bridged over the incision. On 3/23/15, the LPN documented Patient #5 had open area at the incision site with redness in color. There was no documentation of measurements of the open area. The discharge instructions did not include a scheduled follow up appointment with Patient #5's surgeon or a primary care provider. An email, detailing events after Patient #5's discharge, was received by surveyors on 4/03/15 at 3:30 PM. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local shelter. The email dated 4/03/15 at 2:32 PM, and written by the VP of the hospital, was addressed to the SNF AIT. The email documented a timeline of events that occurred after Patient #5's discharge from the hospital. Patient #5 was driven to the shelter by a hospital van after picking up his prescriptions. He was told by the shelter employees it was too early for admittance and to return between 5:00 and 6:00 PM. Patient #5 returned to the shelter several times over the course of the evening and he also went back to the facility requesting to be let in. He was refused admittance and went to the facility's corporate office the next morning. The corporate office then arranged for Patient #5 to be admitted to an ALF, after 2 encounters with police, missing personal effects, and a bloody face. There was no other documentation in the facility of Patient #5's return during the middle of the night on 3/25/15 Patient #5 was not referred or given a follow up appointment with his primary care provider or	BB283		

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BB283	Continued From page 80 surgeon to monitor his post-operative incision or completion of his antibiotic regimen. During an interview on 4/03/15 at 12:55 PM, the Director of Social Services reviewed the record and confirmed the plan was for Patient #5 to return to his previous ALF. She confirmed the discharge plan did not include follow up with his surgeon or a primary care physician. During an interview on 4/01/15 at 5:20 PM, RN C reviewed the record and confirmed discharge orders did not include a follow-up appointment with his surgeon. Patient #5's record did not contain the information necessary to monitor his condition or ensure his follow-up appointment with a physician for his abdominal wounds occurred after his discharge. b. Patient #1 was a 40 year old male admitted to the facility on 3/26/15 to 3/31/15, from a local ED. His psychiatric diagnoses included schizoaffective disorder, substance dependence, and PTSD. Patient #1's record included a nutritional assessment dated 3/31/15, and signed by the dietary manager. The dietary manager documented Patient #1 needed a carbohydrate controlled diet. Included in the record were orders for blood glucose levels to be measured 4 times daily. Patient #1's blood glucose levels were consistently elevated from 172 mg/dl to 540 mg/dl during his admission. The hospital orders had no diet ordered for Patient #1 upon admission. There were no further orders documented in the record for a	BB283		

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BB283	Continued From page 81 special diet. During an interview on 4/03/15 at 1:40 PM, the NP reviewed the records and confirmed no special diet was ordered for Patient #1. She stated she did not read the recommendations from the RD or dietary manager in patient records. The NP stated if there are concerns the RD or dietary manager would talk with her personally. The NP confirmed the conversations are not documented in patients' records. Patient #1's nutritional consultations and recommendations were not reviewed or implemented by a provider or nursing staff involved in their care. c. Patient #10 was a 67 year old male admitted to the hospital on 11/07/14, from an ALF. His psychiatric diagnoses were conduct disorder and depression. Additional diagnoses included history of a stroke, seizure disorder, non-insulin dependent diabetes, and constipation. Patient #10's record included a nursing flow sheet, signed by the RN on 11/08/14 at 9:35 AM. The flow sheet contained sections to document assessment of Patient #10's physical and behavioral status, pain, and current safety precautions in effect. However, the flow sheet was blank. Patient #10's record did not include a nursing assessment for the day shift on 11/08/14. Patient #10's record included a nursing flow sheet, signed by the RN on 11/09/14, untimed. The flow sheet contained sections to document assessment of Patient #10's physical and behavioral status, pain, and current safety precautions in effect. However, the flow sheet was blank. Patient #10's record did not include a	BB283		

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BB283	Continued From page 82 nursing assessment for the day shift on 11/09/14. During an interview on 4/01/15 at 4:30 PM, RN C reviewed Patient #10's record and confirmed the 2 nursing flow sheets were blank and there was no patient assessment documented during those 2 shifts. Patient #10 record did not include an assessment of his physical and behavioral status on every shift. d. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14, from a SNF. Her psychiatric diagnoses were psychosis, bipolar disorder and congenital brain injury with mental disability. Additional diagnoses included renal insufficiency, CHF and diabetes. Patient #11's admission orders included the following laboratory tests: CMP, CBC, Free T4, TSH, RPR, UA, B12, Folate, Depakote level and Hgb A1C. An entry on Patient #11's MAR, initialed by the RN, documented her blood was drawn and sent to the laboratory on 11/26/14. Patient #11's record included results of a UA. However, her record did not include results of the blood tests ordered at the time of admission. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it did not include results of the blood tests drawn on 11/26/14. She stated the laboratory results are available through the laboratory's website, and it was the responsibility of the unit clerk to access the website, print the results and put them in the patient's chart. RN C confirmed the test results were not always accessed online, printed and placed in the patient's chart.	BB283		

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BB283	Continued From page 83 Patient #11's medical record did not include results of the laboratory tests completed on 11/26/14. The hospital failed to ensure patients' medical records contained comprehensive information. 2. Refer to BB459 as it relates to the hospitals' failure to ensure patient medical records included comprehensive information related to their psychiatric needs.	BB283		
BB430	16.03.14.450.03 Policies and Procedures 03. Policies and Procedures. Policies and procedures shall be developed to include the following: (10-14-88) a. Services offered; and (10-14-88) b. Identification of relationship with other hospital and community services; and (10-14-88) c. Definition of other support personnel for patient care; and (10-14-88) d. Procedure for discharge planning; and (10-14-88) e. Procedure for referral and consultation. (10-14-88) This Rule is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure policies and procedures were followed for discharge planning and referral and consultation	BB430	See also BB117, BB283, BB461 Action to Correct Deficiency: The Hospital has implemented and developed a well organized/defined policy and procedure program. The policies and procedures are fully implemented, developed and addressed in written form for all patient and non-patient care services. The policy and procedures are strictly enforced by hospital administration for all staff members. Facility staff are continually educated, trained, prompted, tested and updated on all policies/ procedures. How Action Improves Process: Assurance that all policies and procedures are accounted for and cover all acts within the hospital will enhance and improve all patient care outcomes. Specific policies and admissions/ discharges will greatly improve the processes. With the inclusion of all services provided for will ensure compliancy with all Standards of Practice and improve all patient outcomes.	

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BB430	Continued From page 84 of patients upon discharge. These failures had the potential to cause undue stress, increase the likelihood of readmission, and possible negative outcomes for all patients. Findings included: A policy, titled Discharge Planning, revised 11/14, stated the social worker will ensure that appropriate and comprehensive discharge planning occurs in cooperation with the physician, family members, or significant others involved in the patient's care. Additionally, it stated "Prior to discharge the social worker will contact the appropriate facility or individuals responsible to care for the patient following discharge from the hospital. All necessary treatment interventions that must cross over to new care givers will be coordinated via social service discharge planning." A policy, titled Discharge Anticipated, revised 11/14, stated "To assure there is continuity of care when a patient has an anticipated discharge. Discharge planning occurs upon admit to the hospital and continues throughout the patient's stay." The hospital did not follow its policies for discharge ensuring a patients' capacity for self-care or need for post-hospital services was comprehensively evaluated and included in the discharge planning process. 1. Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia and depression. a. Patient #5's psychiatric evaluation was completed on 3/10/15 by the NP. The psychiatric evaluation documented he did not know why he	BB430	Procedure for Implementation: Monthly all staff meetings to highlight individual policy and procedures have been scheduled for education in-service. Policy and Procedures will be reviewed on hire and annually thereafter. These policy and procedures will be available on employee website as well as designated areas (i.e.,nurses station). A Table of Contents has been created available for reference. Monitoring and Tracking: Administration, Administrator, CNO, Nursing staff, consultants, contracted staff and the MD will follow, address, act upon all Hospital policies and procedures; and ensure completeness and thoroughness in all patient care issues addressing all changes in patient's condition with proper follow-up and physician intervention. All policies and procedures will also be monitored for accuracy and completeness by the QAPI Committee with minutes from their meeting made available to all staff members concerned. With assurance that all policy and procedures have been implemented, followed and practiced; the systems improvement will greatly improve patient care outcomes. The program implementations will continue to be monitored for accuracy and completeness for approximately six months at 100% accuracy and; thereafter, every quarter period. Title of Person(s) Responsible: Administrator, CNO, Medical Director, Pharmacist, Medical Records personnel, Ward Clerk, GB, Medical Staff, Consultative staff and the Organization	8/17/2015

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BB430	Continued From page 85 was admitted to the facility and included documentation that Patient #5's speech was slurred during the beginning of the interview, and he was oriented to self and only partially to place. The psychiatric evaluation further documented Patient #5 was "unaware of the world around him" and his judgment was "Markedly impaired." Patient #5 was to be assessed for dementia. Patient #5's record included an Inpatient Diagnoses form which documented he had schizophrenia, borderline intellectual functioning, and issues with primary support. On 3/23/15, a Psychiatric Progress Note documented Patient #5 had limited judgement and insight, and he had grave disability. The progress note further documented Patient #5 had an active mental disorder present and persistent inability to care for himself, or that he may be cared for in a less restrictive environment. There was no further documentation by the NP prior to his discharge. b. Patient #5's record included a medical evaluation, which was completed on 3/10/15. The medical evaluation documented an extensive history of abdominal surgeries with associated complications over the last 5 months. During 1 of his admissions Patient #5 was hospitalized for a 2 month period. At that time Patient #5 had a tracheostomy, PEG tube, MRSA, and repair of wound dehiscence with significant malnutrition problems. Upon his admission to the facility Patient #5 had large retention sutures to his abdomen which were to be removed 2 days after his admission to the hospital. c. Patient #5's record included a social history completed by an LMSW on 3/13/15. The social history documented recommendations for coordination of discharge placement and	BB430		

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BB430	Continued From page 86 aftercare, and Patient #5 was to return to an ALF. Social service progress notes documented working on Patient #5's discharge placement beginning on 3/14/15, 5 days after admission. The SS Assistant documented at 3:57 PM, she spoke with the Administrator for Patient #5's previous ALF and they would not take him back upon discharge. On 3/25/15 at 1:15 PM, the LMSW documented she spoke with an ALF and they indicated Patient #5 may be accepted if his wounds were cultured for MRSA and came back negative. A nursing note dated 3/25/15, documented Patient #5's wounds were cultured by the RN at 9:45 AM. There were no results from the wound culture in Patient #5's record. The LMSW documented Patient #5 did not want to stay at the hospital and he wanted to go to the shelter. She documented Patient #5 was competent to make decisions, but did not necessarily make the best choices. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local shelter. c. Patient #5's discharge instructions included a medication list with an antibiotic for infection. Patient #5 had numerous abdominal surgeries, including post-operative complications, documented in his H&P, over the previous 5 months. Patient #5's record did not include progress notes from the MD after the initial H&P was completed. On 3/23/15, the LPN documented Patient #5 had an open area at the incision site with redness in color. There was no documentation of measurements of the open area.	BB430		

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BB430	Continued From page 87 Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local shelter. Included on his discharge medication list was an antibiotic for infection. There was no follow up appointment scheduled with Patient #5's surgeon or a primary care provider. The discharge instructions documented his diagnoses as chronic schizophrenia with R/O dementia. d. An email, detailing events after Patient #5's discharge, was received by surveyors on 4/03/15 at 3:30 PM. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local shelter. The email dated 4/03/15 at 2:32 PM, and written by the VP of the hospital, was addressed to the SNF AIT. The email documented a timeline of events that occurred after Patient #5's discharge from the hospital. Patient #5 was driven to the shelter by a hospital van after picking up his prescriptions. He was told by the shelter employees it was too early for admittance and to return between 5:00 and 6:00 PM. Patient #5 returned to the shelter several times over the course of the evening and he also went back to the facility requesting to be let in. He was refused admittance and went to the facility's corporate office the next morning. The corporate office then arranged for Patient #5 to be admitted to an ALF, after 2 encounters with police, missing personal effects, and a bloody face. There was no other documentation in the facility of Patient #5's return during the middle of the night on 3/25/15 During an interview on 4/03/15 at 12:55 PM, the Director of Social Services reviewed the record and confirmed the discharge plan was for Patient #5 to return to an ALF. She stated the discharge plan had not changed until the day of his	BB430		

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BB430	Continued From page 88 discharge. The Director of Social Services confirmed the wound culture was not done prior to the day of discharge. She confirmed Patient #5's follow-up and post-discharge needs were not comprehensively assessed. During an interview on 4/01/15 at 5:20 PM, the RN reviewed the record and confirmed the wound culture was done on the day of Patient #5's discharge. The hospital failed to follow their discharge policies to ensure Patient #5's post-hospitalization needs were met. 2. Patient #13 was a 69 year old male admitted to the hospital on 1/01/15, with diagnoses of psychosis and depression. Patient #13's record included an order for Seroquel 25 mg to be given daily at bedtime. The order was signed by the NP on 1/04/15 at 6:05 PM. Per the Nursing 2015 Drug Handbook, Seroquel is an antipsychotic medication that requires careful monitoring, due to the risk of adverse reactions. Patient #13's record included a social service progress, dated 1/05/15. The note stated "When SS discussed discharges with [NP] she reported that due to staffing [patient] was being discharged." During an interview on 4/03/15 at 2:45 PM, the SS Assistant who wrote the note confirmed Patient #13 was discharged on 1/05/15, to an ALF, due to lack of sufficient staff. Patient #13's nurses notes documented he was discharged to an ALF on 1/05/15 at 4:45 PM. He	BB430		

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NAME OF PROVIDER OR SUPPLIER: SAFE HAVEN HOSPITAL OF POCATELLO

STREET ADDRESS, CITY, STATE, ZIP CODE: 1200 HOSPITAL WAY POCATELLO, ID 83201

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BB430	Continued From page 89 did not receive a dose of Seroquel prior to his discharge. Patient #13's record included a copy of discharge instructions, including discharge medication orders, that were sent to the ALF. The discharge medication order form included an area to document the number of antipsychotics ordered upon discharge, along with any special instructions. The section was blank, although Seroquel, an antipsychotic was included in his discharge medication orders. Additionally, there was no documentation stating he had not received Seroquel during his hospitalization. The ALF staff were not informed they would be administering his first dose, meaning he should be closely monitored for adverse effects. During an interview on 4/01/15 at 4:20 PM, RN C reviewed Patient #13's record. She stated when a new medication is ordered the first dose should be given that day unless the order states otherwise. She stated medications ordered for bedtime are administered at 8:00 PM. RN C confirmed Patient #13 should have been given a dose of Seroquel at 8:00 PM on 1/04/15. She reviewed the discharge instructions and confirmed the ALF staff was not informed Patient #13 did not receive Seroquel in the hospital. The hospital did not follow their policies to ensure Patient #13's discharge plan was reassessed and updated to reflect his new medication, and his unanticipated discharge.	BB430		
BB454	16.03.14.470.01 Psychiatric Service, Staffing 470. PSYCHIATRIC SERVICE. If the hospital offers psychiatric service it shall be	BB454	See also BB116, BB117, BB144, BB173, BB458, BB461, BB527	8/17/2015

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BB454	Continued From page 90 organized, staffed and equipped to provide inpatient and outpatient treatment to the mentally ill. (10-14-88) 01. Staffing. If the hospital offers psychiatric service, it shall be directed and evaluated by a psychiatrist and staffed by adequate numbers of qualified personnel to meet patient needs. (10-14-88) a. A registered nurse qualified by training or experience in psychiatric nursing shall supervise the nursing care rendered in the psychiatric service. (10-14-88) b. Psychiatric service staff shall collaborate with medical, nursing, and other professional personnel in patient care planning, and provide consultation to staff of other services regarding the psychiatric problems of patients. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of medical records, policies, and Medical Staff Bylaws, it was determined the hospital failed to ensure appropriate organization and staffing was provided to meet the inpatient psychiatric needs of 17 of 17 patients (Patients #1 - #17) whose records were reviewed. This resulted in the inability of the hospital to provide necessary services to promote the health and safety of patients. Findings include: 1. Safe Haven Hospital of Pocatello specialized in the treatment of patients with psychiatric conditions. "BYLAWS OF THE MEDICAL STAFF OF SAFE HAVEN HOSPITAL," not dated, stated NPs were defined as Allied Health Professionals. Article	BB454	Action to Correct Deficiency: Medical Bylaws have been reviewed and revised by GB and Organization to meet the individual needs of the hospital. A Medical Director has been appointed that reside within 30 minutes of the facility. A Licensed Individual Practicer (LIP) has been appointed to work under the supervision of the Medical Director. A full time CNO has been hired to supervise the nursing care provided to patients. A policy and procedure outlining staffing grid has been reviewed and revised by GB to adequately meet patient needs. How Action Improves Process: The process has been improved by a complete revision of the MS bylaws. The bylaws are specific to this facility and all of the terms outlined in IDAPA 60.3.14 have been addressed. The Medical Director will be responsible for the monitoring and tracking of assigned tasks by QAPI Coordinator. Any concerns will be reported to GB and Organization for review. There is now a CNO to provide direction to the nursing department and to ensure that appropriate staffing needs are met. Procedure for Implementation: Credentialing and review process to be completed by Health Information Management (HIM). This process also to be overseen by Human Resources. The MS bylaws have been adopted by the GB and are strictly enforced, followed, and adhered to. CNO to work in tandem with floor nurse to ensure staffing needs are met.	

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BB454	Continued From page 91 VIII Section I of the bylaws stated "All Allied Health Professionals providing direct patient care in the hospitals shall do so under the direct supervision of the attending psychiatrist." The Bylaw was not followed. A contract with a psychiatrist, dated 9/25/13, documented he became Medical Director on that date. The psychiatrist was interviewed on 4/02/15 beginning at 4:45 PM. He confirmed he had served as Medical Director through 3/31/15. He stated he no longer worked for the hospital. He stated while he was Medical Director there were 3 physicians, including himself, on the Medical Staff. The prior Medical Director stated during his time as Medical Director he lived in Boise, Idaho, which is approximately 235 miles from the hospital. He stated he had not treated any patients at the hospital. He stated he started visiting the hospital in 2014. He stated since then he had been coming to the hospital one time a month to provided psychiatric oversight until 2 or 3 months ago, but there was no record of his activities at the hospital. The prior Medical Director stated psychiatric care was primarily provided by one NP. He stated 2 other NPs served as her back up when she was not available. He stated the primary NP was supervised by a psychiatrist who lived in Florida. When asked how the hospital ensured patients were under the care of a physician, the prior Medical Director referred the surveyor to the Florida physician. The Florida psychiatrist was interviewed on 4/03/15 beginning at 1:55 PM. She stated she	BB454	Monitoring and Tracking: Compliance to Hospital Medical Bylaws will be monitored by GB and Organization via required committee meetings 1 X monthly for 6 months than quarterly thereafter. The CNO to review staff assignment sheet weekly. Title of Person(s) Responsible: Organization's CEO, COO, CFO, Hospital Administrator, CNO, HIM, Human Resources, Medical Staff	8/17/2015

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BB454	Continued From page 92 last visited the hospital in February of 2015. She said she was scheduled to come to the hospital on April 9, 13, 14, and 15 of 2015 and then she would not come to the hospital again until the end of May 2015. She stated all direct services were provided by NPs. She stated she teleconferenced with the primary NP 2 times a week. She stated she discussed all patients who were admitted to the hospital with the NP. She stated the NP conducted all Psychiatric Evaluations (a comprehensive assessment of patients' psychiatric status and needs on admission) and she, the physician, edited them. She stated she reviewed all patients' Discharge Summaries. She stated she was available by telephone for consultation most of the time. The Florida psychiatrist stated there was no record of her activities except for her signature on Psychiatric Evaluations and Discharge Summaries. The psychiatrist in Florida stated she did not directly supervise the NPs. She stated she did not know if the hospital had a formal process to supervise NPs. The hospital failed to ensure psychiatric services were directed and monitored by a psychiatrist. 2. During an interview on 4/01/15 at 9:35 AM, the Co-owner of the hospital stated the Administrator was out of town for a week and no one was designated to oversee clinical services while she was out of town. The Co-owner of the hospital stated the CNO resigned in January and they were currently looking for a replacement. She stated the Administrator was currently acting as CNO. The Administrator was interviewed by phone on	BB454		

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BB454	Continued From page 93 4/02/15 beginning at 2:15 PM. She stated she assumed the role of the Interim CNO in January 2015 when the former CNO resigned. She stated there was no documentation stating she was the Interim CNO. She stated an Acting CNO had not been appointed while she was out of town. The hospital failed to ensure a qualified psychiatric nurse was available to supervise the nursing care provided to patients. 3. The hospital failed to provide adequate numbers of staff to meet patient needs in 5 of 5 months (December 2014 - April 2015) for which patient census information and occurrence reports were reviewed. A policy "Staffing of Nursing Care, Acuity Based," effective 1/04, stated "To provide safe, effective nursing care designed to support improvements and innovations in nursing practice based on both the needs of the patients to be served and the mission statement. The plan supports both standards of nursing practice and nursing standards of care. The CNO of Safe Haven is responsible and accountable to ensure that consistent standards are utilized. This plan provides an overview of the unit, which includes staffing plans based on acuity data and core staffing date. Staffing is based upon patient census and acuity. Based on census and patient acuity, the needs of the unit are evaluated on a shift or partial shift basis by the Staffing Coordinator, in collaboration with the charge nurse, in order to provide optimal patient care that is fiscally sound." The following algorithm was included in the policy based on patient census:	BB454		

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BB454	Continued From page 94 Day shift staffing requirements -1 RN per shift -1 to 5 patients, 1 P.T. -6 to 8 patients, 1.5 P.T.s -9 to 13 patients, 2 P.T.s -14 patients, 3 P.T.s -1 to 6 patients, 0 LPN -7 to 10 patients, 1 LPN -11 to 14 patients, 1.33 LPNs Night shift staffing requirements -1 RN per shift -1 to 8 patients, 1 P.T. -9 to 14 patients, 1.5 P.T.s -1 to 8 patients, 0 LPN -9 to 14 patients, 1 LPN The algorithm in the policy stated core staffing consisted of a minimum of 1 RN and 1 P.T. The policy stated, "Psych tech [psychiatric technicians] shifts- if the staffing ladder accounts for 1.5 aides, this means that one full 12 hour shift is approved and one 6 hour shift is approved. The hours may be divided amongst the scheduled Psych tech staff at the direction of the Charge RN as long as the hours stay within the approved total of 18 hours."	BB454		

