STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	054622	A. BUILDING _____ B. WING _____	09/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOCINO COUNTY MENTAL HEALTH	**1120 SOUTH DORA ST UKIAH, CA 95482**

(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
M 000	Initial Comments	M 000		

The following reflects the findings of the California Department of Public Health during a RECERTIFICATION of a Community Mental Health Center.

Representing the California Department of Public Health: 31594 and 32924, Health Facilities Evaluator Nurses (HFEN's).

The Partial Hospitalization Program census on the day of entry, 9/22/15, was 0

There were 10 sampled outpatient clients.

DEFINITIONS:

CFR = Code of Federal Regulations
PHP = Partial Hospitalization Program
CoP = Condition of Participation
CMHC = Community Mental Health Center, that must:
Provide day treatment or other partial hospitalization program (PHP) services, or psychosocial rehabilitation services;

A CMHC that does not provide PHP services does not meet the definition of a Medicare certified CMHC and will not meet the Condition of Participation at the time of survey.

42 CFR, Parts 410.2 states: A "Partial Hospitalization Program means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting."

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

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M 000	Continued From page 1 A PHP furnishes the services described in 42 CFR, Part 410.43 as services that: 1) Are reasonable and necessary for the diagnosis or active treatment of the individual's condition. 2) Are reasonably expected to improve or maintain the individual's condition and functional level, and to prevent relapse or hospitalization, and 3) Are furnished in accordance with a physician certification and plan of care as specified under 42 CFR, Part 424.24 (e)	M 000		
M 256	485.916(e) COORDINATION OF SERVICES The CMHC must develop and maintain a system of communication that assures the integration of services in accordance with its policies and procedures and, at a minimum, would do the following: This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the center failed to develop and maintain a system of communication that assures the integration of services, when documentation that communication between contracted adult mental health services and the client's outside healthcare providers, did not occur. This failure resulted in a lack of coordination of care between Client 10's contracted mental health plan coordinator and his outside primary care provider and/or lack of evidence of coordination between the contracted mental health plan coordinator and the outside healthcare provider that prescribed Client 10's psychiatric medications. Findings:	M 256		

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M 256	Continued From page 2 During an interview on 9/22/15, at 9:15 a.m., Director A stated that the center contracts with two administrative service organizations (ASO's) to provide mental health services under the mental health plan. Director A stated they are with two different organizations; one for youth ages up to 24 years and the other for adults 25 years and older. The center provides guiding principles for services, but the adult contracted services have their own policy and procedures. Director A stated the injection clinics are run by a contracted entity at their Ukiah and Ft Bragg sites. During an interview on 9/23/15, at 1:30 p.m., Management B stated that the ASO that runs the program for adults 25 years and older, manages their own contracted group of employees, and that Management C developed protocols around functions and areas of assessments. Management B continued to state that the contracted services shared clients, with one service providing their intake and Biopsychosocial assessment (BPSA) for the handoff (transfer). Management B stated the adult contracted managed services billing as follows; the daily records (progress notes) go to the executive director of adult managed services, next they are sent to the contracted services fiscal department, then they are sent to the county mental health fiscal department for the actual billing. During an interview on 9/23/15, at 2:35 p.m., Management B stated that the contracted services for adults has used IGBIRP (Introduction-Goals-Behavior-Interview-Respons e-Plan) format charting since 2013.	M 256		

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Management B continued to state that Initial assessments include; BPSA, Plan of care (POC), and an Adult Needs Strengths Assessment (ANSA) and treatment authorization request (TAR). Every six months the county requires an update of the POC and to submit a new TAR, then at 12 months a reassessment, POC and TAR are submitted. Management B also stated that Primary Care Physician's (PCP's) and mental health services divide care; the primary care physician ordering medication is responsible for the side effects, education, diagnostic laboratory testing and the monitoring of symptoms and effectiveness.