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BB454	Continued From page 95 Additionally, the policy stated "LPN shifts- if the staffing ladder accounts for 1.33 LPN's, this means that one full 8 hour shift from 0700- 1500 [7:00 AM to 3:00 PM] is approved. At a census of 11 the LPN staff may then cover the remaining four hours of the 12 hour shift to 1900 [7:00PM]. The hours may not be allotted any other way." Assignment sheets were completed for each 12 hour shift, day and night. The assignment sheet included sections for patients' names, level of monitoring, names of P.T.s working, and 2 hour time periods for the shift. The name of the RN in charge and the date were listed at the top of the form. It also differentiated whether it was the assignments for day or night shift. The bottom of the assignment sheet also included a section with an algorithm. The algorithm was used for staffing the facility with P.T.s depending on the census. The section for P.T.s was numbered 1 through 5, with their names written next to the numbers. The number corresponding to the P.T. was written in the columns broken down into 2 hour time periods for the shift. The 2 hour time period columns corresponded to patient names. For example: P.T. 1 would be assigned from 6:00 AM to 8:00 AM with one patient, then from 8:00 AM to 10:00 AM, P.T. 1 would be assigned to another patient. P.T.s would not be assigned to 1 patient for the entire 12 hour shift. According to the assignment sheets reviewed, they would rotate between the patients. The algorithm at the bottom of the assignment sheet was used for determining staffing of the facility. The algorithm for staffing P.T.s was based on census, rather than acuity. The algorithm was listed as follows:	BB454		

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BB454	Continued From page 96 - Patient census 0, P.T. 0 hours - Patient census 1, P.T. 8 hours - Patient census 2-5, P.T. 12 hours - Patient census 6-10, P.T. 16 hours - Patient census 11-12, P.T. 24 hours - Patient census 13-14, P.T. 26 hours A maximum of 14 patients could be admitted at one time. If a patient was being monitored as a 1:1 (close monitoring of the patient was required and the assigned P.T. must be within arm's reach of the patient at all times), 1 tech would be assigned for monitoring the patient and was not included in the algorithm. A corresponding policy for close monitoring, titled "Suicide/Homicide Precautions Protocol," revised 10/12, stated a precaution level was assigned for the protection of patients requiring a safety intervention. The following precaution levels were identified and defined: -15 minute checks: Patient was observed every 15 minutes for safety -Line of sight (LOS): Keep patient in the line of sight at all times -1:1 monitoring: Observation with 1:1 contact at all times On 4/01/15 at 4:55 PM, RN C confirmed an assignment sheet was to be filled out for each shift. She stated an LPN was scheduled for	BB454		

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BB454	Continued From page 97 medications if the patient census was greater than 8, otherwise the LPN worked 7:00 AM to 11:00 AM and came back and worked 5:00 PM to 9:00 PM. RN C stated she coordinated the staffing of P.T.s. RN C stated P.T.s worked a 12 hour shift, but depending on the algorithm they may work 4 hours, 8 hours, or the full 12 hours. She explained when 16 hours were allotted based on census, 1 P.T. would work 12 hours and another P.T. would work for 4 hours. RN C stated staffing of P.T.s was not acuity or behaviorally based, but was based on the algorithm. During an interview on 4/02/15 at 5:05 PM, RN B confirmed the algorithm was what she used to staff the P.T. hours. She further confirmed staffing for P.T.s was based on census and algorithm, it was not acuity or behaviorally based. However, the use of the staffing algorithm, without consideration of patient acuity was not sufficient to ensure patient needs were met, as follows: a. During an observation on 4/02/15 at 12:00 PM, 5 patients were observed at the facility. In the dayroom there were 2 patients and 2 P.T.s present. One patient was in her assigned room, and 1 patient was observed walking in the hall. A third P.T. was observed in the nursing station behind a locked door. No RN was observed on the unit. After approximately 5 minutes, the RN was observed entering the patient unit from the other side of the locked doors. An interview was conducted with P.T. E at 12:10 PM on 4/02/15. He stated there were 5 patients in the hospital and 3 of the patients were on 1:1 monitoring. P.T. E stated he did not feel staffing	BB454		

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BB454	Continued From page 98 was adequate that day because only 3 P.T.s were scheduled to work. Three patients required 1:1 monitoring, therefore, the 2 remaining patients were not assigned a P.T. During an interview on 4/02/15 at 5:05 PM, RN B stated she was a concerned about safety at the facility. She stated staffing was based on census rather than acuity. Therefore, additional staff were not added when 1 or more patients exhibited behaviors that required close observation and possible intervention, to prevent injury to themselves or others. b. On 3/07/15 at 3:15 PM, a P.T. note attached to an "Occurrence Report" stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. Additionally, on 3/08/15 at 2:00 PM, an "Occurrence Report," completed by the RN on duty, documented Patient #8 was aggressive to another patient and that P.T.s were unable to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. The actions of the SNF male aide were not described. The hospital's policy, assignment sheet, and algorithms did not include using aides from the adjoining SNF when additional staff were required for patient restraint.	BB454	Policy and Procedure on Absenteeism was reviewed and revised with in-service given to staff to ensure adequate coverage is maintained. Administration to pro-actively to hire and orient new staff on an ongoing basis to meet hospital needs.	8/17/2015

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BB454	Continued From page 99 c. On 12/05/14 at 4:30 AM, an "Occurrence Report," completed by the RN on duty, documented Patient #21 had an altercation with his roommate. The report included a nurses note documenting Patient #21 was placed on "1:1/LOS." However, the facility's "Suicide/Homicide Precautions Protocol" did not include a definition for "1:1/LOS." Without clear instruction to staff, it would not be possible to determine if adequate numbers of staff were present to meet patient needs. d. Patient #13's record documented he was a patient in the hospital from 1/01/15 to 1/05/15, with diagnoses of psychosis and depression. His record included a social service progress note, dated 1/05/15. The note stated "When SS discussed discharges with [NP] she reported that due to staffing [patient] was being discharged." During an interview on 4/03/15 at 2:45 PM, the SS Assistant who wrote the note stated she remembered the conversation with the NP. She stated during the Treatment Team meeting it was determined there were not enough staff to take care of the number of patients that were in the hospital, therefore someone had to be discharged. She stated Patient #13 was closest to his planned discharge date so he was the one who was discharged. The facility failed to ensure adequate number of staff were provided to meet patients' health and safety needs. 4. Refer to BB455 as it relates to the hospital's failure to ensure collaboration with other professional staff occurred and that written treatment plans were developed for Patients #1 -	BB454		

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BB454	Continued From page 100 #17.	BB454		
BB455	16.03.14.470.02 Patient Treatment Plan 02. Patient Treatment Plan. Patient's records shall reflect that an individualized plan of treatment is developed for each patient which is specific and appropriate to individual problems and takes into consideration strengths as well as disabilities. The plan shall designate the persons responsible for each component of care and shall be reviewed, evaluated, and updated at regularly scheduled intervals by all professional personnel involved in the patient's care. (10-14-88) This Rule is not met as evidenced by: Based on observation, review of medical records and policies, and staff interview, it was determined the hospital failed to ensure written treatment plans were developed for 17 or 17 patients (Patients #1 - #17) whose records were reviewed. This resulted in the of the hospital to provide necessary services to promote the health and safety of patients. Findings include: 1. The policy "ICTP, Comprehensive," dated 1/31/12, stated "An ICTP that includes measurable objectives and time tables to meet the patient's mental, psychological, and psychosocial needs shall be developed for each patient." The policy included a procedure to develop and monitor a comprehensive treatment plan for patients. However, on 4/02/15 beginning at 11:50 AM, a Treatment Team group consisting of RN C, the Director of Social Services, and the Program Director was observed. They discussed patients' needs and progress at the hospital. They did not	BB455	See also BB146, BB175 Action to Correct Deficiency: A full time Hospital Administrator and Chief Nursing Officer (CNO) have been hired to ensure that Patient Care Plans are completed in a timely manner and maintained throughout hospitalization. All administration has been familiarized with policy and procedures regarding Patient Care Plans. The initial care plan will be completed by admitting nurse and completed with IDT input within 72 hours. Social Services gathers all of the necessary pertinent information needed for patient admissions. Social Services/Program Director review identified problem listings with the legal patient representative (if necessary) within 72 hours of admission. Discharge needs are assessed at this time as well and will be revised throughout hospitalation. Direct care staff are expected to become educated on Care Plans for each patient throughout hospitalization. Problem lists will be completed within 24 hours of admission by the Interdisciplinary Team (IDT). IDT meetings are daily, with days set aside to include patient/legal representatives to participate in treatment planning process. Chart audits are completed to review documentation. Treatment plans are reviewed and revised throughout the patient's hospitalization. In-service for all IDT members on Treatment Plan policy and procedures constantly evolves to ensure all patient care issues are addressed.	

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BB455	Continued From page 101 develop or document written treatment plans. The Director of Social Services stated the group reviewed patients' problem lists but she said there were no written treatment plans. She stated she was not aware of a procedure to develop and review treatment plans. During an interview on 4/03/15 at 10:30 AM, the NP stated ICTPs had not been developed since the CNO left in January. She confirmed patients currently did not have ICTPs. The records of 17 patients (#1 - #17) with an admission date range of 9/24/14 to 3/31/15, were reviewed. The 17 patient records did not include care plans to address patient needs. Goals were not identified, and interventions were not initiated to minimize the risk of complications related to psychiatric diagnoses. The hospital failed to ensure patients had written treatment plans to direct staff. 2. Patient records did not include documentation of a psychosocial POC for management and interventions related to physical and/or verbal aggression. Staff did not have direction regarding ways to decrease restraint/seclusion usage and ways to keep patients safe. Examples included, but were not limited to, the following: a. Patient #8 was a 65 year old male admitted to the facility on 3/06/15, for care related to dementia, psychosis, HTN, and PTSD. His medical record from 3/06/15 to 3/24/15, as well as, records from ED visits on 3/23/15, and 3/24/15, at an acute care facility, were reviewed. There was no documentation in Patient #8's records of a psychosocial POC for management	BB455	How Action Improves Process: Patients receive competent and individualized care to meet their mental health and physical needs throughout hospitalization and following discharge. Communications between IDT members and patient/legal representative, will result in improvement in patient care. Treatment Care Plans more accurately reflect patient conditions and needs on an ongoing basis. Patients/ legal representatives have a clear understanding of treatment goals and discharge planning. IDT cohesion continues and increased improvement encourages continued team input from all IDT members. Procedures for Implementation: Patient Care Plans are reviewed on an ongoing basis which allows for modifications throughout hospital stays and thoroughly meets and addresses patient care needs. Hand-off documentation between providers encourages and includes de-escalation techniques and current behaviors. Monitoring and Tracking: Staff nurses (and/or designees) complete 24 hour chart audits. Signatures of IDT members and the patient(s) are signed and dated at completion of Patient Care Plan(s). The QAPI program tracks and monitors timeliness and completeness of Patient Care Plans on an on-going basis for accuracy and all minutes from the monitoring and tracking process are made available for all staff members concerned. Discharge Planning will also be assessed and presented at this time to ensure all patient needs were addressed.	

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BB455	Continued From page 102 and interventions related to physical and/or verbal aggression. Staff did not have direction regarding ways to decrease restraint/seclusion usage and ways to keep Patient #8 safe. Examples included, but were not limited to, the following: - On 3/07/15 at 9:00 AM, an "Occurrence Report," written by the RN on duty, noted Patient #8 hit a staff member and another patient. He was noted to be restrained by P.T. D. Additionally, the Occurrence Report documented Patient #8 had another physical altercation with P.T. D, his behavior escalated, and he struck a patient. The report documented he was physically restrained, and administered an IM injection. Patient #8 was placed on 1:1 status, and remained on that status throughout his stay at the facility. The types of restraints used by staff to restrain Patient #8 were not specified. -A tech note attached to an "Occurrence Report" dated 3/07/15 at 3:15 PM stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. He was then given an injection of Geodon IM 20 mg. Patient #8's record did not include documentation of the actions were necessary to "redirect" Patient #8 to his room. Additionally his record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection. - On 3/08/15, an "Occurrence Report," written by the RN on duty, noted at 9:30-10:30 AM, Patient #8 became agitated and was threatening P.T. D.	BB455	Title of Personnel Responsible: Hospital Administrator, CNO, Staff Nurses, Ward Clerk, QAPI Coordinator, Social Services Director, Program Director and the Medical Staff.	8/17/2015

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BB455	Continued From page 103 The report indicated P.T. D performed a Mandt hold on Patient #8, and then 4 employees were required to assist him back to his room. There was no documentation in Patient #8's record that described the type of Mandt restraint used. A nurses note documented at 10:50 AM on 3/08/15 also stated Patient #8 continued to "go after staff" and was given an IM injection of 20 mg Geodon. The type of restraint used to allow the IM injection was not specified. The nurses note went on to say that after the injection Patient #8 continued to require physical redirection by staff. There was no documentation to describe the "redirection " used by staff. - An "Occurrence Report," dated 3/08/15 at 2:00 PM, was completed by the RN on duty. The RN documented Patient #8 was aggressive to another patient and that P.T.s were able to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. Patient #8 was given an injection but did not calm down until 5:00 PM according to the documentation on the Report. The type of restraint used to allow for the IM injection and actions of the SNF male aide were not described. - On 3/12/15, Patient #8's MAR indicated he was administered Geodon 20 mg IM at 3:00 PM. The P.T. narrative indicated Patient #8 was visited by his son, and complained of pain, for which he was medicated with Tylenol at 5:00 PM. A nurses note, also documented at 3:00 PM on 3/12/15, stated "Patient seems to be agitating another patient, which in turn seems to agitate the patient. Patient pacing and getting louder. Medicated per MAR." The type of restraint used to restrain Patient #8 to allow the IM injection, was not documented.	BB455		

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BB455	Continued From page 104 - On 3/14/15, an "Occurrence Report", written by the RN on duty, noted at 4:00 PM, Patient #8 was involved in a physical altercation with another patient. The report documented he was physically redirected by staff, and was assisted to his room. In his room he began to swing at staff, was restrained on a total of 4 occasions, and administered Zyprexa IM. There was no documentation to describe the "redirection" used by staff or the technique used to assist him to his room. Additionally, there was no documentation describing the type of restraints used the 4 restraints. -On 3/16/15 Patient #8's MAR stated he received Haldol 5 mg IM at 8:55 PM. His record included an "Emergency Treatment Override Orders for Seclusion," completed by the NP and RN at 9:30 PM. He was noted to be agitated, hit the staff, punched the fire door, his knuckles were bleeding. A nurses note, dated 3/16/15 at 7:40 PM indicated Patient #8 He was escorted to the seclusion room after grabbing the RN's wrist. The nurses note indicated Patient #8 resisted and staff continued to escort him to seclusion. It further stated "Staff into seclusion room and stabilized pts arms" and Haldol injection given. There was no documentation in Patient #8's record that described how staff "escorted" him to the seclusion room or the type of restraint used to stabilize his arms. - A 3/18/15 at 6:05 PM Emergency Treatment Override Orders for Hold and Restraint form, indicated Patient #8 was physically restrained using a "Staff Hold" to allow for an IM injection of Geodon 20 mg and placement in seclusion. A tech note documented at the time of the incident, stated Patient #8 was agitated and combative at	BB455		

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BB455	Continued From page 105 the beginning of the shift and that he was getting worked up from other patients. There was no documentation describing the type of restraint hold used. -A tech note, documented on 3/21/15 at 6:30 AM, indicated Patient #8 was agitated and P.T. D came to help and Patient #8 was restrained twice. The type of restraints used were not described. The NP was interviewed on 4/03/15 beginning at 10:30 AM. She stated patients did not have nursing POCs or treatment plans. She stated it was the CNO's job to develop those plans. She said since the CNO resigned in January, 2015, POCs and treatment plans were not developed. The facility failed to ensure a plan of care for Patient #8 was developed and updated to include use of restraint and seclusion. b. Patient #15 was a 60 year old man who was a patient in the facility from 3/15/15 to 3/26/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. Patient #15's record included "EMERGENCY TREATMENT OVER RIDE ORDERS FOR HOLD AND RESTRAINT" dated 3/17/15 at 12:45 PM, signed by RN C and the NP. The form documented "seclusion room" as the type of physical restraint. Patient #15's record documented he was placed in the facility's seclusion room on 3/17/15, from 12:45 to 1:45 PM. Patient #15's record did not include documentation of updates to his POC during or after the use of seclusion. Patient #15's record	BB455		

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BB455	Continued From page 106 did not include a nursing or a treatment plan of care. During an interview on 4/01/15 at 4:45 PM, RN C reviewed Patient #15's record and confirmed it did not include a nursing or treatment plan of care, therefore, there was no update in his plan of care related to the use of seclusion. The facility failed to ensure a plan of care for Patient #15 was developed and updated to include use of seclusion. c. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an ALF. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included the following documented incidents of physical restraint. - A nurses note signed by the RN, dated 3/08/15 at 8:00 AM, documented Patient #4 became agitated and started yelling at other patients and staff. The RN documented Patient #4 was verbally threatening a peer with physical aggression. Patient #4 was physically removed to his room. There was no documentation what preceeded Patient #4's agitation and verbal aggression towards his peer. Additionally, there was no documentation how the RN intervened prior to physically restraining Patient #4. - A nurses note signed by the RN, dated 3/14/15 at 4:05 PM, documented Patient #4 was yelling and shaking his fist at peers. There was no documentation what preceeded Patient #4's yelling and threatening manner. The RN documented Patient #4 was physically separated from his peer. There was no documentation of	BB455		

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BB455	Continued From page 107 interventions the RN attempted to address Patient #4's verbal aggression before he was physically restrained. Patient #4's record did not include a nursing POC or treatment plan. During an interview on 4/01/15 at 3:00 PM, RN C reviewed the record and confirmed there were no nursing or treatment care plans for Patient #4, therefore it was not updated. Patient #4's record did not have a care or treatment plan to address his physical and verbal aggression. The hospital failed to ensure written treatment plans were developed and updated to meet the psychiatric and psycho-social needs of each patient.	BB455	See BB117, BB527 Action to Correct Deficiency: Policies and procedures were reviewed and revised with in-service scheduled for staff orientation. All new employees to be oriented to patient's rights and to become MANDT certified. The Restraint/Seclusion Policy has been posted at the nurse's station for immediate reference (see attached). IDT members will assess each new patient on admission for behavioral concerns. A list of interventions for deescalation will be created by team members and relayed to all necessary staff to prevent adverse events. Appropriate committees have been established to ensure concerns and patient safety are addressed in accordance to hospital policy and procedures. Any information gathered by these committees will be reported to QAPI coordinator. Reports of Abuse or neglect will be reported to the GB and Orgauization immediately.	
BB458	16.03.14.470.05 Patient's Rights 05. Patient's Rights. Written Policies and procedures shall be developed regarding patient's rights. (10-14-88) a. Use of any form of physical restraint, forced treatment, chemical restraint or seclusion shall only occur in circumstances where there is established written policy and approved procedures to warrant such action and/ or is ordered by a physician; and (10-14-88) b. Each patient shall be allowed to communicate with persons outside the facility, except where excluded or limited in accordance with his comprehensive treatment plan. (10-14-88)	BB458		

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BB458	Continued From page 108 c. Each patient shall be apprised of his rights. (10-14-88) This Rule is not met as evidenced by: Based on review of patient records and policies, and staff interviews, it was determined the facility failed to ensure restraints, forced treatments, and seclusion were completed consistent with the hospital's policies and/or as ordered by a physician for 3 of 3 patients (#4, #8, and #15) for whom such interventions were used, and had the potential to impact all patients receiving services at the hospital. This resulted in one patient sustaining fractures to both arms and a shattered pelvis, unnecessary use of restraints and forced treatment, and restraints and forced treatment initiated by untrained staff. Findings include: The hospital's policies and procedures titled "RESTRAINTS", effective date 1/25/12, included the following: -Seclusion or restraint use in emergency situations is limited to adequate clinical justification (imminent risk of physical violence; behavior that is likely to result in self-injury) and only when positive individualized alternative nonphysical intervention procedures have failed. -All seclusion and restraint shall be ordered by a physician credentialed by Safe Haven Hospital. -Seclusion or restraint shall be initiated and terminated by competent trained staff. -The patient will be secluded or restrained in a manner that does not cause undue psychological or physical harm based upon results of an initial assessment at the time of admission.	BB458	Following all adverse events, an Incident Report and a Root-Cause Analysis will be presented to administration. Employees believed to be responsible for the abuse or neglect of hospital patients will be immediately suspended from duty pending administrative investigation. How Action Improves Process: All IDT members will have input into methods to deescalate patients prior to potential incident. This will result in a decrease in the use of restraint/seclusions and also improve staff and patient safety . It will also maintain dignity and autonomy for each patient. Policy and procedures are in place to assure that other less restrictive methods have been exhausted. With established education and communication flow, staff competency will be improved. Procedure for Implementation: In-service and ongoing education scheduled for all staff members on patient rights. In the event of an adverse patient event, staff documentation will be completed prior to end of shift following each occurrence. IDT members will debrief within 24 hours following occurrence. QAPI coordinator will gather data for analysis and present to GB quarterly. On admission patients/legal representative will be educated by the admitting nurse/designee on their Patient Rights and will receive a printed copy. The Patient Rights has also been posted at the nurse's station along with a direct number to Safe Haven's CEO and COO to report immediate concerns.	

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BB458	Continued From page 109 -All patients in seclusion or restraint will be assessed within one hour by an RN trained to complete this assessment. -A treatment program designed to reduce or eliminate the target behavior requiring the emergency seclusion or restraint would be developed. The hospital's "RESTRAINTS" policy was not followed. Examples include: 1. Patient #8's record documented a 65 year old male who was at the facility from 3/06/15 to 3/24/15 for psychiatric services related to dementia, and psychosis with behavioral disturbances. Additional diagnoses included HTN and PTSD. a. Patient #8 experienced multiple forced treatments and physical restraints that were not initiated and carried out consistent with the hospital's policy. Examples include: - On 3/07/15 at 9:00 AM, an "Occurrence Report," written by the RN on duty, noted Patient #8 hit a staff member and another patient. He was noted to be restrained by P.T. D. Additionally, the Occurrence Report documented Patient #8 had another physical altercation with P.T. D, his behavior escalated, and he struck a patient. The report documented he was physically restrained, and administered an IM injection. A corresponding P.T. note, untimed, stated "Pt. was pacing the floor-fist clenched tight - yelling out, threatening hands, male tech tried (sic) to get him under a more controlled mind - Pt swung his elbow up and hit the tech on his jaw." Patient #8 was placed on 1:1 status, and remained on that	BB458	Monitoring and Tracking: All adverse events will be reviewed daily with IDT members. Administration to be notified of all weekend occurrences and QAPI Coordinator to ensure policy and procedures were followed. Title of Person(s) Responsible: Hospital Administrator, CNO, QAPI coordinator, Staff Nurse, Direct Care Staff, Social Service Director, Program Director, Medical Director.	8/17/2015

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BB458	Continued From page 110 status throughout his stay at the facility. Patient #8's record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection. Patient #8's record did not include documentation of a physician's order for the restraint to allow the IM injection, use of less intrusive interventions, a face-to-face assessment, or a treatment plan. -A P.T. note, attached to an "Occurrence Report" dated 3/07/15 at 3:15 PM stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. He was then given an injection of Geodon IM 20 mg. A second P.T. note attached to the Occurrence Report, documented by P.T. D on 3/07/15 at 4:00 PM, stated "I was walking in the hall to the front door cause the door bell rang when [Patient #8] swung at me, I blocked that hit, then after he elbowed me in chin." Patient #8's record did not include documentation of the actions necessary to "redirect" Patient #8 to his room or if he was blocked from leaving the room. Additionally his record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection, use of less intrusive intervention, a physician's order for the restraint to allow the IM injection, a face-to-face assessment, or a treatment plan. - On 3/08/15, an "Occurrence Report," written by the RN on duty, noted at 9:30-10:30 AM, Patient	BB458		

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BB458	Continued From page 111 #8 became agitated and was threatening P.T. D. The report indicated P.T. D performed a Mandt hold on Patient #8, and then 4 employees were required to assist him back to his room. A nurses note documented at 10:50 AM on 3/08/15, also stated Patient #8 continued to "go after staff" and was given an IM injection of 20 mg Geodon. The nurses note went on to say that after the injection Patient #8 continued to require physical redirection by staff. There was no documentation of antecedents to the behaviors that occurred prior to Patient #8 becoming agitated and subsequently, aggressive. A nurses note documented on the same date at 11:00 AM, stated Patient #8 was "physically assisted" to the seclusion room. Patient #8's record did not include a physician's order for the restraint and forced treatment, documentation of less restrictive interventions. evidence of a face-to-face assessment, or a treatment plan. - An "Occurrence Report," dated 3/08/15 at 2:00 PM, was completed by the RN on duty. The RN documented Patient #8 was aggressive to another patient and that P.T.s were able to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF. Patient #8 was given an injection but did not calm down until 5:00 PM according to the documentation on the Report. Patient #8's record did not include a physician's order for the restraint required to give the IM injection, evidence of less restrictive interventions, an order for the forced treatment, evidence of a face-to-face assessment, or a treatment plan. - On 3/12/15, Patient #8's MAR indicated he was administered Geodon 20 mg IM at 3:00 PM. The P.T. narrative indicated Patient #8 was visited by his son, and complained of pain, for which he was	BB458		

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BB458	Continued From page 112 medicated with Tylenol at 5:00 PM. A nurses note, also documented at 3:00 PM on 3/12/15, stated "Patient seems to be agitating another patient, which in turn seems to agitate the patient. Patient pacing and getting louder. Medicated per MAR." Patient #8's record did not include documentation of the use of less restrictive interventions, a physician's order for the restraint required to give the IM injection, evidence of a face-to-face assessment, or a treatment plan. - On 3/14/15, an Occurrence Report, written by the RN on duty, noted at 4:00 PM, Patient #8 was involved in a physical altercation with another patient. The report documented he was physically redirected by staff, and was assisted to his room. In his room he began to swing at staff, was restrained on a total of 4 times, and administered Zyprexa IM. In a narrative note attached to Occurrence Report, written by a P.T., indicated Patient #8 was in the dining room. He was noted to have a verbal interchange with another patient, both Patient #8 and the other patient started yelling and hitting each other. Patient #8's record did not include documentation of a physician's order for the restraints, evidence of a face-to-face assessment, or a treatment plan. - On 3/16/15 Patient #8's MAR stated he received Haldol 5 mg IM at 8:55 PM. His record included an "Emergency Treatment Override Orders for Seclusion," completed by the NP and RN at 9:30 PM. He was noted to be agitated, hit the staff, punched the fire door, his knuckles were bleeding. A nurses note, dated 3/16/15 at 7:40 PM indicated Patient #8 He was escorted to the seclusion room after grabbing the RN's wrist. The nurses note indicated Patient #8 resisted and staff continued to escort him to seclusion. It	BB458		

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BB458	Continued From page 113 further stated, "Staff into seclusion room and stabilized pts arms" and Haldol injection given. There was no documentation in Patient #8's record that described how staff "escorted" him to the seclusion room or the type of restraint used to stabilize his arms. Patient #8's record did not include evidence that less restrictive interventions were tried to protect Patient #8 and others. Patient #8's record did not include a physician's order for the restraint used to stabilize his arm and the "escort" required to get him to the seclusion room, documentation of the use of less restrictive interventions, evidence of a face-to-face assessment, or a treatment plan. -A P.T. note, documented on 3/21/15 at 6:30 AM, indicated Patient #8 was agitated and P.T. D came to help and Patient #8 was restrained twice. Patient #8's record did not include documentation of the use of less restrictive interventions, a physician's order for the restraints, evidence of a face-to-face assessment, or a treatment plan. -During an interview on 4/03/15 beginning at 4:00 PM, P.T. H described an event that occurred when she requested assistance from a peer. She stated P.T. D did not like Patient #8. She stated when Patient #8 exhibited aggressive behavior, P.T. D was the first to jump in to restrain him. She described an incident that occurred on Sunday 3/22/15. She stated Patient #8 did not sleep for about a day and a half, and he was agitated. She stated Patient #8 grabbed her by the throat, she brought his hand down and then went to get the assistance from P.T. D. When he entered the room, Patient #8 tried to punch P.T. D, so he grabbed Patient #8 with his arms under Patient #8's armpits and pulled his arms up and outward. Patient #8 attempted to fight him off, and P.T. D held him again in that manner and	BB458		

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BB458	Continued From page 114 threw him face down on the bed, with his body on him to pin him down. Patient #8 was held down until after the RN gave him a shot. She stated she felt that P.T. D used excessive force, and reported the incident to the RN on duty. P.T. H stated she has submitted grievances about P.T. D's behavior, but felt no action has been taken by the facility. She also stated she had not received Mandt or any kind of restraint training since her hire at the facility. P.T. H stated Patient #8 slept most of the day on 3/22/15, and then when he got up, he was noted to be 'shuffling' around, dragging his legs, like he could not put pressure on his legs and not walking like he usually did. P.T. H demonstrated to the surveyors a slow shuffling movement, as well as, the hold maneuver P.T. D used on Patient #8. It was similar to a Full Nelson wrestling move. She said she had filed complaints against P.T. D at least once a week since January, 2015. P.T. H stated P.T. D leaves his 1:1 assignments unsupervised, he picks on patients to provoke behavior, and says things intentionally to make patients angry. Nurses notes documentation on 3/23/15 at 10:45 AM, noted Patient #8 was observed by facility staff to have a seizure. He was observed to yell, bring his hands upwards about shoulder height, and fall straight back, landing flat on the floor. His seizure lasted approximately 2-2.5 minutes. After the seizure was over, paramedics were called to take him to the ED of an acute care hospital for assessment. He was transported to the hospital by EMS, and was not accompanied by facility staff. An incident report was not initiated by the RN or the NP which described the seizure, or the	BB458		

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BB458	Continued From page 115 transfer to acute care hospital. At the acute care hospital Patient #8 was noted to be poetical, sleepy, and non-verbal. X-Rays of were taken of Patient #8's cervical, lumbar, and thoracic spine. Labs were drawn. He was determined to be stable to be discharged the same day to return to Safe Haven with a tech and the van driver. The staff [P.T. A] that arrived to pick up Patient #8, was interviewed. She stated that when she removed the pulse oximeter sensor from his finger, he winced in pain. She stated he was unable to stand up, and was transferred to the wheelchair with assistance from the van driver and the ED RN. A physical assessment by an RN was not completed when Patient #8 arrived back at the facility. Patient #8 was noted to be sleepy, was placed in bed, and remained there throughout the night. Staff documented that night "Pt appeared tired, He did not eat very much. Pt slept thru the night, talking in his sleep. Pt stated in loud voice 'NO, NO' when staff changed his clothes and took vitals." The P.T. assigned to Patient #8 on 3/24/15 day shift, documented "Pt resting/sleeping AM. Talking restless sleep. Appears [to be] having night terrors (?) talking in sleep saying 'Don't Push Me Down,' 'I hate cigarettes.' Pt stating he is in pain, mentions heart hurting - very lethargic. Ate some lunch, appears more alert. Complaining of cramp pain." On 3/24/15, at 8:40 AM, P.T. C noted Patient #8 was in bed and was not acting like he normally did and grimaced with movement of his right leg, and when she moved his left arm, he grimaced. The patient was administered Tylenol for pain at	BB458		

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BB458	Continued From page 116 10:30 AM. Patient #8 was sent back to the ED on 3/24/15, after a text order was received from the MD on 3/24/15 at 2:30 PM, stating "Send pt to the ER for x-rays of bilateral upper & lower extremities d/t [due to] decreased ROM & grimacing [with] movement." An admission H&P from the receiving hospital, dictated on 3/24/15 at 10:06 PM, noted: "...was brought to the ER in return today, because of significant altered mental status and inability to respond or speak, which he had been doing previously. Upon arrival in the ER, the patient was examined and family notably reported that the patient was repeatedly lifting his left leg and moaning in apparent pain." The H&P noted "Diffuse intermittent bruising across body, Bruising appears to be old and near staging with no large mass effect of bruising noted, but left arm bruise is quite large on the medial and superior aspect of upper arm." A consultation report, dictated 3/25/15 at 10:02 AM, noted: "...There is a question of seizure versus stroke. His initial workup was negative. He was then taken to the Emergency Department as noted above on [March 24th], where a chest, abdomen, and pelvis CT revealed a comminuted right acetabular fracture. The patient was also found to have rhabdomyolysis and lactic acidosis. He was admitted to the Intensive Care Unit for further monitoring. Orthopedics was consulted. Because of bruising on his upper arms, bilateral Humeri x-rays were performed today, on March 25th, demonstrating bilateral completely displaced two part proximal humerus fractures." At the hospital where Patient #8 was admitted, in	BB458		

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BB458	Continued From page 117 a progress note on 3/25/15 at 6:44 PM, an RN documented a meeting with Patient #8's family and the Orthopedic Surgeon that was held that afternoon at 12:00 PM: "Dr.[name] met with patient's wife and son. Dr. [name] reviewed injury findings. He explained the injury pattern was strange and not consistent. He explained the significance of the hip fracture. He discussed that the hip fracture is so complex that it will need to be repaired at [another hospital in another state]. He explained that without repair, the patient would need to heal as is. Once fracture is healed, he would anticipate that patient would not have any motion in his extremity and it would continue to be very painful. He would likely be bedridden the remainder of his life. He also reported to wife and son that patient had bilateral humerus fractures. These fractures appear to be in about the same spot that is not consistent with a fall. He explained that both Humerus fractures would need repairing with pins and possibly ORIF [Open Reduction and Internal Fixation]. He has also noted some bruising on the right lower extremity and plans to take the patient to radiology for further radiology exams." Patient #8 was critically injured. Patient #8 was not protected from injury during the initiation of restraints. His record did not include documentation of the use of less restrictive interventions, a physician's order for the restraints, evidence of a face-to-face assessment, or a treatment plan. During an interview on 4/02/15 beginning at 10:45 AM, the NP reviewed Patient #8's record. She stated male staff members would increase Patient #8's aggression, and confirmed the male staff were summoned to assist when Patient #8's	BB458		

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BB458	Continued From page 118 agitation escalated. During the same interview the NP confirmed Patient #8' record did not include orders for the restraints and forced treatment. She further verified one hour face-to-face assessments were not performed. The NP was interviewed on 4/03/15 beginning at 10:30 AM. She stated patients did not have nursing POCs or treatment plans. She stated it was the CNO's job to develop those plans. She said since the CNO resigned in January, 2015, POCs and treatment plans were not developed. Patient #8 experienced forced treatments and restraints that were not initiated consistent with the hospital's policy or as ordered by a physician. 2. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an ALF. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included the following documented incidents of physical restraint for verbal aggression. A nurses note signed by the RN, dated 3/08/15 at 8:00 AM, documented Patient #4 became agitated and started yelling at other patients and staff. The RN documented Patient #4 was verbally threatening a peer with physical aggression. Patient #4 was physically removed to his room. There was no documentation what preceded Patient #4's agitation and verbal aggression towards his peer. Additionally, there was no documentation how the RN intervened prior to physically restraining Patient #4. A nurses note signed by the RN, dated 3/14/15 at 4:05 PM, documented Patient #4 was yelling and	BB458		

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BB458	Continued From page 119 shaking his fist at peers. There was no documentation what preceded Patient #4's yelling and threatening manner. The RN documented Patient #4 was physically separated from his peer. There was no documentation of interventions the RN attempted to address Patient #4's verbal aggression before he was physically restrained. Patient #4's record did not include a nursing or treatment care plan for interventions related to his verbal aggression and agitation. During an interview on 4/01/15 at 3:00 PM, RN C reviewed the record and confirmed there was not a nursing or treatment care plan for Patient #4. She stated physically moving a patient to his/her room was considered a restraint. RN C verified Patient #4's record did not include an order for the physical restraint and a 1 hour face-to-face assessment was not performed. She confirmed there was no documentation related to what preceded Patient #4's agitation and yelling. RN C further confirmed Patient #4's record was not clear whether other interventions were attempted prior to restraining Patient #4. Patient #4 experienced forced treatments and restraints that were not initiated consistent with the hospital's policy or as ordered by a physician. 3. Patient #15 was a 60 year old man admitted to the facility on 3/15/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. The facility's policy, "Refusal of Medications and Treatments-Treatment Override," effective 6/19/11, stated "Admitted patients have the right to refuse specific modes of treatment.	BB458		

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BB458	Continued From page 120 Possessing this right, they are entitled to due process proceedings prior to being administered medication treatment against their will, unless involuntary treatment is necessary because of emergency. During hospitalization, involuntary administration of medication treatment may be used when an emergency exists or a patient is deemed to be gravely disabled or dangerous. Override of a patient's treatment refusal can occur provided certain conditions are met." Patient #15's record included documentation of medication administration under "show of force" by hospital staff. The incident was documented as follows: -A nurses note, dated 3/17/15 at 11:10 AM, and signed by the RN, stated "Due to his agitation, this nurse was instructed to attempt to get the patient to take oral Geodon. Patient refused. At that time, the Provider [name of NP] left the room and got a show of force (men) and the medication nurse [name of nurse] who had some Geodon injectable. After a short explanation, the patient agreed to take the PO pill. However, even though the patient was asked to open his mouth and show that he had indeed swallowed the pill, after a short period of time, the patient had removed the medication from his mouth and threw it on the table. The Provider, again, left the room to get a show of force at which time the patient was convinced to take the injection. He was unhappy about this." Patient #15's record did not document an emergency situation in which he was a danger to himself or others, at the time of the medication administration. During an interview on 4/01/15 at 4:45 PM, the	BB458		

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BB458	Continued From page 121 RN reviewed Patient #15's record and confirmed it documented the use of intimidation related to medication administration. The facility failed to ensure Patient #15's right to refuse medication, and to be free from intimidation, as a means of force treatment. Patient #15 was restrained without evidence that he or others were in imminent danger.	BB458		
BB459	16.03.14.470.06 Records 06. Records. Adequate and comprehensive records shall be retained for assessment, evaluation and treatment purposes. Admitting and subsequent psychiatric diagnoses shall be recorded in currently accepted terminology; and (10-14-88) a. The patient's psychiatric history and social evaluation shall provide information regarding the patient's background, the onset and development of the illness, including factors and precipitating circumstances that led to the patient's admission, and data useful for patient care and discharge planning; and (10-14-88) b. A properly executed consent form shall be obtained and incorporated into the record in any case of treatment approach that carries significant risks, and shows that the patient, his family, or other legally responsible person is informed of available alternative approaches; and (10-14-88) c. Documentation shall show that the patient, his family, or other legally responsible person is informed of the treatment to be given; and (10-14-88)	BB459	See also BB117, BB175, BB283, BB430	8/17/2015

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BB459	Continued From page 122 d. Documentation shall show that planning for continued care and treatment in the community are coordinated with the patient's family and others in his social environment. (10-14-88) This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure medical records included comprehensive information for 4 of 17 patients (#10, #11, #13, and #15) whose records were reviewed. This had the potential to result in the inability of patients or their representatives to make informed decisions about their care and a lack of information on which to base treatment decisions. Findings include: 1. The facility failed to obtain consent for services and involve patients and their guardians in care decisions. a. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14, from a skilled nursing facility, with diagnoses of psychosis, bipolar disorder and congenital brain injury with mental disability. Patient #11's medical record for her hospital admission of 11/25/14 to 11/29/14 was reviewed. Her record included a letter of guardianship and conservatorship. The letter stated Patient #11 was impaired to the extent she was unable to make responsible decisions. Patient #11's record did not include documentation of contact with her guardian to obtain consent for services or to discuss care planning and treatment. Patient #11's record did not include an admission agreement or a consent	BB459		

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BB459	Continued From page 123 for services. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it did not include signed consent forms. Additionally, she confirmed there was no documentation of contact with Patient #11's guardian. The facility failed to obtain consent for services from Patient #11's guardian, and failed to include her guardian in decisions regarding her care. b. Patient #13 was a 69 year old male admitted to the hospital on 1/01/15, with diagnoses of psychosis and depression. Patient #13's medical record for his hospital admission of 1/01/15 to 1/05/15 was reviewed. His record did not include a signed consent for services or an admission agreement. Additionally, his record did not include a care plan or treatment plan developed and discussed with Patient #13. During an interview on 4/01/15 at 4:20 PM, RN C reviewed Patient #13's record and confirmed it did not include a signed consent for services or indication of his participation in development of his treatment plan. The facility failed to obtain consent for services from Patient #13, and failed to allow him the opportunity to make informed decisions about his care. c. Patient #15 was a 60 year old man who was a patient in the facility from 3/15/15 to 3/26/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder.	BB459		

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BB459	Continued From page 124 A nurses note, dated 3/23/15 at 6:15 PM, documented Patient #15 refused to take an increased dose of Seroquel. The note stated "Pt [patient] verbalizes not being happy about Provider making changes in his medication without talking to him first." During an interview on 3/30/15 at 3:35 PM, the NP stated she met with the psychiatrist by teleconference 2 times a week, and discussed all patients treatment plans. She confirmed the psychiatrist did not see Patient #15. During an interview on 4/03/15 at 10:15 AM, the NP reviewed the record and confirmed there was no documentation of Patient #15's involvement in his treatment plan. Patient #15 was not given the opportunity to be involved in decisions regarding his medication changes. The facility failed to obtain consent for services and involve patients and their guardians in care decisions. 2. Patient #10 was a 67 year old male admitted to the hospital on 11/07/14, from an ALF. His psychiatric diagnoses were conduct disorder and depression. Additional diagnoses included history of a stroke, seizure disorder, non-insulin dependent diabetes, and constipation. Patient #10's record included a nursing flow sheet, signed by the RN on 11/08/14 at 9:35 AM. The flow sheet contained sections to document assessment of Patient #10's physical and behavioral status, pain, and current safety precautions in effect. However, the flow sheet was blank. Patient #10's record did not include a	BB459		

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BB459	Continued From page 125 nursing assessment for the day shift on 11/08/14. Patient #10's record included a nursing flow sheet, signed by the RN on 11/09/14, untimed. The flow sheet contained sections to document assessment of Patient #10's physical and behavioral status, pain, and current safety precautions in effect. However, the flow sheet was blank. Patient #10's record did not include a nursing assessment for the day shift on 11/09/14. During an interview on 4/01/15 at 4:30 PM, RN C reviewed Patient #10's record and confirmed the 2 nursing flow sheets were blank and there was no patient assessment documented during those 2 shifts. Patient #10 record did not include an assessment of his physical and behavioral status on every shift.	BB459	See also BB124, BB175, BB283, BB458 Action to Correct Deficiency: Designated areas have been specified to ensure physical and mental assessments are performed in a confidential and private manner. Patient Material will be secure and out of view for others to see. Renovations made to nurse's Station to limit access to confidential material. How Action Improves Process: The confidentiality of patient's medical and psychiatric information shall be maintained. Procedure for Implementation: Medical Staff provided with a secure and private area to interview patients. Direct Care Staff will be educated on the importance of patient privacy and methods to secure it. A Revision of Hospital policy and procedures has been scheduled to educate staff about changes and revisions.	
BB460	16.03.14.470.07 Special Medical Record Requirements for Psych 07. Special Medical Record Requirements for Psychiatric Hospitals or Services. In addition to meeting all the requirements contained in Section 360, patient medical records maintained by a psychiatric hospital or service unit shall clearly reflect the types and intensity of treatment provided to patients in the hospital. The records shall contain the following: (12-31-91) a. Information essential for identifying the patient's problems, for developing treatment objectives, and other information necessary for psychiatric evaluation and diagnosis; and (10-14-88)	BB460		

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BB460	Continued From page 126 b. A record of the treatment received by the patient, including records of all treatment related to short-term and long-term goals, including discharge planning; and (10-14-88) c. The medical record shall provide information regarding the management of the patient's condition and of changes in treatment and patient status. Progress notes shall reflect that care provided in accordance with the treatment plan is recorded at least weekly for the first two (2) months after admission and at least monthly thereafter; and (10-14-88) d. Every safeguard shall be employed to preserve confidentiality of the patient-therapist relationship and to prevent revelation of information that would be harmful or embarrassing to the patient, his family, or others. (10-14-88) This Rule is not met as evidenced by: Based on review of patient records and hospital policies, observation, and patient and staff interview, it was determined the facility failed 1) to ensure the records of 3 of 3 patients (#3, #4 and #8) for whom restraints were used, documented the type of behavioral treatment interventions used; 2) to ensure 17 of 17 patients (#1 - #17) whose records were reviewed, included progress notes that reflected care provided in accordance with a treatment plan; 3) ensure that while gathering information for inclusion in patients medical records, the confidentiality of the patient-therapist relationship was maintained for 2 of 7 patients who were observed (#9 and #17). These system failures created the risk for patients to be subjected to inappropriate, and potentially harmful, behavioral and therapeutic interventions, and for confidential patient information to be shared with patients, visitors,	BB460	HIM or designee to complete daily audits of patient chart to ensure all necessary documentation is contained within. Policy effectiveness of the audit to be reviewed by GB via QAPI. All contact with legally responsible person(s) will be documented throughout hospitalization Monitoring and Tracking: Random administrative rounds will be conducted throughout the facility to ensure compliance of policies and procedures. Preliminary chart audit to be completed within 24 hours of admission followed by a complete chart audit to be completed within 48 and 72 hours. Title of Person(s) Responsible: - \Hospital Administration, CNO, Medical Staff, Staff RN, Direct Care Staff, QAPI coordinator, Program director, Social Services Director, Medical Records	8/17/2015