During a review of Client 10's outpatient clinical record on 9/23/15, at 6:15 p.m., indicated the open date of 8/28/13, and Mental Health Rehab Specialist (MHRS) G was assigned as Client 10's care manager. Client 10's BPSA, dated 11/19/14, indicated that he had been coming to adult services (wellness/drop-in center) since 2/2011. The psychiatric provider, listed as a Psychiatrist, was actually a Psychiatric Nurse Practitioner (NP) with Client 10's outpatient medical/mental health clinic. The reassessment indicated that Client 10 had admitted to relapse (drinking beer) recently. The treatment plan dated 11/19/14, contained two goals with two interventions each and was signed by Client 10. There was no discharge note found in the record.

During a review of Client 10's outpatient clinical record and concurrent interview on 9/23/15, at 6:35 p.m., Management B stated, "(it) appears (as though this Client's care) has fallen off (a) cliff," and acknowledged that the last progress note in Client 10's clinical record, dated 12/29/14,

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M 256	Continued From page 4	M 256		

included, "Plan: Writer will follow up with client on 1/13/15, for rehabilitation services and to follow up with his housing needs to maintain independent living."

During a subsequent clinical record review and concurrent interview on 9/23/15, at 6:40 p.m., Management C stated that Client 10's opening date was 8/28/13, and the closing date was 3/2/15. The clinical record document titled, "MANAGED CARE PLAN - CLOSING SUMMARY," dated 3/20/15, indicated under section C. "CONCLUSION, Executive Director received a call from Management C, Monday, March 2, 2015, as notifying the agency, contracted adult services, that our care managed client was discovered in his apartment having passed away." Management C subsequently located (on his laptop computer - not present in Client 10's clinical record) a progress note, dated 03/02/15, for Client 10 and printed a copy. During a review of Client 10's clinical progress note, dated 03/02/15, signed by MHRS G on 3/20/15, indicated under, "PLAN: Writer will close client's file and give the file to executive director at [named adult contracted service], to lock up." Management C stated that Client 10's, "Chart (was) sequestered separately once notified of death."

During clinical record review and concurrent interview on 9/24/15, at 8:15 a.m., Director A stated that, "case management cases are slower to close," and normally would expect 60 days, and if no follow up, then county policy was to close case. If there was a no-show, the manager would call the client.

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M 256	Continued From page 5 During an interview on 9/24/15, at 11 a.m., MHRS G stated that she was assigned as Client 10's care manager which included: Case management, rehabilitative sessions and linkage to other services. At 11:32 a.m., MHRS G stated that the 12/29/14, progress note was her first visit documented since she began Client 10's care management. When asked why there was no further documentation of visits since the note dated 12/29/14, MHRS G stated, "My mistake - I was seeing him briefly discussing follow-up when (he was) seen at the wellness center/drop-in (non-billable services) informally and did not document the visits." During a review of the contracted adult services wellness center/drop-in services dual diagnosis (mental health and alcohol or drug issues) sign-in sheets, dated 12/18/13 through 11/19/14, Client 10's name appeared on the following dates: 7/16/14, 9/10/14, 9/24/14, and on 10/15/14. During a subsequent interview with MHRS G, she acknowledged that Client 10's name did not appear on dual diagnosis sign-in sheets between 11/2013 and 7/9/14. During continued review of their dual diagnosis sign-in sheets indicated that Client 10 attended the following dual groups; 11/12/14, 11/19/14, 11/20/14, 11/21/14, 11/24/14, 11/25/14, 12/2/14, 12/3/14, 12/4/14, 12/5/14, 12/8/14 and 12/29/14. During review of their anger management sign-in sheets indicated that Client 10 attended the following groups; 9/8/14, 9/22/14, 11/24/14, 12/8/14, and 12/15/14, which was acknowledged by Management H. During a telephone interview on 9/24/15, at 12 p.m., Client 10's Psychiatric NP provider stated that there was little collaboration with the centers	M 256		

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M 256	Continued From page 6	M 256		

contracted adult services; that she was unaware of what services were available, that she knew there were no medical provisions and asked if there were any clinical providers on staff. The Psychiatric NP stated her last note indicated that Client 10 was attending the center's contracted adult services and AA meetings. She continued to state that there was not much communication in general with the centers contracted adult services, that she speaks with the contracted services and medical providers more often around medications.