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BB460	Continued From page 127 and others in the hospital. Finding include: 1. Patient records failed to documented the type of behavioral interventions used by staff. Examples include: a. Patient #8's record documented a 65 year old male who was at the facility from 3/06/15 to 3/24/15 for psychiatric services related to dementia, and psychosis with behavioral disturbances. Additional diagnoses included HTN and PTSD. - On 3/07/15 at 9:00 AM, an "Occurrence Report," written by the RN on duty, noted Patient #8 hit a staff member and another patient. He was noted to be restrained by P.T. D. Additionally, the Occurrence Report documented Patient #8 had another physical altercation with P.T. D, his behavior escalated, and he struck a patient. The report documented he was physically restrained, and administered an IM injection. Patient #8 was placed on 1:1 status, and remained on that status throughout his stay at the facility. The types of restraints used by staff to restrain Patient #8 were not specified. -A P.T. note attached to an "Occurrence Report" dated 3/07/15 at 3:15 PM stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. He was then given an injection of Geodon IM 20 mg. Patient #8's record did not include documentation of the actions were necessary to "redirect" Patient #8 to	BB460		

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BB460	Continued From page 128 his room. Additionally his record did not include documentation of the type of restraint used to restrain Patient #8 for the IM injection. - On 3/08/15, an "Occurrence Report," written by the RN on duty, noted at 9:30-10:30 AM, Patient #8 became agitated and was threatening P.T. D. The report indicated P.T. D performed a Mandt hold on Patient #8, and then 4 employees were required to assist him back to his room. There was no documentation in Patient #8's record that described the type of Mandt restraint used. A nurses note documented at 10:50 AM on 3/08/15 also stated Patient #8 continued to "go after staff" and was given an IM injection of 20 mg Geodon. The type of restraint used to allow the IM injection was not specified. The nurses note went on to say that after the injection Patient #8 continued to require physical redirection by staff. There was no documentation to describe the "redirection " used by staff. - An "Occurrence Report," dated 3/08/15 at 2:00 PM, was completed by the RN on duty. The RN documented Patient #8 was aggressive to another patient and that P.T.s were able to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. Patient #8 was given an injection but did not calm down until 5:00 PM according to the documentation on the Report. The type of restraint used to allow for the IM injection and actions of the SNF male aide were not described. - On 3/12/15, Patient #8's MAR indicated he was administered Geodon 20 mg IM at 3:00 PM. The P.T. narrative indicated Patient #8 was visited by his son, and complained of pain, for which he was medicated with Tylenol at 5:00 PM. A nurses	BB460		

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BB460	Continued From page 129 note, also documented at 3:00 PM on 3/12/15, stated "Patient seems to be agitating another patient, which in turn seems to agitate the patient. Patient pacing and getting louder. Medicated per MAR." The type of restraint used to restrain Patient #8 to allow the IM injection, was not documented. - On 3/14/15, an "Occurrence Report", written by the RN on duty, noted at 4:00 PM, Patient #8 was involved in a physical altercation with another patient. The report documented he was physically redirected by staff, and was assisted to his room. In his room he began to swing at staff, was restrained on a total of 4 occasions, and administered Zyprexa IM. There was no documentation to describe the "redirection" used by staff or the technique used to assist him to his room. Additionally, there was no documentation describing the type of restraints used during the 4 restraint interventions. -On 3/16/15 Patient #8's MAR stated he received Haldol 5 mg IM at 8:55 PM. His record included an "Emergency Treatment Override Orders for Seclusion," completed by the NP and RN at 9:30 PM. He was noted to be agitated, hit the staff, punched the fire door, his knuckles were bleeding. A nurses note, dated 3/16/15 at 7:40 PM indicated Patient #8 He was escorted to the seclusion room after grabbing the RN's wrist. The nurses note indicated Patient #8 resisted and staff continued to escort him to seclusion. It further stated "Staff into seclusion room and stabilized pts arms" and Haldol injection given. There was no documentation in Patient #8's record that described how staff "escorted" him to the seclusion room or the type of restraint used to stabilize his arms.	BB460		

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BB460	Continued From page 130 - A 3/18/15 at 6:05 PM Emergency Treatment Override Orders for Hold and Restraint form, indicated Patient #8 was physically restrained using a "Staff Hold" to allow for an IM injection of Geodon 20 mg and placement in seclusion. A tech note documented at the time of the incident, stated Patient #8 was agitated and combative at the beginning of the shift and that he was getting worked up from other patients. There was no documentation describing the type of restraint hold used. -A P.T. note, documented on 3/21/15 at 6:30 AM, indicated Patient #8 was agitated and P.T. D came to help and Patient #8 was restrained twice. The types of restraints used were not described. During an interview on 4/02/15 beginning at 10:45 AM, the NP reviewed Patient #8's record and confirmed there was no documentation of the type of restraints the staff used when he was restrained. The NP stated she took Mandt training in 2010, when she worked at the facility as an RN, but her certification expired. The NP was unable to describe the methods of restraint the staff used when physically restraining Patient #8. The facility failed to ensure staff specifically described the type of restraints, redirections, escorts, and holds used on Patient #8. b. Patient #4 was a 64 year old male admitted to the hospital on 3/02/15 to 3/16/15, from an assisted living facility. His psychiatric diagnoses included schizophrenia, depression, and mild mental disability. Patient #4's record included documentation of physical restraint by staff for verbal aggression.	BB460		

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BB460	Continued From page 131 A nurses note signed by the RN, dated 3/08/15 at 8:00 AM, documented Patient #4 became agitated and started yelling at other patients and staff. The RN documented Patient #4 was threatening a peer with physical aggression. There was no documentation what preceded Patient #4's agitation and verbal aggression towards his peer. Patient #4 was physically restrained and taken to his room by staff. During an interview on 4/01/15 at 3:00 PM, the RN reviewed the record and confirmed the documentation of physical restraint. She stated physically moving a patient to their room was considered a restraint. Patient #4's record did not include documentation of the type of restraint used. c. Patient #15 was a 60 year old man who was a patient in the facility from 3/15/15 to 3/26/15, with diagnoses of Schizoaffective Disorder and Borderline Personality Disorder. A nurses note, documented at 9:00 PM on 3/22/15, stated Patient #15 eloped, was followed by hospital staff, hit and spit at hospital staff, and was "escorted back to the hospital by 2 male staff. The note further stated Patient #15 continued to be upset and when he returned he punched the entry door and slammed his door multiple times. Patient #15 was documented as stating he wanted the police called so he could go to jail. There was no documentation of the type of "escort" used by the 2 male staff to return Patient #15 to the hospital. In an interview on 4/01/15 at 4:45 PM, RN C reviewed Patient #15's record and confirmed the	BB460		

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BB460	Continued From page 132 escort back to the facility was considered a restraint. Patient #15's record did not include documentation of the type of restraint used. 2. The policy "ICTP, Comprehensive," dated 1/31/12, stated "An ICTP that includes measurable objectives and time tables to meet the patient's mental, psychological, and psychosocial needs shall be developed for each patient." The policy included a procedure to develop and monitor a comprehensive treatment plan for patients. The policy and procedure were not followed. The records of 17 patients (#1 - #17) with an admission date range of 9/24/14 to 3/31/15, were reviewed. None of the 17 patient records contained a documented treatment plan. Goals were not identified, and interventions were not specified in order to direct staff in caring for these patients. During an interview on 4/03/15 at 10:30 AM, the NP stated ITCPs had not been developed since the CNO left in January. She confirmed patients currently did not have ITCPs. On 4/02/15 beginning at 11:50 AM, a Treatment Team group consisting of RN C, the Director of Social Services, and the Program Director was observed. The discussed patients' needs and progress at the hospital. They did not develop or document written treatment plans. The Director of Social Services stated the group reviewed patients' problem lists but she said there were no written treatment plans. She stated she was not aware of a procedure to develop and	BB460		

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BB460	Continued From page 133 review treatment plans. Patients medical records did not include a treatment plan or progress notes reflective of care provided in accordance with one. 3. The unit was locked with double doors that opened into a large hallway. The hallway to the right was short, and had two leather oversized chairs against the wall. The chairs were facing the hallway, and on multiple occasions providers were observed speaking with family and/or patients. The area was open, close to patient rooms and the locked unit doors. Patients and staff were observed to walk by the individuals in the chairs. a. On 4/01/15 at 2:00 PM, Patient #9 was observed with his wife, talking to the social worker. He was in a wheelchair, and his wife was sitting in the large leather chair, talking with the social worker in the other chair. Their conversation was overheard by a surveyor, they were discussing Patient #9's pending discharge, and plans for his placement. It was in a high traffic area, staff, visitors, and patients could hear confidential information. During an interview on 4/03/15 at 3:45 PM, the Director of Social Services confirmed that patient and family meetings are often conducted in the sitting area at the end of the hallway. b. The dining/multipurpose room included a couch, large recliner chairs, a large table surrounded by chairs, a TV, and craft supplies. Meals were served in the room. Group activities were also completed in the room. Patient and provider interviews, evaluations, and other interactions were observed in the room as	BB460		

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BB460	Continued From page 134 follows: - On 4/01/15 at 4:00 PM, the NP was observed talking with Patient #20, who was admitted to the facility the night before. The conversation was overheard by 3 other patients sitting at a table playing scrabble, as well as, a surveyor, and the other staff that were in the room. The patient was sitting at the dining table, facing the open doorway that went into the hall, and close to the patio area where patients could go outside. The location of the patient and the NP was in a high traffic area. The conversation continued for approximately 30 minutes, during which time the patient disclosed personal information, and stated that he was feeling suicidal and homicidal. - During a tour of the facility on 3/30/15 beginning at 2:00 PM, an open notebook was observed on the dining table. The book included patient information related to bathing schedules, oral intake, bowel movements, and other personal information. A P.T. was asked about the book. She stated it was for the techs to record patients' ADL information. She stated it was usually kept in the dining area for the staff to enter their documentation. During an interview on 4/02/15 at 8:45 AM, Patient #17 stated she did not feel that her privacy was protected. She stated interviews with the providers occurred in the dining area, or "down the hall." She stated her room just had a bed and no chair, so she was not able to talk with anyone in her room. During an interview on 4/02/15 at 5:00 PM, the NP was asked about her conversation with the patient in the dining room. She confirmed the activity was an "Initial Psychiatric Evaluation," and	BB460		

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BB460	Continued From page 135 she stated she had first obtained his permission to talk in that area. The NP then stated she does not have a private area to talk to patients. She stated she routinely met with patients in the dining area. The facility did not ensure the confidentiality patients' medical and psychiatric information. 4. Refer to BB283 as it related to the failure of the hospital to ensure medical records included comprehensive information. 5. Refer to BB455 as it relates to the failure of the facility to ensure treatment plans were developed and implemented.	BB460		
BB461	16.03.14.470.08 Discharge Planning 08. Discharge Planning. Consideration for continued care and services in the community after discharge, placement alternatives, and utilization of community resources shall be initiated on admission and carried out to ensure that each patient has a documented plan for continuing care that meets his individual needs. Provision shall be made for exchange of appropriate information with outside resources. (10-14-88) This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure referrals were made for continued care and services in the community after discharge that met the patient's individual needs for 1 of 16 patients (#5) who were discharged and whose records were reviewed. This failure negatively impact a discharged patient by resulting in deteriorated	BB461	See also BB175 Action to Correct Deficiency: Policy and Procedures revised and education given to staff members. Discharge planning will be initiated upon admit to the hospital and will continue throughout the patients stay. All patients will be evaluated to assess their needs within 72 hours. DC plan will be reevaluated during daily IDT meetings throughout hospital stay. Discharge instructions will include any changes that may arise and will be reviewed with patient/ responsible party prior to discharge. All discharge planning and procedures to be documented in patients chart appropriately.	

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BB461	Continued From page 136 health status and had the potential of that patient and all other discharged patients to be readmitted to a hospital. Findings include: Patient #5 was a 55 year old male admitted to the hospital on 3/09/15 to 3/25/15, from an ALF. His psychiatric diagnoses included schizophrenia and depression. Patient #5's record included a medical evaluation, which was completed on 3/10/15. The medical evaluation documented an extensive history of abdominal surgeries with associated complications over the last 5 months. During 1 of his admissions Patient #5 was hospitalized for a 2 month period. At that time Patient #5 had a tracheostomy, PEG tube, and repair of wound dehiscence with significant malnutrition problems. Upon his admission to the facility Patient #5 had large retention sutures to his abdomen which were to be removed in 2 days of his admission to the hospital. Patient #5's record included social history completed by a LMSW on 3/13/15. The social history documented recommendations for coordination of discharge placement and aftercare, and Patient #5 was to return to an ALF. Patient #5's discharge instructions included a medication list with an antibiotic for infection. Patient #5 had numerous abdominal surgeries, including post-operative complications, documented in his H&P, over the previous 5 months. Patient #5's record did not include any progress notes from the medical physician after the initial H&P was completed. The H&P documented Patient #5 had a midline surgical incision which was being held with large retention sutures with rubber tubing around them that	BB461	How Action Improves Process: Staff will have a full understanding of departmental policy and procedures through in-service education. Patients will receive appropriate mental health/medical services following their discharge. Inappropriate discharges will be eliminated by ensuring proper review by IDT members. Procedure for Implementation: In-services will be scheduled with staff as needed to review policy and procedure changes. Social Service Director or designee will be responsible for the monitoring of the appropriateness of discharges. DC instructions will be initiated on admit by Ward Clerk. Monitoring and Tracking: Social Service Director to complete chart audits of sample patient discharges. Findings will be presented at quarterly GB and CQI meetings. Title of Person(s) Responsible: Social Service Director, Ward Clerk, Medical Records, CNO, Administrator	8/17/2015

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BB461	Continued From page 137 bridged over the incision. On 3/23/15, the LPN documented Patient #5 had open area at the incision site with redness in color. There was no documentation of measurements of the open area. The discharge instructions did not include a scheduled follow up appointment with Patient #5's surgeon or a primary care provider. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local shelter. Included on his discharge medication list was an antibiotic for infection. There was no follow up appointment scheduled with Patient #5's surgeon or a primary care provider. An email, detailing events after Patient #5's discharge, was received by surveyors on 4/03/15 at 3:30 PM. Patient #5 was discharged from the facility on 3/25/15 at 3:30 PM, to a local shelter. The email dated 4/03/15 at 2:32 PM, and written by the VP of the hospital, was addressed to the SNF AIT. The email documented a timeline of events that occurred after Patient #5's discharge from the hospital. Patient #5 was driven to the shelter by a hospital van after picking up his prescriptions. He was told by the shelter employees it was too early for admittance and to return between 5:00 and 6:00 PM. Patient #5 returned to the shelter several times over the course of the evening and he also went back to the facility requesting to be let in. He was refused admittance and went to the facility's corporate office the next morning. The corporate office then arranged for Patient #5 to be admitted to an ALF, after 2 encounters with police, missing personal effects, and a bloody face. There was no other documentation in the facility of Patient #5's return during the middle of the night on 3/25/15	BB461	Since time of survey, ownership of the hospital has changed which reflects a different set of values aimed at patient care. Previous co-owner is no longer affiliated with the operations of the hospital.	8/17/2015

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BB461	Continued From page 138 Patient #5 was not referred or given a follow up appointment with his primary care provider or surgeon to monitor his post-operative incision or completion of his antibiotic regimen. During an interview on 4/03/15 at 12:55 PM, the Director of Social Services reviewed the record and confirmed the plan was for Patient #5 to return to his previous ALF. She confirmed the discharge plan did not include follow up with his surgeon or a primary care physician. During an interview on 4/01/15 at 5:20 PM, RN C reviewed the record and confirmed discharge orders did not include a follow-up appointment with his surgeon. Patient #5's discharge plan and post-hospitalization placement did not take into consideration his individual needs.	BB461	See also BB144	
BB462	16.03.14.470.09 Physician Services 09. Physician Services. A board certified or board eligible psychiatrist shall provide the overall direction of the service including monitoring and evaluating the quality and appropriateness of psychiatric services rendered. Physicians shall be available at all times to provide medical and surgical diagnosis and treatment services. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of Medical Staff Bylaws and meeting minutes, it was determined the hospital failed to ensure the psychiatrist provided sufficient oversight and monitoring of patient psychiatric services and that	BB462	Action to Correct Deficiency: The hospital has ensured adequate numbers of qualified professional and supportive staff are available to evaluate all patients. A licensed, Board Certified Director of inpatient psychiatric services physician has been employed as the Hospital's Medical Director (MD). The MD meets all training and experience requirements for examination by the American Board of Psychiatry and Neurology qualifications. The MD monitors and evaluate the quality and appropriateness of all patient services and treatments provided by the Medical Staff. The MD will be available at all times to provide medical and treatment services for the Hospital's patients.	

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BB462	Continued From page 139 physicians were available to meet patient medical needs. This resulted in the inability of the hospital to ensure patients' psychiatric and medical needs were met. Findings include: 1. "BYLAWS OF THE MEDICAL STAFF OF SAFE HAVEN HOSPITAL," not dated, stated NPs were defined as Allied Health Professionals. Article VIII Section I of the bylaws stated "All Allied Health Professionals providing direct patient care in the hospital shall do so under the direct supervision of the attending psychiatrist." The prior Medical Director, who was a psychiatrist, was interviewed on 4/02/15 beginning at 4:45 PM. He confirmed he had served as Medical Director from 9/25/13 through 3/31/15. He stated while he was Medical Director, the Medical Staff consisted of 2 psychiatrists, including himself, another psychiatrist, and a Family Practice Physician. The prior Medical Director stated no Medical Staff meetings had been held during the 18 months he was the Medical Director. The prior Medical Director stated there was no documentation of Medical Staff Activities. The prior Medical Director stated the hospital had no peer review program or other process to evaluate members of the Medical Staff. The prior Medical Director stated during his time as Medical Director he lived in Boise, Idaho, which is approximately 235 miles from the hospital. He stated he had not treated any patients at the hospital. He stated he started visiting the hospital in 2014. He stated since then he had been coming to the hospital one time a month until 2 or 3 months ago. He stated his activities at the hospital were not documented.	BB462	Medical Executive committee has been established with the Administrator serving as chair and the CNO serving as co-chair other remaining members to be composed of all medical staff. This committee to meet 1 X monthly for 6 months and then quarterly to coincide with GB meeting thereafter. The Governing Body Bylaws and Medical Staff Bylaws, ensure compliance with IDAPA 16.03.14.470.00 (Physician Services). How Action Improves Process: Compliance with the Federal and State licensing laws for employment of a board certified psychiatrist for the Hospital ensures quality patient care is provided and available at all times for patient treatment services. Procedure for Implementation: Employment of a board certified psychiatrist ensures compliancy with Federal and State laws to ensure psychiatrist physician patient services are provided and available at all times for the Hospital's patient treatment services. Monitoring & Tracking: The Governing Board Bylaws and MS Bylaws have addressed and will continually ensure that the Federal and State law for the employment of a board certified psychiatrist is always met with the physician's employment. In addition, the Organization and Governing Body will ensure and monitor that compliance is met at all times with the employment of a board certified psychiatrist. Title of Personnel Responsible: The Organization, the GB, the MS, Administrator and CNO.	8/17/2015

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BB462	Continued From page 140 The prior Medical Director stated psychiatric care was primarily provided by one NP. He stated 2 other NPs served as her backup when she was not available. He stated the primary NP was supervised by the other psychiatrist who lived in Florida. The Florida psychiatrist was interviewed on 4/03/15 beginning at 1:55 PM. She stated she last visited the hospital in February of 2015. She said she was scheduled to come to the hospital on April 9, 13, 14, and 15, of 2015 and then she would not come to the hospital again until the end of May 2015. She stated all direct services were provided by NPs. She stated she teleconferenced with the primary NP 2 times a week. She stated she did not directly supervise the NPs. She stated she did not know if the hospital had a formal process to supervise NPs. The hospital failed to ensure the psychiatrist provided sufficient oversight and monitoring of patient psychiatric services. 2. The "SAFE HAVEN HOSPITAL BYLAWS OF THE GOVERNING BOARD," not dated, stated "PATIENT CARE. It is Hospital policy that every patient shall be under the care of a physician...a physician shall be on duty or on call at all times and shall provide onsite supervision when necessary." The prior Medical Director was interviewed on 4/02/15 beginning at 4:45 PM. He stated a Family Practice Physician had privileges at the hospital to provide for patients' medical care. The prior Medical Director stated he had not had contact with the Family Practice Physician.	BB462		

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BB462	Continued From page 141 The Family Practice Physician was interviewed on 4/01/15 beginning at 1:30 PM. The Family Practice Physician stated he did not know the name of the prior Medical Director and had not met him. The Family Practice Physician stated he worked at a wound clinic and was not available to the hospital until after 3:00 PM. The facility failed to ensure physicians were available to meet patient medical needs.	BB462		
BB463	16.03.14.470.10 Nursing Services 10. Nursing Service. The nursing service shall be under the overall direction of a psychiatric nurse qualified by training or experience in psychiatric nursing, who monitors and evaluates nursing care provided. (10-14-88) a. A registered nurse shall be on duty twenty-four (24) hours a day, seven (7) days a week to provide direct patient care, and to assign and supervise nursing care activities performed by other nursing personnel. (10-14-88) b. There shall be adequate numbers of qualified registered nurses, licensed practical (vocational) nurses, psychiatric technicians, and other supportive nursing personnel to carry out the nursing aspects of the individual treatment plan for each patient and capable of maintaining progress notes on all patients. (10-14-88) This Rule is not met as evidenced by: Based on review of clinical records, hospital policies, and staff interviews, it was determined the facility failed to ensure a qualified psychiatric nurse provided sufficient oversight and monitoring	BB463	See also BB116, BB117, BB146, BB173 Action to Correct Deficiency: A full-time CNO has been hired and will oversee nursing services for the Hospital. CNO to audit charts daily for vital sign trends. CNO to provide support to nursing staff. New pharmacist has been hired and will provide education to staff and patients about medications in addition to attending IDT meetings for unity of treatment team goal planning. Nurses have been assessed for competence and qualification and replaced as necessary by administration. High-performing, qualified Psychiatric Technicians (PTs) have been invited back to work upon re-opening. Orientation to all staff about Hospital Policy and Procedure manual revision and education provided to nurses about emergency management, head-to-toe nursing physical assessment, focused assessment and physical exam for changes and problems that occur and elements of required documentation to follow such.	