During clinical record review and concurrent interview on 9/24/15, at 12:50 p.m., MHRS G stated that the progress note, dated 9/26/14, indicated that she drove Client 10 to his outpatient medical clinic appointment.

During continued clinical record review and concurrent interview on 9/24/15, at 12:55 p.m., Management B acknowledged that Client 10's name was not seen on any of the wellness/drop-in centers sign-in sheets between 12/29/14 and 3/2/15.

During an interview on 9/24/15, at 1 p.m., MHRS G stated that she provided care management, reviewed the plan goals, assisted Client 10 to problem solve, and taught skills according to the treatment plan. MHRS G stated that she normally called the client one day prior to a scheduled appointment and the day after the appointment, if they did not show. When asked why the clinical record did not indicate that for Client 10's 1/13/15 appointment; MHRS G replied that telephone calls were not billable.

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M 256	Continued From page 7 During a review of the outpatient clinical record for Client 10, the document titled, "Progress notes," dated 11/19/14, indicated under Intervention: "Writer met with client to gather information for clients and updated reassessment following client's recent psychotic episode." Under Response: "Client reported that his recent episode of not being well was related to having heard news about, 'the Islamic jihads taking over Iraq and other states,' that triggered bad memories from his time in the navy"... reported, "that he is back on medication (benedryl, lithium, resperidol), but he hasn't been prescribed mellaril, yet. He'd like to take mellaril because it was, 'good for sleep,' and reported that he had resumed smoking ('I smoke a lot.') and drinking occasionally ('I have a beer every once in a while. I don't think there's anything wrong with that.')" and stated, "I don't mind coming to [named adult contracted service] and the [named outpatient medical health provider]." ... "Client agreed to the objectives and signed his updated plan. Client meets criteria for specialty mental health services." During a review of the outpatient clinical record for Client 10, the facility document titled: "Adult services plan of care," dated 11/19/14, indicated under Goal 1: "I want to help people. I like to do volunteer work, I enjoy it," and under Barriers to achieving goal: "Lack of transportation. Medication side effects. My medication, sometimes I get a little spaced out sometimes it's hard to stay focused." Under Objective 1: "To increase socialization through helping others, client will work toward volunteering 2 days per week over 6 months from a baseline of 0 days per week." Under Intervention 1: "Care	M 256		

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management, individual and group rehabilitation, collateral, each intervention to address increasing socialization through helping others - the frequency, intensity and duration included 60 minutes 1 time per week for 6 months for each intervention." Under Objective 2: "To increase coping skills for symptoms of schizoaffective disorder and support client in maintaining increasing independence, client will problem solve ways to address challenges (e.g. lack of transportation, housing challenges, navigating medical care, medication side effects, maintaining sobriety, etc.) one time per month, increasing from 0 times per month." Under Intervention 2: "Care management, individual and group rehabilitation, collateral, each intervention to support client in maintaining independence" - the frequency, intensity and duration included, "60 minutes 1 time per week for 6 months for each intervention."

Under Goal 2: "I want to sleep more." Under strengths: "Client has stopped taking the medication that was interfering with his sleep. Client is receptive to support from care manager." Under Barriers: "Client is not currently engaged with his doctors." Under Objective 1: "Client will decrease difficulty sleeping as measured by increasing the number of nights per week that he sleeps 6-8 hours from 4 to 7 nights per week." Under Interventions 1: "Care management, individual and group rehabilitation, collateral, each intervention to decrease difficulty sleeping" - the frequency, intensity and duration included, "60 minutes 1 time per week for 6 months for each intervention."