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BB463	Continued From page 142 of patient services for 10 of 17 patients (#1, #5, #7, #8, #10 - #12, and #16 - #17) whose records were reviewed. The lack of nursing assessment and oversight resulted in the lack of interventions and physician notification of deterioration in patients' medical conditions which led to the death of 3 patients (#10, #11, and #12) and had the potential to adversely impact the health and safety of all patients receiving services at the facility. Findings include: 1. The hospital failed to provide nursing services necessary to identify and address patients' deteriorating health status, which contributed to the deaths of Patients #10, #11, and #12, as follows: a. Patient #10 was a 67 year old male admitted to the hospital on 11/07/14, from an ALF. His psychiatric diagnoses were conduct disorder and depression. Additional diagnoses included history of a stroke, seizure disorder, non-insulin dependent diabetes, and constipation. Patient #10 expired at the hospital on 11/17/14. Patient #10's record included an Inpatient Psychiatric Evaluation, completed by the NP on 11/07/14. The evaluation documented he was admitted from an ALF due to verbally aggressive behaviors, inappropriate defecation and inappropriate sexual behavior. The evaluation stated "He has a bowel obsession....he refused to use the bathroom." Patient #10's record included an Admission History and Physical, completed by the MD on 11/07/14. It documented Patient #10 had a bowel obsession and refused to use the bathroom. Additionally, it documented possible anorexia (loss of appetite) stating "He is on Megace	BB463	All patients admitted to the Hospital will meet the criteria for medical clearance prior to admission and be evaluated by an MD within 24 hours. Orders for chronic and acute disease management to be provided by MD and LIP at that time and updated as needed based on nursing assessment data and communication with providers. MD or Licensed Independent Practitioner (LIP) to participate in IDT meetings at least weekly to review and sign vital sign flow sheets, and skin (including wound assessments) and bowel monitoring log for acknowledgment and to contribute to care planning and interventions for chronic or acute disease management. Changes in patient condition, including pain to be assessed, documented, and discussed in IDT for problem list update and interventions. Labs ordered and drawn to be resulted and those finding presented for review at IDT meetings. Parameters for vital signs, including urine output and blood glucose to be established for each patient during initial MD evaluation. Nurses to contact provider when vital signs are outside of the designated parameters. PTs will be educated about accurate intake and output (I&O) monitoring and reporting. New I&O log generated with provision for the reviewing RN to calculate mL of urine per hour trend average for the shift. Findings are to be presented to the provider and documented as such during the shift if outside of the normal range (1mg/kg/hr) for an average adult.	

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BB463	Continued From page 143 without a diagnosis otherwise." Nursing 2015 Drug Handbook listed indications for Megace, including anorexia, or unexplained significant weight loss. Patient #10's Psychiatric Evaluation and History and Physical indicated risks related to bowel function and poor appetite. Patient #10 exhibited signs and symptoms of physical decline related to bowel function and weight loss. However, his symptoms were not addressed by the nursing staff, thoroughly assessed or reported to the MD or mid level practitioner. Examples include: On 11/07/14: -Patient #10's record documented his weight upon admission as 132.2 pounds. On 11/09/14: -Patient #10's weight was documented as 129.9 pounds, a loss of 2.3 pounds in 2 days. On 11/10/14: -A Nursing flow sheet, signed by the RN at 3:06 AM, documented Patient #10 complained of pain rated as a 4 on a scale of 1-10, however, the location of the pain was not documented. -A nurses note, signed by the RN at 7:55 AM, documented Patient #10 refused to come to breakfast and stated he was "hurting," however, it did not document an assessment of the pain to determine the severity or location of his pain. On 11/11/14: -Patient #10's weight was documented as 127.4 pounds, a loss of 4.8 pounds in 4 days. On 11/12/14: -A nurses note, signed by the RN at 11:50 AM, documented Patient #10 was agitated about	BB463	Wound assessment tool revised to include a measuring scale, and requite documeutation components, including: color, temperature, drainage, odor, and communication with provider for orders for wound care or other treatment/follow up. An organizational flow sheet to indicate chain-of-command has been created and posted in employee work area and in the employee handbook for reference. On admission patients/legal representative will be educated by the admitting nurse/designee on their Patient Rights and will receive a printed copy. The Patient Rights has also been posted at the nurse's station along with a direct number to Safe Haven's CEO and COO to report immediate concerns. Staffing grid (attached) utilized to provide direction for staffing the Hospital to avoid staffing shortages leading to a decline in the quality of Hospital care. How Action Improves Process: Patient outcomes will be significantly improved with the addition of high-quality staff and administration to oversee patient care servicing. Patient outcomes are improved by increasing all care-giver's access to accurate and timely assessment data for use to plan interventions. Patient, caregiver, and community satisfaction is increased when patients feel safe and cared for as evidenced by positive outcomes pertaining to quality medical care.	

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BB463	Continued From page 144 being in pain, however, it did not document an assessment of the pain to determine the severity or location of his pain. -A meal intake flow sheet documented Patient #10 refused dinner. On 11/14/14: -A nurses note, signed by the RN at 3:50 AM, documented Patient #10 vomited, however, it did not document a physical assessment was completed. -A nurses note, signed by the RN at 11:00 AM, documented Patient #10 had a small appetite, and when encouraged to eat lunch, he refused. -A meal intake flow sheet documented Patient #10 refused dinner. On 11/15/14: -Patient #10's medication administration record documented he was given Mylanta 30 cc po for nausea, at 3:55 AM. -A nurses note, signed by the RN at 8:15 AM, documented he was eating very little. -The meal intake flow sheet documented Patient #10 refused breakfast and lunch. His intake at dinner was not documented. -A nurses note, signed by the RN at 10:10 PM, documented Patient #10 vomited, his physician was notified, and a new medication order was obtained. However, there was no documentation of a physical assessment or Patient #10's response to the medication, including the effectiveness. On 11/16/14: -A nurses note signed by the RN at 8:05 AM, documented he ate very little and complained of a stomach ache, however, it did not document a physical assessment or the severity of the pain. -A nurses note, signed by the RN at 12:05 PM,	BB463	Staff will experience greater job satisfaction when all members of a patient's treatment team are organized and focused on high quality, competent care for Hospital patients. Grievance reporting and investigation is an improved process by the addition of a telephone number(s) to reach the Hospital CEO provided openly in common areas. Procedure for Implementation: A Hospital Administrator, CNO, Pharmacist and new Nurses have been hired. Prior caregivers with inadequate performance will not be returning to the Hospital. New employees will complete the requisite orientation per HR Policy and Procedure. An orientation to the Hospital in addition, will be provided by the CNO prior to new nurses providing direct patient care and will include education about specific Hospital Policy and Procedures addressing emergency management, nursing assessment, and the culture of patient safety. MD and LIPs to be notified of their requirement to attend the IDT meetings as part of the care planning process and to sign/initial sign flow sheets as presented by the nursing department at those meetings. Criteria for medical clearance to be identified, met and documented on each patient during the admission process. Wound assessment and documentation tool to be developed by QAPI Coordinator/Infection Control Nurse and presented to nursing staff for implementation.	

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BB463	Continued From page 145 documented he refused most of his lunch. -A nurses note, signed by the RN at 6:05 PM, documented Patient #10 refused to come to dinner. On 11/17/14: -A nursing flow sheet, signed by the RN at 7:50 AM, documented he complained of a stomach ache, however, it did not document a physical assessment or the severity of the pain. -A nurses note, signed by the RN at 8:05 AM, documented Patient #10 ate very little and complained of a stomach ache. -A Patient Behavior Shift Summary for the day shift, from 6:00 AM to 6:00 PM, documented Patient #10 did not eat any of his meals and kept sliding out of his chair. -Patient #10's weight was documented as 123 pounds, a loss of 9.2 pounds in 10 days. Patient #10's record included a flow sheet that documented he did not have a bowel movement on any shifts, from 11/07/14 to 11/17/14. His nursing admission assessment did not document his last bowel movement prior to admission, so it was unclear how long it was since his last bowel movement. Patient #10's admission assessment, completed by the RN on 11/07/14, stated his abdomen was round and bowel sounds were present, however, his record did not document another nursing assessment of his abdomen prior to 11/17/14, to determine distension, tenderness, or quality of bowel sounds. Patient #10's medication orders included Hydrocodone/APAP to be given 4 times per day. According to Nursing 2015 Drug Handbook, constipation is a very common adverse effect of Hydrocodone. It stated constipation should be treated aggressively. However, Patient #10's	BB463	Monitoring and tracking: Daily chart audits of vital sign flow sheet to be conducted for early detection of negative trends by CNO. Vital sign flow sheets to be initialed by providers to indicate communication by nursing to medical staff of these trends. Report to QAPI committee for further tracking and trending of outcomes. Chart audits by HIM or designee to be reviewed for completeness of documentation at 24,48,72 hours and throughout remainder of hospitalization as needed. This data will be given to QAPI for analysis. HR to continue to monitor and maintain current employee certifications, licensures, and ongoing education. Documentation of Hospital employee orientation checklists to be provided to HR prior to 90-day evaluation. CNO to audit new employee chart documentations for completion, accuracy, and appropriateness prior to 90-day evaluation to identify areas for improvement and education. Pharmacist to maintain documentation of staff and patient education provided about medications. Contracted service with vendor to conduct discharge surveys to track patient care experiences and unreported grievances. Title of Person(s) Responsible: CEO, Administrator, CNO, Pharmacist, IDT, QAPI Coordinator/Infection Control Nurse, HR, Staff RN, PTs, HIM, Ward Clerk	8/17/2015

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BB463	Continued From page 146 record did not document physician notification of his constipation. Patient #10's admission physician orders included a Fleet's enema to be given as needed if no bowel movement in 3-4 days. However, administration of a Fleet's enema was not documented during his 10 day hospitalization. Patient #10's record documented the MD was called, on 11/15/14, to report his nausea and vomiting. A medication for nausea was ordered and administered. However, his record did not document the MD was contacted the following day to report his continued complaints of nausea and stomach pain, as well as his weight loss and lack of bowel movements. A nurses note dated 11/17/14 at 5:00 PM, documented the MD was notified Patient #10 was not feeling well, and orders were received. However, his record did not document the MD was notified of his weight loss, complaints of pain and nausea, and lack of bowel movements. Patient #10's record included an order dated 11/17/14, untimed, for Dulcolax 5 mg, 2 tablets to be given every 12 hours for 3 doses, and Senna-S, 2 tablets to be given daily. Patient #10's MAR documented a 6:00 PM dose of Dulcolax was given, however, it did not document his condition at the time it was administered, or if he had difficulty swallowing the 2 tablets. A nurses note dated 11/17/14 at 5:55 PM, and signed by the RN, documented a P.T. reported Patient #10 did not look well, and sounded "rattily." The RN's assessment noted hypoactive bowel sounds and crackles throughout his lungs. MD orders were obtained to transfer Patient #10 to the ED at an acute care hospital. The RN noted she placed phone calls to begin to arrange	BB463		

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BB463	Continued From page 147 transport to the hospital. A nurses note dated 11/17/14 at 6:15 PM, documented staff reported Patient #10 was not breathing. The RN documented Patient #10 was unresponsive and 911 was called at that time. Patient #10's record included a death certificate with date and time of death documented on 11/17/14 at 6:20 PM. The cause of death was listed as cardiorespiratory failure. During an interview on 4/01/15 at 4:30 PM, the RN reviewed Patient #10's record and confirmed he lost 9.2 pounds and his bowels did not move during his hospitalization. She stated the MD should have been notified of his weight loss and bowel status, as well as his complaints of pain and nausea. During an interview on 4/01/15 at 2:00 PM, the MD stated he would have expected the nurses to inform him of Patient #10's significant weight loss. Additionally, he stated he should have been informed by the nurses that Patient #10 complained of pain and nausea, and did not have a bowel movement for 10 days. During an interview on 4/03/15 at 1:15 PM, the NP stated the nurses did not inform her of Patient #10's weight loss or lack of bowel movements during his hospitalization. However, the NP's notes, dated 11/16/14, the day prior to Patient #10 death, stated he was "...improving on his current medications as evidenced by no sexually inappropriate behavior towards staff or other patients, and no inappropriate defecation noted." Patient #10's admission evaluations documented he was at risk for weight loss and bowel complications. During his 10 day hospitalization	BB463		

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	IDKT4M		C 04/03/2015

NAME OF PROVIDER OR SUPPLIER: SAFE HAVEN HOSPITAL OF POCATELLO

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BB463	Continued From page 148 he complained of pain and nausea, had no bowel movements, and lost 7% of his body weight. However, he was not thoroughly assessed by the nursing staff, and significant signs and symptoms were not reported to the MD. Therefore, interventions were not initiated to address his medical problems and Patient #10 died at the hospital on 11/17/14. b. Patient #11 was a 66 year old female admitted to the hospital on 11/25/14, from a SNF. Her psychiatric diagnoses were psychosis, bipolar disorder and congenital brain injury with mental disability. Additional diagnoses included renal insufficiency, CHF and diabetes. Patient #11 was transferred to an acute care hospital on 11/29/14, where she was admitted to the ICU. She died at the acute care hospital on 12/31/14. The National Institutes of Health website, accessed 4/08/15, defined renal insufficiency as "the slow loss of kidney function over time. The main job of the kidneys is to remove wastes and excess water from the body." It defined CHF as "a condition in which the heart can't pump enough blood to meet the body's needs. The weakening of the heart's pumping ability causes blood and fluid to back up into the lungs, and the buildup of fluid in the feet, ankles and legs, called edema." Patient #11's record included a nursing admission assessment, dated 11/25/14, and signed by RN C. The cardiac section of the assessment included check boxes to document location and degree of edema, however, the boxes were blank with a question mark next to them. Therefore, it was unclear if Patient #11 had edema at the time of admission to the facility. Her record did not document additional assessments of edema during her hospitalization.	BB463		

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BB463	Continued From page 149 Patient #11's record included a document titled "Treatment Plan." Problem 4, dated 11/26/14, was identified as renal insufficiency. However, there was no plan documented to address her renal insufficiency, and the document did not include interventions, notes or updates. CHF was not identified as a problem on the treatment plan. Patient #11's record included admission orders, signed by the RN on 11/25/14, and signed by the NP on 11/26/14, that contained orders for laboratory tests, including a CMP. The National Institutes of Health website, accessed 4/08/15, stated a CMP includes BUN and creatinine levels, tests done to assess kidney function. Patient #11's record documented her blood was drawn and sent to the laboratory on 11/26/14, however, her record did not contain results of the blood tests, and there was no documentation to indicate the results were reviewed by the RN, NP or MD. Patient #11's Inpatient Psychiatric Evaluation documented a diagnosis of diabetes. Her admission orders, signed by the NP on 11/26/14, included a Hgb A1C laboratory test. A Hgb A1C shows the average blood sugar over the previous 2-3 months to measure how well the diabetes is being controlled. Patient #11's record documented her blood was drawn for a Hgb A1C and sent to the lab on 11/26/14, however, her record did not include results of her Hgb A1C. Additionally, her record did not include evidence of random blood sugar readings. Therefore, her diabetes was not monitored during her hospitalization. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it did	BB463		

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BB463	Continued From page 150	BB463		

not include results of her blood tests. She stated it was possible Patient #11's blood was not drawn, or the tests were completed but the results were not obtained and put in her record. RN C stated it was the responsibility of the ward clerk to access laboratory results on-line and put them in the patient's chart, and stated that was not always done. She stated the RN was responsible to follow up on laboratory results if the results are not in the patient's record. Additionally, it was the RN's responsibility to report abnormal results to the MD.

Patient #11's record included a nurses note, dated 11/26/14 at 3:30 PM, that documented a foley catheter was inserted. Her record also included an intake and output flow sheet. The flow sheet documented a fluid intake of 2640 ccs between 11/26/14 at 5:00 PM and 11/27/14 at 7:30 PM. The first documentation of foley catheter urine output was 310 ccs on 11/27/14 at 7:30 PM, 28 hours after the catheter was inserted. This indicated a urine output of approximately 11 ccs per hour.

The Lippencott Manual of Nursing Practice, 10th edition, released 5/2013, stated a urinary output of less than 30 ccs per hour is abnormally low and should be reported to the physician. However, Patient #11's low urine output and discrepancy between intake and output was not reported to the MD.

Patient #11's flow sheet documented a fluid intake of 2840 ccs in the next 24 hours. However, it documented only 200 ccs of urine was emptied from the foley catheter bag on 11/28/14 at 7:07 PM, in the same 24 hour period. This indicated a urine output of approximately 8 ccs per hour.

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BB463	Continued From page 151 Patient #11's record did not document her weight at the time of her admission. The first weight recorded was 315.4 pounds on 11/27/14. Her weight was documented as 318 pounds on 11/28/14, indicating a 2.6 pound weight gain in one day. Per the Mayo Clinic website, accessed on 4/09/15, a rapid weight gain can be a sign of fluid retention due to insufficient cardiac or renal function. However, Patient #11's low urine output, discrepancy between intake and output, and significant weight gain were not reported to the MD. Patient #11's nursing admission assessment documented her respiratory status was normal and her lung sounds were clear. A nurses note, dated 11/28/14 at 9:40 PM, stated lung sounds were diminished in all lobes. The note did not document the MD was notified of the change in her respiratory status. Patient #11's urine output was documented as 100 ccs on 11/29/14 at 6:30 AM, approximately 11.5 hours after the last measurement. This indicated a urine output of approximately 9 ccs per hour. Patient #11's fluid intake during the same period was documented as 960 ccs. Patient #11's blood pressure, documented on 11/29/14 at 6:30 AM, was 80/50. The National Institutes of Health website, accessed 4/08/15, stated a blood pressure less than 90/60 is abnormally low. Patient #11's record did not documented her low blood pressure, low urine output, and discrepancy between intake and output for a 3 day period were reported to the MD. Patient #11's record included a nurses note,	BB463		

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BB463	Continued From page 152 dated 11/29/14 at 12:20 PM. The note stated the MD was notified Patient #11 had less than 75 ccs of urine output for the shift. Orders were obtained to start intravenous fluids and obtain blood for a CMP, however, a nurses note stated the nurses were unable to insert the IV or draw the blood. A nurses note at 2:00 PM stated orders were received to transport Patient #11 to the ED at an acute care hospital. A nurses note at 3:10 PM stated Patient #11 was transported to the ED via the facility's van. A Social Services Progress Note, dated 11/30/14 at 9:00 AM, documented Patient #11 was in the acute care hospital's ICU due to renal insufficiency. She expired at the acute care hospital on 12/31/14. Patient #11's ED record at the acute care hospital documented she was unresponsive, had a temperature of 92.5, blood pressure of 68/45, 3 + pitting edema in her lower extremities, and oxygen saturation level of 84% on 4 liters of oxygen. The Mayo Clinic website, accessed on 4/13/15, stated: - Normal body temperature ranges between 97 and 99. - "Swelling of the foot, ankle and leg can be severe enough to leave an indentation, or 'pit,' when you press on the area. This swelling (edema) is the result of excess fluid in your tissues - often caused by congestive heart failure..." - "Normal pulse oximeter readings range from 95 to 100 percent, under most circumstances. Values under 90 percent are considered low."	BB463		

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BB463	Continued From page 153 Patient #11's laboratory results while in the ED included a BUN of 37 (normal value 7-25) and creatinine of 2.3 (normal value 0.6-1.0), indicating decreased kidney function. The ED physician's assessment stated "[Patient #11] is critically ill with encephalopathy, septic shock, acute on chronic respiratory failure, acute on chronic kidney disease, and multiple medical problems." The acute care hospital's death summary stated "The [Patient #11] was admitted on 11/29/14, with recurrent healthcare-associated pneumonia and aspiration pneumonias. After a lengthy hospital stay, with very little progression despite BiPAP and other modalities, the patient's status continued to decline. Family members were contacted, decision was made to place the patient on comfort care measures. On the evening of 12/31/2014, patient passed away from respiratory failure secondary to recurrent healthcare associated pneumonias." Patient #11's record did not document the MD was notified of her decreased urine output, rapid weight gain or low blood pressure. During an interview on 4/01/15 at 4:00 PM, RN C stated the P.T.s empty the catheter bags and document the urine output on their flow sheet. Additionally, the P.T.s were responsible for obtaining patient weights daily and vital signs, including blood pressure, every shift. She stated the RNs do not always review the flow sheets documenting intake/output, weights and vital signs. RN C reviewed Patient #11's record and stated the P.T.s should have reported her decreased urinary output to the RN on duty, so the MD could be notified. However, RN B stated she did not think the P.T.s had been instructed when to report	BB463	Education and training of all nurses on appropriate reporting protocol for significant patient changes. CNO to review nurse's flow sheets for completeness daily. HIM or designee to complete preliminary chart audit 24 hours after admission. This will be followed by a complete audit 48 and 72 hours after admission to ensure completeness of record. Policy effectiveness of the audit to be reviewed by GB via QAPI.	8/17/2015

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BB463	Continued From page 154 intake/output levels or discrepancies. She confirmed Patient #11 should have been weighed daily and her weight gain should have been reported to the RN. During an interview on 4/03/15 at 12:55 PM, the NP stated she was not notified of Patient #11's low urine output. She stated a urine output of less than 40 cc's per hour should be reported to the physician. During an interview on 4/02/15 at 4:15 PM, the MD stated he was not notified of Patient #11's weight gain, diminished lung sounds or low blood pressure. He stated he was not notified of her decreased urine output until 11/29/14 at 12:20 PM. Patient #11 was known to have a history of renal insufficiency and CHF. Her record documented adequate fluid intake, however her urine output, ranging from 8-11 cc's per hour, was well below the normal output of at least 30 cc's per hour. Her weight gain of 2.6 pounds in 24 hours was an additional indication of possible renal or congestive heart failure. Patient #11's record did not document an assessment of edema. The nurses did not promptly notify Patient #11's physician of her decreased urine output, rapid weight gain, diminished lung sounds or low blood pressure. Therefore, her symptoms were not addressed in a timely manner, and medical care at the acute care hospital was delayed. c. Patient #12 was an 87 year old male admitted to the facility on 12/26/14, for psychiatric treatment related to dementia and psychosis. Additional diagnoses included chronic constipation and UTI.	BB463		

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BB463	Continued From page 155 Patient #12's admission orders included a mechanical soft diet with "Nectar thick" liquids. His admission orders also included an order for a Speech Therapy evaluation, however, his record did not indicate an evaluation was performed. A nurses note, dated 12/29/14 at 8:07 AM, and signed by the RN, documented Patient #12 required assistance with meal and fluid intake. His diet was changed to pureed consistency until his Speech Therapy evaluation could be completed. She also noted Patient #12 had difficulty swallowing and had frequent coughing. On the nurses note later that day, at 12:05 PM, the RN documented Patient #12 had difficulty with swallowing and required small portions and nectar thick liquids. That evening at 7:45 PM, the RN documented Patient #12 was calling for help. He wanted water, so she assisted him with drinking a cup of water. She noted the Medication Nurse also gave him 8 ounces of fluids. The nurse did not indicate if Patient #12 was receiving thickened liquids. She documented Patient #12 coughed and sputtered after drinking. On 12/30/14 at 1:00 PM, the RN documented in the nurses notes that Patient #12 continued to choke on his food. At 7:00 PM, the RN documented Patient #12 had decreased oxygen saturation at 81%. The RN noted he was coughing and breathing shallow, his lips were bluish in color, and he was started on oxygen. She noted EMS was called and Patient #12 was transferred to an acute care hospital. Patient #12's record included documentation he	BB463		

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BB463	Continued From page 156 was admitted to the hospital with a diagnosis of aspiration pneumonia. Per the Mayo Clinic website, accessed on 4/16/15, "Aspiration pneumonia occurs when you inhale food, drink, vomit or saliva into your lungs." Patient #12's record noted he was placed on comfort measures and died 1/19/15. Patient #12's record included a form titled "ADL Sheets." The form included documentation by the P.T.s of such activities for each patient including oral hygiene, toileting, bowel and bladder elimination, skin care, and meal intake. Patient #12's form documented he had no bowel movements in the 5 days that he was at the facility. His medication record included orders for Dulcolax 5 mg BID, and indicated he received the medication throughout his stay. Additionally, Patient #12's MAR included PRN medications of Senna 1 tablet BID, (none were given), Milk of Magnesia 30 ml, BID, (for which he received 1 dose on 12/29/14), and Fleets enema, ordered for constipation/no BM for 3-4 days, (which was not administered). Patient #12's record did not indicate his physician was notified of his constipation. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #12's record and confirmed Speech Therapy was ordered, and was not able to find evidence an evaluation took place. She stated the ward clerk would call when an evaluation was ordered, but stated there was no method to follow up to ensure the speech therapist was notified. The RN stated she was not aware that Patient #12 was documented as having no bowel movement for 5 days. She	BB463		

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BB463	Continued From page 157 stated the nursing staff depended on the P.T.s to alert them when a patient had not had a BM. Patient #12's record included orders for a Speech Therapy evaluation, which was not performed. His record indicated on 12/29/14, on 3 separate occasions, he was having difficulty with swallowing fluids, his medications, and his food, and he was not treated for constipation. Patients #10, #11, and #12's records documented significant decline in their health status which was not identified, assessed or reported to the MD, which contributed to their deaths. During an interview on 4/01/15 at 2:00 PM, the MD stated the nurses in the facility are "psych" nurses, and he did not expect them to do "heavy medical nursing." He stated "If patients are sick we send them out." He stated if the hospital was expected to provide medical care, "They need to train the nurses." Due to the inability of the nursing staff to identify, address, and report significant health concerns, the facility would not be able to ensure the health and safety of the patients receiving services at the facility. This placed all patients in immediate jeopardy and at risk of suffering serious harm, impairment and death. The co-owner of the facility was notified of the immediate jeopardy verbally on 4/03/15, and in writing on 4/07/15. 2. A policy "Skin Assessment & Care," revised 9/09/12, stated "Skin assessments will be done upon admission, by an RN, to facility within the first (24) hours. After completion of the initial skin assessment the patient shall be monitored for	BB463	Due to the lack of administrative oversight, nursing did not identify, assess or report to the MD in accordance to hospital policy and procedures. Since time of survey a full time CNO has been hired to supervise the nursing care provided to patients. A full time Administrator has also been hired to oversee the management of the hospital. Policy and procedures have also been reviewed and revised with staff education to be completed by administration prior to providing patient care. CNO to review nurse's flow sheets for completeness daily. HIM or designee to complete preliminary chart audit 24 hours after admission. This will be followed by a complete audit 48 and 72 hours after admission to ensure completeness of record. Policy effectiveness of the audit to be reviewed by GB via QAPI.	8/17/2015

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BB463	Continued From page 158 skin issues weekly and as the need arises." Additionally, surgical wounds were to be monitored for signs or symptoms of infection. The policy was not implemented, as follows: a. Patient #5 was admitted to the hospital on 3/09/15 to 3/25/15. His H&P documented he had numerous abdominal surgeries over the previous 5 months, including post-operative complications. The H&P documented Patient #5 had a midline surgical incision which was being held with large retention sutures with rubber tubing around them that bridged over the incision. The physician documented in the H&P the sutures were to be removed in 2 days. Patient #5's record included a weekly skin integrity review sheet. The review sheet included 2 entries dated 3/09/15 and 3/23/15. On 3/09/15, the LPN documented Patient #5 had scabs with multiple open areas, redness at the incision site, and drainage. There were no measurements documented and no description of the drainage. On 3/23/15, the LPN documented Patient #5 had open area at the incision site with redness in color. There were no measurements documented. Patient #5's record did not include documentation that his skin was assessed by nursing during week 2 of his admission. A nursing note signed by the RN, dated 3/12/15 at 7:15 AM, documented she had spoken to Patient #5 about removing his sutures. Patient #5 stated to the RN he would only allow his surgeon to remove them.	BB463		

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BB463	Continued From page 159 There was no documentation the physician was notified. Additionally, there was no documentation in Patient #5's record whether the sutures were removed while he was at the facility. During an interview on 4/01/15 at 5:20 PM, the RN reviewed the record and confirmed wound assessments were required to be documented weekly. She confirmed Patient #5's wounds were not documented per policy and there were no measurements for Patient #5's post-operative wounds. Patient #5's wounds were not assessed and addressed by nursing staff in accordance with facility policy. b. Patient #8 was admitted to the facility on 3/06/15. His medical record from 3/06/15 to 3/24/15, as well as records from ED visits on 3/23/15 and 3/24/15 at an acute care facility, were reviewed. Patient #8's record included an admission skin assessment on 3/07/15. His record also included a form titled "Weekly Skin Integrity Review Sheet." The sheet did not include any further skin assessments after 3/07/15. Patient #8 was due to have a skin assessment each week, due 3/14/15 and 3/21/15. The weekly sheet in Patient #8's record included an entry dated 3/19/15, with the word "refused." The record did not indicate any further attempts were made to assess his skin. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #8's record and confirmed skin assessments were not performed weekly as per facility policy. The RN stated if a patient refuses	BB463		

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	IDKT4M		C 04/03/2015

NAME OF PROVIDER OR SUPPLIER: SAFE HAVEN HOSPITAL OF POCATELLO

STREET ADDRESS, CITY, STATE, ZIP CODE: 1200 HOSPITAL WAY, POCATELLO, ID 83201

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BB463	Continued From page 160 a skin check, the staff is supposed to then re-attempt, and a good opportunity is when the patient is showering. c. Patient #11's record included a skin assessment completed on 11/25/14, and signed by the RN. The assessment documented 2 blisters on her lower legs, measuring 6 cm by 2 cm, and 7 cm by 1 cm. The assessment documented dressings were applied to the blisters on Patient #11's lower legs. A nurses note, dated 11/28/14 at 4:45 PM, stated a blister on Patient #11's left lower leg ruptured and a dressing was applied. A nurses note, dated 11/28/14 at 9:40 PM, stated blisters on Patient #11's right lower leg "popped" and were cleaned and wrapped in gauze. However, Patient #11's record did not include orders or protocols related to wound care, to include frequency, or products to be used to cleanse and cover the blisters. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed there were no orders or care plan related to wound care to her lower leg blisters. The facility failed to ensure skin assessments were completed and identified needs were appropriately addressed. 3. The hospital's policy "Nursing Process - Vital Signs" effective 8/23/11, stated "A daily assessment of vital signs and weight is completed on every patient, unless there is a reason to complete the vitals signs and/or weights more frequently." Additionally it stated "The RN assesses the patients' vital signs and refers significant problems to the MD or mid level	BB463		

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BB463	Continued From page 161 provider for follow-up, evaluation, and treatment if needed." An additional hospital policy "Nursing Process - Weights protocol," effective 8/23/11, stated "All patients are weighed daily and the weights are documented in the patients chart." The policies were not implemented, as follows: a. A vital sign record form documented Patient #5 had a temperature of 100.9 at 2:00 PM on 3/12/15. There was no documentation the physician was notified. Additionally, there was no documentation by the RN this was reassessed or addressed. At 8:30 PM on 3/12/15, the RN documented Patient #5 had a temperature measurement of 106 and felt hot with pain. The RN documented medication was given for his high temperature and pain. There was no documentation the physician was notified. During an interview on 4/01/15 at 5:20 PM, the RN reviewed the record and confirmed the physician should have been called for the elevated temperatures. Patient #5's abnormal vital signs were not assessed and addressed by nursing staff in accordance with facility policy. b. Patient #16 was a patient in the hospital from 3/15/15 to 3/26/15, with diagnoses of psychotic disorder, dementia with behavioral disturbance and chronic depression. Patient #16's record was reviewed on 4/03/15. His record did not include documentation of his weight. During an interview on 4/03/15 at 11:00 AM, the	BB463		

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BB463	Continued From page 162 NP reviewed his record and confirmed his weight was not documented for the 4 days he was in the hospital. The NP stated patients were to be weighed daily. 5. Patients were not provided with appropriate diabetic care, as follows: a. Patient #1 was admitted to the facility on 3/26/15 to 3/31/15, from a local ED. His diagnoses included DM. Patient #1 was not taking his medications prior to his hospitalization. The NP documented he had stopped taking them because Patient #1 was hoping he would die. His H&P, dated 3/26/15 and signed by the MD, documented Patient #1's blood glucose level was 296 mg/dl upon admission. The American Diabetes Association website accessed 4/7/15, stated a normal (non-diabetic) blood glucose means levels between 70 and 130 mg/dl before meals, and less than 180 two hours after starting a meal. Patient #1's record included physician verbal orders, dated 3/16/15 at 9:15 AM, to check his blood glucose level before each meal and at bedtime. The verbal order included a standard sliding scale for Humalog insulin (a quick acting insulin). The American Diabetes Association website, accessed 4/07/15, defined a sliding scale as a set of instructions for adjusting insulin on the basis of blood glucose test results, meals, or activity levels. The standard sliding scale ordered for Patient #1 included instructions to phone the physician if the blood glucose levels were lower than 70 mg/dl or greater than 450 mg/dl. A blood glucose log was included in Patient #1's	BB463		

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BB463	Continued From page 163 record. The log documented blood glucose levels during Patient #1's admission. Patient #1's blood glucose levels were recorded as follows: - 3/27/15 at 9:00 PM: 540 mg/dl - 3/29/15 at 6:00 PM: 478 mg/dl -3/30/15 at 12:00 PM: 582 mg/dl - 3/30/15 at 6:45 PM: 515 mg/dl There was no documentation in the nursing notes the physician was notified of the documented blood glucose levels greater than 450 mg/dl, as ordered. During an interview on 4/01/15 at 5:40 PM, the RN reviewed the record and confirmed the blood glucose level log. She confirmed the physician was not notified for each blood glucose reading greater than 450 mg/dl. The RN stated she did not discuss Patient #1's continued elevated blood glucose levels with the physician. Further, Patient #1's record included a nutritional assessment dated 3/31/15, and signed by the dietary manager. The Dietary Manager documented Patient #1 needed a carbohydrate controlled diet. However, his hospital admission orders did not include a diet order and there were no other orders documented in the record for a special diet. A nursing note, dated 3/29/15 at 4:06 PM, documented Patient #1 was offended when staff asked about his diet and eating habits. There was no further documentation regarding education related to DM or nutrition.	BB463		

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BB463	Continued From page 164 During an interview on 4/03/15 at 1:40 PM, the NP reviewed the record and confirmed no special diet was ordered for Patient #1. She stated she did not read the recommendations from the RD or dietary manager in patient records. The NP stated if there were concerns, the RD or dietary manager would talk with her personally. The NP confirmed the conversations are not documented in patients' records. The NP stated she did not address or assess medical problems with patients. She stated this was the responsibility of the MD. During an interview on 4/01/15 at 5:40 PM, the RN reviewed the record and stated "I never even see the dietary assessment." She stated she discussed Patient #1's diet with him, but this was not documented in the record. b. Patient #11's Inpatient Psychiatric Evaluation documented a diagnosis of diabetes. Her admission orders, signed by the NP on 11/26/14, included a Hgb A1C laboratory test. Patient #11's record documented her blood was drawn for a Hgb A1C and sent to the lab on 11/26/14, however, her record did not include results of her Hgb A1C. Additionally, her record did not include evidence of random blood sugar readings. Therefore, her diabetes was not monitored during her hospitalization. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed it documented her blood was drawn and sent to the laboratory. She stated the results of the tests were available on-line through the laboratory's website, however, the results were not accessed, reviewed, or placed in Patient #11's record. She stated the unit clerk was responsible for obtaining	BB463	A Hospital Administrator, CNO, Pharmacist and new Nurses have been hired. Prior caregivers with inadequate performance will not be returning to the Hospital. New employees will complete the requisite orientation per HR Policy and Procedure. An orientation to the Hospital in addition, will be provided by the CNO prior to new nurses providing direct patient care and will include education about specific Hospital Policy and Procedures addressing emergency management, nursing assessment, and the culture of patient safety.	8/17/2015

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BB463	Continued From page 165 the on-line results, however, the RN was responsible to ensure the results were obtained and reviewed. Additionally, RN C confirmed Patient #11's record did not include a nursing care plan related to her DM, therefore nursing interventions were not developed to monitor her blood sugar levels. c. Patient #10's Inpatient Psychiatric Evaluation and H&P documented a diagnosis of diabetes. His admission orders, signed by the NP on 11/07/14, included a Hgb A1C laboratory test. Patient #10's record included an order for a Hgb A1C laboratory test, signed by the MD on 11/07/14. A telephone order from the MD, signed by the RN on 11/08/14, canceled the Hgb A1C, stating it was completed on 11/05/14, 2 days prior to admission. However, Patient #10's record did not include results of a Hgb A1C. Additionally, his record did not include evidence of random blood sugar readings. Therefore, his diabetes was not monitored during his hospitalization. During an interview on 4/01/15 at 4:30 PM, RN C reviewed Patient #10's record and confirmed it did not include results of a Hgb A1C. RN C confirmed a nursing care plan related to his DM was not created, therefore nursing interventions were not developed to monitor his blood sugar levels. During an interview on 4/03/15 at 1:15 PM, the NP reviewed Patient #10's record and confirmed the result of his Hgb A1C was not part of his record. Additionally, she confirmed his medical needs were not addressed during his hospitalization. d. Patient #17 was admitted to the facility on	BB463		

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BB463	Continued From page 166 3/27/15. Her diagnoses included Type II DM. A H&P, dated 3/28/15, documented as part of her admission evaluation an A1C would be obtained. However, an A1C was not ordered. Patient #17's record also documented she had DM and received an oral hypoglycemic medication twice daily, but a diabetic diet was not ordered on her admission orders. During an interview on 3/30/15 at 9:45 AM, RN C stated Patient #17 was on a regular diet. She reviewed Patient #17's record and confirmed the diet section of her admission orders remained blank. The RN stated an A1C was not ordered, therefore it had not been drawn. 6. Lab work and tests were not ordered and completed to meet the patients' medical needs, as follows: a. Patient #1's record included a Hospital Admission Order form dated 3/26/15, signed by the NP. Under the section Laboratory Tests the following tests were ordered: CMP, CBC, Free T4, TSH, RPR, UA, B12, and Folate. The H&P, dated 3/26/15, and signed by the medical physician documented Patient #1 would need a Hemoglobin A1C, ANA (antinuclear antibodies) panel, Rheumatoid Arthritis, and sedimentation rate. There were no orders documented for these laboratory tests. There was no documentation in Patient #1's record of the laboratory test results. A request was made on 3/30/15 at 3:20 for laboratory results. At 3:35 PM on 3/30/15, the laboratory test results were printed and given to the surveyor.	BB463		

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BB463	Continued From page 167 The laboratory results form included the results of the CMP, Hgb A1C, Rheumatoid Arthritis, ANA panel, and sedimentation rate. Patient #1's record did not include the results of the ordered CBC, Free T4, TSH, RPR, UA, B12, or Folate. During an interview on 3/30/15 at 4:05 PM, the NP reviewed Patient #1's record and confirmed the laboratory tests which she ordered on admission. She stated if the patient was transferred from a hospital or ED the results would be included with the transfer paperwork. The NP confirmed when laboratory results were ordered on the hospital admission sheet she expected the tests were done. She confirmed 7 of the ordered laboratory tests were not completed. During an interview on 4/01/15 at 1:55 PM, the MD confirmed that although his H&P included recommendation that the tests be done, he did not write the orders for the laboratory tests. Patient #1's laboratory tests were not completed as ordered. b. Patient #5's hospital admission orders dated 3/09/15, included orders for the following tests: CMP, CBC, Free T4, TSH, RPR, UA, B12, Folate, and PT/INR. Patient #5's record had laboratory results dated 3/14/15, for UA and PT/INR. There were no other laboratory results in the record. The dietary manager documented a request for Patient #5's weight and 2 laboratory tests, a CMP and BMP. The record did not include orders for the laboratory tests requested. During an interview on 4/01/15 at 5:20 PM, the	BB463		

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BB463	Continued From page 168 RN reviewed the record. She confirmed the laboratory tests were not done as ordered. The RN stated she was unaware of the request for the laboratory tests. During an interview on 4/03/15 at 1:35 PM, the NP reviewed the record and confirmed the laboratory tests were not done as ordered. Additionally, Patient #5's record documented he was receiving Coumadin, a blood thinner, for a pulmonary embolism (a blood clot in the lung). According to the Drugs.com website, a national medication reference accessed 4/10/15, Coumadin may increase bleeding which could be dangerous or life threatening. The website further stated bleeding times must be monitored with frequent blood tests. Physician orders included in Patient #5's record documented he had 3 blood tests ordered to check his bleeding times on 3/14/15, 3/17/15, and 3/24/15. These were ordered by the facility pharmacist. Patient #5's Coumadin dosage was increased on 3/14/15 and 3/17/15. Patient #5's record did not include a nursing care plan which addressed his anticoagulation therapy or possibly increased bleeding times. During an interview on 4/01/15 at 5:20 PM, the RN confirmed the bleeding times were tested as ordered by the pharmacist. She confirmed there was no nursing care plan related to changes in his anticoagulation therapy, laboratory testing, or history of blood clots in the lung. c. Patient #8's record included an order, written on 3/12/15 at 12:59 PM, for an EKG. His record did not include the results of the EKG, and the	BB463		

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BB463	Continued From page 169 MAR included an empty space beside the word "EKG" on 3/12/15. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #8's record and confirmed Patient #8's EKG was not performed. 7. Patients were not adequately assessed after incidents and unusual occurrences, as follows: a. Patient #7 was admitted to the facility on 3/23/15 to 4/01/15. He was sent to a local hospital on 3/24/15 for an x-ray, the day after his admission, after punching a wall with his right hand the previous day. The nurses note for the previous day, 3/23/15, did not include documentation of Patient #7 hitting a wall. On 3/25/15 at 3:45 PM, the nurses note documented Patient #7 refused to wear the splint prescribed for his right hand. On 3/31/15 at 7:00 PM, the nurse documented Patient #7 complained of a vibrating sensation in his arm, she did not specify which arm. There was no further musculoskeletal assessment documented. However, Patient #7's discharge orders dated 4/01/15 at 11:40 AM, documented he was to make an appointment with the orthopedic physician for follow up related to a boxer's fracture in his right hand. b. Patient #8 was admitted to the facility on 3/06/15. His medical record from 3/06/15 to 3/24/15 documented he was physically restrained on 9 occasions, and placed in seclusion 3 times during his admission at the facility. Comprehensive evaluations were not documented after the events to assess for injury. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #8's record and confirmed assessments were not documented after the	BB463		

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BB463	Continued From page 170 restraint and seclusion events. 8. Patients were not provided with appropriate bowel care, as follows: a. Patient #8's record included a form titled "ADL Sheets." The form included documentation of such activities for each patient including oral hygiene, toileting, bowel and bladder elimination, skin care, and meal intake. Patient #8's form documented he did not have a bowel movement from 3/06/15 to 3/14/15, a period of 8 days. Additionally, he did not have a bowel movement from 3/15/15 to 3/18/15, a period of 4 days. Patient #8's MAR included PRN orders for Milk of Magnesia 30 ml, BID, and Fleets enema, ordered for constipation/no BM for 3-4 days, The PRN medications were not administered. During an interview on 4/01/15 at 3:30 PM, RN C reviewed Patient #8's record confirmed the duration of 8 days and 4 days that he did not have documentation of a bowel movement. She stated the nursing staff depended on the P.T. staff to alert them when a patient has not had a BM. b. Patient #11's record Inpatient Psychiatric Evaluation documented a history of constipation. Her record included a nursing admission assessment, completed on 11/25/14, and signed by the RN. The assessment documented her last bowel movement as "couple days ago." Patient #11's record included a flow sheet on which staff documented information, including bowel movements. The flow sheet indicated Patient #11 did not have a bowel movement during her 5 day	BB463		

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BB463	Continued From page 171 hospitalization. Patient #11's admission orders, signed by the NP on 11/26/14, included Milk of Magnesia 30 ccs po every 12 hours as needed for constipation, and Fleets enema as needed for constipation after 3-4 days with no bowel movement. However, Patient #11 did not receive MOM or Fleets enema during her hospitalization. During an interview on 4/01/15 at 4:00 PM, RN C reviewed Patient #11's record and confirmed there was no documentation of a bowel movement during her hospitalization. The RN stated Patient #11's record did not include a nursing care plan related to constipation, therefore, no interventions were developed to monitor or report her lack of bowel movements to the MD. 9. Patients were not provided with appropriate care related to Hepatitis, as follows: a. Patient #15's Inpatient Psychiatric Evaluation completed by the NP on 3/15/15, and History and Physical completed by the MD on 3/15/15, documented diagnoses of Hepatitis B and C. Patient #15's record did not include a nursing care plan to address his needs related to Hepatitis. Additionally, there was no documentation of a plan to prevent the transmission of Hepatitis to other patients and/or clinical staff. During an interview on 4/01/15 at 4:45 PM, RN C reviewed Patient #15's record and confirmed it did not include a nursing care plan. Additionally, she confirmed Patient #15 was not placed on precautions to prevent the possible transmission	BB463		