During a subsequent interview, Management H

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M 256	Continued From page 9 stated there was no policy on the frequency of visits, and care management visits were driven by the care plan and acknowledged that under Goals 1 and 2 and Interventions 1 and 2, it indicated the frequency and intensity, and duration included 60 minutes 1 time per week for 6 months for each intervention.	M 256		
M 304	485.918 ORGANIZATION, GOVERNANCE, ADMIN. & PHP Condition of Participation: Organization, governance, administration of services, and partial hospitalization services. The CMHC must organize, manage, and administer its resources to provide CMHC services, including specialized services for children, elderly individuals, individuals with serious mental illness, and residents of its mental health services area who have been discharged from an inpatient mental health facility. This CONDITION is not met as evidenced by: Based on observations, staff interviews, clinical record reviews, and center document review, the center failed to organize, manage and administer its resources to provide Community Mental Health Center services as evidenced by the failure to: 1. Provide an outpatient Partial Hospitalization Program (PHP) service.(Cross Reference M313) 2. Maintain an accurate accounting of the center's active clientele. (Cross Reference M333) 3. Provide documentation of inspection of a fire extinguisher. (Cross Reference M346)	M 304		

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M 304	Continued From page 10 4. Practice effective infection control measures. (Cross Reference M348) The cumulative effect of these systemic problems resulted in the CMHC's clientele to not receive Partial Hospitalization Program services and the potential to be exposed to unsafe service areas.	M 304		
M 313	485.918(b)(1)(iii) PROVISION OF SERVICE Provides day treatment, partial hospitalization services, other than in an individual's home or in an inpatient or residential setting, or psychosocial rehabilitation services. This ELEMENT is not met as evidenced by: Based on observations, interviews, clinical record and center document reviews, the Community Mental Health Center (CMHC) failed to ensure the Standard for Partial Hospitalization Program (PHP), when an active day treatment, or other partial hospitalization services, or psychosocial rehabilitation services for ten of ten sampled outpatient clients, was not provided. This failure resulted in the CMHC's clientele to not receive any PHP services. Findings: During an observation on 9/22/15 at 9:01 a.m., the facility's address had changed. During an interview on 9/22/15 at 9:40 a.m., Director A stated that the county no longer provided PHP services. Director A stated that since 2013, the county stopped providing medicare services, and contracted out services to access and provider services.	M 313		

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M 313	Continued From page 11 A record review of ten sampled clients on 9/23/14 to 9/25/15, indicated that the facility had not provided the sampled clients with PHP services.	M 313		
M 333	485.918 (c) PROFESSIONAL MANAGEMENT RESPONSIBILITY A CMHC that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management and oversight of staff and services for all arranged services. As part of retaining financial management responsibility, the CMHC must retain all payment responsibility for services furnished under arrangement on its behalf. Arranged services must be supported by a written agreement which requires that all services be as follows: (1) Authorized by the CMHC. (2) Furnished in a safe and effective manner. (3) Delivered in accordance with established professional standards, the policies of the CMHC, and the client's active treatment plan. This STANDARD is not met as evidenced by: Based on observation, interview and record reviews, the center failed to maintain an accounting of its active clientele when: 1. There was a name (un-sampled Client 0) listed on two sections of the provided active client lists; 2. Un-sampled Client 3 was listed on the active client list and was not an actual client of Mental Health Services; 3. Sampled Client 10 was listed on the active client list; however he was found deceased on 3/2/2015; and 4. Drug testing kits were located in the	M 333		

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contracted adult mental health access/crisis services Med Room, which was not a substance use disorder (SUD) qualified or certified site to conduct such testing.

For all clients with contracted adult mental health services, under the County's contracted adult mental health services, this failed practice had the potential for inaccurate billing to occur when submitting documents to Mendocino County Mental Health Services.

Findings:

1, 2 & 3. During a record review of the center's active clientele in the outpatient service area, on 9/22/15, at 2:15 p.m., Un-sampled Client 0 was on two lists. During a subsequent interview, Director A acknowledged the name was present on both lists and stated that Client 0 must be at the, "[named city] Hospitality House," acknowledging that the name should not be on either of the two lists provided as their active clientele roster.

During facility document review and subsequent interview on 9/23/15, at 9:15 a.m., ten sampled clients were selected for the survey - five clients contracted with adult mental health services, and five clients contracted with the children's mental health services. Director A acknowledged that Client 3 was not actually open and active with the mental health department, and Client 3 was listed under the probation department.