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BB463	Continued From page 172 of Hepatitis B and C through his body fluids. b. Patient #1 was admitted to the facility on 3/26/15 to 3/31/15. His Admission H&P, completed on 3/26/15, and signed by the MD, documented diagnoses which included Hepatitis C. Patient #1's record did not include a nursing care plan to address his needs related to Hepatitis. Additionally, there was no documentation of a plan to prevent the transmission of Hepatitis to other patients and/or clinical staff. During an interview on 4/01/15 at 5:40 PM, the RN reviewed the record and confirmed she did not discuss or address his diagnosis of Hepatitis C. The facility failed to ensure patients' medical care needs were addressed. 10. During an interview on 4/01/15 at 9:35 AM, the Co-owner of the hospital stated the CNO resigned in January and they were currently looking for a replacement. She stated the Administrator was currently acting as CNO. However, upon arrival at the facility on 3/30/15 at approximately 1:15 PM, surveyors were greeted by an employee who introduced himself as the Administrator in Training for the attached SNF. He stated the Administrator of the hospital was out of town for the week. He stated he was the hospital's liaison for the surveyors. He stated he did not work for the hospital and did not know about much about the hospital. When interviewed later on 4/01/15 at 9:05 AM, the SNF AIT stated nobody was appointed as Acting Administrator for the hospital while the	BB463		

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	IDKT4M		C 04/03/2015

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BB463	Continued From page 173 Administrator was out of town that week. During an interview on 4/01/15 at 9:35 AM, the Co-owner of the hospital confirmed the Administrator was out of town for a week and no one was designated to oversee clinical services while she was out of town. The Administrator was interviewed by phone on 4/02/15 beginning at 2:15 PM. She stated she assumed the role of the Interim CNO in January 2015 when the former CNO resigned. She stated there was no documentation stating she was the Interim CNO. She stated an Acting CNO had not been appointed while she was out of town. During an interview on 4/01/15 beginning at 9:05 AM, RN C, the Charge Nurse, stated nobody was designated as Acting CNO while the Administrator was out of town. She stated she did not know who to call if there was a nursing problem. During an interview on 4/03/15 at 10:10 AM, RN E stated she thought the Administrator was also the CNO. She stated there was no formal announcement, but she assumed the Administrator took over the CNO role. She stated she did not know who the Acting Administrator was or who the Acting CNO was on the date of the interview (while the Administrator was out of town). During an interview on 4/02/15 at 5:00 PM, RN B stated her first day on the job was 3/23/15. She stated it was her understanding there was no CNO. When asked who she would call with a question or problem, she stated she did not know. The hospital failed to ensure nursing services were under the direction of a psychiatric nurse at	BB463		

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BB463	Continued From page 174 the time of the survey.	BB463		
BB527	16.03.14.530.02 Safety 02. Safety. The hospital shall have a safety committee and shall be responsible for at least the following: (10-14-88) a. There shall be comprehensive written safety procedures for all areas of the hospital which shall include the safe use of equipment and handling of patients; and (10-14-88) b. Safety orientation of new employees; and (10-14-88) c. Establishment of an incident/accident system for all patients, personnel and visitors, to include: (10-14-88) i. Reporting procedure; and (10-14-88) ii. Investigation of incidents; and (10-14-88) iii. Documentation of investigation and disposition. (10-14-88) This Rule is not met as evidenced by: Based on observation, record review, staff interview, review of staff and patient grievances, and review of policies, it was determined the hospital failed to ensure safe handling of patients and effective implementation of a system for reporting, investigating, and disposition of incidents and accidents. The hospital failed to 1) respond to patient and staff written allegations of abuse, 2) investigate serious patient injuries to determine the cause and implement corrective actions, 3) ensure sufficient numbers of trained	BB527	See also BB116, BB117 Action to Correct Deficiency: Policies outlining Incident Reporting, Admission Criteria, and Patient Rights were reviewed and revised with in-service scheduled for staff orientation. All new employees to be oriented to patient's rights with proper documentation to follow. On admission patients/legal representative will be educated by the admitting nurse/designee on their Patient Rights and will receive a printed copy. The Patient Rights has also been posted at the nurse's station along with a direct number to Safe Haven's CEO and COO to report immediate concerns. MANDT Training to be provided to all new employees and annually to existing employees. The use of restraints will follow Hospital protocol which include proper documentation, previous attempts at deescalation, orders for restraint if indicated, and notification to legal representative. Appropriate committees have been established to ensure concerns and patient safety are addressed in accordance to hospital Policy and Procedures. Any information gathered by these committees will be reported to QAPI coordinator. Following all adverse events, a Root-Cause Analysis will be presented to administration. Employees believed to be responsible for the abuse or neglect of Hospital patients will be immediately suspended from duty pending administrative investigation.	

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BB527	Continued From page 175 staff were available to safely care for patients with behavioral concerns, and 4) develop policies to direct staff on how respond if persons came to the hospital and requested emergency care. This resulted in 1 of 3 sample patients (#8) for whom restraints and/or seclusion were used, sustaining bilateral arm fractures and a shattered pelvis, 5 unidentified patients who submitted written grievances experiencing mental anguish and fear, 1 of 16 discharged patients (Patient #5) experiencing physical injury after discharge, early discharge of 1 of 16 discharged (Patient #13) due to insufficient staff, and endangered the health and safety of all patients receiving services at the facility. Findings include: A facility policy titled "Abuse and neglect policy/Inservice," included the following definitions: -Physical Abuse includes slapping, hitting, bruising, beating, or any other intentional act that causes someone physical pain, injury, or suffering. Physical abuse also includes excessive forms of restraints use to confine someone against their will. - Emotional Abuse is threatening, humiliating, or intimidation an individual and causing them emotional pain, distress or anguish. Emotional abuse can be verbal or non-verbal; it includes insults, yelling and threats of harm or isolation. - Neglect takes place when, intentionally or not, a caregiver fails to support the physical, emotional or social needs of the resident. Neglect can include denying food or medications, health services, or contact with friends and family. The policy also noted, "The first thing that occurs	BB527	How Action Improves Process: Staff will be educated on procedures to deescalate situations which will increase patient and staff safety. This will reduce the need for chemical and physical restraints. Procedure for Implementation: Staff will be oriented to hospital policy and procedures at time of hire and throughout employment as revisions to policies occur. All Staff will be MANDT certified by 90 days of employee start date. Employee will not be allowed to participate in any restraint/seclusion until certification is complete. If and when an adverse event occurs, a Root-Cause Analysis will be completed per policy and procedure, with appropriate actions to follow. Monitoring and Tracking: CNO or designee will ensure that policy and procedures are being followed by completing internal audits. Immediate action will be taken to address any concerns that may arise. Designated committee members of Quality Assurance Program will gather necessary documentation and review finding with Governing Board at quarterly meeting. Title of Person(s) Responsible: Administrator, CNO, HR, Staffing Developer, Staffing Coordinator, Infection Control Coordinator, QAPI Nurse	8/17/2015

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BB527	Continued From page 176 when a staff member is accused of abusing a resident is that the accused goes on immediate suspension. The administrator (or designee) will investigate the allegation of abuse. If the allegation of abuse is substantiated the appointed member of administration will call and report all of our findings to the Bureau of facility standards. If the suspected abuse case is determined to be abuse the staff member is then dismissed as an employee." The hospital failed to ensure to above policy was followed to protect the health and safety of patients, as evidenced by the following: 1. Patient #8 was a 65 year old male admitted to the facility on 3/06/15 for care related to dementia, psychosis, HTN, and PTSD. His medical record from 3/06/15 to 3/24/15 was reviewed, as well as, records from ED visits on 3/23/15 and 3/24/15, and admission at an acute care facility were reviewed. Patient #8 was not protected from harm as follows: a. During an interview on 4/03/15 beginning at 4:00 PM, P.T. H described an event that occurred when she requested assistance from a peer. She stated P.T. D did not like Patient #8. She stated when Patient #8 exhibited aggressive behavior, P.T. D was the first to jump in to restrain him. She described an incident that occurred on Sunday 3/22/15. She stated Patient #8 did not sleep for about a day and a half, and he was agitated. She stated Patient #8 grabbed her by the throat, she brought his hand down and then went to get the assistance from P.T. D. When he entered the room, Patient #8 tried to punch P.T. D, so he grabbed Patient #8 with his arms under Patient #8's armpits and pulled his arms up and outward. Patient #8 attempted to fight him off, and P.T. D held him again in that manner and	BB527		

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BB527	Continued From page 177 threw him face down on the bed, with his body on him to pin him down. Patient #8 was held down until after the RN gave him a shot. She stated she felt that P.T. D used excessive force, and reported the incident to the RN on duty. P.T. H stated she has submitted grievances about P.T. D's behavior, but felt no action has been taken by the facility. She also stated she had not received Mandt or any kind of restraint training since her hire at the facility. P.T. H stated Patient #8 slept most of the day on 3/22/15, and then when he got up, he was noted to be 'shuffling' around, dragging his legs, like he could not put pressure on his legs and not walking like he usually did. P.T. H demonstrated to the surveyors a slow shuffling movement, as well as, the hold maneuver P.T. D used on Patient #8. It was similar to a Full Nelson wrestling move. She said she had filed complaints against P.T. D at least once a week since January, 2015. P.T. H stated P.T. D leaves his 1:1 assignments unsupervised, he picks on patients to provoke behavior, and says things intentionally to make patients angry. Nurses notes documentation on 3/23/15 at 10:45 AM, noted Patient #8 was observed by facility staff to have a seizure. He was observed to yell, bring his hands upwards about shoulder height, and fall straight back, landing flat on the floor. His seizure lasted approximately 2-2.5 minutes. After the seizure was over, paramedics were called to take him to the ED of an acute care hospital for assessment. He was transported to the hospital by EMS, and was not accompanied by facility staff. An incident report was not initiated by the RN or the NP which described the seizure, or the	BB527		

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BB527	Continued From page 178 transfer to acute care hospital. At the acute care hospital Patient #8 was noted to be poetical, sleepy, and non-verbal. X-Rays of were taken of Patient #8's cervical, lumbar, and thoracic spine. Labs were drawn. He was determined to be stable to be discharged the same day to return to Safe Haven with a tech and the van driver. The staff [P.T. A] that arrived to pick up Patient #8, was interviewed. She stated that when she removed the pulse oximeter sensor from his finger, he winced in pain. She stated he was unable to stand up, and was transferred to the wheelchair with assistance from the van driver and the ED RN. A physical assessment by an RN was not completed when Patient #8 arrived back at the facility. Patient #8 was noted to be sleepy, was placed in bed, and remained there throughout the night. Staff documented that night "Pt appeared tired, He did not eat very much. Pt slept thru the night, talking in his sleep. Pt stated in loud voice 'NO, NO' when staff changed his clothes and took vitals." The P.T. assigned to Patient #8 on 3/24/15 day shift, documented "Pt resting/sleeping AM. Talking restless sleep. Appears [to be] having night terrors (?) talking in sleep saying 'Don't Push Me Down,' 'I hate cigarettes.' Pt stating he is in pain, mentions heart hurting - very lethargic. Ate some lunch, appears more alert. Complaining of cramp pain." On 3/24/15, at 8:40 AM, P.T. C noted Patient #8 was in bed and was not acting like he normally did and grimaced with movement of his right leg, and when she moved his left arm, he grimaced. The patient was administered Tylenol for pain at	BB527		

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BB527	Continued From page 179 10:30 AM. Patient #8 was sent back to the ED on 3/24/15, after a text order was received from the MD on 3/24/15 at 2:30 PM, stating "Send pt to the ER for x-rays of bilateral upper & lower extremities d/t [due to] decreased ROM & grimacing [with] movement." An admission H&P from the receiving hospital, dictated on 3/24/15 at 10:06 PM, noted: "...was brought to the ER in return today, because of significant altered mental status and inability to respond or speak, which he had been doing previously. Upon arrival in the ER, the patient was examined and family notably reported that the patient was repeatedly lifting his left leg and moaning in apparent pain." The H&P noted "Diffuse intermittent bruising across body, Bruising appears to be old and near staging with no large mass effect of bruising noted, but left arm bruise is quite large on the medial and superior aspect of upper arm." A consultation report, dictated 3/25/15 at 10:02 AM, noted: "...There is a question of seizure versus stroke. His initial workup was negative. He was then taken to the Emergency Department as noted above on [March 24th], where a chest, abdomen, and pelvis CT revealed a comminuted right acetabular fracture. The patient was also found to have rhabdomyolysis and lactic acidosis. He was admitted to the Intensive Care Unit for further monitoring. Orthopedics was consulted. Because of bruising on his upper arms, bilateral Humeri x-rays were performed today, on March 25th, demonstrating bilateral completely displaced two part proximal humerus fractures." At the hospital where Patient #8 was admitted, in	BB527		

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BB527	Continued From page 180 a progress note on 3/25/15 at 6:44 PM, an RN documented a meeting with Patient #8's family and the Orthopedic Surgeon that was held that afternoon at 12:00 PM: " Dr.[name] met with patient's wife and son. Dr. [name] reviewed injury findings. He explained the injury pattern was strange and not consistent. He explained the significance of the hip fracture. He discussed that the hip fracture is so complex that it will need to be repaired at [another hospital in another state]. He explained that without repair, the patient would need to heal as is. Once fracture is healed, he would anticipate that patient would not have any motion in his extremity and it would continue to be very painful. He would likely be bedridden the remainder of his life. He also reported to wife and son that patient had bilateral humerus fractures. These fractures appear to be in about the same spot that is not consistent with a fall. He explained that both humerus fractures would need repairing with pins and possibly ORIF [Open Reduction and Internal Fixation]. He has also noted some bruising on the right lower extremity and plans to take the patient to radiology for further radiology exams." An investigation of the restraint, seizure, and care leading to Patient #8's admission at the receiving hospital was not completed by the facility. b. Patient #8 was not protected from self harm while in seclusion and from the verbal and physical aggression of other patients. Examples include: * 3/14/15, In a narrative note attached to an Occurrence Report, written by a P.T., indicated Patient #8 was in the dining room. He was noted to have a verbal interchange with another patient,	BB527		

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BB527	Continued From page 181 both Patient #8 and the other patient started yelling and hitting each other. Patient #8 was noted to be restrained by a total of 4 staff. He was taken to his room by the 4 staff, and medicated by the RN. * On 3/16/15, an Emergency Treatment Override Order for Seclusion, dated 3/16/15 and signed by an NP at 9:30 PM, documented Patient #8 was placed in Seclusion for violent/self destructive behavior to himself and others. The NP documented he spoke with Patient #8 through the seclusion room door, and Patient #8 was noted to be highly agitated. He also documented Patient #8 had bloody knuckles related to hitting doors prior to being placed in seclusion. Patient #8 received Haldol 5 mg IM before being placed in seclusion. Nurses notes from 6:15 PM to 9:20 PM included the following documentation: "Pt behavior became more and more agitated. Staff attempt to deescalate. Pt told staff to 'get out' and then pushed staff into the wall. Pt exit seeking then came away from doors and charged staff with his fist doubled up and then punched staff in arm. After he hit staff he went by staff and punched fire door which caused knuckles to bleed. Pt attempted to strike this nurse and grabbed this nurse by wrists. Fellow nurse assisted in removal of pt hands from wrists and escorted pt to seclusion room. Pt resisted and staff continued to escort pt to seclusion. Order for seclusion obtained by provider and Zyprexa 10 mg IM which was unavailable. Provider then ordered Haldol 5 mg. Pt hitting the walls and window on seclusion door. " * A nurses note, dated 3/18/15 from 5:00 PM to 8:00 PM, described Patient #8's aggressive behavior. "Medication nurse attempted to give patient a PRN by mouth for agitation, this was	BB527		

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BB527	Continued From page 182	BB527		

ineffective, patient refused. While staff continued to attempt to get the patient to de-escalate, he was getting into the face of staff and patients. He was raising his fists at his 1:1 and this nurse. Patient began to shove and hit at this nurse and another staff. After more attempts at trying to de-escalate the patient, the patient was escorted into the seclusion room. Restraint protocol started. PRN medication given IM by RN. Patient banging his fists, feet and shoulders into the walls and door of the seclusion room. Attempts to get the patient to stop were unsuccessful. This continues for over 40 minutes."

The facility failed to ensure Patient #8 was protected from staff abuse, assault by other patients, and self harm.

2. The following staff and patient grievances and staff interviews include allegations of staff to patient abuse by P.T. D. The written staff and patient grievances did not include evidence of investigation, action, or resolution. They further demonstrate the facility was aware of, yet failed to act, to formal reports of P.T. D's abusive behavior:

Patient Grievances -

a. One grievance dated 12/15/14, the patient wrote "Nurse [name] and teck [P.T. D] co-insided one with the other to force me into an arguable instance that lead to an anxiety attack." The back section of the form to indicate the grievance was addressed, and resolved, remained blank.

b. A grievance dated 12/15/14, stated "[P.T. D] was near the TV. I walked in sat down on the reclyner (sic) and asked if I could watch TV. And

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BB527	Continued From page 183 he said 'We are not doin that crap and that's just how it is.' With attitude." The form included a question "How do you want the suggestion/grievance corrected?" The patient wrote "I want him to stop belittling the patients." The back section of the form to indicate the grievance was addressed, and resolved, remained blank. c. A grievance dated 12/15/14, a patient wrote "I was sitting eating my dinner and [patient name] started talking about his girlfriend. [P.T. D] pops off said something sexual about his girlfriend. That got [patient name] to get very upset & [patient name] said i'll (sic) kill you before you touch my girl. [P.T. D] popped off and said that will get you more time here & [patient name] exploded." The form included a question "How do you want the suggestion/grievance corrected?" The patient wrote "I want him to stop belittling the patients when no one is around. His attitude is horrible." The back section of the form to indicate the grievance was addressed, and resolved, remained blank. d. Another grievance dated 12/15/14, by a different patient, complained of P.T. D's disrespect to patients when asking about a smoke break. The form included a question "How do you want the suggestion/grievance corrected?" The patient wrote "He need to talke (sic) beter (sic) to clients and tret (sic) us beter (sic). We are people." The back section of the form to indicate the grievance was addressed, and resolved, remained blank. e. In a grievance dated 3/28/15, a patient wrote "[P.T. D] AM tech - My 2nd day here I complained that he just threw my belongings in my room. He was told not to talk or even look at me but he	BB527		

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BB527	Continued From page 184	BB527		

continued to do so. Today (Saturday) he starts making comments to me 1st thing when I woke up. I've been ignoring it and staying in my room most of the day. I've said thank you to him; have a good lunch, thanks when he lit my cigs, and staying in my room all day to avoid him. Now he's on the phone talking about me, saying I'm the one being an ass to someone. I'm so sad. Today I get to see my service puppy and should be happy. This was approved by [name of NP]. He walked by me while ago saying I can't see my dog. Also another staff let me keep muscle rub, dog treats for tonight & some trail mix. He tore my room up in a search but I was compliant. This harassment is not right. He even brings others ice but not me when I asked." The grievance did not include documentation of an investigation, actions taken, or resolution.

Staff Interviews and grievances -

a. P.T. E stated that he did not get along with P.T. D. He stated P.T. D was bossy to residents as well as, other P.T.'s. He stated P.T. D would tease residents, and intentionally push them to the point of eliciting negative behaviors. He described an incident when P.T. D had a 1:1 and while walking down the hall with the resident, tapped him on the far shoulder. The resident would look around as if looking to see who was tapping him. He stated the resident thought he was going crazy.

P.T. E described another incident in 2/2015 when a resident was acting out, and he demonstrated how P.T. D grabbed the resident around his arms from behind, and sat him on the floor forcibly.