During a record review of Client 10's (picked from the active client roster provided 9/22/15) outpatient clinical record and concurrent

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interview, on 9/23/15, at 6:35 p.m., Management B stated, "(it) appears (as though this Client's care) has fallen off (a) cliff," and acknowledged that the last progress note in Client 10's clinical record, dated 12/29/14, included, "Plan: Writer will follow up with client on 1/13/15, for rehabilitation services and to follow up with his housing needs to maintain independent living."

During a subsequent record review and concurrent interview on 9/23/15, at 6:40 p.m., Management C stated that Client 10's opening date was 8/28/13, and the closing date was 3/2/15. The clinical record document titled, "MANAGED CARE PLAN - CLOSING SUMMARY," dated 3/20/15, indicated under section C. "CONCLUSION. Executive Director received a call from Management C, Monday, March 2, 2015, as notifying the agency, contracted adult services, that our care managed client was discovered in his apartment having passed away." Management C subsequently located (on his laptop computer - not present in Client 10's clinical record) a progress note, dated 03/02/15, for Client 10 and printed a copy. Management C stated that Client 10's, "Chart (was) sequestered separately once notified of death."

During a review of Client 10's clinical progress note, dated 03/02/15, signed by MHRS G on 3/20/15, indicated under, "PLAN: Writer will close client's file and give the file to executive director at [named adult contracted service], to lock up."

During clinical record review and concurrent interview on 9/24/15, at 8:15 a.m., Director A

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stated that, "case management cases are slower to close," normally would expect 60 days, and if no follow-up, then County policy was to close case. If there was a no show, the manager would call the client.

4. During an observation and concurrent interview on 10/22/15, at 12:30 p.m., while touring the substance abuse treatment room and bathroom, Director I stated that the contracted organization for adult services did not store urine samples onsite, and explained that the injection clinics were held at the Ukiah and Ft. Bragg sites.

During an observation in the adult contracted mental health access/crisis Med Room, the upper unlocked cabinets of the Med Room contained a single (sealed in package) urine specimen cup. During a subsequent interview on 9/23/15, at 10:12 a.m., Management C stated that, "Urine sampling is not done here."

During continued observations in the Med Room and concurrent interview, on 9/23/15, at 10:30 a.m., located in an unlocked cabinet under the sink, was a full box of 25 unopened specimen containers [product name - drug test kits), that indicated on the opened box, "Clia waived." Management B stated that the facility has, "No Clia waiver and (that) no labs or draw station (onsite)," ... and that she was, "not sure about drug testing."

The County's substance use disorders treatment program policy and procedure titled "Drug Screening," revised 1/14, indicated under, "Policy ... to screen clients for drug use on a random basis ... as our working standard ... to attain and

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M 333	Continued From page 15 maintain abstinence ... shall be observed by a staff member of the client's same gender." Under, "Test Types and Materials," did not contain the product name listed that were stored in the contracted access/crisis Med Room. Under, "Guidelines: ... 5. A general logbook or file(s) should be maintained to record collected specimens. These will be kept in a locked, secured environment at all times when not in use." Under, "COLLECTION PROTOCOL: URINE COLLECTION Principle: The validity of urine drug screen results is dependent on the specimen integrity.....8. Documentation Protocol: All OP/TX (outpatient/treatment) clients have a UA (urine test) folder or logbook available in the UA cabinet... Folders are made at time of a primary counselor assignment."	M 333		
M 346	485.918 (e)(1) ENVIRONMENTAL CONDITION The CMHC must provide a safe, functional, sanitary, and comfortable environment for clients and staff that is conducive to the provision of services that are identified in paragraph (b) of this section. This ELEMENT is not met as evidenced by: Based on observation and interview, the center's contracted adult access's/crisis services location failed to provide documentation of fire extinguisher inspection by a local health and safety officer. This deficient practice had the potential for its fire extinguishers to not operate correctly, in the case of a small fire where an extinguisher could be used, and increase the potential for said fire to spread and encompass the entire building and possibly the office suites occupied by other companies.	M 346		

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M 346	Continued From page 16 Findings: During an observation and concurrent interview on 9/23/15, at 11:30 a.m., there were two fire extinguishers present, one on either end of the main hallway. The extinguishers were unlabeled A, B,or C, a tag was attached with illegible initials, dated 7/27 (no year). Management C stated that the Fire Marshall came to certify moving in to the building in July 2014. During an interview on 9/24/15, at 2:40 p.m., Management C stated that this location did not hold fire drills and added that he had discussed the need of forming a safety committee. Management C failed to provide documentary evidence of fire extinguisher monitoring, requested on 9/23/15 at 6 p.m. and 9/24/15 at 2:40 p.m.	M 346		
M 348	485.918(e)(3) INFECTION CONTROL There must be policies, procedures, and monitoring for the prevention, control, and investigation of infection and communicable diseases with the goal of avoiding sources and transmission of infection. This ELEMENT is not met as evidenced by: Based on observations, interviews and record reviews, the centers contracted adult access/crisis service location failed to practice effective infection control measures when: The supplied sharps containers located in the Med Room did not have the manufacturer's lid closure completely sealed, or at all, which nullified the safety feature of the manufacturer's	M 348		

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M 348	Continued From page 17 supplied lids. Additionally, the center's sharp's container had numerous medication tablets and capsules mixed in and were not disposed of timely, or kept in a manner according to the contracted adult mental health service provider's Policy and Procedure. This deficient practice had the potential for biohazardous waste to spill out in the medication room that would then contaminate surfaces, and the potential for staff exposure to used needles that could have been contaminated by blood-transmitted infectious disease. Findings: During an observation of the contracted adult mental health access/crisis service Med Room and concurrent interview on 9/23/15, at 9:55 a.m., located on the Med Room counter were two sharps containers; one container did not contain the manufacturer's lid over the opening and had several pills mixed in with the sharps, and the other container had the lid over the opening, however it was not completely sealed, both acknowledged by Management B who stated, "It needs a lid." The Med Room had three small piles of blank forms on the counter: 1. Order sheet from pharmacy for injectable decanoates (long-acting antipsychotic medication given by shot into a muscle); 2. Medication receipt log; and 3. Medication disposal log, which were acknowledged by Management B and C. When they were asked where the	M 348		

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completed logs were kept, they provided no answer.

During continued observations in the Med Room and concurrent interview, on 9/23/15, at 10:35 a.m., located in the unlocked cabinet under the sinks was a large Ziploc bag (dated 9/20/14) containing six labeled bottles of medications. When asked why these med's were in the cabinet, they were acknowledged by Management B who stated, "they need to be disposed of."

During a subsequent interview on 9/23/15 at 10:40 a.m., Management C stated, "I do not see (a) disposal log in (the client's chart)." At 10:44 a.m., stated, "Med's have never been given here."

During an observation on 9/24/15, at 2 p.m., the prior two larger sharps containers were no longer present in the Med Room, and one smaller sharps container was brought from the Med Room into the interview room, by Licensed Staff E, who stated that the center now had a new med waste box and sharps container.

During an interview on 9/24/15, at 2:30 p.m., Management B was asked who stocked the Med Room, and stated the nurse would order supplies, with direction from Medical Staff.

During an interview on 9/28/15, at 7:45 a.m., Licensed Staff F stated that the adult mental health access/crisis service never had a contract for handling or discarding the biohazardous waste and sharps containers while under their employ, and that she had to take six filled sharps

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M 348	Continued From page 19 containers, by private car, to the county waste disposal site because they were crowding the medication room. The adult mental health access/crisis service policy and procedure titled, "Biohazardous Waste and Disposal," dated November 2013, indicated under, "Procedure: Sharps containers are placed in the medication room for disposal of syringes after medication administration ... insert contaminated devices into the puncture resistant sharps container located in the medication room. When the sharps container is 3/4 full it is capped off pending biohazardous pick up and disposal. All biohazardous materials will be removed by an approved contractor with the proper license and certification for handling such materials."	M 348		