P.T. E was questioned as to who was in charge of nursing at the hospital, and he stated he did

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BB527	Continued From page 185 not know. He said he knew who was the Administrator, but had never met the CNO, and did not know if the hospital had one. b. Submitted by P.T. E on 3/30/15: "My first Saturday working at Safe Haven, I watched P.T. D walk behind patients, tap them on shoulder and move to other side or kind of hide from them. I have also heard him tell a patient to "Shut up, you are annoying." P.T. D pawns off his 1:1's a lot more often than he should, going out to sneak off for smokes with the girls. Flirts a little with co-workers. This occurred on 2/07/15. P.T. D and I also on this day argued a little because he came up to me, pointed and told me I needed to catch up on Q 15's (every 15 minute patient checks) and to do it now. I asked him to please not delegate to me but to ask me to do something. That's when he walked away and said 'whatever.' Before working on this day I wanted to change schedule and work the weekends. After working I changed my mind and almost decided to just quit my job. He teases a lot of our patients and can be pretty inappropriate towards both patients and co-workers with the jokes and teasing." As of 5:00 PM on 4/03/15 no action had been by the facility to investigate the allegations and protect patients from potential abuse or mistreatment. c. Submitted by P.T. I, on 3/30/15: In the allegations P.T. I noted P.T. D engaged in inappropriate sexual behavior towards her, which made her feel intimidated and afraid to come to work. She further stated "...on March 21st I was with a patient 1:1 and I asked P.T. D to take a patient to the restroom and he took the patient and left her in the hall and left outside. P.T. D is verbally abusive to patients, saying things like 'If you don't respect me, I will take away all your	BB527		

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BB527	Continued From page 186 privileges from you." As of 5:00 PM on 4/03/15 no action had been by the facility to investigate the allegations and protect patients from potential abuse, neglect, or mistreatment. During an interview on 4/03/15 at 5:00 PM, the Co-Owner confirmed the grievances had not been addressed, and was not able to provide an explanation for the failure of the facility to investigate, take action, and resolve the grievances. The facility did not ensure patients were protected from abuse. 3. A policy "Staffing of Nursing Care, Acuity Based," effective 1/04, stated "To provide safe, effective nursing care designed to support improvements and innovations in nursing practice based on both the needs of the patients to be served and the mission statement. The plan supports both standards of nursing practice and nursing standards of care. The CNO of Safe Haven is responsible and accountable to ensure that consistent standards are utilized. This plan provides an overview of the unit, which includes staffing plans based on acuity data and core staffing date. Staffing is based upon patient census and acuity. Based on census and patient acuity, the needs of the unit are evaluated on a shift or partial shift basis by the Staffing Coordinator, in collaboration with the charge nurse, in order to provide optimal patient care that is fiscally sound." The following algorithm was included in the policy based on patient census: a. Day shift staffing requirements	BB527		

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BB527	Continued From page 187 -1 RN per shift -1 to 5 patients, 1 P.T. -6 to 8 patients, 1.5 P.T. -9 to 13 patients, 2 P.T.s -14 patients, 3 P.T.s -1 to 6 patients, 0 LPN -7 to 10 patients, 1 LPN -11-14 patients, 1.33 LPNs b. Night shift staffing requirements -1 RN per shift -1 to 8 patients, 1 P.T. -9 to 14 patients, 1.5 P.T.s -1 to 8 patients, 0 LPN -9 to 14 patients, 1 LPN The algorithm in the policy stated core staffing consisted of a minimum of 1 RN and 1 P.T. The policy stated, "Psych tech [psychiatric technicians] shifts- if the staffing ladder accounts for 1.5 aides, this means that one full 12 hour shift is approved and one 6 hour shift is approved. The hours may be divided amongst the scheduled Psych tech staff at the direction of the Charge RN as long as the hours stay within the approved total of 18 hours." Additionally, the policy stated "LPN shifts- if the	BB527		

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BB527	Continued From page 188 staffing ladder accounts for 1.33 LPN's, this means that one full 8 hour shift from 0700- 1500 [7:00 AM to 3:00 PM] is approved. At a census of 11 the LPN staff may then cover the remaining four hours of the 12 hour shift to 1900 [7:00PM]. The hours may not be allotted any other way." Assignment sheets were done for each 12 hour shift, day and night. The assignment sheet included sections for patient's names, level of monitoring, names of P.T.s working, and 2 hour time periods for the shift. The name of the RN in charge and the date were listed at the top of the form, it also differentiated whether it was the assignments for day or night shift. The bottom of the assignment sheet also included a section with an algorithm. The algorithm was used for staffing the facility with P.T.s depending on the census. The section for P.T.s was numbered 1 through 5, with their names written next to the numbers. The number, corresponding to the P.T., was written in the columns broken down into 2 hour time periods for the shift. The 2 hour time period columns corresponded to patient names. For example: P.T. 1 would be assigned from 6:00 AM to 8:00 AM with one patient, then from 8:00 AM to 10:00 AM P.T. 1 would be assigned to another patient. P.T.'s would not be assigned to 1 patient for the entire 12 hour shift. According to the assignment sheets reviewed they would rotate between the patients. The algorithm at the bottom of the assignment sheet was used for determining staffing of the facility. The algorithm for staffing P.T.s was based on census, rather than acuity. The algorithm was listed as follows: - Patient census 0, P.T. 0 hours	BB527		

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BB527	Continued From page 189 - Patient census 1, P.T. 8 hours - Patient census 2-5, P.T. 12 hours - Patient census 6-10, P.T. 16 hours - Patient census 11-12, P.T. 24 hours - Patient census 13-14, P.T. 26 hours The policy, assignment sheet, and algorithms did not include using aides from the adjoining SNF when additional staff was required for patient restraint. A maximum of 14 patients would be admitted at one time. If a patient was being monitored as a 1:1 (close monitoring of the patient was required and the assigned P.T. must be within arm's reach of the patient at all times), 1 tech would be assigned for monitoring the patient and was not included in the algorithm. A policy, "Suicide/Homicide Precautions Protocol," revised 10/12, stated a precaution level was assigned for the protection of patients requiring a safety intervention. The following precaution levels were identified and defined: -15 minute checks: Patient was observed every 15 minutes for safety -Line of sight (LOS): Keep patient in the line of sight at all times -1:1 monitoring: Observation with 1:1 contact at all times On 12/05/14 at 4:30 AM, an "Occurrence Report,"	BB527		

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BB527	Continued From page 190 completed by the RN on duty, documented a patient had an altercation with his roommate. The report included a nurses note documenting the patient was placed on "1:1/LOS." The policy did not include a definition for "1:1/LOS." During an interview on 4/01/15 at 4:55 PM, RN C confirmed an assignment sheet was to be filled out for each shift. She stated an LPN was scheduled for medications if the patient census was greater than 8, otherwise the LPN worked 7:00 AM to 11:00 AM and came back and worked 5:00 PM to 9:00 PM. RN C stated she coordinated the staffing of P.T.s. RN C stated P.T.s worked a 12 hour shift, but depending on the algorithm they may work 4 hours, 8 hours, or the full 12 hours. She explained when 16 hours were allotted based on census, 1 P.T. would work 12 hours and another P.T. would work for 4 hours. RN C stated staffing of P.T.s was not acuity or behaviorally based, but is based on the algorithm. During an interview on 4/02/15 at 5:05 PM, RN B confirmed the algorithm was what she used to schedule the P.T. hours. She further confirmed staffing for P.T.s was based on census and algorithm, it was not acuity or behaviorally based. Use of the staffing algorithm, without consideration of patient acuity was not sufficient to ensure patient needs were met, as follows: On 3/07/15 at 3:15 PM, a P.T. note attached to an "Occurrence Report," stated Patient #8 was aggressive toward another patient and P.T.s were able to remove him from the day room. The note also said the RN had called for all male staff on the attached SNF. Patient #8's record also included a nurses note, documented on 3/07/15	BB527		

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BB527	Continued From page 191 at 3:45 PM, which stated he was physically aggressive and was redirected to his room with the assist of family and staff. Patient #8's record did not include documentation of the actions which were necessary to "redirect" Patient #8 to his room. On 3/08/15 at 2:00 PM, an "Occurrence Report," completed by the RN on duty documented Patient #8 was aggressive to another patient and that P.T.s were unable to get him moved out of the day room. The RN documented she called for any male aide on the attached SNF to come to the psychiatric hospital. During an observation on 4/02/15 at 12:00 PM, 5 patients were currently in the facility. In the dayroom there were 2 patients and 2 P.T.s present. One patient was in her assigned room, and 1 patient was observed walking in the hall. Another P.T. was observed in the nursing station behind a locked door. No RN was observed on the unit. After approximately 5 minutes, the RN was observed entering the patient unit from the other side of the locked doors. An interview was conducted with P.T. E at 12:10 PM on 4/02/15. He stated there were 5 patients in the hospital and 3 of the patients were on 1:1 monitoring. P.T. E stated he did not feel staffing was adequate that day because only 3 P.T.s were scheduled to work. Three patients required 1:1 monitoring, therefore, the 2 remaining patients were not assigned a P.T. During an interview on 4/02/15 at 5:05 PM, RN B stated she was a concerned about safety at the facility. She stated staffing was based on census rather than acuity. Therefore, additional staff were not added when 1 or more patients	BB527		

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BB527	Continued From page 192 exhibited behaviors that required close observation and possible intervention, to prevent injury to themselves or others. Further, Patient #13's record documented he was a patient in the hospital from 1/01/15 to 1/05/15, with diagnoses of psychosis and depression. His record included a social service progress note, dated 1/05/15. The note stated "When SS discussed discharges with [NP] she reported that due to staffing [patient] was being discharged." During an interview on 4/03/15 at 2:45 PM, the SS Assistant who wrote the note stated she remembered the conversation with the NP. She stated during the Treatment Team meeting it was determined there was not enough staff to take care of the number of patients currently in the hospital, therefore someone had to be discharged. She stated Patient #13 was closest to his planned discharge date so he was the one to be discharged. The facility failed to ensure staffing levels were sufficient to ensure individual patient's needs, including safety, were met. 4. Refer to BB461 as it relates to failure of the hospital to develop policies to direct staff on how respond if persons came to the hospital and requested emergency care. 5. Refer to BB124 as it relates to failure of the hospital to effectively implement a hospital-wide QAPI program to ensure patients' health and safety were protected.	BB527		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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May 14, 2015

Scott Burpee, Owner
Safe Haven Hospital Of Pocatello
1200 Hospital Way
Pocatello, ID 83201

Provider #134011

Dear Mr. Burpee:

An unannounced on-site complaint investigation was conducted from March 30, 2015 to April 3, 2015 at Safe Haven Hospital Of Pocatello. The complaint allegation, findings, and conclusion are as follows:

Complaint #ID00006939

Allegation: A patient sustained multiple critical injuries of unknown origin while at the facility.

Findings: During the investigation, policy and procedures, incident and grievance reports, patient records were reviewed, and staff were interviewed.

The records of 17 patients were reviewed, which represented both open and closed records.

Incident reports, and grievance reports for facility staff and patients were reviewed. Multiple incident reports were noted that described employee to patient abuse that were not further investigated by the administrator.

A facility policy titled "Abuse and neglect policy/Inservice," included the following definitions:

-Physical Abuse includes slapping, hitting, bruising, beating, or any other intentional act that causes someone physical pain, injury, or suffering. Physical abuse also includes excessive forms of restraints use to confine someone against their will.

- Emotional Abuse is threatening, humiliating, or intimidation of an individual and causing them emotional pain, distress or anguish. Emotional abuse can be verbal or non-verbal; It includes insults, yelling and threats of harm or isolation.

- Neglect takes place when, intentionally or not, a caregiver fails to support the physical, emotional or social needs of the resident. Neglect can include denying food or medications, health services, or contact with friends and family.

The policy also noted, "The first thing that occurs when a staff member is accused of abusing a resident is that the accused goes on immediate suspension. The administrator (or designee) will investigate the allegation of abuse. If the allegation of abuse is substantiated the appointed member of administration will call and report all of our findings to the Bureau of facility standards. If the suspected abuse case is determined to be abuse the staff member is then dismissed as an employee."

The facility grievance and complaint logs was reviewed. They contained numerous patient and staff complaints that included allegations of abuse. There was no documentation the complaints and grievances were reviewed, acknowledged, or investigated by facility administration. No actions were taken to ensure patients were protected from further abuse.

One record documented a patient who was transferred to another hospital for treatment of bilateral upper arm fractures and a shattered pelvis.

During an interview with a staff member on 4/03/15 beginning at 4:00 PM, an event was described that occurred when she requested assistance from a peer. She stated when a specific patient exhibited aggressive behavior, a male staff member was the first to jump in to restrain him. She described an incident that occurred on Sunday 3/22/15. She said the patient was agitated and grabbed her by the throat, she was able to bring his hand down and then went to get assistance from the male staff member. When they re-entered the room, the patient tried to punch the male staff member, so he grabbed the patient with his arms under the patient's armpits and pulled his arms up and outward. She demonstrated the hold maneuver that was used on the patient. It was similar to a "Full Nelson" wrestling move. When the patient attempted to fight him off, the male staff held him again in that manner and threw him face down on the bed, with his body on him to pin him down. She reported the patient was held down until after the RN gave him a shot. She stated she felt that excessive force was used, and reported the incident to the RN on duty.

The staff further stated the patient slept most of that day, and when he got up, he was noted to be 'shuffling' around, dragging his legs like he could not put pressure on his legs, and not walking like he usually did.

In a nurses note, on 3/23/15 at 10:45 AM, an RN noted the patient was observed by facility staff to have a seizure. He was observed to yell, bring his hands upwards about shoulder height, and fall straight back, landing flat on the floor. His seizure lasted approximately 2-2.5 minutes. After the seizure was over, paramedics were called to take him to the ED of an acute care hospital for assessment. He was transported to the hospital by EMS, and was not accompanied by facility staff.

An incident report was not completed which described the seizure, or the transfer to an acute care hospital. At the acute care hospital the patient was noted to be postictal, sleepy, and non-verbal. X-Rays were taken of his cervical, lumbar, and thoracic spine. Labs were drawn. He was determined to be stable to be discharged the same day to return to Safe Haven Hospital.

A physical assessment was not completed when the patient arrived back at the facility.

That night, the staff documented: "Pt appeared tired, He did not eat very much. Pt slept thru the night, talking in his sleep. Pt stated in loud voice 'NO, NO' when staff changed his clothes and took vitals."

The day shift staff on 3/24/15, documented "Pt resting/sleeping AM. Talking restless sleep. Appears to be having night terrors (?) talking in sleep saying 'Don't Push Me Down,' 'I hate cigarettes.' Pt stating he is in pain, mentions heart hurting - very lethargic. Complaining of cramp pain."

An additional note documented the patient was in bed and was not acting like he normally did and grimaced with movement of his right leg. It was noted that when he moved his left arm, he grimaced. He was administered Tylenol for pain at 10:30 AM.

The patient was sent back to the ED on 3/24/15, and was admitted.

An admission H&P from the receiving hospital, dictated on 3/24/15 at 10:06 PM, noted: "...was brought to the ER in return today, because of significant altered mental status and inability to respond or speak, which he had been doing previously. Upon arrival in the ER, the patient was examined and family notably reported that the patient was repeatedly lifting his left leg and moaning in apparent pain." The H&P noted "Diffuse intermittent bruising across body, Bruising appears to be old and near staging with no large mass effect of bruising noted, but left arm bruise is quite large on the medial and superior aspect of upper arm."

A consultation report, dictated 3/25/15 at 10:02 AM, noted: "...There is a question of seizure versus stroke. His initial workup was negative. He was then taken to the Emergency Department as noted above on March 24th, where a chest, abdomen, and pelvis CT revealed a comminuted right acetabular fracture. The patient was also found to have rhabdomyolysis and lactic acidosis. He was admitted to the Intensive Care Unit for further monitoring. Orthopedics was consulted. Because of bruising on his upper arms, bilateral Humeri x-rays were performed today, on March 25th, demonstrating bilateral completely displaced two part proximal humerus fractures."

At the hospital where the patient was admitted, in a progress note on 3/25/15 at 6:44 PM, an RN documented a discussion the family of the patient had with the orthopedic surgeon who reviewed the injury findings. He explained the injury pattern was strange and not consistent. He discussed that the hip fracture was complex. He also reported that the patient had bilateral humerus fractures that appeared to be in about the same spot that was not consistent with a fall.

Additionally, the patient was not protected from harm, both from other patients, and from self harm during seclusion as follows:

In a narrative note attached to an Occurrence Report, written on 3/14/15, the patient was in the dining room. He was noted to have a verbal interchange with another patient, both he and the other patient started yelling and hitting each other. The patient was noted to be restrained by a total of 4 staff. He was taken to his room by the 4 staff, and medicated by the RN.

On 3/16/15 at 9:30 PM, the patient was placed in seclusion for violent/self destructive behavior to himself and others. The NP documented he spoke with the patient through the seclusion room door, and was noted to be highly agitated. He also documented the patient had bloody knuckles related to hitting doors prior to being placed in seclusion. The patient received an injection of Haldol before being placed in seclusion. Nurses notes included the following documentation: "Pt behavior became more and more agitated. Staff attempt to deescalate. Pt told staff to 'get out' and then pushed staff into the wall. Pt exit seeking then came away from doors and charged staff with his fist doubled up and then punched staff in arm. After he hit staff he went by staff and punched fire door which caused knuckles to bleed. Pt attempted to strike this nurse and grabbed this nurse by wrists. Fellow nurse assisted in removal of pt hands from wrists and escorted pt to seclusion room. Pt resisted and staff continued to escort pt to seclusion. Pt hitting the walls and window on seclusion door. "

On 3/18/15 from 5:00 PM to 8:00 PM, another incident described the patient's aggressive behavior. "Medication nurse attempted to give patient a PRN by mouth for agitation, this was ineffective, patient refused. While staff continued to attempt to get the patient to de-escalate, he was getting into the face of staff and patients. He was raising his fists at his 1:1 and this nurse. Patient began to shove and hit at this nurse and another staff. After more attempts at trying to de-escalate the patient, the patient was escorted into the seclusion room. Restraint protocol started. PRN medication given IM by RN. Patient banging his fists, feet and shoulders into the walls and door of the seclusion room. Attempts to get the patient to stop were unsuccessful. This continues for over 40 minutes."

The facility failed to ensure the patient was protected from staff abuse, assualt by other patients, and self harm.

During an interview on 4/03/15 at 5:00 PM, the Co-Owner confirmed the allegations of staff to patient abuse had not been addressed, and was not able to provide an explanation for the failure of the facility to investigate and take action to protect the patients.

The facility did not ensure patients were protected from abuse.

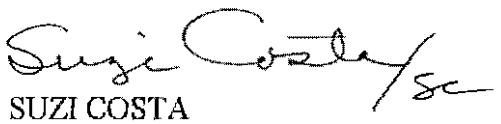
Therefore, the allegation was substantiated and federal deficiencies related to the allegation were cited. The federal deficiencies cited were 42 CFR 482.13 Patient's Rights related to the facility's failure to ensure patients were protected from abuse and neglect, sufficient numbers of trained staff were available to safely care for patients with behavioral concerns, restraints and seclusion were safely and appropriately implemented by trained staff, and staff were trained to meet patients' behavioral and health care needs. Related deficiencies were also cited at 42 CFR 482.12 Governing Body, 42 CFR 482.21 Quality Assessment and Performance Improvement, 42 CFR 482.22 Medical Staff, and 42 CFR 482.23 Nursing Services.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



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July 28, 2015

Scott Burpee, Administrator
Safe Haven Hospital Of Pocatello
1200 Hospital Way
Pocatello, ID 83201

Provider #134011

Dear Mr. Burpee:

An unannounced on-site complaint investigation was conducted from March 30, 2015 to April 3, 2015 at Safe Haven Hospital Of Pocatello. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006710

Allegation #1: Patient care plans were developed and implemented without the involvement and consent of patients and/or patient representatives.

Findings #1: Safe Haven Hospital of Pocatello was a hospital that provided services to patients with psychiatric diagnoses. Psychiatric care was provided by a Family Practice Nurse Practitioner (NP) with a supervising physician.

The NP and the Psychiatrist were interviewed. Both practitioners stated the Psychiatrist lived in Florida and teleconferenced with the NP 2 times a week. The Psychiatrist stated she normally did not see patients or communicate with them or with families. Both practitioners stated the NP was the only practitioner on site. The NP stated the hospital's census reached 14 at times and she also was working to establish an outpatient practice. She stated she worked very hard but it was difficult to provide care for all of the patients and communicate with everyone.

Interactions between the Nurse Practitioner and patients were routinely documented. Interactions between the Nurse Practitioner and families were not well documented.

At the time of the survey 17 patient records were reviewed. None of the 17 patients had treatment plans in place. This prevented patients and their representatives from participating in the care planning process. The records of 2 patients lacked signed informed consent for services and admission. The record of one patient noted medication changes were made without the consent and involvement of the patient and/or patient representative. One patient's record included documentation that the patient refused to take an increased dose of a medication because the increase was not discussed with him first.

One medical record documented a 79 year old female who was admitted from 9/24/14 to 10/03/14. Her diagnoses included psychosis and dementia. A social service note, dated 9/25/14, documented the patient's Durable Power of Attorneys were her son and daughter. There was no documentation to indicate the patient's son and/or daughter were involved in the development of her care plan.

The complaint was substantiated. Federal deficiencies were cited under the Code of Federal Regulations (CFR) at 42 CFR 482.(b)(1) and (b)(2) as they relate to the failure of the facility to ensure patients and/or their representatives participated in the care planning process and were allowed and encouraged to make informed decisions regarding treatment.

Conclusion #1: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: The hospital failed to sufficiently monitor and supervise patients to ensure their health and safety.

Findings #2:

Insufficient Staff - A hospital policy "Staffing of Nursing Care, Acuity Based," effective 1/04, outlined staffing guidelines for the hospital. The policy assigned numbers of staff based on the number of patients. The policy did not take the acuity of patients into account, for the number of patients who required 1 to 1 monitoring to prevent aggressive or self-injurious behaviors.

Nurses and Psychiatric Technicians were interviewed during the survey. They stated they did not feel staffing levels were sufficient to keep patients safe and to provide needed care. They stated staff from the adjacent skilled nursing facility had to be summoned at times to manage patients who exhibited aggressive behaviors.

One Psychiatric Technician stated at times they were not able to perform the 15 minute patient checks they were assigned because of staff shortages. In another interview with a Psychiatric Technician, he stated there were currently 5 patients in the hospital and 3 of the patients required 1 to 1 monitoring. The Psychiatric Technician stated he did not feel staffing was adequate because only 3 Technicians were on duty. As a result, a Psychiatric Technician was not assigned to the 2 remaining patients.

"Occurrence Reports" dated 3/07/15 and 3/08/15 stated staff needed to be summoned emergently from the skilled nursing facility to manage aggressive patients at the hospital.

Staffing levels were not adequate to monitor and supervise all patients.

Lack of Nursing Care Plans - During an interview on 4/03/15 at 10:15 AM, the Nurse Practitioner (NP) stated a nursing care plan should be part of an interdisciplinary treatment plan, however, the development of a nursing care plan was the responsibility of the Chief Nursing Officer (CNO), and as they did not currently have a CNO, it was not being done.

During an interview on 4/01/15 at 4:00 PM, an RN stated the CNO was in charge of creating nursing care plans. She said, "We don't have a [CNO] so it's not happening."

The records of 17 patients with admission date range of 9/24/14 to 3/31/15, were reviewed. The 17 patient records did not include nursing care plans to address patient needs. Goals were not identified, and interventions were not initiated to minimize the risk of complications related to psychiatric or medical diagnoses. For example:

One patient was a 79 year old female who was in the facility from 3/25/15 to 4/01/15, with diagnoses of psychosis, dementia, and chronic pain syndrome.

The patient's record did not include a nursing care plan. Her record did not include direction to staff to care for her psychosis, her memory, or her chronic pain.

An interview was conducted with the NP on 4/03/15 beginning at 3:50 PM. She confirmed the patient did not have a documented nursing care plan.

The facility did not ensure a nursing care plan was developed to address the patient's psychiatric and medical needs.

Lack of sufficient oversight by registered nurses (RNs) - The facility also failed to ensure the health status of patients' was effectively monitored and interventions initiated to prevent serious harm or death. The resulted in the death of 3 patients who were hospitalized at the facility.

Federal deficiencies were cited at 42 CFR 482.23(b) for the failure of the hospital to ensure sufficient numbers of staff, and at 42 CFR 482.23(b)(3) and (b)(4) for the failure of the hospital to ensure nursing care plans were developed and patients were sufficiently monitored and supervised to ensure their health and safety were protected.

During the investigation, it was determined the hospital failed to protect patients from harm. It was also determined the hospital's Governing Board and Medical Staff failed to provide oversight of patient care. As a result, the hospital's agreement with Medicare was terminated. The hospital has an Idaho hospital license, however, the hospital ceased operations shortly after the investigation and remains non-operational at this time.

Conclusion #2: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

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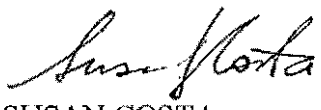

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